

In The Matter Of:

*Christopher S. Long v.
Cleveland Clinic Foundation*

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

*McCorkle Court Reporters, Inc.
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*Original File 012802SM.TXT, 165 Pages
Min-U-Script® File ID: 1701020437*

Word Index included with this Min-U-Script®

Page 1		Page 3	
[1]	IN THE COURT OF COMMON PLEAS	[1]	INDEX
[2]	STATE OF OHIO	[2]	ATTORNEY EXAMINATION
[3]	COUNTY OF CUYAHOGA	[3]	Mr. Jackson 4
[4]		[4]	
	CHRISTOPHER S. LONG,)	[5]	
[5]	Executor, etc.,)	[6]	
[6]	Plaintiff,)	[7]	
[7]	vs.) CASE NO. 419978	[8]	
[8]	CLEVELANDCLINIC FOUNDATION,)	[9]	
[9]	Defendant.)	[10]	
[10]		[11]	
[11]	The deposition of W. Stephen Minore, M.D.,	[12]	
[12]	taken by the defendant before Tracy L. Abbott, Certified	[13]	
[13]	Shorthand Reporter and Notary Public, at 2:00 p.m.,	[14]	
[14]	January 28, 2002, in the offices of Rockford	[15]	
[15]	Anesthesiology Associates, 2202 Harlem Road, Suite 200,	[16]	
[16]	Loves Park, Illinois.	[17]	
[17]		[18]	
[18]		[19]	
[19]		[20]	
[20]		[21]	
[21]		[22]	Signature Page 163
[22]		[23]	
[23]		[24]	Certificate 164
[24]			
Page 2		Page 4	
[1]	APPEARANCES:	[1]	WILLIAM S. MINORE, M.D.,
[2]		[2]	having been first duly sworn, was examined and testified
[3]	BECKER & MISHKIND CO., L.P.A.,	[3]	as follows:
[4]	BY: MS. JEANNE M. TOSTI,	[4]	
[5]	Skylight Office Tower	[5]	EXAMINATION
[6]	1660 West Second Street, Suite 660	[6]	BY MR. JACKSON:
[7]	Cleveland, Ohio 44113	[7]	Q: Dr. Minore, you have been identified as an
[8]	(216) 241-2600	[8]	expert, and I understand you are going to render
[9]	appeared on behalf of the Plaintiff;	[9]	opinions in this matter. Am I correct in that
[10]		[10]	understanding?
[11]	ROETZEL & ANDRESS,	[11]	A: That is correct.
[12]	BY: MR. JOHN V. JACKSON	[12]	Q: I just looked at what I understand is at least
[13]	1375 East Ninth Street	[13]	a portion of your file. There was a three-ring binder
[14]	One Cleveland Center, Tenth Floor	[14]	with records from the Cleveland Clinic, correct?
[15]	Cleveland, Ohio 44114	[15]	A: That is correct.
[16]	(216) 623-0150	[16]	Q: And there are some depositions?
[17]	appeared on behalf of the Defendant.	[17]	A: That is correct.
[18]		[18]	Q: Is there anything else you reviewed as it
[19]		[19]	relates to this matter?
[20]		[20]	A: I have not.
[21]		[21]	Q: Do you have any other file as it relates to
[22]		[22]	this matter other than the records and the depositions?
[23]		[23]	A: I don't have anything that is present with me,
[24]		[24]	no.
			MS. TOSTI: I will —

Page 5

[1] **MR. JACKSON:** Let me finish my question.
[2] **MS. TOSTI:** Okay.
[3] **EXAMINATION**
[4] **BY MR. JACKSON:**
[5] Q: My question was, do you have any other file?
[6] **A:** I have no other files. I have some
[7] correspondence with regards to letters I have received
[8] from the attorney, but it's not with me.
[9] Q: Where is it?
[10] **A:** That's a good question.
[11] Q: Did you have it here today?
[12] **A:** I did not.
[13] Q: She was about to say she removed some things
[14] from your file.
[15] **MS. TOSTI:** Well, let me speak for myself. I
[16] did remove our correspondence from the file as attorney
[17] work product.
[18] **MR. JACKSON:** Where is it now, Doctor?
[19] **MS. TOSTI:** I believe it's still in the
[20] doctor's office.
[21] **MR. JACKSON:** Here?
[22] **MS. TOSTI:** Yes.
[23] **THE WITNESS:** Across the street. I don't have
[24] it with me personally.

