In The Matter Of:

Christopher S. Long v.
Cleveland Clinic Foundation

W. Stephen Minore, M.D.
January 28,2002

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IN THE COURT OF COMMON PLEAS
STATE OF OHIO
COUNTY OF CUYAHOGA

CHRISTOPHER S. LONG, Executor, etc., Plaintiff, vs. CLEVELAND CLINIC FOUNDATION, Defendant.) CASE NO. 419978

The deposition of W. Stephen Minore, M.D., taken by the defendant before Tracy L. Abbott, Certified Shorthand Reporter and Notary Public, at 2:00 p.m., January 28,2002, in the offices of Rockford Anesthesiology Associates, 2202 Harlem Road, Suite 200, Loves Park, Illinois.

APPEARANCES:

BECKER & MISHKIND CO., L.P.A.,
BY: MS. JEANNE M. TOSTI,
Skylight Office Tower
1660 West Second Street, Suite 660
Cleveland, Ohio 44113
(216) 241-2600
appeared on behalf of the Plaintiff;

ROETZEL & ANDRESS,
BY: MR. JOHN V. JACKSON
1375 East Ninth Street
One Cleveland Center, Tenth Floor
Cleveland, Ohio 44114
(216) 623-0150
appeared on behalf of the Defendant.

INDEX

WILLIAM S. MINORE, M.D.,
having been first duly sworn, was examined and testified as follows:

EXAMINATION

BY MR. JACKSON:

Q: Dr. Minore, you have been identified as an expert, and I understand you are going to render opinions in this matter. Am I correct in that understanding?

A: That is correct.

Q: I just looked at what I understand is at least a portion of your file. There was a three-ring binder with records from the Cleveland Clinic, correct?

A: That is correct.

Q: And there are some depositions?

A: That is correct.

Q: Is there anything else you reviewed as it relates to this matter?

A: I have not.

Q: Do you have any other file as it relates to this matter other than the records and the depositions?

A: I don't have anything that is present with me, no.

MS. TOSTI: I will —

Page 5

MR. JACKSON: Let me finish my question.
MS. TOSTI: Okay.

EXAMINATION

BY MR. JACKSON:

Q: My question was, do you have any other file?
A: I have no other files. I have some correspondence with regards to letters I have received from the attorney, but it's not with me.
Q: Where is it?
A: That's a good question.
Q: Did you have it here today?
A: I did not.
Q: She was about to say she removed some things from your fie.
MS. TOSTI: Well, let me speak for myself. I did remove our correspondence from the file as attorney work product.
MR. JACKSON: Where is it now, Doctor?
MS. TOSTI: I believe it's still in the doctor's office.
MR. JACKSON: Here?
MS. TOSTI: Yes.
THE WITNESS: Across the street. I don't have it with me personally.

Page 6

BY MR. JACKSON:

Q: When you say across the street, do you mean the attached building here?
A: The building next to us.
Q: Okay. What was removed?
A: What was my what?
Q: What was removed from your file?
A: The letters I had received from Cindy Ebner. It wasn't really removed. I have my files — just maybe this will be helpful. I keep my stuff that I review in one box; and then there's a letter, the correspondence letters that I have that I have received from the attorneys in another file. So nothing was removed from the file; but there are two, discrete, separate files.
Q: How do you coordinate the two files?
A: Well, one, the correspondence with the attorney can fit into a nice, little, thin file in my folder. This is usually kept off site or kept in the storage locker.
Q: What in addition to the correspondence from the attorney is kept in your other folder?
A: That's it.
Q: Well, how do you identify the folder? Is there a marker on it, a case number on it?

Page 7

A: Well, there's a name on it.
Q: What would be the name on this file?
A: Long versus Cleveland Clinic.
Q: And I assume that you reviewed these materials in preparation for the depo —
A: I did.
Q: — what you have in front of you?
A: That is correct.
Q: And you reviewed your correspondence file?
A: I did not review my correspondence file in the sense that — other than the letters that were in there.
Q: Well, I am having trouble understanding that. Other than the letters that are in there, is there anything else in your correspondence fie?
A: No: no. My correspondence file I keep so that I know who sent me the case.
Q: I understand. My question to you was, did you review that? Your answer was I reviewed it other than — nothing other than the correspondence, so that led me to believe there might be something else in there.
A: There's nothing else in there.
Q: You did review that for the deposition?
A: The correspondence file?

Page 8

Q: Uh-huh; yes.
A: There's nothing in there. It's other than a letter asking me to review the case.
Q: There's one letter?
A: One or two.
Q: What do those letters contain, what type of information?
A: Well, I guess I'd have to go pull them; but all they were was would I serve as an expert, and this was a case that was presented.
Q: And how was the case summarized for you?
A: Well, the case wasn't summarized. As I said, there was — you know, I don't really have recall of that. It wasn't something I really reviewed just prior before coming in here.
Q: Do you think it has any significance at all to the facts in the case or your opinions in the case?
A: My opinions are my opinions.
Q: I understand. My question is, do you think the correspondence has any significance as it relates to the facts in the case or your opinions in the case?
A: Well, it has significance to the case in as much as I was asked to be the expert on the case. As far as — there's nothing in there that isn't stated in

Page 9

my letter to the attorneys.
Q: Okay. So in addition from the correspondence that they sent to you, there are facts and opinions that you wrote back to them; is that what I understand you just to say?
A: That's not what I just said.
Q: Okay. Then let me clarify it. When they sent you this letter asking you to review it, did they list a factual summary of the case?
A: I would have to go back and review it. I don't recall that.
Q: Do you recall if they listed opinions that other people have rendered in this case?
A: I don't believe that there were. I don't recall those.
Q: Did it list any opinions that they were asking you to render in this case?
A: They asked me to review the case.
Q: Was that all? Let's do this to save guessing time. I mean, we're 50 feet from — I mean, these buildings are attached, aren't they?
A: I go outside.
Q: Would you go take a look at those? I'd like you to go and take a look at those correspondence and

Page 10

then let me ask you some questions about them. They're not going to let me see them apparently. So I am going to have to ask it this way. So let's take a minute. Please go look at it.
MS. TOSTI: No, the doctor isn't going to go look at his correspondence. We removed the correspondence from the file as attorney work product. You can ask the doctor whatever you want about them. You can ask him if he's relied on them for his opinions.
MR. JACKSON: I want to know what's in them, Jeanne; and if you're not going to let me see them —
MS. TOSTI: Well, then we can fight about that later.
MR. JACKSON: We will. Doctor —
MS. TOSTI: Basically we have removed it as attorney work product. If you want to take his deposition, take his deposition and ask him questions; but, you know, that's a whole different issue.
MR. JACKSON: Doctor, I want to break for a minute. I want you to go look at that correspondence so that you can tell me generally what's in it. Please do that, and then we will reconvene.
MS. TOSTI: Doctor, let's — I am going to go look at the correspondence and see if we'll produce

Page 11

those to Mr. Jackson so that we can get on with the deposition.
THE WITNESS: Okay.
(A brief recess was taken.)
MS. TOSTI: He has all of the correspondence. You can have it.

EXAMINATION

BY MR. JACKSON:

Q: Is this everything that you received from them, Doctor?
A: That is correct.
Q: Is there anything you sent them that —
A: There is not.
Q: — that we don't have in front of us here or your reports here?
A: There is not.
Q: Okay. It appears that you were first contacted sometime before August 23rd of 2000, that's the first letter?
A: It would be — that would be correct.
Q: Do you remember how you were contacted?
A: By phone.
Q: By whom?
A: Cindy Ebner.

Page 12

Q: And what were you asked to do?
A: Review a case.
Q: What were you told about the case?
A: That it was a cardiac surgical case, cardiac anesthesia case, and would I review it.
Q: And apparently with that record or that letter of August 23rd, 2000?
A: That is correct.
Q: August 23, 2000?
A: That is correct, 23 August 2000.
Q: They sent you the medical records?
A: That is what I would assume.
Q: Would that be the three-ring binder then, that's what you received first?
A: That would be correct.
Q: Was there any particular thing you were asked to do other than review the records?
A: They asked me to review the records and then discuss the case with them.
Q: With what particular specialty or point of interest in mind?
A: From an ICU anesthesia standpoint.
Q: And then apparently on February 14th of 2001, I will hand you this in a minute to confirm it, they sent

Page 13

to you the reports of Denise Hrobat — excuse me, the depositions of Denise Hrobat, Katherine Zilka and Angelique Young; is that correct?

A: That is correct.

Q: And you made some writings on that one. Tell me what you wrote on there.

A: I believe I circled one of the individual's names and wrote space cadet.

Q: What do you mean by that?

A: That I wasn't sure that that patient — or that that nurse had a good handle on what she was doing.

Q: What was — I mean, was space cadet an insult to her; is that what you were trying to do?

A: Oh, it wasn't pejorative. It was just not in keeping with the care that I would expect in a patient.

Q: 'What does the term mean to you, Doctor? What does space cadet mean?

A: What? I think it's self-evident.

Q: I am asking you to explain it for me.

A: I think that that individual based on my interpretation of the records and her deposition didn't have a clue of what was going on with the patient.

Q: What are the other numbers that are written on there? What do those signify?

Page 14

A: The amount of time I spent on it, and then the bill that was sent.

Q: How much time did you spend on it?

A: Four hours.

Q: And you billed them how much?

A: $1,650.

Q: There was some of that writing on that first sheet also, and I didn't ask you about it.

A: That is correct.

Q: Tell me what that is on the first one, on the August letter.

A: There was a 9/5 call to Ebner and —

Q: 9/5 would have been the date?

A: That is correct. And Michael Becker.

Q: You spoke with Mr. Becker and Ms. Ebner?

A: I placed a call to them. It looks like I just talked to Ms. Ebner.

Q: For how long, and what did you charge?

A: Well, it doesn't say there. There's some numbers on there, but —

Q: What do those mean?

A: I am not sure.

Q: 'What are the numbers that are there?

A There's one that says 3,950.

Page 15

Q: That has no meaning to you?

A: Well, that may have been the total bill to date or for the total review of the records to date.

Q: November 28th they sent you a letter regarding when your deposition was to be taken, correct?

A: That is correct.

Q: And then on January 22nd they sent you a Federal Express package apparently containing the deposition transcripts of Dr. Hernandez, Dr. Hearn and Dr. Koch, K-o-c-h, is that correct?

A: That is correct.

Q: Did you — do I assume then that you reviewed those depositions that were listed in those two letters at a point in time after you received them with those letters of transmittal?

A: That would be fair to assume.

Q: Did you review any other depositions?

A: Just the ones that I have before me.

Q: When did you get those?

A: I believe that they would have come with time. I don't really have the exact dates.

Q: In what areas of medicine do you consider yourself an expert, Doctor?

A: I practice anesthesiology.

Page 16

Q: In what areas do you consider yourself to be an expert?

A: I consider myself an expert in anesthesiology.

Q: Any particular areas of anesthesiology?

A: I do cardiac anesthesia, pain management and critical care.

Q: Would you consider yourself to be an expert then in cardiac anesthesia?

A: Yes, I would.

Q: Do you consider yourself to be an expert in pain management anesthesia?

A: Yes, I would.

Q: Or pain management in general, would that be a better way to say it?

A: That would be fine.

Q: Do you consider yourself to be an expert in critical care?

A: Yes.

Q: Are you married?

A: Yes, I am.

Q: Any children?

A: Two.

Q: How old are they?

A: 14 and 13.

Page 17

Q: Explain for me, if you would, what your normal workweek is like. What's your current practice?

A: Get up about 4:00 o'clock in the morning, lift weights from 5:00 to 6:00 three days a week, make rounds at the hospital starting at 6:45 usually. If I am in the OR that day, I will get to the hospital at 6:00 and start my first case by 7:00, usually work until 8:00 or 9:00 at night, have dinner at one of the local restaurants and get home by about 11:00.

Q: And that schedule is your schedule how many days a week?

A: Pretty much every day.

Q: Seven days?

A: No, Monday through Friday. Sometimes I get done a little bit earlier around 6:00 or 7:00. Weekends it can be feast or famine. It can be starting at 7:00 a.m. on a Saturday and finish at 7:00 a.m. on Monday or variable in between.

Q: What is the nature of your practice?

A: I run my group. It's a group of physicians. My practice is three-and-a-half to four days a week I am clinical, one to one-and-a-half days I am nonclinical. I confine myself to pain management and cardiac anesthesia, high-risk cases, high-risk vascular cases,

Page 18

high-risk aneurysms. I am the director of our cardiac anesthesia group, and I am responsible for teaching the other partners and our CRNAs the nuances of cardiac anesthesia.

Q: Where do you spend your time as an anesthesiologist in terms of rendering patient care?

A: Well, I am on staff at Saint Anthony's hospital, SwedishAmerican Hospital. It's all contained in my CV. It would probably be easier that way.

Q: All right.

A: Occasionally go to the Surgery Center. I am on staff at several hospitals, but Saint Anthony's and Swede's are the two hospitals that we do our hearts at. We do approximately 1,000 pumps a year. And one of our cardiac surgeons is one of the pioneers of off-pump bypass, and we have physicians come in from all over the country to learn how to do it.

Q: Show me where your hospital affiliations are.

MS. TOSTI: Here's one here if you want to give him back his, and you can talk back and forth if that makes it easier.

EXAMINATION

BY MR. JACKSON:

Q: What page on your CV?

Page 19

A: I apologize. It looks like they dropped it off. The word processor deleted it. Again SwedishAmerican Hospital, Saint Anthony's hospital, Freeport Memorial Hospital, Northwest Suburban Community Hospital, the Rockford Ambulatory Surgical Treatment Center, and Medical Pain Management Services. The *two* where the hearts are done are Saint Anthony's Medical Center and SwedishAmerican Hospital.

Q: How much of your time do you spend at SwedishAmerican?

A: About 20 percent.

Q: That's 20 percent of the week that you described for me just a little bit ago?

A: That is correct.

Q: How much of your time do you spend at Saint Anthony's?

A: About 50 to 60 percent.

Q: Again these percentages are based on that week that you described for me?

A: That's correct.

Q: How about Freeport?

A: Very rarely. It's a smaller hospital. They don't do the kind of cases that I am involved in. Same thing with the Surgery Center, same thing with Northwest

Page 20

Suburban. And Medical Pain is where I see my pain patients.

Q: So you are rarely at Northwest Suburban?

A: That is correct.

Q: And you are rarely at the Surgical Treatment Center?

A: That is correct.

Q: How about the Pain Management Center?

A: There about 20 percent, *25* percent, maybe *30*.

Q: Where is SwedishAmerican located?

A: On State Street — or Charles Street, *14* —

Q: You don't have to be that specific. I am looking for a city.

A: They're within three miles of one another. It's approximately a —

Q: In Rockford?

A: Yes.

Q: How big a hospital is SwedishAmerican?

A: About *430* beds. Saint Anthony's is about *350*.

Q: And what types of cardiac surgery do they do at SwedishAmerican?

A: The same thing they do at Saint Anthony's. We do everything except for heart transplants. We limit ourselves — we don't do very many kids anymore.

Page 21

Q: Everything but heart transplants, and you don't do children now?
A: We do VSDs or ASDs if they're straightforward, but we haven't done TETs in a while or those types of cases.
Q: Where do you send the VSDs, ASDs?
A: It depends. Either to Chicago, Children's or Christ Hospital, depending on where Dr. Ilbawi operates.
Q: Who are the cardiac surgeons with whom you work doing the cardiac surgery?
A: Drs. Chang, Harper, Stieglitz.
Q: Spell Stieglitz for me, please.
A: S-t-i-e-g-l-i-t-z. And Dr. —
Q: Are they at SwedishAmerican?
A Well, they're ail one group, so it doesn't really matter.
Q: They go to both hospitals?
A: That is correct. And there's one other one. Chang — I always call him by his first name, so I never think of his last name.
Q: What's his first name?
A: John. Actually I call him something else, but we're good friends.
Q: Something you'd rather not put on the record?

Page 22

I won't press you on that one, Doctor.
A: We've got to stop. I have got to think of this name now.
Q: When it comes to you, let me know. Are there any other anesthesia groups?
A: We are the sole provider of anesthesia for these two hospitals.
Q: What type of postoperative unit does SwedishAmerican have?
A: Well, they have a regular ICU.
Q: Excuse me; for cardiac patients.
A: They have two ICUs that they can go to, the CCU or the ICU. They're adjacent to one another. Each one is a 12-bed unit.
Q: And what makes the determination as to whether a patient goes to CCU or ICU at SwedishAmerican, a cardiac patient?
A: It depends on which unit either has the least patients or the most open beds.
Q: So it's a matter of availability as opposed to —
A: That is correct.
Q: What's the setup at Saint Anthony's for postoperative patients?