Page 6

[1] **BY MR. JACKSON:**
[2] Q: When you say across the street, do you mean the
[3] attached building here?
[4] **A:** The building next to us.
[5] Q: Okay. What was removed?
[6] **A:** What was my what?
[7] Q: What was removed from your file?
[8] **A:** The letters I had received from Cindy Ebner.
[9] It wasn't really removed. I have my files — just maybe
[10] this will be helpful. I keep my stuff that I review in
[11] one box; and then there's a letter, the correspondence
[12] letters that I have that I have received from the
[13] attorneys in another file. So nothing was removed from
[14] the file; but there are two, discrete, separate files.
[15] Q: How do you coordinate the two files?
[16] **A:** Well, one, the correspondence with the attorney
[17] can fit into a nice, little, thin file in my folder.
[18] This is usually kept off site or kept in the storage
[19] locker.
[20] Q: What in addition to the correspondence from the
[21] attorney is kept in your other folder?
[22] **A:** That's it.
[23] Q: Well, how do you identify the folder? Is there
[24] a marker on it, a case number on it?

Page 7

[1] **A:** Well, there's a name on it.
[2] Q: What would be the name on this file?
[3] **A:** Long versus Cleveland Clinic.
[4] Q: And I assume that you reviewed these materials
[5] in preparation for the depo —
[6] **A:** I did.
[7] Q: — what you have in front of you?
[8] **A:** That is correct.
[9] Q: And you reviewed your correspondence file?
[10] **A:** I did not review my correspondence file in the
[11] sense that — other than the letters that were in there.
[12] Q: Well, I am having trouble understanding that.
[13] Other than the letters that are in there, is there
[14] anything else in your correspondence file?
[15] **A:** No: no. My correspondence file I keep so that
[16] I know who sent me the case.
[17] Q: I understand. My question to you was, did you
[18] review that? Your answer was I reviewed it other
[19] than — nothing other than the correspondence, so that
[20] led me to believe there might be something else in
[21] there.
[22] **A:** There's nothing else in there.
[23] Q: You did review that for the deposition?
[24] **A:** The correspondence file?

Page 8

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

Page 9

Page 11

[1] my letter to the attorneys.
[2] Q: Okay. So in addition from the correspondence
[3] that they sent to you, there are facts and opinions that
[4] you wrote back to them; is that what I understand you
[5] just to say?
[6] A: That's not what I just said.
[7] Q: Okay. Then let me clarify it. When they sent
[8] you this letter asking you to review it, did they list a
[9] factual summary of the case?
[10] A: I would have to go back and review it. I don't
[11] recall that.
[12] Q: Do you recall if they listed opinions that
[13] other people have rendered in this case?
[14] A: I don't believe that there were. I don't
[15] recall those.
[16] Q: Did it list any opinions that they were asking
[17] you to render in this case?
[18] A: They asked me to review the case.
[19] Q: Was that all? Let's do this to save guessing
[20] time. I mean, we're 50 feet from — I mean, these
[21] buildings are attached, aren't they?
[22] A: I go outside.
[23] Q: Would you go take a look at those? I'd like
[24] you to go and take a look at those correspondence and

[1] those to Mr. Jackson so that we can get on with the
[2] deposition.
[3] THE WITNESS: Okay.
[4] (A brief recess was taken.)
[5] MS. TOSTI: He has all of the correspondence.
[6] You can have it.
[7] EXAMINATION
[8] BY MR. JACKSON:
[9] Q: Is this everything that you received from them,
[10] Doctor?
[11] A: That is correct.
[12] Q: Is there anything you sent them that —
[13] A: There is not.
[14] Q: — that we don't have in front of us here or
[15] is your reports here?
[16] A: There is not.
[17] Q: Okay. It appears that you were first contacted
[18] sometime before August 23rd of 2000, that's the first
[19] letter?
[20] A: It would be — that would be correct.
[21] Q: Do you remember how you were contacted?
[22] A: By phone.
[23] Q: By whom?
[24] A: Cindy Ebner.