Page 23

A: They have a large, 30-bed unit; and the fresh postops go in one end and come out the other end. So they kind of migrate down.
Q: Are these cardiac patients we're talking about?
A: Primarily cardiac, but all types of ICU patients; but primarily fresh open hearts in this unit. It's on the second floor,
Q: Okay. Do they do minimally invasive cardiac surgery at either SwedishAmerican or Saint Anthony's?
A: Yes, Dr. Chang does.
Q: Do you know the types of minimally invasive cardiac surgery he does?
A: Well, he does the off-pump procedure. He does the revascularization procedures.
Q: When you say revascularization, you're talking about bypasses?
A: That is correct.
Q: How about valves, does he do valves?
A: I have not personally done a minimally invasive valve with him, but he has done them. Although, quite honestly, minimally invasive if you go trans-sternal isn't so minimally invasive.
Q: In your opinion?
A: Based on the amount of chest pain patients have

Page 24

postoperatively.
Q: Is it — I am talking about the minimally invasive that would be designated by, for example, Dr. Chang as a minimally invasive procedure; is that what you have outlined for me?
A: That is correct.
Q: He does off-pumps, revascularizations?
A: Yes, sir.
Q: He does some valves?
A: He does lots of valves.
Q: But you haven't worked with him on them?
A: Not on the minimally invasive valve.
Q: Who does his anesthesia for minimally invasive patients — valve patients?
A: We have a rotation in the cardiac anesthesia group, so it depends on who is assigned that day.
Q: Is there anyone particular that Dr. Chang selects as his anesthesiologist when he has a minimally invasive valve?
A: One of the people in the group. Pretty much all of us that do cardiac anesthesia do all the cases in there, and it's just how it comes up. I tend to do the higher-risk patients or the higher-profile cases.
Q: Is there an anesthesiologist in your group or

Page 25

more than one anesthesiologists who Dr. Chang prefers to have with him when he is doing minimally invasive valve surgery?

A: He does not.

Q: Is Dr. Chang the only surgeon in that group that does the minimally invasive surgeries?

A: I believe Dr. Harper does some and Dr. Polidori does some.

Q: Is that your friend, Polidori?

A: No. Well, I know who he is. He is brand-new.

Q: Chang, Harper, Stieglitz, your friend and Dr. Polidori, that's a fourth or fifth in the group?

A: That is correct.

Q: Can spell that?

A: P-o-l-i-d-o-r-i.

Q: Harper does some minimally invasive?

A: Yes, he does.

Q: When you say some, is that a big part of his practice?

A: No. Collectively they do — between the four of them they do 1,000 pumps a year, and they tailor the operation to the patient. I would say the majority of our pumps are off-pump now.

Q: When you use the term "they do a pump," what do you mean?

Page 26

A: Cardiopulmonary bypass machine.

Q: Do you know what frequency — or with what frequency Dr. Chang does the minimally invasive surgeries?

A: It's coded the same way as a regular procedure, so there really is no way to tell.

Q: Is the anesthesia different from your point of view for minimally invasive cardiac surgery rather than sternotomy, open sternotomy cardiac surgery?

A: Well, obviously there's a little bit more concern for the ventilation in how you perfuse. You have a little bit less exposure in certain things, but it's still cardiac anesthetic.

Q: Have you ever received training for minimally invasive cardiac surgery anesthesia?

A: I have not.

Q: Is there any special training that would apply to that?

A: Well, if you're at a fellowship program when I did a fellowship — obviously this wasn't around — but by going to meetings and conversations since we were one of the initial proponents of off-pump surgery, Dr. Chang was, obviously we have kept the dialogs up. It's not considerably different than you would for a non-pump case or a full-pump case with a median sternotomy. There are some other implications, but they're more surgical implications than anesthetic implications.

Page 27

Q: Is there anyone in your group that does more of these than the rest of you?

A: I don't think so.

Q: Is this same group, Dr. Chang and his associates or partners, who do the cardiac surgeries at both Swedish American and Saint Anthony's?

A: They are the only group that does them.

Q: With what frequency do you do cardiac surgery —

A: I never do cardiac surgery.

Q: You didn't let me finish. Cardiac surgery anesthesia?

A: The direct case where I am sitting in the room, I'd have to pull my billing records. I am in the room three days a week consulting with my partners. I do the transesophageal echos for them. Many of them do not have the ability to do that. So I am there at the beginning of the case, help them start the case, and we use two physicians on a case. So I am there for probably — well, I am there three days a week. So whatever the number of cases is. Some days you do no cases; other days you can do five.

Page 28

Q: Do I understand you to tell me that as it relates to cardiac surgery, your particular expertise is to do the TEEs?

A: And help supervise the case with the CRNAs. We have CRNAs that assist us. And so when you say do the case, the CRNAs name may be on the case, but you're the staff, just like they have it at Cleveland Clinic.

Q: Let me understand. You were talking about being in the room and direct — and about consulting with your partners, and maybe I'm confused. So let me try to clear this up. You do OR work three days a week, is that a correct understanding?

A: Up to three days a week.

Q: Sometimes less, sometimes three?

A: That's correct.

Q: On these three days a week, your duties in the operating room are what? I would like to limit it to cardiac surgery right now when we're talking about cardiac surgery.

A: The only cases that I do in the OR with the exception of one or two requests for other types of cases are cardiac cases.

Page 29

Q: Okay.
A: And when I am in there, some weeks I can do 10 or 15 cases. Other weeks I might do one or two. It's purely on the busyness. If one of the heart surgeons is on vacation or more importantly if one of the cardiologist or two of the cardiologists are gone, it can be a very slow week. The week that the cardiologists come back, we're there every night until midnight.
Q: What actually is your role as an anesthesiologist in these surgeries then?
A: Well, you are responsible for putting the patient asleep, anesthetizing them, putting them on bypass, taking them off bypass, running the inotropes, typical anesthesia role and, in addition to, being responsible for the transesophageal or supervising the CRNAs if they're doing the case with you.
Q: Maybe I misunderstood you before, but I had the impression that you do the TEEs for your partners?
A: Well, I also do the TEEs for my partners. So you can be in one room supervising a CRNA and have to go to the other room if they're doing two cases simultaneously and do the echo for them.
Q: How many rooms do you normally work at a time?

Page 30

A: Two.
Q: Simultaneously two?
A: Well, work in two, but not solely responsible for two.
Q: Okay.
A: I can't do that.
Q: How many are you solely responsible for?
A: One.
Q: One at a time?
A: That is correct.
Q: But you supervise two rooms?
A: Well, you assist in two rooms.
Q: Okay. I don't want to get caught up in words. Define solely responsible versus assist.
A: If you are supervising a CRNA, you are solely responsible for the room. If you assist, you may be supervising another room, but you may be going in there to do the transesophageal echo.
Q: Do I understand you to say that in your hospitals here, there's always an anesthesiologist present in the room?
A: There's always an anesthesia care provider present in the room.
Q: Are the cases sometimes run by the CRNA after the intubation and induction?

Page 31

A: We're just talking cardiac cases? The cases are run by the physician. The CRNA would be there to assist.
Q: Is the physician — when you say the physician, we're talking about the anesthesiologist, correct?
A: That is correct.
Q: Is there an anesthesiologist present in the room at all times in your cardiac cases?
A: No. When you are on bypass, you may be in the little boys room or — you're in the operating room theater itself. You may not be inside the four walls of the room, but you may be in the room next door.
Q: Is there always some anesthesia person there, either the anesthesiologist —
A: Absolutely,
Q: — or the CRNA?
A: Absolutely.
Q: Are there occasions where you are responsible for two operations at the same time in which there's a CRNA actually physically present in the room?
A: That is correct.
Q: Does that happen in your cardiac cases, also?
A: Once in a while.

Page 32

Q: What do you mean once in a while?
A: Well, they will be in there solely if you are on bypass and nothing is going on from an anesthetic standpoint.
Q: How many cases per day would you say on average you do that are cardiac cases?
A: Well, as I stated, you can do five cardiac cases in a day or you can do one cardiac case.
Q: What's your maximum?
A: I think the most we have ever done in one day was six.
Q: No, you. I want to know how many you have done in a day.
A: The most I have been involved with in one day was several years ago we did six.
Q: How long ago was that?
A: More than ten years ago.
Q: What's the normal average now for you?
A: Three, two to three.
Q: Once the — in your practice at Saint Anthony's and Swedish American, once the patient leaves the operating room, what do you do? What's your responsibility as an anesthesiologist?
A: Depends on the case. And we're still talking

Page 33

cardiac cases. If you and the surgeon decide that we're going to try to do a fast wean on this patient instead of the typical wean, we will run the ventilator, manage the fluids and inotropes until the patient is extubated or manage them concurrently. There's a lot of overlap with the surgeons. A lot of it depends on who the surgeon is and who the anesthesiologist is, the amount of interplay that occurs.

Q: Okay. Let's talk about your experience with Dr. Chang because — is he the one that you do the most cardiac cases?

A: He is one of the ones.

Q: Who do you personally work mostly with?

A: Dr. Chang would be the one that would be the most.

Q: That you work with?

A: That is correct.

Q: What is your experience with Dr. Chang? Let's say a cardiac case finishes. What do you do, and what is your responsibility with that patient?

A: You will — if you're going to do a fast wean, you will be responsible for weaning the patient off the ventilator.

Q: Where is the patient now?

Page 34

A: In the ICU.

Q: Okay.

A: Then the nurses will call you with the vent parameters, and then you will titrate the analgesics and effect the quick extubation; or there's a protocol that you sign that we have come up with, and nurses do that. And they call you with the extubation parameters, vital capacity, the NIF, negative inspiratory force; and then you can make the decision to extubate them. It's done a lot by protocol. If there's questions, nurses here function like residents in an academic center.

Q: So you're responsible for the respiratory status of the patient in the ICU?

A: That is correct.

Q: Are you also responsible for the pain management of the patient in the ICU?

A. That is correct.

Q: And who takes care of the rest of the management of the patient in the ICU? Again we're talking about cardiac cases; you understand that, right?

A: It varies sometimes between surgeon and surgeon and patient to patient. Oftentimes the cardiologists are involved if the patient — they have had the patient for four or five days in the ICU, and obviously they would know them better than anyone else. Sometimes it's the pulmonologist if you believe the major problem the patient is going to have is their pulmonary status. And many times it's just Dr. Chang going through the protocol.

Page 35

Q: Is there an anesthesiologist, critical care specialist assigned to the ICUs in which you work at SwedishAmerican and Saint Anthony's?

A: Currently there is not.

Q: How current is that? I mean, was that the case for some period of time?

A: For a long period of time we ran the —

Q: We meaning?

A: The anesthesiologists, ran all the critical care for the postop hearts. And, quite honestly, with the shortages of anesthesiologists now, we have delegated some of that responsibility either back to the surgeon or some of the other specialists since we are needed in the operating room more.

Q: When did that change?

A: Couple years ago.

Q: Couple meaning?

A: Probably 1998.

Q: So from '98 until the present, there is no anesthesiologist assigned specifically to the ICUs at either SwedishAmerican or Saint Anthony's?

Page 36

A: That is correct. We are available 24/7 for consultation, and we are involved in several patients' care; but before it was a mandatory anesthesia consult. We no longer do that.

Q: And what would be your practice as it relates to once a patient goes to the ICU, a cardiac patient, and you have — you hear from the nurses regarding this patient's condition and once the patient is weaned, do you ever go back and see or reassume care of the patient?

A: We go back and write a post-operative note the next day, but we do not have an ongoing clinical obligation to the patient.

Q: Okay. Is it often the case that you don't even go back and see these patients again after you have had the — after you have left them in the ICU? The patient is taken care of by the nurses; and barring some unusual respiratory problem, you would have no need to go back?

A: Well, you would go back, again, to do your postop note. You have to do a postoperative note.

Q: Okay. Understood.

A: But having done that, if everything went well,

Page 37

you would not be involved.
Q: In the actual care of the patient in the ICU?
A: After you have signed off, that is correct.
Q: Do you have any of your partners who are actually certified in critical care medicine?
A: A bunch of us are critical care eligible through the American Board of Anesthesiology as intensivists. We have stopped keeping up the accreditation because I told you like about four years ago we stopped doing it on a regular basis.
Q: Are you critically care certified?
A: I am certified critical care eligible by the American Board of Anesthesiology.
Q: That means you could become board certified in critical care, but you are not?
A: Well, I have special qualifications in critical care. Up until recently for anesthesia, there was not a board certification for that.
Q: Up until recently. How recently?
A: 1995 or '96 they had that.
Q: Did you take that test?
A: I did not. I took it for pain management.
Q: So that I am clear, you are not board certified in critical care medicine?

Page 38

A: That is correct.
Q: And you have never attempted to become board certified in critical care medicine?
A: Yes. The scope of anesthesiology encompasses that.
Q: I understand that, but they have a special board certification.
A: Now they do, yes.
Q: And have since '95, did you say?
A: '95, '93, in that range.
Q: Are you an intensivist? I mean, you're board certified as an intensivist? Is there such a board certification?
A: The pulmonologists have a board certification, but it's through the American Board of Internal Medicine. We do not qualify for that.
Q: You used that term before, and that's why I asked you. As an anesthesiologist, you wouldn't be termed an intensivist; is that right?
A: If we were assigned to the unit, and there was four of us that used to do all of the unit work, we were — we had credentials as intensivists.
Q: Was there a time when you were assigned to one of the intensive care units, you personally, at either

Page 39

one of these hospitals where you work for cardiac surgery?
A: No. It was — we had a pulmonologist there, and I was at another hospital prior to this in town here that we no longer serve.
Q: Where they did cardiac?
A: Where they did cardiac, and then I was the person assigned there.
Q: Assigned there?
A: To the ICU.
Q: To the ICU?
A: That is correct.
Q: So you were the anesthesiologist/critical care specialist at that hospital?
A: That is correct.
Q: What hospital was that?
A: Rockford Memorial.
Q: And when did that stop, your association?
A: 1996 — 1995.
Q: Why did it stop?
A: Contractual. They wished us to become employees. We did not wish to become employees.
Q: Who does their anesthesia?
A: They have hired people from the outside. It's

Page 40

a vertically integrated system.
Q: And did I understand you to say before to me that at Swedish American and Saint Anthony's where your group works with the heart surgeons, you are the only anesthesia group?
A: That is correct.
Q: That's contractually with the hospital?
A: That is correct.
Q: You are with Rockford Anesthesia Associates?
A: Yes, I am.
Q: You are the president, is that correct?
A: Yes, I am.
Q: How long have you been the president?
A: Since I believe it was March of 1995.
Q: What are your responsibilities as president of your group?
A: I am responsible for the business end of the group, and I am also responsible — I run all the risk management seminars and new technology seminars. I have been the one that's brought the new technology to the group as far as cardiac anesthesia, different ways of doing cardiac anesthetics, transesophageal echo. I was the first person in Rockford to do transesophageal echo among all physicians including the cardiologists. And I

Page 41

introduce the newer concepts of cardiac anesthesia, the fast wean off of bypass, waking the patient up on the table after a short bypass run.

We have a very, very talented cardiac surgeon, and some of the things that we can do here are not possible elsewhere because his pump runs are so short.

Q: This is Dr. Chang?

A: That is correct. So that we can be fairly aggressive. And we have patients that have their bypass surgery in the morning, are extubated; and if they have to be, they can be moved out of the ICU that night to an intermediate bed.

Q: You also said earlier that you were the head of the cardiac anesthesia group for your partnership here?

A: That is correct.

Q: How many different groups are there?

A: There's really just two, the cardiac group and then the pain group.

Q: And you are the head of the cardiac group?

A: Yes.

Q: Someone else has the pain group?

A: I also have the pain group.

Q: So you are the head of both groups?

A: That is correct.

Page 42

Q: You said there are two groups. So tell me, how does that work?

A: They're not two groups. We are the same group, but there are people that like doing hearts and are proficient doing hearts. Not all the partners do hearts. So we haven't done it for six months or so; but we'll have dinner somewhere, bring out a bunch of papers, bring out a couple of the cardiac surgeons. And we will discuss either a new technique and say look at the results and how we can modify our practice.

We have a very low rebleed rate, and I think that's because of our surgeons and also the fact that our patients are warmer, and they don't get cold. So we look at the outcomes, data, and we make comments on it and see what we can do to improve our quality of care.

And then some of us will go to a meeting and come back and decide — you know, half the stuff you hear at meetings is good: other stuff is garbage. The problem is trying to find out which half is which.