Page 10

Page 12

[1] then let me ask you some questions about them. They're
[2] not going to let me see them apparently. So I am going
[3] to have to ask it this way. So let's take a minute.
[4] Please go look at it.
[5] MS. TOSTI: No, the doctor isn't going to go
[6] look at his correspondence. We removed the
[7] correspondence from the file as attorney work product.
[8] You can ask the doctor whatever you want about them.
[9] You can ask him if he's relied on them for his opinions.
[10] MR. JACKSON: I want to know what's in them,
[11] Jeanne; and if you're not going to let me see them —
[12] MS. TOSTI: Well, then we can fight about that
[13] later.
[14] MR. JACKSON: We will. Doctor —
[15] MS. TOSTI: Basically we have removed it as
[16] attorney work product. If you want to take his
[17] deposition, take his deposition and ask him questions;
[18] but, you know, that's a whole different issue.
[19] MR. JACKSON: Doctor, I want to break for a
[20] minute. I want you to go look at that correspondence so
[21] that you can tell me generally what's in it. Please do
[22] that, and then we will reconvene.
[23] MS. TOSTI: Doctor, let's — I am going to go
[24] look at the correspondence and see if we'll produce

[1] Q: And what were you asked to do?
[2] A: Review a case.
[3] Q: What were you told about the case?
[4] A: That it was a cardiac surgical case, cardiac
[5] anesthesia case, and would I review it.
[6] Q: And apparently with that record or that letter
[7] of August 23rd, 2000?
[8] A: That is correct.
[9] Q: August 23, 2000?
[10] A: That is correct, 23 August 2000.
[11] Q: They sent you the medical records?
[12] A: That is what I would assume.
[13] Q: Would that be the three-ring binder then,
[14] that's what you received first?
[15] A: That would be correct.
[16] Q: Was there any particular thing you were asked
[17] to do other than review the records?
[18] A: They asked me to review the records and then
[19] discuss the case with them.
[20] Q: With what particular specialty or point of
[21] interest in mind?
[22] A: From an ICU anesthesia standpoint.
[23] Q: And then apparently on February 14th of 2001, I
[24] will hand you this in a minute to confirm it, they sent

Page 13

[1] to you the reports of Denise Hrobat — excuse me, the
[2] depositions of Denise Hrobat, Katherine Zilka and
[3] Angelique Young; is that correct?
[4] A: That is correct.
[5] Q: And you made some writings on that one. Tell
[6] me what you wrote on there.
[7] A: I believe I circled one of the individual's
[8] names and wrote space cadet.
[9] Q: What do you mean by that?
[10] A: That I wasn't sure that that patient — or that
[11] that nurse had a good handle on what she was doing.
[12] Q: What was — I mean, was space cadet an insult
[13] to her; is that what you were trying to do?
[14] A: Oh, it wasn't pejorative. It was just not in
[15] keeping with the care that I would expect in a patient.
[16] Q: 'What does the term mean to you, Doctor? What
[17] does space cadet mean?
[18] A: What? I think it's self-evident.
[19] Q: I am asking you to explain it for me.
[20] A: I think that that individual based on my
[21] interpretation of the records and her deposition didn't
[22] have a clue of what was going on with the patient.
[23] Q: What are the other numbers that are written on
[24] there? What do those signify?

Page 14

[1] A: The amount of time I spent on it, and then the
[2] bill that was sent.
[3] Q: How much time did you spend on it?
[4] A: Four hours.
[5] Q: And you billed them how much?
[6] A: \$1,650.
[7] Q: There **was** some of that writing on that first
[8] sheet also, and I didn't ask you about it.
[9] A: That is correct.
[10] Q: Tell me what that is on the first one, on the
[11] August letter.
[12] A: There was a 9/5 call to Ebner and —
[13] Q: 9/5 would have been the date?
[14] A: That is correct. And Michael Becker.
[15] Q: You spoke with Mr. Becker and Ms. Ebner?
[16] A: I placed a call to them. It looks like I just
[17] talked to Ms. Ebner.
[18] Q: For how long, and what did you charge?
[19] A: Well, it doesn't say there. There's some
[20] numbers on there, but —
[21] Q: What do those mean?
[22] A: I am not sure.
[23] Q: 'What are the numbers that are there?
[24] A: There's one that says 3,950.