Q: So you are the president of your association?

A: Yes.

Q: You are the head of the two groups within the association?

A: That is correct.

Page 43

Q: And the responsibilities as the president, you have told me the responsibilities as the head of these groups is to conduct these meetings and keep your partners and associates updated?

A: That is correct,

Q: And are you compensated — I am not going to ask you how much, but are you compensated for these positions within your group?

A: There are tradeoffs. One of the tradeoffs that I have is that I don't take weekend OR call.

Q: Are you — do you receive compensation for these positions?

A: There's a small stipend, but it's a — more it's relieving me from certain obligations like I don't go to the smaller hospitals. I don't travel. I do a lot of the business, and I don't use my own time to do it. In other words, I do it on company time.

Q: You do it during your workweek then, the business?

A: That is correct.

Q: How much time does that take you?

A: It depends. Some weeks — you know, I have very good department heads — it takes me no time. Other weeks it can be quite tiresome.

Page 44

Q: What would you say your average per week for your business for the Rockford Anesthesia Associates and the two groups within them?

A: 15 to 20 hours a week.

Q: That's an average?

A: That would be an average. Maybe a little bit higher some weeks — definitely higher some weeks, sometimes less. Also, you know, a lot of the stuff I can do concomitantly.

Q: How high can it get for you?

A: It can get to 30 hours a week.

Q: Now, you're also the president of Rockford Ambulatory Surgery Center?

A: That is correct.

Q: What does that mean? What does that position entail?

A: I am chairman of the board or president of the board of the freestanding surgery center.

Q: Is that where we are right now?

A: No. This is the RAA business office.

Q: RAA meaning?

A: Rockford Anesthesiologists Associates business office.

Q: The Ambulatory Surgery Center is what?

Page 45

A: An outpatient, free-standing, surgical treatment center.
Q: You are the president of that facility?
A: Yes, I am.
Q: Are you also an owner in that facility?
A: Yes, I am.
Q: How many owners are there? Is it your anesthesia group, or are there other owners?
A: There are other owners.
Q: You are one of how many?
A: Well, I am one of — my group has about 20 percent total ownership, and then one of the hospitals owns 40 percent; and the rest are owned by other physicians in town.
Q: So the 20 percent is your anesthesia group owns that?
A: That is correct.
Q: You don't personally own a —
A: I have a small share. I believe it's —
Q: Above and beyond that?
A: Yes.
Q: How much do you own?
A: I am trying to think. Maybe 1 percent.
Q: You are an owner of Rockford Anesthesia

Page 46

Associates?
A: Yes, I am.
Q: How much of that do you own?
A: 1/37th.
Q: 37, meaning you have 36 partners?
A: That is correct.
Q: What are your responsibilities as the president of Rockford Ambulatory Surgery Center?
A: To make sure my administrator does a good job, and that requires — other than around contract time, that requires maybe a couple 10-minute phone calls a couple times a week.
Q: What type of surgeries are done at the —
A: Strictly outpatient.
Q: Give me an example.
A: Knee arthroscopy, D&Cs, tonsillectomies.
Q: What type of a volume does Rockford Ambulatory Surgery Center do? How many patients a week?
A: I believe a good number would probably be about 150.
Q: Per week?
A: Yes.
Q: And it's your responsibility as president to see that all that runs smoothly?

Page 47

A: Is to make sure that I have an administrator that sees that it all runs smoothly. Delegation is the key.
Q: I understand. But ultimately I take it you are responsible as the president?
A: Yes.
Q: How much of your time does that take you per week?
A: Like I said, it's a couple phone calls every now and then when they have a question. I have pretty much relegated myself to the chairman of the board where I sign the contracts, make sure the contracts look like they're appropriate, make sure we're thin to start provisions, make sure that we keep it legal; but that's either relegated to the attorneys or to the administrator who is a physician/partner of mine, and he does that. He is 99 percent of that.
Q: Do you actually spend any time there in the week, any given week?
A: Once in a while stop by and have a cup of coffee to drop in to see people.
Q: When were you last there?
A: About 6:15 this morning.
Q: For how long?

Page 48

A: Enough time to grab a copy of the OR schedule and a Diet Coke.
Q: How about before that?
A: Last Thursday.
Q: How long?
A: About the same amount of time.
Q: Operating schedule, Diet Coke?
A: Breakfast of champions.
Q: Medical Pain Management Services, you are the president of that organization, also?
A: Yes.
Q: And what is Medical Pain Management Services?
A: It's a free-standing facility that does advanced and interventional pain techniques.
Q: Who owns that?
A: RAA.

Page 49

quality issues are there.
Q: Where is Medical Pain Management Services located?
A: About 250 feet from the Surgery Center in Rockford, Illinois.
Q: How much time do you spend there in a week?
A: Probably a day and a half.
Q: Are you compensated for your position as president of Rockford Ambulatory Surgery Center?
A: Yes, I am.
Q: Are you compensated for your position as the president of Medical Pain Management Services?
A: I receive the honor and the privilege.
Q: Of being compensated or of having the title?
A: Of having the title.
Q: Does that mean that you are not compensated?
A: There is no direct compensation for that. I might get a meeting out of it a year.
Q: They pay your way to some seminar. What does Talen Consulting mean?
A: Talen Consulting is a consulting business that I solely and wholly own.
MS. TOSTI: Doctor, if you need to —
MR. JACKSON: Go ahead, Doctor. So the record

Page 50

is clear, you just got paged. If you need to take that, go ahead.
(A brief recess was taken.)
BY MR. JACKSON:
Q: What is the nature of Talen Consulting's business?
A: Well, I needed a vehicle to put outside moneys that I have earned, and I help physician groups negotiate their contracts; and that was a vehicle I set up. By setting it up that way, I can have another pension plan set up. And so I also put moneys that I accrue from reviewing cases or doing depositions in there.
Q: The business of Talen Consulting then is working with other physician groups for contract negotiations?
A: For contract negotiations, practice management, help how to run a business. Traditionally physicians are very poor businessmen.
Q: I am sorry. Go ahead.
A: And so — or business people, and as a result I have offered my services to other groups in the past. And through word of mouth I have been contacted, and I needed a way to have a — a way to set up a pension

Page 51

plan.
Q: When did you set up the Talen Consulting, Inc.?
A: I'd have to look back, probably five or six years ago.
Q: How many employees does Talen Consulting, Inc., have?
A: No regular employees. I contract out if I need other things, keeps the overhead low.
Q: It's located in Rockford, but what's the physical location, the address?
A: Oh, I have a place in Chicago. Lake Zurich is the physical address of the — I have someone there that grabs my mail for me because it's closer to Chicago, so if I need to meet someone.
Q: You have it set up in Chicago?
A: Well, halfway.
Q: I am sorry, Doctor. I don't understand. Explain that for me again. I missed your point there.
A: I have it set up so that it is halfway between here and Chicago; and if I need to meet someone from Chicago, it's a halfway meeting point since it's almost 100 miles from downtown out to here. And what I do is have my mailbox set up there and someone grabs my mail. And if I need to meet, I can meat in the office building

Page 52

there, rent space for a meeting.
Q: The Spring Creek Road is —
A: That's my house.
Q: Oh, that's where — okay. 2616 Spring Creek Road is your home?
A: That is correct.
Q: What is the address of Talen Consulting then, this other —
A: I'd have to — I know how to get there, but I don't have the address on top of me.
Q: That's just a post office box?
A: It's a post office box, and it's an office building where I can meet people if I need to.
Q: But do you actually rent space in the building?
A: Well, there's people that have offices and the space that if I needed an office to meet halfway, I will rent their office for a day or a couple days.
Q: How much time does your business with Talen Consulting, Inc., take?
A: I think it's variable. I usually do it on the weekends.
Q: How much of your time per week does that take?
A: You know, it would be variable. It could take eight or ten hours on some weekends, less on others,

Page 53

more on others.
Q: What would be the average?
A: Probably eight to ten.
Q: Do you in terms of expert witness consultation and testimony channel all that through Talen Consulting?
A: I channel the income through Talen Consulting, yes.
Q: How about for your partners, do you do that for your partners also?
A: What do you mean?
Q: Well, do your partners here at Rockford Anesthesiologist Associated act as experts in medical/legal matters?
A: No; none of them have any interest in doing it.
Q: Are you the only one in the group of the 37 doctors that does medical/legal expert testimony?
A: That is correct.
Q: You are the only one?
A: That is correct, that I know of. There may be some that are doing it that I don't know of, but I don't know of any of them that are doing it.
MS. TOSTI: Can I interrupt?
(Discussion held off the record.)
BY MR. JACKSON:

Page 54

Q: Does Talen Consulting set up experts for — strike that.
I am trying to determine if you use Talen Consulting as a vehicle whereby you help people who want to be experts in their dealings with lawyers and — do you understand the gist?
A: I am not a broker if that's what you're asking. All the work for Talen is solely provided by myself.
Q: You don't have any other doctors that you channel through Talen or help get consulting work on medical/legal matters through Talen?
A: I do not.
Q: The fees that Talen charges, who sets those?
A: I do.
Q: And your fee for depositions is $1,500?
A: $500 an hour. Me review fee is $350 an hour.
Q: The $500 per hour with a minimum of $1,500, where does that come from? Where did you come up with that?
A: We do depositions.
Q: We meaning you?
A: We meaning two of my partners do depositions as treaters from the pain clinic; and according to Illinois law, the depositions can run three hours. And so we set our fees appropriately.
Q: How do you come up with $500 per hour as an appropriate fee?
A: That's what the fee schedule is in this area.
Q: How long has it been that?
A: As long as I have been doing depositions since '93 or '94. Neurosurgeons charge more. The orthopedic spine surgeons charge more.
Q: So for anesthesiologists in your area here as long as you have been doing this, they charge $500 an hour; is that for depos?
A: Yes.
Q: How long has the $350 per hour for review been?
A: Probably the last two years. Prior to that it was 250.
Q: What do you charge for trial time?
A: Depends if it's in state or out of state.
Q: Give me both then.
A: Well, if I can get there quickly, I charge the hourly rate; but usually it's $8,500 a day plus my expenses.
Q: That's in state or out of state or both?
A: Well, that's if I have to travel. If I can testify in town here, it's just my time.

Page 55

Page 56

Q: Okay. So if there's traveling involved, it's 8,500 plus expenses. If it's in town meaning Rockford?
A: Yes.
Q: That would be 500 an hour?
A: That is correct.
Q: How long has that fee, $8,500, been in place? Again the same length of time since you have been doing this?
A: About two years.
Q: What was it before that?
A: 7,500.
Q: How many cases do you currently have pending where you're acting as an expert in a medical/legal matter?
A: I believe five or six.
Q: Where are they venued?
A: Two are in Oklahoma. I'm the defense expert in both of those. Two are in Chicago where I am the defense expert in both of those. One is — I am not sure where one is going to be. One is in federal court, and I am the plaintiff's expert in that one.
Q: But you don't know the state?
A: Well, I don't know which federal court it's going to be in because sometimes they can go to Indiana;

Page 57

sometimes they can come to Chicago.
Q: Where was care rendered?
A: Care **was** rendered in Illinois. And this case.
Q: Now, the two cases in Oklahoma, you did some training in Oklahoma?
A: No. First time I was in Oklahoma is when I went down to testify.
Q: In Nebraska, is that where you were?
A: I did a year in Nebraska, heart transplants, cardiac adult and kids; but no, Oklahoma, I was contacted by a defense attorney there.
Q: Okay. Doing two cases for the same defense attorney?
A: Yes.
Q: Who is that?
A: John Paul.
Q: What city? P-a-u-l I take it?
A: Uh-huh.
Q: The Paul Law Firm. I think he is in Tulsa, but it could be Oklahoma. I'd have to pull his .
Q: What's the nature of the cases?
A: One of them was an alleged penetration of an eye by a needle during a block. Another one was a child that arrested upon induction of anesthesia, and they

Page 58

thought he had a cardiac anomaly.
Q: You're testifying in both of those on behalf of an anesthesiologist?
A: One on behalf of an anesthesiologist and one on behalf of CRNA.
Q: Which one involves the CRNA?
A: The eyeball case is the CRNA, and then the other case is the anesthesiologist.
Q: I take it that you are testifying that the anesthesiologist did not negligently induce this child?
A: That is correct.
Q: The two in Chicago, what's the — who are you working for there?
A: DiFalco is her name. I have just —
Q: D-e?
A: D-i-F-a-l-c-o.
Q: Same attorney for both cases?
A: No. The other attorney I don't know the name of. I haven't heard anything on the case, and it's been like three years.
Q: And what is the nature of the case with Ms. DiFalco?
A: You know, I don't remember.
Q: What about the other case?

Page 59

A: I'd have to pull that. I thought the case was dead, and I called a couple weeks ago; and they said oh, no, we are doing something, so .
Q: You can't tell me on either one of those?
A: I can't, no.
Q: What about the federal court case?
A: That's a products liability case.
Q: What product are you critical of?
A: I'd rather not discuss that right now since it's coming up. It's something that was used in a patient right after a cardiac cath.
Q: Is that a drug or a device?
A: Device.
Q: What was the device?
A: It was a part of respiratory therapy equipment.
Q: And of whom are you critical?
A: Of the device.
Q: Not the caregivers?
A: No.
Q: What was the device?
A: I'd rather not talk about it if that's okay.
Q: Have you been deposed in the case?
A: Not yet. I have been disclosed but not deposed.

Page 60

Q: Have you written a report?
A: I have written a report.
Q: Okay. Then it's basically public then, Doctor, if you have been identified and you're part of the case. I am not going to explore your opinions. I **just** want to know what the device is.
A: It's a PEAP valve.
Q: Who is the attorney for whom you are working?
A: I believe — it's the Office of Ken Chessick.
Q: C- —
A: C-h-e-s-s-i-c-k.
Q: Who is the attorney in Mr. Chessick's office with whom you are working?
A: That's what I am trying to think of. There's three attorneys I have talked to on the case. I don't know who the lead one is. It may be Joan Stohl, S-t-o-h-l.
Q: Is Mr. Chessick venued — is his office located in Chicago?
A: Chicago suburb.
Q: But in Illinois?
A: Yes.
Q: Is a company a named defendant or a manufacturer?

Page 61

A: I believe it is.
Q: Who is the manufacturer?
A: That's the question. The company has changed its name three times. I don't have that handy.
Q: Do you know any of the names?
A: For fear of making a mistake and having the wrong company mad at me, I can't be sure.
Q: You get the chance to review this, you know that. You can correct that when it's finalized.
A: Well, I'd rather not make the mistake in the first place. I can leave it blank and fill it in if you want.
Q: You will do that for us when you review the transcript; you'll fill in whoever the —
A: Yeah, I will reserve signature.
Q: I understand you are going to do that. So what I am asking you is if you don't know it now, and you're concerned about stating the wrong company, then when you review the transcript, I am asking you to add the name of the company that is involved in that case.
A: That won't be a difficulty.
Q: Fair enough. Do you have the plaintiff's name handy?
A: I'll have to go back and look it up.

Page 62

Q: Will you also add the plaintiff's name when you do your correction of the transcript to review?
A: That is fine.
Q: Are there any other cases pending in which you are acting as an expert in a medical/legal matter?
A: There may be a couple other cases where I have been asked to be the defense expert, but I have not heard anything on it.
Q: How many times have you been asked to be an expert in a medical/legal matter, either by plaintiffs or defendants?
A: I would say 10 to 15, maybe 20.
Q: And on how many occasions have you acted as an expert for the defense as opposed to the plaintiff?
A: About 75 percent.
Q: Have been defense?
A: Defense, right.
Q: How long have you been doing medical/legal review?
A: Probably since about 1993.
Q: And the numbers you gave me, the percentages would last from '93 to present?
A: Initially all I ever did was defense.
Q: When did you start doing plaintiff's review?

Page 63

A: Probably about four years ago, three years ago.
Q: Was that because you weren't asked by plaintiffs to do it or because you chose not to review plaintiff's cases, or was there some other reason?
A: After I testified a few times, a few of the plaintiff's attorneys asked me if I would review cases. And I said if I think it has merit — I mean, I will review the case. If it has merit, I can tell you one way or the other.
Q: How many times have you testified? Let's talk by way of deposition fist of all.
A: As a treater or as an expert?
Q: Either and both.
A: As an expert in court, maybe four or five times.
Q: Four to five times in court?
A: In court. In depositions —
Q: Let's talk about treater in court.
(A brief recess was taken.)