Page 15

[1] Q: That has no meaning to you?
[2] A: Well, that may have been the total bill to date
[3] or for the total review of the records to date.
[4] Q: November 28th they sent you a letter regarding
[5] when your deposition was to be taken, correct?
[6] A: That is correct.
[7] Q: And then on January 22nd they sent you a
[8] Federal Express package apparently containing the
[9] deposition transcripts of Dr. Hernandez, Dr. Hearn and
[10] Dr. Koch, K-o-c-h, is that correct?
[11] A: That is correct.
[12] Q: Did you — do I assume then that you reviewed
[13] those depositions that were listed in those two letters
[14] at a point in time after you received them with those
[15] letters of transmittal?
[16] A: That would be fair to assume.
[17] Q: Did you review any other depositions?
[18] A: Just the ones that I have before me.
[19] Q: When did you get those?
[20] A: I believe that they would have come with time.
[21] I don't really have the exact dates.
[22] Q: In what areas of medicine do you consider
[23] yourself an expert, Doctor?
[24] A: I practice anesthesiology.

Page 16

[1] Q: In what areas do you consider yourself to be an
[2] expert?
[3] A: I consider myself an expert in anesthesiology.
[4] Q: Any particular areas of anesthesiology?
[5] A: I do cardiac anesthesia, pain management and
[6] critical care.
[7] Q: Would you consider yourself to be an expert
[8] then in cardiac anesthesia?
[9] A: Yes, I would.
[10] Q: Do you consider yourself to be an expert in
[11] pain management anesthesia?
[12] A: Yes, I would.
[13] Q: Or pain management in general, would that be a
[14] better way to say it?
[15] A: That would be fine.
[16] Q: Do you consider yourself to be an expert in
[17] critical care?
[18] A: Yes.
[19] Q: Are you married?
[20] A: Yes, I am.
[21] Q: Any children?
[22] A: Two.
[23] Q: How old are they?
[24] A: 14 and 13.

Page 17

Page 19

[1] Q: Explain for me, if you would, what your normal
[2] workweek is like. What's your current practice?
[3] A: Get up about 4:00 o'clock in the morning, lift
[4] weights from 5:00 to 6:00 three days a week, make rounds
[5] at the hospital starting at 6:45 usually. If I am in
[6] the OR that day, I will get to the hospital at 6:00 and
[7] start my first case by 7:00, usually work until 8:00 or
[8] 9:00 at night, have dinner at one of the local
[9] restaurants and get home by about 11:00.
[10] Q: And that schedule is your schedule how many
[11] days a week?
[12] A: Pretty much every day.
[13] Q: Seven days?
[14] A: No, Monday through Friday. Sometimes I get
[15] done a little bit earlier around 6:00 or 7:00. Weekends
[16] it can be feast or famine. It can be starting at 7:00
[17] a.m. on a Saturday and finish at 7:00 a.m. on Monday or
[18] variable in between.
[19] Q: What is the nature of your practice?
[20] A: I run my group. It's a group of physicians.
[21] My practice is three-and-a-half to four days a week I am
[22] clinical, one to one-and-a-half days I am nonclinical.
[23] I confine myself to pain management and cardiac
[24] anesthesia, high-risk cases, high-risk vascular cases,

[1] A: I apologize. It looks like they dropped it
[2] off. The word processor deleted it. Again
[3] Swedish American Hospital, Saint Anthony's hospital,
[4] Freeport Memorial Hospital, Northwest Suburban Community
[5] Hospital, the Rockford Ambulatory Surgical Treatment
[6] Center, and Medical Pain Management Services. The two
[7] where the hearts are done are Saint Anthony's Medical
[8] Center and Swedish American Hospital.
[9] Q: How much of your time do you spend at
[10] Swedish American?
[11] A: About 20 percent.
[12] Q: That's 20 percent of the week that you
[13] described for me just a little bit ago?
[14] A: That is correct.
[15] Q: How much of your time do you spend at Saint
[16] Anthony's?
[17] A: About 50 to 60 percent.
[18] Q: Again these percentages are based on that week
[19] that you described for me?
[20] A: That's correct.
[21] Q: How about Freeport?
[22] A: Very rarely. It's a smaller hospital. They
[23] don't do the kind of cases that I am involved in. Same
[24] thing with the Surgery Center, same thing with Northwest

Page 18

Page 20

[1] high-risk aneurysms. I am the director of our cardiac
[2] anesthesia group, and I am responsible for teaching the
[3] other partners and our CRNAs the nuances of cardiac
[4] anesthesia.
[5] Q: Where do you spend your time as an
[6] anesthesiologist in terms of rendering patient care?
[7] A: Well, I am on staff at Saint Anthony's
[8] hospital, Swedish American Hospital. It's all contained
[9] in my CV. It would probably be easier that way.
[10] Q: All right.
[11] A: Occasionally go to the Surgery Center. I am on
[12] staff at several hospitals, but Saint Anthony's and
[13] Swede's are the two hospitals that we do our hearts at.
[14] We do approximately 1,000 pumps a year. And one of our
[15] cardiac surgeons is one of the pioneers of off-pump
[16] bypass, and we have physicians come in from all over the
[17] country to learn how to do it.
[18] Q: Show me where your hospital affiliations are.
[19] MS. TOSTI: Here's one here if you want to give
[20] him back his, and you can talk back and forth if that
[21] makes it easier.
[22] EXAMINATION
[23] BY MR. JACKSON:
[24] Q: What page on your CV?

[1] Suburban. And Medical Pain is where I see my pain
[2] patients.
[3] Q: So you are rarely at Northwest Suburban?
[4] A: That is correct.
[5] Q: And you are rarely at the Surgical Treatment
[6] Center?
[7] A: That is correct.
[8] Q: How about the Pain Management Center?
[9] A: There about 20 percent, 25 percent, maybe 30.
[10] Q: Where is Swedish American located?
[11] A: On State Street — or Charles Street, 14 —
[12] Q: You don't have to be that specific. I am
[13] looking for a city.
[14] A: They're within three miles of one another.
[15] It's approximately a —
[16] Q: In Rockford?
[17] A: Yes.
[18] Q: How big a hospital is Swedish American?
[19] A: About 430 beds. Saint Anthony's is about 350.
[20] Q: And what types of cardiac surgery do they do at
[21] Swedish American?
[22] A: The same thing they do at Saint Anthony's. We
[23] do everything except for heart transplants. We limit
[24] ourselves — we don't do very many kids anymore.

Page 21

[1] Q: Everything but heart transplants, and you don't
[2] do children now?
[3] A: We do VSDs or ASDs if they're straightforward,
[4] but we haven't done TETs in a while or those types of
[5] cases.
[6] Q: Where do you send the VSDs, ASDs?
[7] A: It depends. Either to Chicago, Children's or
[8] Christ Hospital, depending on where Dr. Libawi operates.
[9] Q: Who are the cardiac surgeons with whom you work
[10] doing the cardiac surgery?
[11] A: Drs. Chang, Harper, Stieglitz.
[12] Q: Spell Stieglitz for me, please.
[13] A: S-t-i-e-g-l-i-t-z. And Dr. —
[14] Q: Are they at Swedish American?
[15] A: Well, they're all one group, so it doesn't
[16] really matter.
[17] Q: They go to both hospitals?
[18] A: That is correct. And there's one other one.
[19] Chang — I always call him by his first name, so I never
[20] think of his last name.
[21] Q: What's his first name?
[22] A: John. Actually I call him something else, but
[23] we're good friends.
[24] Q: Something you'd rather not put on the record?

Page 22

[1] I won't press you on that one, Doctor.
[2] A: We've got to stop. I have got to think of this
[3] name now.
[4] Q: When it comes to you, let me know. Are there
[5] any other anesthesia groups?
[6] A: We are the sole provider of anesthesia for
[7] these two hospitals.
[8] Q: What type of postoperative unit does
[9] Swedish American have?
[10] A: Well, they have a regular ICU.
[11] Q: Excuse me; for cardiac patients.
[12] A: They have two ICUs that they can go to, the CCU
[13] or the ICU. They're adjacent to one another. Each one
[14] is a 12-bed unit.
[15] Q: And what makes the determination as to whether
[16] a patient goes to CCU or ICU at Swedish American, a
[17] cardiac patient?
[18] A: It depends on which unit either has the least
[19] patients or the most open beds.
[20] Q: So it's a matter of availability as opposed
[21] to —
[22] A: That is correct.
[23] Q: What's the setup at Saint Anthony's for
[24] postoperative patients?