BY MR. JACKSON:

Q: I think we were talking about your trial testimony, Doctor. You said you testified four to five times as an expert in court in medical/legal matters. Then you said you testified also as a treater. Now, the

Page 64

question is how many times?
A: In court?
Q: Yes.
A: Probably four or five at the Industrial Commission.
Q: Other than Industrial Commission, you haven't testified in court as a treater?
A: I don't believe so.
Q: Your experience as an expert in court in medical/legal matters, where have these four to five cases been venued?
A: One I said was in Oklahoma. Two were in Chicago. The other two I can't remember. I knew one of them I got lost going to. I spent all night driving. I want to say it was somewhere in southern Illinois, but it's been a while. I just remember I drove all night to get there.
Q: This four to five times in trial testimony has extended over this time since 1993? That's when you told me you started doing this.
A: Yeah. As an expert in open court, I think it's only been four or five times. The rest of the cases seem to settle.
Q: Now, I am assuming this one in Oklahoma, these

Page 65

two in Chicago are different cases than the ones we talked about a little bit ago, the pending cases; is that true?

A: I am a little bit confused.

Q: All right. I asked you earlier, do you have any pending cases where you are medical/legal expert; and you said five roughly?

A: That is correct.

Q: We went through those. There were two in Oklahoma, two in Chicago, one in federal court.

A: That's correct.

Q: Now I have asked you how many times have you actually testified as an expert in court, and you said one in Oklahoma and two in Chicago. My question is, those are different cases, I assume?

A: Yes, that is correct.

Q: In the Oklahoma case, what were you testifying on — the nature of the case?

A: That there was no malpractice.

Q: What was the nature of the case?

A: Needle injury to the eye.

Q: So that is the same case we talked about before?

A: Yes, but that case went up on appeal; so it's

Page 66

still open. I guess it's the same case, but that's the one that's up on appeal.

Q: The two in Chicago, what were the nature of those cases? What were the claims in those?

A: You know, I'd have to go back and look. I don't remember.

Q: You don't remember the nature of the case. Do you remember who you worked for?

A: I'd have to go back and look. The guys in Chicago move around so much.

Q: Do you remember when you last testified in trial as an expert in a medical/legal matter?

A: I believe it was December 11th. It was the day we had the big snowfall two years ago. December 11th, 2000.

Q: Was that in Chicago or Oklahoma?

A: Yes. It was at the Daley Center on the 27th floor.

Q: And as we sit here, you can't tell me what that case was about, is that what I understand, or for whom you testified? Doctor, if you can't, I'll accept that.

A: I can't.

Q: And again is that information that you'd be able to find easily and you could add to your —

Page 67

MS. TOSTI: No, he is not going to be adding all types of information to the depo. If he doesn't recall, he doesn't recall.

MR. JACKSON: Fine. Then we'll sit here and figure it out.

MS. TOSTI: If you don't recall, Doctor, tell him that; and we'll move on.

A: It would be hard because after a case is done, I send everything off to Shred-X.

BY **MR. JACKSON:**

Q: So you don't remember for whom you testified or what the allegations in the case were?

A: I don't.

Q: How about depositions, Doctor, how many times have you been deposed in medical/legal matters?

A: In medical/legal matters? Well, I would say I have been deposed for every case that I have reviewed. That's, you know, the 15 to 20. And then I have been deposed as a treater.

Q: How many times as a treater have you been deposed?

A: It would probably average once a month.

Q: In terms of your deposition testimony for medical/legal matters, how frequently are you deposed?

Page 68

A: Well, the cases I would get, I would get deposed once.

Q: When were you last deposed in a medical/legal matter?

A: Last year.

Q: Is that in one of the cases we have already talked about?

A: Yes, it is.

Q: When were you last involved in actually giving anesthesia to a patient in the operating room?

A: About 24 hours ago.

Q: How about a cardiac patient, when was the last time you were in an operating room with a cardiac patient as an anesthesiologist?

A: 36 hours ago, maybe *40* hours.

Q: Do you teach?

A: Yes, I do.

Q: Can you explain your teaching experience for me?

A: Teach medical students and family practice residents, critical care nurses and OR nurses as well as other physicians.

Q: Where do you teach and what method do you use? What type of teaching do you do?

Page 69

A: Well, there's a couple ways. You use didactic, lectures. You use direct observation, and then you do clinical training.
Q: Where do you teach?
A: Well, either at the hospital or in the auditorium over at the medical school.
Q: Medical school being what medical school?
A: University of Illinois College of Medicine or students when you're on rounds, they'll round with you, spend time with you.
Q: Are you assigned to teach any particular course right now?
A: Currently, no. I used to teach the cardiac physiology and the pharmacology.
Q: When did you last teach that?
A: Well, I gave lectures in it last year. I used to be more heavily involved in the past, but I give the refresher courses for the nurses that go into the critical care units.
Q: Those are like one- or two-time lectures?
A: Like two or three three-hour sessions. I review pharmacology. If I have a couple partners that need a review, we'll sit down; I'll give them the information. And we'll spend a few hours on a weekend

Page 70

going over everything.
Q: When did you last actually teach a course at the University of Illinois, you were the instructor for the course?
A: Oh, several years ago.
Q: How long?
A: More than five.
Q: From your CV — do you have a copy in front of you? You have given a number of presentations. Are any of those presentations presentations which would deal with issues that you would consider relevant to this case?
A: Well, they all in some ways touch on it, some of the presentations.
Q: Well, maybe I should ask this first. What issues do you consider — medical issues do you consider relevant to this case?
A: Well, I think, you know, we can jump right in. I think the way in which the patient was monitored or not monitored is a germane issue.
Q: Okay. That's one. Are there any others?
A: And then the rest is just clinical issues.
Q: Such as?
A: Such as not reporting to hire authorities what

Page 71

was going on with the patient, communication.
Q: So it's monitoring and communication?
A: That is correct.
Q: With those issues in mind, are any of your presentations presentations which would deal with those type of issues?
A: Well, I think starting at Page 6, "Invasive Hemodynamic Monitoring and Its Applications," I gave grand rounds on that. "Use of Inotropes" —
Q: Excuse me; that's the one in October of '86 at University of Nebraska?
A: Yeah.
Q: "Use of Inotropes in Cardiac and Noncardiac Surgical Procedures."
Q: Again in '87, and that was at —
A: Yes. "Review of Inotropic Drugs," '87.
Q: The second one was at the University of Nebraska, and the third one was Denver Anesthesiology Society?
A: Yes; that's correct. "Use of Antihypertensives in Anesthesia."
Q: What page are we on?
A: Page 7, June of '87, at the Nashville, Tennessee State Society Meeting.

Page 72

Q: I don't see that one, Doctor.
A: Three up from the bottom.
Q: Oh, I see it now.
A: "Use of Inotropes in Cardiac Anesthesia," Page 8, Missouri State Society Meeting.
Q: January of '88?
A: Yes.
Q: What does that mean, review course?
A: Well, they had — I gave the review course lectures in cardiac anesthesia. Page 9, "Use of Transesophageal Echocardiography in Diagnosis of Myocardial Ischemia."
Q: January, '90?
A: Yes.
Q: "Cardiac Anesthesia and Critical Care" is No. 3 on that page, April of '90. "Advanced —
Q: Hold on. Page 9 are you saying?
A: Page 10. Page 10, "Advanced Techniques in Transesophageal Echocardiography for Diagnosticians."
Q: '93, is that right, April of '93?
A: That is correct.
Q: It says here you were course director. Did you give presentation also?
A: Well, I moderated it and gave the talk on

correct?
A: Yes. The second from the bottom or bottom "Advanced Techniques in Transesophageal Echo," Kenora, Ontario.
Q: In October of '94?
A: That's correct.
Q: Again that says course director, does that mean you monitored?
A: I monitored, moderated and gave some of the talks. That's about it.
Q: Okay. Did you keep — did you make presentations by way of handouts or anything in any of those courses?
A: Oh, I am sure I did.
Q: Would you *still* have them?
A: I probably don't.
Q: How about your publications, there are three chapters in books. Do those in any way relate to this case? Four chapters, excuse me.
A: Monitoring Critical Care.
Q: That's the —

A: Last one.
Q: Edited by Popovich?
A: Yeah.
Q: Has that been printed?
A: You know, it was supposed to be. I got a rough copy of it. And I don't know. I stopped getting my royalties. So I don't know if it's still in press or not.
Q: When you say in press, that means it's been printed?
A: Well, I don't know if they all the way went through with it. They had some financial problems, that was good old El Sedvire (phonetic).
Q: *So* you don't know whether that was published?
A: That is correct.
Q: Do you have a copy of that?
A: I may somewhere.
Q: Where would one get a copy if it wasn't in publication?
A: Well, it may have been printed. I don't know. It could be in the warehouse somewhere.
Q: Let's assume it was not published. Where would I get a copy of that other than asking you for a copy?
A: I can call El Sedvire to see if they have it.
never got any more; but then it's also the time I moved.
Q: When was that put in press?
A: I'd have to go back and look.
Q: There's no dates on any of those chapters, that's why I ask you.
A: Well, like I said, I'd have to go back and look.
Q: Were any of your chapters actually published?
A: I submitted them to the publisher. I got a letter saying that they were going to press, and they enclosed one royalty check; and that was it, and then I moved.
Q: So this was how long ago?
A: Well, I moved about six, seven years ago. So may be a little bit more than that.
Q: So if I understand you correctly, these four chapters and books were written six or seven years ago or more?
A: That is correct.
Q: And you don't know whether they were ever published or not?

A: No. When I left academics, publishing lost a lot of its importance.
Q: I am just curious as to whether you know they have or have not been published.
A: I know I received a rough copy or a printed copy and then a royalty check, and that was it.
Q: But whether these are in press — or in publication anywhere, do I still understand you don't know?
A: You know, I am not sure if they're still in press — or if they're still in publication.
Q: Were they ever published?
A: I assume they were. I got a copy of it.
Q: Which one, just the second one?
A: They're all chapters. They have to be in a book.
Q: I mean, which one was published. You said you got one check.
A: No; no; no. I got a copy of the book that was published.
Q: Oh, I see what you're saying.
A: But I don't know if they went and ran 50,000 copies is what I am saying.
Q: All right. Do you know which book it was,

Page 77

which of these four?
A: Those were chapters in a book.
Q: I understand that. One book?
A: There was one book with about 110 chapters in it. It was a thick book.
Q: And you edited four of those chapters or wrote —
A: I wrote four of those chapters.
Q: Okay. Do you have any other training or education or experience that you believe qualifies you as an expert in this case that we haven't talked about?
A I think we have covered it.
Q: Do I understand that to be board certified in pain management, you need to devote over 50 percent of your time to pain management?
A: Nowadays you do. I received my board certification in pain management prior to them having fellowship.
Q: When were you board certified in pain management?
A: October of 1993.
Q: And the current requirement is that you need to devote more than 50 percent of your time to pain management to qualify for board certification, is that

Page 78

correct?
A: Or have special training in it. The 50 percent isn't necessarily — in other words, in order to sit for the boards, you have to — you can get it either by training or by your current practice. These are the new rules. Back when the test was offered, it was offered if you wanted to take test, you'd get the accreditation because I came out before there was formal pain training. Since I did do some interventional pain of the surgical type, I thought it prudent to get the certification and sit for the exam. So I sat — I have Certificate No. 287 I think.
Q: Would you now qual@ with that requirement that you devote more than 50 percent of your time to pain management?
A: It depends on devout pain management. If you manage people postoperatively, their pain — let's say you manage all the people postoperative surgical, you can still have a large anesthesia practice but still have a pain management practice. So I think it's a semantics term. The idea is that you are involved in your pain management. If you do straight OR anesthesia but you write 50 percent of your patients for postoperative PCAs, that would qualify. So it's

Page 79

somewhat nebulous.
Q: Well, do I understand then that if you were to sit today for that, you would still qualify or you would not qualify?
A: It's how you want to play the numbers game.
Q: I don't know how they do that or how they interpret that; but with your interpretation, would you still devote more than 50 percent of your time to pain management, yes or no? Because I have to rely upon you, Doctor. How do you interpret that? Do you or don't you now devote more than 50 percent of your time to pain management?
A: Depends on what days. Some days yes. Some days no. If you look at all your patients, I think we're asking semantic questions. I believe that if you look at it — you know, you do two jobs. If you do OR anesthesia and if you manage the patients afterwards, you could have 100 percent of your time devoted to pain management because technically in the OR you are doing that.
Q: But is that what they talk about when they certify people for pain management?
MS. TOSTI: If you know.
A: I'd have to look at it. I don't have it in

Page 80

front of me.

BY MR. JACKSON:

Q: So you don't know whether they would qualify operative time as pain management?
A: It depends what you're doing in the operation. There's a lot of overlap there. It's not a cut-and-dry thing.
Q: All right. So I just want to understand this issue, Doctor. If someone does just OR anesthesia, from what you're telling me, they would qualify —
A: No.
Q: They could qualify —
A No; that's not what I said.
Q: Okay. Well, then clarify for me because I don't understand what you're saying.
A: I am not sure what you're asking. I think that if you're doing pain management, you're doing pain management. You can anesthetize a patient; and if you do an epidural on him afterwards for postoperative pain, that's pain management. So where do you draw the line at?
Q: I have to ask you that question. If you give anesthesia to a patient intraoperatively —
A That's correct.

Page 81

Q: — is that considered pain management in your opinion?

A: Depends what you do to them. I mean —

Q: Depends what the procedure is you mean?

A: Depends on the procedure, depends if you're putting in an epidural for postoperative pain management. I think we're splitting hairs.

Q: I am just trying to understand that because I don't understand it. That's why I am asking.

MS. TOSTI: Doctor, if you need to take it, go ahead.

A: Thanks. Well, I think that, you know, they have certain guidelines.

BY MR. JACKSON:

Q: They meaning?

A: The American Board, and they may have changed over the years. I haven't looked — it's a ten-year certification, and I haven't really looked at the new guidelines.

Q: So you can't answer that question as we sit here?

A: Not without having the actual statute and new rules in front of me, no.

Q: Have you ever other than this case acted as an

Page 82

expert for the Becker, Mishkind firm?

A: I have not.

Q: Or anyone in the firm?

A: I have not.

Q: Other than the states you have already described for me, have you ever been an expert in a medical/legal matter in any other states?

A: I don't believe so.

Q: So it's been Illinois, Oklahoma?

A: That is correct.

Q: Do you know any **of** the doctors or nurses or other experts in this case?

A: I do not.

Q: Do you know anyone associated with this case, any of the caregivers?

A: I do not.

Q: Did you review the deposition testimony of Dr. Smith, plaintiff's expert?

A: I believe I looked at it.

Q: When?

A: Well, obviously sometime after he did it, but I can't give you the exact date and time.

Q: Well, has it been in the last — within the last week?

Page 83

A: I am trying to think. Let me see if I have the date on this here.

Q: I will tell you it's not in the pile of depositions you have in front of you, Doctor.

A: No, but I'm just trying to think. I'm trying to think if that was one I looked at at my cabin or not.

Q: I'm sorry. I didn't understand what you just said.

A: I am trying to think if I reviewed it at my cabin or not.

Q: And at your cabin was where you reviewed depositions preparing yourself for the deposition today?

A: Well, that's where I do most of my work. You don't get 100 pages a day.

Q: Pardon me?

A: You don't get 100 pages a day.

Q: I don't know what you mean by that.

A: Distractions.

Q: Oh. I thought you were talking about deposition pages. You mean being paged by someone.

A: Yeah. It may have been in the last week.

Q: But you can't tell me for certain?

A: Because I was re-reviewing the depositions I have here. I am not sure if it was or if I just glanced

Page 84

at it. I don't want to tell you the wrong thing.

Q: But you have reviewed his deposition at some time?

A: I believe I have.

Q: You think that **was** in the last week?

A: It may have been.

Q: Would you have reviewed it before you wrote your report?

A: No, I would not have.

Q: How do you know that?

A: Because I wrote my report after I did my initial review, and — I'm trying to think — no, I know I didn't do that.

Q: That meaning review his deposition before your report?

A: That is correct.

Q: So it was sometime between the time you wrote your report and today?

A: That **is** correct.

Q: And when did you receive it?

A: What's that?

Q: The deposition of Dr. Smith.

A: You know, I'd have to look. I may have an envelope. I may not.