Page 23

[1] A: They have a large, 30-bed unit; and the fresh
[2] postops go in one end and come out the other end. So
[3] they kind of migrate down.
[4] Q: Are these cardiac patients we're talking about?
[5] A: Primarily cardiac, but all types of ICU
[6] patients; but primarily fresh open hearts in this unit.
[7] It's on the second floor.
[8] Q: Okay. Do they do minimally invasive cardiac
[9] surgery at either Swedish American or Saint Anthony's?
[10] A: Yes, Dr. Chang does.
[11] Q: Do you know the types of minimally invasive
[12] cardiac surgery he does?
[13] A: Well, he does the off-pump procedure. He does
[14] the revascularization procedures.
[15] Q: When you say revascularization, you're talking
[16] about bypasses?
[17] A: That is correct.
[18] Q: How about valves, does he do valves?
[19] A: I have not personally done a minimally invasive
[20] valve with him, but he has done them. Although, quite
[21] honestly, minimally invasive if you go trans-sternal
[22] isn't so minimally invasive.
[23] Q: In your opinion?
[24] A: Based on the amount of chest pain patients have

Page 24

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

Page 25

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

[4] A: He does not.

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

[7] A: I believe Dr. Harper does some and Dr. Polidori
[8] does some.

[9] Q: Is that your friend, Polidori?

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

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

[13] A: That is correct.

[14] Q: Can spell that?

[15] A: P-o-l-i-d-o-r-i.

[16] Q: Harper does some minimally invasive?

[17] A: Yes, he does.

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

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

[24] Q: When you use the term "they do a pump," what do

Page 26

[1] you mean?

[2] A: Cardiopulmonary bypass machine.

[3] Q: Do you know what frequency — or with what
[4] frequency Dr. Chang does the minimally invasive
[5] surgeries?

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

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

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

[15] Q: Have you ever received training for minimally
[16] invasive cardiac surgery anesthesia?

[17] A: I have not.

[18] Q: Is there any special training that would apply
[19] to that?

[20] A: Well, if you're at a fellowship program when I
[21] did a fellowship — obviously this wasn't around — but
[22] by going to meetings and conversations since we were one
[23] of the initial proponents of off-pump surgery, Dr. Chang
[24] was, obviously we have kept the dialogs up. It's not

Page 27

[1] considerably different than you would for a non-pump
[2] case or a full-pump case with a median sternotomy.
[3] There are some other implications, but they're more
[4] surgical implications than anesthetic implications.

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

[7] A: I don't think so.

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

[11] A: They are the only group that does them.

[12] Q: With what frequency do you do cardiac
[13] surgery —

[14] A: I never do cardiac surgery.

[15] Q: You didn't let me finish. Cardiac surgery
[16] anesthesia?

[17] A: The direct case where I am sitting in the room,
[18] I'd have to pull my billing records. I am in the room
[19] three days a week consulting with my partners. I do the
[20] transesophageal echos for them. Many of them do not
[21] have the ability to do that. So I am there at the
[22] beginning of the case, help them start the case, and we
[23] use two physicians on a case. So I am there for
[24] probably — well, I am there three days a week. So

Page 28

[1] whatever the number of cases is. Some days you do no
[2] cases; other days you can do five.

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

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

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

[15] A: Up to three days a week.

[16] Q: Sometimes less, sometimes three?

[17] A: That's correct.

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

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

Page 29

[1] Q: Okay.
[2] A: And when I am in there, some weeks I can do 10
[3] or 15 cases. Other weeks I might do one or two. It's
[4] purely on the busyness. If one of the heart surgeons is
[5] on vacation or more importantly if one of the
[6] cardiologist or two of the cardiologists are gone, it
[7] can be a very slow week. The week that the
[8] cardiologists come back, we're there every night until
[9] midnight.

[10] Q: What actually is your role as an
[11] anesthesiologist in these surgeries then?

[12] A: Well, you are responsible for putting the
[13] patient asleep, anesthetizing them, putting them on
[14] bypass, taking them off bypass, running the inotropes,
[15] typical anesthesia role and, in addition to, being
[16] responsible for the transesophageal or supervising the
[17] CRNAs if they're doing the case with you.

[18] Q: Maybe I misunderstood you before, but I had
[19] the impression that you do the TEEs for your partners?

[20] A: Well, I also do the TEEs for my partners. So
[21] you can be in one room supervising a CRNA and have to go
[22] to the other room if they're doing two cases
[23] simultaneously and do the echo for them.

[24] Q: How many rooms do you normally work at a time?

Page 30

[1] A: Two.

[2] Q: Simultaneously two?

[3] A: Well, work in two, but not solely responsible
[4] for two.