Page 85

Q: Well, it was represented to me earlier, Doctor, that the correspondence there was all the correspondence that we had in the case, that you had received from plaintiff's counsel?
A: It is.
Q: And when did you get — how did you get Dr. Smith's deposition?
A: I don't think I'm following you.
Q: Well, if you'll go back to those four letters — and by the way, I'd like a copy of those before we leave today. You can copy those here for me?
A: That shouldn't be a problem.
Q: Okay. There's no listing of Dr. Smith's deposition there, is there?
A: There is not.
Q: And Dr. Smith's deposition is not in the stack of depositions or copies of depositions sitting in front of you, is it?
A: It is not.
Q: And so I assume you have a copy of it somewhere, but you didn't bring it with you; and there's no record that you received it?
A: I think, Mr. Jackson, I received three depositions approximately a week ago, the last three

Page 86

depositions of Hernandez, Hearn and Koch.
Q: Okay. You got those three a week ago?
A: I had those. Those are the ones I took up north with me. That's why when you mentioned the name, if that was the plaintiff's expert, you caught me off guard because I went and looked and thought one of these might have been that name. So if that's the case, and I don't see it here and I don't have it in front of me, I don't believe I have reviewed the plaintiff's expert. I reviewed — I have the list here of the following materials. I also have these three here; and for a split second when you asked me that, I thought I might have reviewed it. But I have not reviewed it. These are the ones that I have reviewed.
Q: Do you know who Dr. Smith is?
A: I do not.
Q: Never heard his name before I mentioned it here?
A: Quite honestly if I have, I don't remember it because a lot of the names have flown together on this case. So I do not have that recollection.
Q: As to who he is?
A: That is correct.
Q: Have you been aware before I said that, just

Page 87

said his name, that Dr. Smith was involved in this case at all?
A: I have another case where there's a Smith involved, and it may have run together; but I do not have Dr. Smith's complaint letter with me nor have I looked at it here.
Q: I am talking about his deposition, Doctor.
A: Well, I haven't looked at that then.
Q: We're not sure if you've looked at it or not?
A: No; that's not what I said. I said when you first asked me that — let's get this real clear so there's no attempt at any misperception or deception.
Q: I'm not — Doctor —
MS. TOSTI: Let him finish.
MR. JACKSON: No, I am going to finish,
MS. TOSTI: Let him finish his answer, John.
BY MR. JACKSON:
Q: I am not attempting any misperception or deception here. I asked you a very straightforward question, and you hesitated for a long time; and then you told me you had reviewed the depo. So please don't suggest that I am trying to mislead or cause any deception here because that's not the case.
A: Well, I am also not trying to mislead or

Page 88

deceive; but when you said Smith, there's Hernandez, there's Hern, and there's Koch which you mispronounced Koch. It's Koch in German. And when you said that, I thought for a minute did I or did I not, and I looked through this. And I don't necessarily identify them by their last names. I said this was a fellow, this was the person taking care of it. So no, I have not reviewed that. And if I stated that I reviewed it, I misspoke; and that's why when I looked at these names here, I wanted to make sure that I didn't have something here that said I did review it because I didn't remember reviewing it. That's why I hesitated.
Q: What's your understanding of who the experts in this case are?
A: I know I am one of the experts. I know there's a cardiac surgeon.
Q: Who?
A: I am not sure.
Q: On whose side, plaintiff or defense?
A: Well, I would assume there's one on each.
Q: Okay. Where do you get this understanding?
A: Well, usually if you have different physicians in the case, you usually have different experts.
Q: Understood. But did you have some discussions

Page 89

with plaintiff's counsel about the experts in this case?
A: I have not.
Q: None?
A: Not that I recall other than that there was expert — other experts.
Q: Did you ask who they were?
A: I didn't.
Q: So your understanding is there are cardiac surgeon experts?
A: There are other experts period.
Q: What are they or do you have any understanding?
A: I don't have the understanding.
Q: Did you ask for their names?
A: I did not.
Q: Did you ask to see their depositions?
A: I don't believe I have.
Q: Did you ask to see their reports?
A: I have not seen their reports.
Q: Did you ask to see their reports?
A: I don't believe I did.
Q: Why not?
A: Because in most cases, they want your opinion to be your opinion and not something that you build it on someone else's report. So my opinion is based on my

Page 90

review not a summation of someone else's.
Q: Did you read Dr. Lyons' deposition, it's listed in your —
A. I believe I did.
Q: Do you know Dr. Lyons?
A: I do not.
Q: Do you disagree with his comments in his deposition?
A: If you want to show me what you're referring to, I'd be more than willing to give an opinion on it.
Q: In general.
A: I don't like generalities. People make mistakes.
Q: You don't remember — do you know who he is?
A: I believe Dr. Lyons is an anesthesiologist, but I am not sure. Let me check.
Q: He is an anesthesiologist. We'll save time, Doctor. Do you know his role in this case? Do you know Dr. Lyons' role in this case?
A: Let — I'm just refreshing myself again on his deposition.
Q: Okay.
A: He was a cardiac anesthesiologist.
Q: Do you know his role in this case? And so the

Page 91

record is clear, Doctor, I know you're reading through that; but it doesn't show that there was a pause of like three or four minutes there between the question and when you just made that answer. I want to make note of that.
A: Dr. Lyons also did his training at the Cleveland Clinic and is currently I believe at Case Western Reserve doing cardiac anesthesia.
Q: What is your understanding as you sit here, Doctor, of Dr. Lyons' role in this case?
A: I believe he is one of the anesthesiologists for the Cleveland Clinic.
Q: Who treated Mr. Long?
A: No, he did not treat Mr. Long. I believe he is their expert.
Q: What is your understanding of Dr. Muehlbach's role in this case?
A: Dr. Muehlbach was a cardiac fellow on the service of Dr. Cosgrove.
Q: Did he treat Mr. Long?
A: Yes, he did.
Q: How about Dr. Yared?
A: Yared was the intensivist in the case.
Q: Did he treat Mr. Long?

Page 92

A: Yes, he did.
Q: Nurse Hrobat, H-r-o-b-a-t, what was her role?
A: She was one of the nurses involved.
Q: Do you know what role she played?
A: She was allegedly the supervisor to the other nurse.
Q: How about Nurse Zilka, Z-i-l-k-a, what was her role in this case?
MS. TOSTI: Doctor, if you want to refer to any of the medical records, please, feel free to do so.
BY MR. JACKSON:
Q: While you're doing that, Doctor, while your going through those depos, there's numbers on the top page. What do those signify? You wrote — somebody wrote a number on the top of that. For example, the one in your right hand has a three circled. The one in your left hand has a two circled. What does that mean?
A: They were separated into stacks when I put them out.
Q: I don't understand. What do the numbers mean?
A: Well, it means if I grab a stack of the depositions, when I look at them, I look at them in groups. So this was stack two. This was part of stack three. This one doesn't have a number on it. This one

doesn't have a number on it because they just recently came. This one was in stack one.
Q: Which one?
A: The Hrobat.
Q: Those don't have numbers either, though.
A: I know that. One, two, three. This was a new group. I never really got a chance to mark these.
Q: The new group are which?
A: Hernandez, Hern, and Koch.
Q: How would you distinguish stack one from stack two from stack three?
A: Which ones I reviewed so I don't review them twice for the same thing.
Q: There's no marks on stack one, so how do you know —
A: If it's not marked, it's stack one.
Q: Okay. I was asking about Nurse Zilka, what was her role?
A: She was one of the nurses, and I think one of the other preceptors for Ms. Young.
Q: Have you ever been sued?
A: Yes, I have.
Q: How many times?
A: Once.

Q: What was that for?
A: An alleged esophageal intubation.
Q: Where did that occur?
A: Rockford Memorial Hospital.
Q: Tell me when that happened first of all?
A: 1987 or '88. Might have been '88.
Q: The case I assume is resolved, done?
A: Never went to trial. They took one deposition of the surgeon; and it went to three plaintiff's lawyers, and they all said there was no case.
Q: So you were actually sued, and then it was dismissed: is that what happened?
A: Well, they had — I don't know. You can tell me the legal terms for it. They took the deposition. They made an allegation. They took the deposition of the surgeon, and then the case dropped, so —
Q: They filed it and then dismissed it, that's what I am hearing you say?
A: That is correct.
Q: Other than that, you have never been sued?
A: I have not.
Q: Tell me what specific training you have had for cardiac anesthesia?
A: Well, I did two years of general surgery at the

University of Michigan. I spent half my time on the cardiac service. I was going to do cardiac surgery. I had an eye problem that resolved but went into anesthesia, did a fellowship in cardiac anesthesia. My whole senior year was all cardiac, and then I went into practice and did cardiac anesthesia.
Q: Okay. You switched from general surgery — you switched from surgery to anesthesia because of an eye problem which has resolved?
A: That's correct.
Q: I have a report that — a letter that you wrote dated June 11th, 2001?
A: That is correct.
Q: Three pages, correct?
A: That is correct.
Q: Is that your only letter to Mr. Becker and/or his firm relative to this?
A: Yes.
Q: Is that your only draft?
A: This is the only draft I have, yes.
Q: Was there another draft?
A: I believe everybody has a rough draft.
Q: How many were there; how many rough drafts?
A: I believe it was just one.

Q: And what did you do with the rough draft?
A: What I do with all confidential medical information: you know, I corrected the time — or not the time, the date. I tend to put things in military time, and other people like regular time. I like military time.
Q: I am not understanding you. In other words, you did a draft of this report, correct?
A: Yeah.
Q: And then at some time — what did you do with the draft? You called Mr. Becker or sent it to him?
A: No. I just — we talked on the phone, and I did my thing.
Q: Well, that's what I am trying to understand.
A: I don't like 6:00 p.m. to 9:00 p.m. I like 1800 to 2100.
Q: So your initial draft had —
A: And I had my date 11 June 2001, and they had June 11, 2001. It was like I dictated it, signed it, and that was it.
Q: You're talking about the draft?
A: No. The thing. I mean, it was one thing. It wasn't like it was sent back and forth.
Q: That's what I am trying to understand. You did

Page 97

a draft?
A: Yeah, I dictated it.
Q: And then you talked to Mr. Becker about it?
A: The only thing we changed was I wanted military time, so I won out on that.
Q: Initially there was other than military time there?
A: It was 6:00 p.m. to 9:00 p.m.
Q: So initially you drafted it in the 6:00 p.m. to 9:00 p.m.?
A: No. I drafted it like this. This is my letter. This is my letter the way I wanted it. And lay people like 6:00 p.m. They like those types of things. That was it.
Q: What I am trying to understand is the process. You received the materials —
A: This was not a collaborative effort. It was my effort upon my review, dictated, transcribed, put on my letterhead, boom, it was done.
Q: That's what I am trying to understand. You got the materials, you reviewed them, correct?
A: That's correct.
Q: You drafted a letter, correct?
A: That is correct.

Page 98

Q: You spoke with Mr. Becker?
A: Well, the letter was done, but I spoke with him.
Q: And then there were some things that you wanted changed, like you talked about these numbers of military time, and you made those changes; correct?
A: Well, I kept them the way I wanted it.
Q: Okay. And then you finalized your report and sent it to him?
A: It was finalized. There was nothing to finalize.
Q: You didn't make any changes in your report from the time you fist drafted it to the time you sent it to him?
A: No; that is correct.
Q: So this is the only draft then of this report; is that what I now understand you to say?
A: That is correct.
Q: Correct?
A: That is correct.
Q: When you say all Cleveland Clinic Foundation records as being some of the materials that you reviewed, is that the three-ring binder that you're talking about?

Page 99

A: That is the extent, that is correct.
Q: Now, since you have authored this report, you have reviewed some additional depositions, correct?
A: That is correct.
Q: And you did that when?
A: After I received them. I received them about a week ago.
Q: Did those in any way change your opinions, alter your opinions, make any type of corrections to your opinions as stated in your June 11th report?
A: They did not.
Q: Did you review any other materials other than those three depositions which you received after your deposition or after your report?
A: I did not.
Q: Did you do any research for this case?
A: I did not.
Q: Did you make any reference to any medical textbooks or journal articles in preparing your opinion?
A: I did not.
Q: Have you asked to review any additional materials in this case?
A: I have not.
Q: Do you intend to?

Page 100

A: I don't intend to.
Q: You are not a surgeon; you're not an expert in cardiac surgery, are you?
A: I am not.
Q: You are not an expert in cardiology?
A: I am not a cardiologist.
Q: How much time have you spent on this case to date not including our depo time here?
A: Probably have to pull my tax records.
Q: You can't give me an estimate?
A: 16, 20 hours, give or take whatever.
Q: How much of that time was time spent preparing for this deposition?
A: None.
Q: Did you spend any time preparing for this deposition?
A: *Yes,* I did.
Q: Howmuch?
A: Couple hours.
Q: 'What'sthat mean?
A: Three hours, maybe four.
Q: 'What'syour understanding of the term standard of care, Doctor?
A: The standard of care is the care rendered by an

Page 101

average provider to a patient that a reasonably well-trained individual could expect to deliver, not the superstar care, not one-in-a-million care, but a reasonable standard which a reasonable physician should perform with reasonable training.

Q: Just let me ask you this: Why do you charge a thousand dollars more for a video? Or why does Talen Consulting charge a thousand dollars more if the deposition is being taken by video?

A: Because you usually have to get there an extra hour and a half ahead of time, and it usually ends up being done in Chicago.

Q: In terms of names of individuals, who do you believe breached the standard of care in this care of James Long?

A: I believe the team that was taking care of Mr. Long in the immediate postoperative period, the residents and fellows and nurses associated with him. I believe that Dr. Cosgrove did absolutely nothing wrong. When he was notified appropriately, he made the appropriate decision; but no one ever notified him. I do not believe that Dr. Cosgrove in any way, shape or form breached the standard of care.

Q: Okay. So Dr. Cosgrove did not breach the

Page 102

standard of care in your opinion?

A: I have no problems with Dr. Cosgrove or his care.

Q: I am asking you to name for me, because we're going to go through what you think they did wrong, the people at the clinic whom you believe breached the standard of care.

A Well, I believe Dr. Muehlbach didn't stay adequately on top of the patient.

Q: Let me stop you for a second, Doctor. Why don't we approach it this way. Just name the people fist for me, and then let me go back through each of them and what you say each of them did wrong, okay? Just tell me the names of the people whom you believe breached the standard of care, and then I will ask you what you believe they did wrong. So you will have the opportunity to say that. I just want to get the list of names first.

A: Dr. Muehlbach, the nurses involved directly with the care.

Q: Give me their names.

MS. TOSTI: John, there was a number of — when you looked at his records originally, there was a number of fanfolded pages.

Page 103

MR. JACKSON: Everything that you gave me is still there. I don't have anything else here. It was still in the stack there, right?

MS. TOSTI: It was in the medical records.

A: Okay. I have mentioned Dr. Muehlbach, Nurse Young, Nurse Hrobat, Zilka, and Hernandez.

BY MR. JACKSON:

Q: You mean Dr. Hernandez?

A: That is correct.

Q: Anyone else?

A: I believe that's what I set forth.

Q: I asked you that because you don't name them in your report. That's why I asked you to name them. So it's Dr. Muehlbach, Nurse Young, Nurse Hrobat, Nurse Zilka, Dr. Hernandez; am I correct?

A: That is correct.

Q: Now, what in your opinion did Dr. Muehlbach do or not do that fell below the standard of care?

A: Well, Dr. Muehlbach was the fellow on the service. He was the one who did the operation with Dr. Cosgrove, and I believe that there's physiologic evidence here that the patient should have been taken back to surgery earlier than they were, and that it was not picked up upon nor was Dr. Cosgrove informed of the

Page 104

situation where he could have made the decision to bring the patient back in an appropriate time.

Q: So you believe Dr. Muehlbach did what wrong?

A: I believe he did not note the physiological changes that were occurring in this patient both hemodynamically and physiologically that were early tipoffs that this patient was not doing well and should have been returned to surgery or warranted much closer care. This was a fresh Bentyl procedure, and patients like this need to be observed and treated aggressively. And there are some diagnostic interventions that could have been performed that would have been helpful to this patient.

Q: So your belief is that Dr. Muehlbach did not note the changes which would have required either a return to surgery or warrant closer care, is that correct?

A: That is correct.

Q: Is there anything else you think Dr. Muehlbach did wrong?

A: I believe he did not transfer the information in a timely basis to Dr. Cosgrove.

Q: He didn't note the changes, and he didn't notify Dr. Cosgrove?

Page 105

A: That is correct.
Q: Anything else you believe Dr. Muehlbach did wrong?
A: I believe I stated my concerns.
Q: You have covered them?
A: For Dr. Muehlbach.
Q: You have covered them?
A: Yes.
Q: Let's go to Dr. Hernandez, what do you believe Dr. Hernandez did wrong? Or let me be more specific, Doctor. In what way do you believe Dr. Hernandez fell below the standard of care?
A: I also believe that, one, he should have been more directly involved with this patient based on the hemodynamic parameters that were presented to him and that were charted on the patient's chart.
Q: What is your understanding of Dr. Hernandez' position at the clinic?
A: He was a surgical resident on the thoracic service. I believe he was an HO-2.
Q: You say he should have been directly involved in the patient's care? Anything else in which — in a manner in which you believe Dr. Hernandez fell below the standard of care?