[5] Q: Okay.

[6] A: I can't do that.

[7] Q: How many are you solely responsible for?

[8] A: One.

[9] Q: One at a time?

[10] A: That is correct.

[11] Q: But you supervise two rooms?

[12] A: Well, you assist in two rooms.

[13] Q: Okay. I don't want to get caught up in words.
[14] Define solely responsible versus assist.

[15] A: If you are supervising a CRNA, you are solely
[16] responsible for the room. If you assist, you may be
[17] supervising another room, but you may be going in there
[18] to do the transesophageal echo.

[19] Q: Do I understand you to say that in your
[20] hospitals here, there's always an anesthesiologist
[21] present in the room?

[22] A: There's always an anesthesia care provider
[23] present in the room.

[24] Q: Are the cases sometimes run by the CRNA after

Page 31

[1] the intubation and induction?

[2] A: We're just talking cardiac cases? The cases
[3] are run by the physician. The CRNA would be there to
[4] assist.

[5] Q: Is the physician — when you say the physician,
[6] we're talking about the anesthesiologist, correct?

[7] A: That is correct.

[8] Q: Is there an anesthesiologist present in the
[9] room at all times in your cardiac cases?

[10] A: No. When you are on bypass, you may be in the
[11] little boys room or — you're in the operating room
[12] theater itself. You may not be inside the four walls of
[13] the room, but you may be in the room next door.

[14] Q: Is there always some anesthesia person there,
[15] either the anesthesiologist —

[16] A: Absolutely,

[17] Q: — or the CRNA?

[18] A: Absolutely.

[19] Q: Are there occasions where you are responsible
[20] for two operations at the same time in which there's a
[21] CRNA actually physically present in the room?

[22] A: That is correct.

[23] Q: Does that happen in your cardiac cases, also?

[24] A: Once in a while.

Page 32

[1] Q: What do you mean once in a while?

[2] A: Well, they will be in there solely if you are
[3] on bypass and nothing is going on from an anesthetic
[4] standpoint.

[5] Q: How many cases per day would you say on average
[6] you do that are cardiac cases?

[7] A: Well, as I stated, you can do five cardiac
[8] cases in a day or you can do one cardiac case.

[9] Q: What's your maximum?

[10] A: I think the most we have ever done in one day
[11] was six.

[12] Q: No; you. I want to know how many you have done
[13] in a day.

[14] A: The most I have been involved with in one day
[15] was several years ago we did six.

[16] Q: How long ago was that?

[17] A: More than ten years ago.

[18] Q: What's the normal average now for you?

[19] A: Three, two to three.

[20] Q: Once the — in your practice at Saint Anthony's
[21] and Swedish American, once the patient leaves the
[22] operating room, what do you do? What's your
[23] responsibility as an anesthesiologist?

[24] A: Depends on the case. And we're still talking

Page 33

[1] cardiac cases.If you and the surgeon decide that we're
[2] going to try to do a fast wean on this patient instead
[3] of the typical wean, we will run the ventilator,manage
[4] the fluids and inotropes until the patient is extubated
[5] or manage them concurrently.There's a lot of overlap
[6] with the surgeons.A lot of it depends on who the
[7] surgeon is and who the anesthesiologist is, the amount
[8] of interplay that occurs.
[9] Q: Okay.Let's talk about your experience with
[10] Dr. Chang because — is he the one that you do the most
[11] cardiac cases?
[12] A: He is one of the ones.
[13] Q: Who do you personally work mostly with?
[14] A: Dr. Chang would be the one that would be the
[15] most.
[16] Q: That you work with?
[17] A: That is correct.
[18] Q: What is your experience with Dr. Chang?Let's
[19] say a cardiac case finishes.What do you do, and what
[20] is your responsibility with that patient?
[21] A: You **will** — if you're going to do a fast wean,
[22] you will be responsible for weaning the patient off the
[23] ventilator.
[24] Q: Where is the patient now?