Page 106

A: And then again notification of his superiors.
Q: Who would that be in Dr. Hernandez' case?
A: Muehlbach and Cosgrove.
Q: Have we covered your opinions as it relates to how Dr. Hernandez fell below the standard of care in his treatment of Mr. Young?
A: Yes, I have.
Q: And I have two general categories. We will explore these more. He should have been more directly involved in the patient's care, and he should have notified Drs. Muehlbach and Cosgrove?
A: That is correct.
Q: Let's talk about Nurse — are the criticisms you have of Nurses Young, Hrobat and Zilka, are those all the same or do they do differ?
A: Well, they're all involved in the care. I can give you my criticisms of the nursing care.
Q: Okay. My question is this — well, let me do it this way. We'll just go through each name. How do you believe Nurse Young fell below the standard of care?
A: Nurse Young was the primary nurse at the bedside.
Q: She was the space cadet, by your words?
A: That was what was written on my sheet.

Page 107

Q: You wrote that, did you not?
A: I wrote that. The patient had hemodynamic aberrations. There's generalized poor charting. There are absent vital signs for extended periods of time. For example, there are no PA pressure readings charted after Line L on the flow sheet.
Q: Okay. I categorized that as poor charting, and there's an absence of vital signs. What else?
A: When the patient had dropped blood out the chest tube on these occasions, there was no notification of Dr. Muehlbach.
Q: What occasions are you referring to, Doctor?
A: Well, the patient dumped 250 out.
Q: What time?
A: At Level G.
Q: Okay.
A: Which is 1930.
Q: Are there other instances where she did not notify Dr. Muehlbach of a dumping of blood from the chest tube in your opinion?
A: That was the one on the chest tube. Then the inotropes were titrated up.
Q: Let me make sure I have it. You said on occasions where he dumped blood from the chest tube, was

Page 108

it just the one you're referring to then?
A: There's nothing charted where she notified Dr. Muehlbach.
Q: But is it just one incident or was there more than one which you were —
A: This is just with regards to the chest tube out drainage.
Q: That's what I was talking about. The impression I got from your first comment regarding drainage from the chest tube suggested to me that you felt that there was more than one occasion when she did not notify Dr. Muehlbach.
A: Of events with the patient.
Q: Of a discharge from the chest tube, is it just the one incident with the chest tube?
A: This is one episode where the patient dumped 250 acutely.
Q: Okay. Then let's move on. There was something you were going to talk about about inotropes after that?
A: Then the inotropes were instituted as well as the Amicar was instituted, and the decision — it was not clear in the orders who ordered it, but obviously she was the one that increased it. She increased the amount of sedation on the patient who is having trouble

Page 109

supporting their blood pressure, knowing that the propofol infusion will necessarily decrease the patient's blood pressure. So you're increasing a drug as an inotrope at the same time you're increasing the drug that lowers the blood pressure.

Q: And you believe that's below standard of care?

A: Absolutely.

Q: Anything else in your opinion that Nurse Young did that fell below standard of care or failed to do?

A: We talked about the charting.

Q: You have talked about poor charting, that was your first,

A: And lack thereof of charting.

Q: Any other ways in which you believe Nurse Young fell below the standard of care?

A: Right here at Level T, if you have a patient who is bleeding, is hypotensive, the last thing you would do would give them 250 micrograms of Fentanyl because its sympatholytic effect will eliminate any blood pressure that they have or significantly impair it.

Q: *So* let me understand what your criticism of her is. You're saying that at LevelT, which is what time?

A: Well, there's no time there.

Page 110

Q: *So* at Level T —

A: But it's written in LevelT, but it looks like it's a continuation of Level S.

Q: What time is Level S?

A: 2340.

Q: At 2340 —

A: But it may be earlier. I am just saying this is all clumped in here. There's a *5* cc or 250 microgram bolus of Fentanyl that's given.

Q: And you are critical of the administration of Fentanyl at that time?

A: 250 microgram in a patient who is hypotensive? Absolutely.

Q: So do I understand you to say that another criticism of Nurse Young is that at **2340** or thereabouts, she gave **250** micrograms of Fentanyl; and you believe that fell below standard of care, is that correct?

A Absolutely.

Q: Any other manners in which you believe Nurse Young fell below standard of care?

A: I believe I have covered it.

Q: Okay. Let'stalk now about Nurse Zilka then. Nurse Zilka, Doctor, how do you believe she fell below standard of care?

Page 111

A: She was the coordinator on the shift that Nurse Young was **on;** and if I have my name correct for her, she was the one — her resource person.

Q: In what way do you believe Nurse Zilka fell below standard of care?

A: Nurse Young —

THE WITNESS: I have to take this.

(A brief recess was taken.)

BY MR. JACKSON:

Q: What'sthe NTB mean, just for my information?

A: Oh, need to bill.

MR. JACKSON: There should be one more.

THE WITNESS: I have three. I have three pages, three originals plus yours.

MR. JACKSON: There's one more, there was a fourth. It was a longer letter.

MS. TOSTI: You know what it is, it'sthe one that has to do with the deposition being scheduled. That'sthe one that's not here. That's from me. It was one that said your depo was being — it was this one; there you go.

MR. JACKSON: Okay. You got a copy of it?

MS. TOSTI: No. Did you make a copy of this one? Do you have the original?

Page 112

THE WITNESS: I have the original.

MR. JACKSON: I have got four. All right. There's a letter of November 28,2001, letter of February 14,2001, January 22nd, 2002, and August 23, 2000.

THE WITNESS: Somebody must have —

MR. JACKSON: All on Becker, Mishkind letterhead.

MS. TOSTI: Yeah, those are the four.

BY MR. JACKSON:

Q: Let'smove on, Doctor, because I know you have a time concern and so do we, I'd like to move through these. Ready?

A: I'm ready.

Q: Nurse Zilka.

A: Nurse Zilka was the supervising nurse for Ms. Young, and she hadn't completed her orientation. And on a case like this, I believe that Ms. Young should have been chatteled a lot closer.

Q: So what did Nurse Zilka do that fell below the standard of care, in your opinion?

A: Well, I believe that she didn'tprovide her with adequate supervision.

Q: Anything else for Nurse Zilka?

Page 113

A: Well, she does have some understanding of the basic pharmacology of some of the medicines that they were administering.
Q: Do you believe that falls below the standard of care for her?
A: If you're administering them, you should know them.
Q: Do you believe that falls below the standard of care for Ms. Zilka not to know the pharmacology of some of these drugs that you just described?
A: Yes, it does.
Q: Okay. Anything else for Nurse Zilka?
A: I believe that's it.
Q: Nurse Hrobat? In what way do you believe Nurse Hrobat fell below the standard of care? What are you looking for, the deposition?
A: Yes.
Q: You know, it's okay to say she didn't fall below the standard of care; you do understand that? Did you ignore me, or you just didn't hear me?
A: What was that?
Q: I said it's okay to say she didn't fall below the standard of care; you understand that, don't you?
A: Well, I wouldn't want to give you the wrong

Page 114

answer.
Q: Did you mark any of those depositions in any way by underlining or highlighting anything?
A: There may have been scratches on one or *two* of them.
Q: But what you are about right now is you're reviewing Nurse Hrobat's depo, kind of speed reading it to see whether or not you can tell me what her involvement was; is that what's happening?
A: No, I am just trying to associate the names with what I felt were their responsibilities that weren't upheld.
Q: It appears to me that you're paging through her depo and reading it now. You are doing that, aren't YOU?
A: Yes, I am.
Q: That's why I asked you about the highlighting. There's nothing that you can go to that highlights what she did or didn't do or how you feel she fell below the standard of care. Do I understand that correctly?
Doctor, let's move on. I really don't want to waste a lot of time here white you read the deposition, *so* . Is there anything that Nurse Hrobat did or didn't do that you wouldn't assign to Nurse Zilka and/or

Page 115

Nurse Young? And let me make sure that I'm clear. You didn't highlight anything in Nurse Hrobat's deposition that you can just go to, correct?
A: Well, I am looking. That's why I am looking.
Q: Did you highlight anything in her depo?
A: I didn't see anything highlighted in her depo.
Q: I didn't see anything highlighted in any of those depos. Would you confirm that for me?
A: Oh, I would disagree.
Q: Show me. Who are you looking for? Who do you have there now?
A: Nurse Zilka. The one I had just before —
Q: You are trying to locate a highlighting or something in there?
A: There is one. Who were we talking about just before?
MS. TOSTI: Nurse Hrobat.
BY MR. JACKSON:
Q: Nurse Zilka and then we went to Nurse Hrobat. I am counting, Doctor. That's three times you went through it.
A: Well, I will just have to take my time and do it right then because I know that there are highlighted spots in here. And you stated that I did not do that.

Page 116

Q: I said I didn't see any in any of them, and you disagreed with me.
A: I am disagreeing with you. It's in blue ink, right here.
Q: You didn't have to throw it, Doctor.
A: I didn't. You're down at the far end of the table.
Q: Is this the only thing you underlined in her depo?
A: I am not sure. I'd have to go through the whole thing.
Q: Well, you have been through it four times. On Page 30 you say in Nurse Zilka's depo, Lines 14 — well, you have a mark between Lines 12 and 18, and you underlined Lines 14 and 15. You say no as it relates to her comments there. Let me read what she says in those lines. "In between that time the patient had received a drug called vecuronium which is a paralytic type drug, and very likely bowel signs will become either very diminished or absent at that point. He had received a dose of that at 1850. So by the time we got there, it was very common, we may not have heard them." And you say no. What's your comment there?
A: Vecuronium is a skeletal muscle relaxant. It

Page 117

has no effect on the GI tract whatsoever.
Q: It is not a paralytic type drug?
A: It is a paralytic type drug for skeletal muscle. The gut is smooth muscle which is not affected by the neuromuscular drugs.
Q: So you are interpreting what she said there that the vecuronium would have a direct relation on the bowel sounds, and you disagreed with that?
A: That is correct.
Q: Now, we were talking about Nurse Hrobat. You didn't highlight anything in her deposition, correct? And are you able to tell me as you sit here without going back through her deposition yet another time what you believe she did or didn't do that fell below the

A: Well, she was the one that took the initial report and also with the propofol administration.

received from Dr. Muehlbach, Dr. Yared.
Q: Are you completed with your answer?

Q: What did she do that fell below standard of care in your opinion or failed to do?
A: Well, the patient was — became hypotensive during the infusion of the medications, and the medications were not slowed down; i.e., the propofol. And —
Q: And you believe — I am sorry. I didn't mean to interrupt you.
A: And this ultimately necessitated the starting of the inotropic drugs.
Q: So what did she do or failed to do that fell below the standard of care?
A: I believe the continued administration of the propofol despite the falling pressure necessitated other things to occur. Propofol does lower the blood pressure and would be one of the **drugs** that one would turn off when the pressure dipped.
Q: That's your answer?
A: Yes.
Q: I still don't understand what you're saying Nurse Hrobat did or failed to do that fell below the standard of care?
A: If you have a drug that lowers blood pressure and the patient experiences a drop in blood pressure,

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Page 119

one would not continue administering a drug that will continue to lower the blood pressure.
Q: So you're saying Nurse Hrobat did what; she continued to administer —
A: The propofol infusion was continued.
Q: So Nurse Hrobat fell below the standard of care in your opinion because propofol was continued to be administered?
A: That is correct.
Q: What time frame is that?
A: Well, the propofol was started when the patient came back. The patient dipped at Time E as in echo to 75/46. The nitroprusside was off, but the propofol was not turned off.

when you say she fell below the standard of care by not turning off the propofol?

golf
Q: So it's time E as in Edward that you're talking about?
A: That is correct.

Q: Have we covered everything in your opinion that — as to why Nurse Hrobat fell below standard of

A. Yes, I have.
Q: Let me go back to Dr. Muehlbach. You said there was some physiological changes that **was** evidence of an indication that this patient should be taken back to the operating room sooner. That was your first comment about Dr. Muehlbach?
A: That is correct.
Q: And what physiological changes are you talking about, and what time do you say this patient should have been taken back sooner? Excuse me. What time do you say the patient should have been taken back?
A: I think that if you look at the trends, the heart rate is going up, started off at 99. At Point G it goes to 107. At Point H it's 110. At Point I it's 104. At Point J it's 110. At Point K it's 110. At Point L it's 110. At Point M it's 110. At Point N it's 116. When the heart rate stayed up from G to H, H to I, he remained tachycardic, the pressure dropped systolic, it went 93 to 88 to —
Q: Excuse me, Doctor. You don't need to list all those for me. I am just asking you what physiological

Page 121

changes. The physiological change was the increase in the heart pressure?
A: The sustained tachycardia, the drop in systolic blood pressure. And what makes it very difficult after —
Q: That's between G and H on the chart?
A: G and J is that time period.
Q: G and J, okay.
A: Okay. One looks at a decreasing systolic blood pressure, an increasing heart rate which is a compensatory tachycardia, and the fact that the patient is requiring more and more inotrope. They have started Amicar because the patient continues to bleed. And then what makes it very difficult because it's obfuscated is that at Point K is the last pulmonary artery pressure reading that is obtained. If the patient — on a Bentyl procedure, these patients can be labile because of the nature of the surgery in and of itself. This patient had had one problem intraoperatively where they had to go back on bypass to fix the proximal suture line.
Q: Is that significant to you in this case?
A: Well, he rebled from the distal suture line; but the most common complication of a root replacement is bleeding.

Page 122

Q: My question was: Is that significant to you in this case, what you just commented on having to go back in and stitch that?
A: Well, they were in there already.
Q: Thank you. Having to go back and stitch that, is that significant in this case?
A: Well, you had a leak, you repaired it because the suture pulled out. That means that the tissue probably isn't as firm as one would hope for or like; however, they had to go back. And a patient that starts hemodynamically deteriorating such as this with a sustained tachycardia, one has to continue to follow the PA pressures and also follow other parameters, i.e., how much blood has come out the chest tube.
Q: Was the fact that they had go back and resuture the distal line significant to you in this case?
A: I think you're asking two difference questions.
Q: I tried to ask you one question three times.
MS. TOSTI: You said distal.
THE WITNESS: You said distal.
BY MR. JACKSON:
Q: I thought you said distal.
A: I said proximal.
Q: Forgive me then. I meant to say proximal. Was the fact that they went back in and stitched the proximal significant to you in this case?

Page 123

A: Only inasmuch as it indicates that the tissue they had to sew to may not have been as good as they liked. Did it change what happened to him? Was it significant in terms of outcome? No.
Q: Okay. Let's go on. In terms of these physiological changes, you're talking about increased heart rate, sustained tachycardia, decreased systolic blood pressure. You're saying that Dr. Muehlbach should have seen these things as an indication, and Mr. Long should have been taken back to surgery sooner, correct?
A: That is correct.
Q: When? When was sooner? When should he have been taken back in your opinion?
A: Well, I think I state in my letter here, I believe that if — beyond a reasonable degree of certainty that if Mr. Long had been taken back at L or prior to L, he would not have sustained the injuries he did.
Q: So it is your opinion that there was physiological changes that indicated that he should be taken back at Time L at the latest, is that correct? Is that what you're saying?

Page 124

A. Yes.
Q: Now, you said earlier that Dr. Muehlbach should have, as a result of these changes, either returned him to surgery or warranted closer care. What do you mean closer care?
A: Well, one of the things that could have been done would have been a transesophageal echo on the patient. The patient had a history preoperatively in the cath report of severe left ventricular dysfunction. He had an aortic gradient. I believe the square surface area was .57 square centimeters which is critical aortic stenosis. Patients like that when you unload the ventricle by putting a homograph valve in there oftentimes need some inotropic support. However, there's also some evidence of dysfunction after being on the bypass machine.
They raised the inotropes up, the pressure was going down, the CVP — if you look at the central venous pressure here from Time A all the way to Time R only went up maybe at one point to 20 at J. In classic tamponade one oftentimes sees a higher CVP but not always. If the patient has left ventricular dysfunction, it may be masked. There is no way to tell that without actually looking at the heart how the heart

Page 125

is beating.
If this patient had your heart and my heart, and hopefully we both have normal ventricular function, as the CVP — as the heart was getting tamponaded, if it went up, you would see a rise in CVP, a decrease in systolic blood pressure.
In a patient who has a compromised heart such as this patient, all bets are off. So just the pressure number on the Swan is not indicative of what's happening. You really need to see — and there's two ways to see. One is by doing a transesophageal echo which tells you that the heart is beating fine but it could be empty or there might be a mass behind it; or two is to expose the heart to the night air and under direct vision look at the heart.
And that's the problem with this care. If this had been a normal ventricle, totally different story; but this is an impaired ventricle with decreased function. And so one has to be somewhat — I don't want to say skeptical but highly suspicious of these numbers, and I would expect someone at Dr. Muehlbach's level of training to be cognizant of that. Because certainly when these parameters — when they persisted and were presented to Dr. Cosgrove, Dr. Cosgrove says meet you in

Page 126

the OR. There was no questions.
But nothing changed from this initial point all the way down. It was just more of the dwindles; and yet they went up on the drugs, the inotropes. So they were supporting it, but you can only beat a heart so hard and then it doesn't perform. And that's exactly what happened in this case.
There was a lack of PA pressure readings, I suspect because they were very high. And those in and of themselves — but there's critical information that's not in here; but just based on what —
Q: Critical information being the PA readings?
A: That's exactly right.
Q: Okay. Anything else?
A: But looking at this —
Q: Anything else other than the PA readings?
A: The PA readings are very important.
Q: Anything else?
A: Well, they didn't do a wedge pressure. I don't know if they follow wedge pressures there. A wedge would have been nice. That would tell you what the other side of the heart is looking at.
Q: Anything else?
A: There was no attempt to investigate the degree

Page 127

of myocardial dysfunction.
Q: Okay. That's information that's not there you say?
A: There was no attempt to do like a transesophageal echo.
Q: Okay. Anything else that's not there, any other information?
A: There's a chest x-ray that was done, showed some perihilar fullness at I believe 6:30 or so. The radiologist said a repeat film would be warranted. If you're suspecting tamponade or myocardial dysfunction, one of the easiest ways to do that would be a repeat chest x-ray. Because if there's some more fullness, that would be helpful. Was there a liter of blood in this man's chest? No. But you don't need a liter to cause the symptoms in a heart that has dysfunction.
And what happened is clearly evident. When he dropped that last 250 of blood, he precipitously tanked. He lost his pressure and everything. At the same time they're increasing his propofol which will drop it even more. It's incongruous.
I mean, it's like you got a gallon of gas in your tank, and then you drill a hole in your tank at the same time. You're going to run out of gas faster, and

Page 128

that's exactly what happened in this patient.
Q: Have you discussed all of your criticisms and the basis for your criticisms against Dr. Muehlbach? You also told me he didn't notify Dr. Cosgrove. When should he have notified Dr. Cosgrove?
A: While he was taking him to the OR about an hour before he did go, two hours before.
Q: He should have notified him —
A: He should have told him that this patient needs to go back to the OR.
Q: Excuse me; I'm trying to get the time that you say that should have happened.
A: It should have happened back when I stated before around L.
Q: Dr. Muehlbach should have notified Dr. Cosgrove at around Level L on the chart that this patient Needed to go to the OR, is that your criticism of Dr. Muehlbach?
A: Yes.
Q: Anything else about Dr. Muehlbach that you wish to say now?
A: I believe he should have been present at the bedside with this patient. Bentyls can be unstable, and I don't think it's prudent that a second-year resident

Page 129

baby-sits a pump.
Q: When should he have been at the bedside?
A: Until he was sure the patient was stable postoperatively. He could have —
Q: He could have what?
A: He could have been there. He had — obviously we all have to make rounds, but he left.
Q: When did he leave?
A: I'd have to look, but he was not present for some of this information.
Q: And is it your position, in your opinion, that Dr. Muehlbach not being at this patient's bedside was below standard of care?
A: I believe it's below the standard of care that this patient was unstable and he was not present.
Q: My question to you is, so I want to understand it: The fact that Dr. Muehlbach was not at this patient's bedside, in your opinion, was below standard of care?
THE WITNESS: Could you repeat that?
(The pending question was read by the court reporter.)
A: I would qualify that saying he was not at the bedside between H and M.

Page 130

BY MR. JACKSON:
Q: What times were those, Doctor?
A: 1950 would be at the end of H to M when the decision or prior — just prior to M should have been made to take this patient back.
Q: What time was M?
A: M is 2150. L which would have been the preceding time 2110.
Q: So between 1950 and —
MS. TOSTI: I think it's 2130. I think N is 2150.
BY MR. JACKSON:
Q: So between 1950 and 2130 it is your opinion that the fact that Dr. Muehlbach was not at the bedside was below standard of care?
A: Yes.
Q: That's a new one, isn't it? You didn't say that earlier.
A: No; this patient was unstable.
Q: No. The business about Dr. Muehlbach not being at bedside, you hadn't mentioned that earlier. That's one you just mentioned for the first time just a moment ago, is that correct?
A: My point was that Dr. Muehlbach was not

Page 131

present, that was my criticism, directing his care.
Q: My question to you was — well, the record will speak for itself. We'll see what it said earlier. You didn't say that earlier. You don't recall that, or do you?
A: I don't recall it.
Q: Is it your opinion that Dr. Muehlbach's breaches in standard of care caused some harm to Mr. Lung?
A: I believe it delayed the time for which Mr. Long got back to the OR.
Q: Did that cause harm to Mr. Long?
A: The delay in him going back to the OR I believe was directly attributable to his anoxic injury.
Q: I still don't have an answer to my question, I don't think. Do you believe that the delay which you think was caused by Dr. Muehlbach's breach of the standard of care caused Mr. Long injury or harm?
A Yes.
Q: And what harm did it cause Mr. Long?
A: I believe that Mr. Long would have had more reserve had he gone back to the OR later — sooner than later.
Q: Let's talk about Dr. Hernandez. Your comments

Page 132

about him earlier were that he should have been more directly involved in the patient's care and that he should have notified Dr. Muehlbach and Dr. Cosgrove. What do you say he — he didn't do that he should have done to be more involved in the patient's care?
A: My understanding is that he was the junior resident on the service. The junior resident usually gets all the scut work and the lab work and presents it to the chief and presents the chief of service which would be Dr. Muehlbach in this case the information. I see Dr. Hernandez getting some of the calls and making some adjustments, but I don't believe that Dr. Muehlbach had gotten all the calls.
Q: I don't understand what you just said, Doctor, as to how that falls below standard of care, Dr. Hernandez being more directly —
A: Dr. Hernandez was involved with the unit. He was covering this and two other units. The junior resident or what we used to call the boy on the service is responsible for all the scut work on the postops. The nurses go through him unless it's a major thing, then they go through the chief resident. And if it's someone arresting right in front of them, they usually call both people. If it looks like

Page 133

someone all of a sudden dumps a lot of blood or volume, they will call the junior chief and then the chief or the chief and the junior chief. But if they call the junior chief or the junior on the service, that person is obligated to call the senior on the service.

I don't believe that Dr. Hernandez kept a running dialogue with Dr. Muehlbach in all these changes.

Q: That's how you believe he fell below the standard of care?

A: Yes.

Q: Did that cause harm to Mr. Long?

A: Again, it's the communication issue that we've talked about.

Q: How did Dr. Hernandez' failure to do what you said he should have done cause harm to Mr. Long?

A: If all the information was not relayed in a timely fashion to Dr. Muehlbach, Dr. Muehlbach wouldn't have all the information nor could he refer it all to Dr. Cosgrove, who when presented with the information didn't even hesitate.

Q: Your first comments about Nurse Young were that she had poor charting, correct?

A: Poor charting.

Page 134

Q: And lack of charting?

A: And lack of charting.

Q: Do you say that caused harm to Mr. Young —

A: Yes.

Q: — Long, excuse me. How did the lack of charting cause harm?

A: Charting is sort of like a picture. The more parts of the puzzle — of the picture that are painted the easier the picture is to see. If you are missing critical information or it is not correctly recorded, the picture is somewhat in a fog or it's not clear.

Q: Well, charting is not a standard of care issue, is it? It's a charting issue?

A: Well, there's a standard of care for charting that allows you to take care of critically ill patients. If we had no charting here, we would never know what happened to this patient.

Q: My question to you was, Doctor, standard of care is different from a charting situation, is it not?

A Well, the standard of care — the delivery of the standard of care — there is a standard of care for charting. You have to have certain things, just like there's a standard of care for my charting in an anesthetic in the OR.

Page 135

Q: You said that she — when there was the initial dump of 250 at about 1930, she did not notify Dr. Muehlbach; that was one of the ways in which you believe she deviated from the standard of care; is that correct? Are you looking for the time?

A: Well, these aren't quite — G corresponds to 1930.

Q: Okay. And it was your belief that she did not notify Dr. Muehlbach of the discharge of 250 from the chest tube, correct?

A: Right. She raised the PEAP and at the same time decreased the FIO2.

Q: Let's talk about Nurse Zilka. In what way do you believe she did not provide adequate supervision for Nurse Young? What did she fail to do?

A: Well, the patient was not doing well. You have a nurse who has not completed her full orientation into a unit. I believe she was in her seventh or eighth week if I remember from the deposition.

Q: Out of how many weeks?

A: Out of 10 or 12. It depends. There's a digression in there, and they talk about balloon pump training also. And you have a patient — you have a nurse who is extremely experienced, and you have a nurse

Page 136

who is relatively inexperienced taking care of a critically ■patient. It's been my practice and it's been what I have observed and know to be what is correct that the nurse at that time, the supervisor or the mentoring nurse, would then slide into the primary physician — or position right there and facilitate that.

Q: Did she fail to do that in your opinion?

A: Yes, she did, and so stated in her deposition.

Q: You said she did not know the pharmacology of the drugs. Which drugs are you referring to?

A: I believe we talked about the vecuronium.

Q: Anyothers?

A: And she made one comment there — I would have to re-review the deposition that she quite — she understood the pharmacology, yet why would you continue to administer a drug and increase a drug that is known to lower blood pressure when you are fighting a low blood pressure.

Q: Okay. Your comment was that she did not know the pharmacology of drugs. You mentioned —

A: Vecuronium.

Q: Anyothers?

A: I would have to re-review it. There was one

Page 137

thing in I saw in there.
Q: Another drug which you — or some comment she made about a drug which led you to believe she did not know the pharmacology of certain drugs?
A: That is correct.
Q: Do you believe her comment about vecuronium caused harm to Mr. Long?
A: No.
Q: Okay. So the fact that she didn't know the pharmacology of these drugs did not cause harm to Mr. Long, is that correct?
A: Well, in vecuronium's case it wouldn't; but if she makes — one can by extrapolation, if you can make a mistake on a very common drug that you use everyday, the inotrope drugs are also very common and used everyday but have very significant problems associated with their misuse. And one has to make sure. That's why you have pharmacology brushup courses. So if she misstates one drug, one could believe that she may misuse other drugs.
Q: Is that the basis of your opinion regarding her?
A: Yes.
Q: Doctor, the decision to return a patient to the operating room, is that an anesthesia decision?

Page 138

A: It depends on the local politics. Sometimes it's very self evident. Sometimes it's a joint decision. Sometimes it's a very strict surgical. It's very easy to know that someone has to go back if they're dumping a liter of blood out their chest every 15 minutes.
Q: Whose decision is it to return a patient to the operating room under these circumstances?
A: In most institutions, it's the surgeon's primary decision.
Q: In what institutions that you are aware of is it not a surgical decision?
A: Well, in institutions where there's a collaborative effort, if someone is sitting there with the patient and the surgeon goes home such as an intensivist, the intensivist can certainly do that. Certainly I have called some of our surgeons at home, I said I think we need to go back, blood pressure is down, echo, heart looks empty, there may be a small clot behind it or a mass; and we'll go back.
Q: Who makes the decision to go back, Doctor?
A: Well, the final decision, the surgeon is the one that has to take them back.
Q: And what institutions — because you said in most institutions that's the way it is. Name an institution where that's not a surgical decision.

Page 139

A: Well, at Texas Heart they have full-time intensivists there. And if they think someone is bleeding or tampomding, they will call the surgeon back in.
Q: Who decides to take the patient back to the operating room under those circumstances?
A: Well, obviously the person with the knife in their hand is going to make the final decision.
Q: Are there any institutions where that's not the case that you can tell me that you're aware of?
A: Well, you can't make somebody go back if they don't want to go back, but the surgeon is the one that has the ultimate decision.
Q: It's a surgical decision to return to the operating room, isn't it?
MS. TOSTI: I think he's answered that about three times now.
BY MR. JACKSON:
Q: Is that a yes or no?
A: I think I said yes.
Q: And do you feel as an anesthesiologist that you're qualified to make that decision and to criticize

Page 140

that decision?
A: Oh, in certain cases, yes.
Q: In this case you think you are?
A: I think the decision to go back to the OR was the appropriate one, and it was just made too late.
Q: But my point is, Doctor, do you feel as an anesthesiologist that you're qualified to make — to criticize the surgical decision as to when a patient should be taken back to the operating room?
A: I think I can in this case.
Q: So you feel qualified to make that decision in this case?
A: I think I have made the decision in many cases I have been involved with and will sit down with the surgeons, and they say do you think the patient needs to go back.
Q: Please, Doctor, I am asking you in this case, do you feel qualified to make a criticism of the decision as to when this patient should go back to the operating room; is that what you're saying?
A I do.
Q: Let me go to your report. Do you have it in front of you? First page at the bottom you have two bullet points there. Those are just comments on facts.

Page 141

You're not making any comment on standard of care, am I correct?
A: That is correct.
Q: Page *2*, you talk about first bullet point there, the normal hemodynamic parameters began to deteriorate. Have you discussed that in detail so far? Is there something more about that that we haven't discussed?
A: Well, it decreased. From the time he left the OR until the time he got to the unit when they first got his vital signs, there was a decrease.
Q: You said it deteriorated during a very short period of time. I am asking you have you already talked about that, or is there more you need to say about that?
A: I think we've talked about it.
Q: The very short period of time when you're talking about his cardiac output of *3.2* and cardiac index of *2.0*, what time frame are you referring to there?
A: His initial at *1730*, time Point A, was 8.0, and his cardiac index was *3.3* there.
Q: I am asking about the cardiac output of *3.2* and cardiac index of *2.0*, when was that?
A: At Point E as in echo, his cardiac index is

Page 142

2.0, and his cardiac output is *3.4*.
Q: Is there a *3.2* and *2.0*, or is that just a misprint on mine?
A: *2.0* is at *E*, that is the cardiac index. And I have a ***3.4.*** Maybe it's a *3.2*.
Q: I am just trying to understand what's in your report. You said *3.2*. Do you believe it's 3.4?
A: It could be. It could be *3.4* or *3.2*.
Q: The next bullet point on Page *2* talks about the use of Levophed and Neo-Synephrine. Do you see that in your report?
A: Yes.
Q: Is the use of those two drugs unusual in this setting?
A: No.
Q: Your next bullet point talks about documented chest tube bleeding followed by a period of no bleeding and then the massive bleed. What period are you referring to when you say "period of no bleeding"?
A: There's a period from right at G to J where there's a minimal amount.
Q: Your report says no bleeding. That's why I asked you the question, Doctor. What period are you referring to when you say there's a period of no

Page 143

bleeding?
A: There's a time where there was no documented bleeding at period H and I. H was 1950. I was *2010*.
Q: When you say documented bleeding, are you referring to chest tube output?
A: That is correct. Then they document at Point J as in John a 50 cc amount. Nothing at K or L, again is quiet, another *50* cc amount.
Q: Is that a normal output for those periods of time, Doctor, running *50* for periods?
A: Well, running *50*, but —
Q: Is that normal?
A: This is a small bolus. They don't say that this is continuous. This is hourly.
Q: Well, how else do you record it where you are?
A: Well, there's time intervals. That's part of the problem with this is that there's no set intervals.
Q: How often do you record those in your hospitals, Doctor?
A: 30 minutes, every *30* minutes.
Q: Every *30* minutes they record chest tube output?
A: That is correct.
Q: Swan-Gam reading is the next bullet point. You say they weren't performed often enough?

Page 144

A: There is nothing performed after Point K.
Q: What time was Point K?
A: *2050*.
Q: So no Swan-Gam readings after Point K?
A: That is correct.
Q: Is that what you're referring to there, that after Point K they didn't do enough Swan-Gam readings?
A That was the point.
Q: That's what I'm trying to understand —
A. That is correct.
Q: — from your report. You're talking about after *2050*. How often should they have done them after 2050?
A: Well, they were doing them every half hour, every **20** minutes.
Q: How often should they have done them after 2050?
A: Half hour would have been fine.
Q: Every half hour?
A: If they would have done them.
O: You say "no one looked at the whole picture," quote, end quote. What do you mean by that?
A: There did not seem to be a total coordination. There was someone — they were giving propofol, and I

Page 145

still don't understand why they're giving propofol and increase the dose when the patient's blood pressure is going down.

Q: What did you mean when you said the whole picture, Doctor?

A: The whole picture. You step back. You look at the picture. You look at the hemodynamics. You look at the respiratory parameters; and God forbid, you look at the patient. You look at the numbers. You look at all the respiratory data. And you actually physically look at the patient. You can't always believe the numbers.

Q: Have you ever cared for a patient like Mr. Long?

A: Absolutely.

Q: How many?

A: I'd have to go back and look, but I have taken care of lots of hearts. I baby-sat the pump service for six months.

Q: Did you ever have to take a patient back to the operating room?

A: Yes.

Q: How often?

A: Depends on who the staff surgeon was.

Q: How so?

Page 146

A: Some were more concerned about hemostasis intraoperatively than others.

Q: So some would take them back sooner, some wouldn't? Some wouldn't take them back at all?

A: No; no, Some had a higher bring-back rate than others.

Q: You make a comment in that last bullet point in your report on Page 2 that it appears that the care provided Mr. Long was given by the least experienced individuals. What does that mean?

A: I think that Dr. Muehlbach should have been more involved in his care. I believe that the more experienced nurse should have been involved in his care.

Q: That being who?

A: The nurse who was the coordinator, Zilka, I believe. And no one let poor Dr. Cosgrove know what was going on. When Dr. Cosgrove got the information, he didn't need all the data. He said what's going on? This is what we need to do. Let's get him to the OR. And I believe that if Dr. Cosgrove knew what was going on and had gone on at L, Point L, Dr. Cosgrove would have taken this patient back.

Q: What is a cardiac tamponade, Doctor?

A: Cardiac tamponade is — you can have a pseudo

Page 147

tamponade or real tamponade. In a nutshell, the heart is an enclosed space. Compression extrinsically on the heart by blood or something else can cause dysfunction. If you have — and as a result, there are certain things that you find oftentimes but not always. There's no one thing that's pathognomonic. And it basically inhibits the preload of the heart or it inhibits cardiac ejection via compressive effort.

Q: What are the signs and symptoms of a cardiac tamponade?

A. In a normal heart, you would have an elevation of your central venous pressure. You may — you would have a decrease in your systemic blood pressure. You may have effects on systemic vascular resistance; but if you're on inotropes, all bets are off. And you may have a decrease in urine output but not necessarily. And if a patient has been given Lasix, you may not see the decrease in urine output because of this loop diuretic effect.

Q: You said that was in a healthy heart. Would those change in a patient such as Mr. Long?

A: Yes.

Q: What would the differences be in a patient such as Mr. Long?

Page 148

A: You may not detect a rise in CVP because they may have an associated right heart dysfunction. We knew he had global hypokinesis based on the report preoperatively. The decrease in blood pressure would be one of the things that you would have. One other thing I failed to mention in the previous, as long as the heart wasn't fully Beta blocked, you would get a reflux tachycardia because that's the only way a compromised heart can increase cardiac output.

If you can't increase stroke volume which is limited, you increase the rate because the cardiac output is the heart rate times the stroke volume. So as a result of that, one then sees a tachycardia that is sustained as defined if a heart rate is sustained above 100 beats per minute. And that's been my experience in practicality and also in conversations with many coordinators of tachycardia, it's probably one of the best signs that's most reliable as long as the patient isn't Beta blocked. CVP is nice if it goes along with it. It's not one simple finding. It's what you'd called the gestalt or the constellation of findings that you see. It's the total package of the presentation.

Q: When did Mr. Long suffer the catastrophic event that led to his vegetative state?

Page 149

A: Sometime after — I believe the exact point in time would be difficult, but it would be after Point — sometime after Point K because that's when the last time the Swan readings were. We don't really know anything else that was going on intracardiac and his pressure because we're not sure — there's a circle there at both L and M. They have recorded supra-high pressures, if those are PA pressures; and one doesn't know if the heart at that point ceased to function.

usually ischemia or something bad happening to the heart; but then there's blood pressures over here at N. But certainly when he came back from surgery he was not right.

Q: You're talking about the second surgery?

A: That is correct. So sometime between, as I stated, L/M that time interval, to the time he came back from the second surgery.

Q: Can you be any more specific in terms of time in your opinion as to when he suffered the catastrophic event?

MS. TOSTI: I think he's answered the question.

MR. JACKSON: No, he hasn't.

MS. TOSTI: He's told you between L and M and when he came back.

BY MR. JACKSON:

Q: I am talking about hours there. My question is, can you be more specific?

A: Well, after M all bets are off because there's no —

Q: Give me times if you would, please.

A: Well, your copy may be better than mine. The time M corresponds to when there's lack of Swan pressures, he went way up on his inotropes, to the time he came back.

Q: What time is M?

A: Well, my copy looks like 21 — well, it just doesn't make sense. It looks like there's two 2150s.

MS. TOSTI: I think it may be — M may be 2130.

A: Between 2130 and when he went to the OR.

BY MR. JACKSON:

Q: Was it too late at 2130 to save Mr. Long in your opinion?

A: Let's take a brake. I'll be right back.

Q: Please, before you do that, answer that question.

A: I believe after 2150 — or Point N here which is the end of M, it is impossible to tell what was going on inside the central perfusion pressures. There's no more things. They went up to maximum amount of drugs. The blood pressures were elevated. He was remaining tachycardic. We have no idea whether or not he had actual central pressures enough to perfuse.

At Point P we know he had a cardiac — at Point O we know he had cardiac output of seven liters per minute. At point P we have nothing. Point P is 2230 hours.

THE WITNESS: Can you reread the question back?

(The requested portion of the transcript was read by the court reporter.)

A: At 2150 I believe — at 2130 is where Mr. Long was in major trouble to the extent that he needed to go back to the OR.

BY MR. JACKSON:

Q: Do you believe you answered the question?

A: I believe so.

Q: At what point was it too late to change the outcome?

A: At Point O, at that point I believe the injury started to Mr. Long, 2210.

Q: Is that the point after which the outcome could not be changed?

MS. TOSTI: What outcome are you referring to, the anoxic encephalopathy?

BY MR. JACKSON:

Q: What were you referring to, Doctor, when you —

MS. TOSTI: What are you referring to as to the outcome?

MR. JACKSON: I want to know what he was referring to when he answered my question.

BY MR. JACKSON:

Q: What were you referring to when you answered my question?

A: The fact that the patient was going to probably arrest or become extremely hemodynamically unstable.

Q: So you believe after 2210 that couldn't be helped or changed, is that correct?

A: That's correct.

Q: Okay.

(A brief recess was taken.)

BY MR. JACKSON:

Q: Doctor, what happened to cause Mr. Long's brain damage?

A: I believe he had hypoperfusion.

Page 153

A: When he was hypotensive or hypoperfused.
Q: When was that, what point of time?
A: Sometime between 2230 and when he came back from the operating room the second time.
Q: Are you able to be any more specific than that time frame?
A: I cannot.
Q: At what point in time do you believe his brain damage could have been prevented?
A: Well, I think it occurred between 2230 and the time he got back from the OR. Had he gone back to the OR earlier, I think it could have been avoided.
Q: You are not critical of any of the care and treatment he received between the time he was sent to the OR and the time he returned, am I correct?
A: Other than that he went too late, the care was appropriate.
Q: Okay. Are you able to tell me the last point in time that he could have been sent to the operating room and not sustained brain damage in your opinion?
A: I think his period — his injury occurred between 2230 and the time he came back from the OR.
Q: That didn't answer my question.
A: I think that's the best I can answer it.

Page 154

Q: I understand that. But the question was, at what point in time before that? You say he should have been sent back earlier, correct?
A: That is correct.
Q: And you're saying if he had been sent back earlier, it would have made a difference in the brain damage. He wouldn't have had brain damage, correct?
A: I believe so.
Q: Why do you say that? What's your basis for that?
A: Because I don't think he would have, to use a euphemism, crashed and burned like he did on the way to the OR that he did. He would have gone down in a more controlled fashion, hemodynamically stable. He went down to the OR hemodynamically unstable.
Q: When is the last point in time, in your opinion, that he would have gone to the OR in a condition that you believe would have prevented the brain damage?
A: Prior to 2230.
Q: How far back?
A Just prior to 2230.
Q: Are you meaning like — are you saying like 2200 or before that when you say just prior? Are you saying immediately prior, or are you saying sometime before?

Page 155

A: I believe that when he dumped at **O,** at 2210, that last 250, he became hemodynamically unstable, hypovolemic, and sent him down on the spiral curve, the slippery slope. I believe that had he been taken back prior to that 2230, he would have had enough reserve so that they could have taken him down there without him getting hypotensive and anoxic.
Q: You changed your times there. You were talking 2210 and then you said ***2230.***
A: Time **O** is when he dumped the last 250.
Q: 2210?
A: That is correct.
Q: Is that the point in time before which he should have been taken to surgery in your opinion, and there would have been a different result?
A: That is correct.
Q: Okay. How much before 2210 do you believe — or how long before 2210 should he have been taken back to surgery where there would have been a different result in your opinion?
A: Prior to that.
Q: 2205?

Page 156

A: 2210 when he dumped that blood, I believe he started down to his ultimate outcome. It should have been done prior to that.
Q: Are you able to say with any more specific time when he could have or should have been taken back to the operating room and the result would have been different?
A: I think if they took him back before he got hemodynamically unstable at Point **O** would have made a difference.
Q: I know that. We have been over that, Doctor. I am asking you if you are able to say with reasonable medical certainty how long before 2210 in your opinion you believe he should have been taken back to the operating room and there would have been a different result?
A: I believe I stated at L and M when we lost the Swan readings, his index dropped, and his drug inotrope increased to *40* at Point N and M that the patient should have gone back then.
Q: Okay. Do you have an opinion that you can state to me as to at what point in time was the last chance to take Mr. Long back to the operating room and not have this result?
MS. TOSTI: Asked and answered. Objection.

Page 157

MR. JACKSON: It hasn't been answered. It's been asked a few.
MS. TOSTI: Objection, asked and answered.
BY MR. JACKSON:
Q: Do you understand my question, Doctor?
A: I believe that if he had gone back to surgery prior to 2210, he would have not have had the neurologic outcome and sequelae that he suffered.
Q: You have said that to me. I am asking you are you able to tell me the last point in time — do you have an opinion as to the last point in time that he could have been taken back to the operating room and not suffered that sequelae?
MS. TOSTI: Objection, asked and answered.
BY MR. JACKSON:
Q: Go ahead, Doctor.
A: I would still stay with what I said, the 2210.
Q: That's the last point in time in your opinion that he could have been taken back and had a different result?
A: That's when he dumped.
Q: My question is: Is that the last point in time? After that time, they couldn't change it?
MS. TOSTI: His answer was prior to 2210.

Page 158

MR. JACKSON: That's what I am trying to figure out, but he won't answer my question.
BY MR. JACKSON:
Q: At what point prior to 2210, Doctor, could he have been taken back and not had the same result?
MS. TOSTI: Objection, asked and answered.
MR. JACKSON: Then tell me what time he said.
MS. TOSTI: I am just putting my objection on the record. He's answered the question about five times now.
MR. JACKSON: He has not. He keeps saying 2210, before 2210.
BY MR. JACKSON:
Q: What's the last point in time, Doctor? And if you can't give it to me, then tell me that.
A: When his inotrope was again increased and the patient's indexes went down, and the patient's blood pressure went down, that's between L and O, that's 2110 to 2210. They maximally increased his inotrope at M which is 2130. Whatever that — it looks like a five but it could be a three, and M.
Q: Is it your opinion that if he had been taken back at 2110, there would have been a different result?
A: Yes.

Page 159

Q: Is it your opinion that if he had been taken back at 2100, there would have been a different result?
A: Yes.
Q: Is 2110 the last point in time that you believe he could have been taken back to the operating room and there been a different result? Is that what I am understanding you to say?
A: No, 2210 is. That's the point at which he dumped. That's the point where he became extremely unstable.
Q: So if he had been taken back any time before 2210 in your opinion, the result would have been different?
A: Yes.
Q: And you say that because you believe what?
A: Because I believe his hemodynamics were deteriorated to the point where he was hypoperfusing and his indexes dropped, and his heart rate proceeded to go up.
Q: Doctor, have I covered all your opinions that you have rendered in this case?
A: You have.
Q: If there's any changes in those, additions, corrections, deletions, you will let us know?

Page 160

A: I would.
Q: Okay. One other — two other questions actually. How did they get to you, do you know? How did the Becker firm get to you?
A: I don't know.
Q: And in terms of care and treatment of a cardiac surgical patient, would you defer to Dr. Cosgrove's opinions?
A: With regard to what?
Q: The care and treatment of a cardiac surgical patient.
A: With what aspects?
Q: All aspects.
A: Well, all aspects includes all the anesthesia aspects?
Q: All aspects.
A: I think we would have things that we would agree on. We would have things we would disagree on. I would not defer to his anesthetic management of a case.
Q: During the course of a surgery you mean?
A: That is correct. I would not defer to his use of the drugs postoperatively such as propofol which is typically an anesthetic drug.
Q: You would not defer to his opinions in that

Page 161

regard. How about his opinions regarding the other medications given to a —

A: Well, I use inotropes just like Cosgrove does. I mean, I would definitely discuss it with him.

Q: Would you defer to his opinion regarding the use of inotropes in a post-cardiac surgery patient?

A: Not necessarily.

Q: Okay. Do you know who Dr. Cosgrove is?

A: I know he is a fairly prominent surgeon at the clinic. He is the head of their cardiac program I believe.

Q: Do you know how many cardiac surgeries he's performed in his career?

A: I am sure it's well in excess of 10 to 15,000.

Q: So I'm clear that you have no criticisms of Dr. Cosgrove's care of this patient, correct?

A: Absolutely none.

Q: You believe what he did and how he treated this patient were appropriate and within standards of care?

A: Yes. I think the patient would have had a good outcome if he had been informed of what was going on earlier.

Q: You would certainly defer to Dr. Cosgrove on surgical decisions as it relates to cardiac patients,

Page 162

would you not?

A: I would.

MR. JACKSON: I don't have any further questions, Doctor. And you have already indicated I think that you are going to reserve signature.

THE WITNESS: I will reserve signature.

THE COURT REPORTER: Ms. Tosti, will you take care of the reading and signing?

MS. TOSTI: Yes, I will take care of signature.

THE COURT REPORTER: Do you want this written up, Mr. Jackson?

MR. JACKSON: Yes, with a mini and an index.

THE COURT REPORTER: Copy, Ms. Tosti?

MS. TOSTI: Yes, and a mini.

(Whereupon, the preceding deposition concluded at 6:20 p.m.)

Page 163

STATE OF ILLINOIS)
) SS
COUNTY OF WINNEBAGO)

CHRISTOPHER S LONG,)
Executor, etc ,)

Plaintiff,)

vs) CASE NO 419978

CLEVELAND CLINIC FOUNDATION,)

Defendant)

This is to certify that I have read the transcript of my deposition taken in the above-enttled cause by Tracy L Abbott, Certified Shorthand Reporter, on January 28,2002. and that the foregoing transcript accurately states the questions asked of me and the answers given by me as they now appear

W Stephen Minore, M D

Subscribed and sworn to before me this _____ day of _____, A D 2002

Notary Public

Page 164

STATE OF ILLINOIS)
) SS.
COUNTY OF WINNEBAGO)

I, Tracy Abbott, a Notary Public within and for the County of Winnebago, State of Illinois, do hereby certify that heretofore, to-wit, on the 28th day of January, 2002, personally appeared before me at 2202 Harlem Road, Suite 200, Loves Park, Illinois, W. Stephen Minore, M.D., in a cause nowpending and undetermined in the Court of Common Pleas, State of Ohio, County of Cuyahoga, wherein Christopher Long is the Plaintiff and Cleveland Clinic Foundation is the Defendant.

I further certify that the said witness was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by said witness was reported stenographically by me in the presence of the said witness and afterwards reduced to typewriting by computer-aided transcription, and the foregoing is a true and correct transcript of the testimony so given by said witness as aforesaid.

I further certify that the signature to the foregoing deposition was reserved by the deponent.

Page 165

I further certify that the taking of this deposition was pursuant to Notice and that there were present at the deposition the attorneys hereinbefore mentioned.

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

In testimony whereof, I have hereunto set my hand and affixed my notarial seal this 7th day of February, 2002.

Tracy L. Abbott
License Number 084-003182
Notary public, Winnebago County,
Illinois

Lawyer's Notes

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Lawyer's Notes