Page 34

[1] A: In the ICU.
[2] Q: Okay.
[3] A: Then the nurses **will** call you with the vent
[4] parameters, and then you **will** titrate the analgesics and
[5] effect the quick extubation; or there's a protocol that
[6] you sign that we have come up with, and nurses do that.
[7] And they call you with the extubation parameters, **vital**
[8] capacity, the NIF, negative inspiratory force; and then
[9] you can make the decision to extubate them. It's done a
[10] lot by protocol. If there's questions, nurses here
[11] function like residents in an academic center.
[12] Q: **So** you're responsible for the respiratory
[13] status of the patient in the ICU?
[14] A: That is correct.
[15] Q: Are you also responsible for the pain
[16] management of the patient in the ICU?
[17] A. That is correct.
[18] Q: **And** who takes care of the rest of the
[19] management of the patient in the ICU?Again we're
[20] talking about cardiac cases; you understand that, right?
[21] A: It varies sometimes between surgeon and surgeon
[22] and patient to patient. Oftentimes the cardiologists
[23] are involved if the patient — they have had the patient
[24] for four or five days in the ICU, and obviously they

Page 35

[1] would know them better than anyone else. Sometimes it's
[2] the pulmonologist if you believe the major problem the
[3] patient is going to have is their pulmonary status. And
[4] many times it's just Dr. Chang going through the
[5] protocol.
[6] Q: **Is** there an anesthesiologist, critical care
[7] specialist assigned to the ICUs in which you work at
[8] SwedishAmerican and Saint Anthony's?
[9] A: Currently there is not.
[10] Q: How current is that? I mean, **was** that the case
[11] for some period of time?
[12] A: For a long period of time we ran the —
[13] Q: We meaning?
[14] A: The anesthesiologists, ran all the critical
[15] care for the postop hearts. And, quite honestly, with
[16] the shortages of anesthesiologists now, we have
[17] delegated some of that responsibility either back to the
[18] surgeon or some of the other specialists since we are
[19] needed in the operating room more.
[20] Q: When did that change?
[21] A: Couple years ago.
[22] Q: Couple meaning?
[23] A: Probably 1998.
[24] Q: So from '98 until the present, there is no

Page 36

[1] anesthesiologist assigned specifically to the ICUs at
[2] either SwedishAmerican or Saint Anthony's?
[3] A: That is correct. We are available 24/7 for
[4] consultation, and we are involved in several patients'
[5] care; but before it **was** a mandatory anesthesia consult.
[6] We no longer do that.
[7] Q: And what would be your practice as it relates
[8] to once a patient goes to the ICU, a cardiac patient,
[9] and you have — you hear **from** the nurses regarding this
[10] patient's condition and once the patient is weaned, do
[11] you ever go back and see or reassume care of the
[12] patient?
[13] A: We go back and write a post-operative note the
[14] next day, but we do not have an ongoing clinical
[15] obligation to the patient.
[16] Q: Okay. Is it often the case that you don't even
[17] go back and see these patients again after you have had
[18] the — after you have left them in the ICU? The patient
[19] **is** taken care of by the nurses; and barring some unusual
[20] respiratory problem, you would have no need to go back?
[21] A: Well, you would go back, again, to do your
[22] postop note. You have to do a postoperative note.
[23] Q: Okay. Understood.
[24] A: But having done that, if everything went well,

Page 37

[1] you would not be involved.
[2] Q: In the actual care of the patient in the ICU?
[3] A: After you have signed off, that is correct.
[4] Q: Do you have any of your partners who are
[5] actually certified in critical care medicine?
[6] A: A bunch of us are critical care eligible
[7] through the American Board of Anesthesiology as
[8] intensivists. We have stopped keeping up the
[9] accreditation because I told you like about four years
[10] ago we stopped doing it on a regular basis.
[11] Q: Are you critically care certified?
[12] A: I am certified critical care eligible by the
[13] American Board of Anesthesiology.
[14] Q: That means you could become board certified in
[15] critical care, but you are not?
[16] A: Well, I have special qualifications in critical
[17] care. Up until recently for anesthesia, there was not a
[18] board certification for that.
[19] Q: Up until recently. How recently?
[20] A: 1995 or '96 they had that.
[21] Q: Did you take that test?
[22] A: I did not. I took it for pain management.
[23] Q: So that I am clear, you are not board certified
[24] in critical care medicine?

Page 38

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

Page 39

[1] one of these hospitals where you work for cardiac
[2] surgery?
Pl A: No. It was — we had a pulmonologist there,
[4] and I was at another hospital prior to this in town here
[5] that we no longer serve.
[6] Q: Where they did cardiac?
[7] A: Where they did cardiac, and then I was the
[8] person assigned there.
[9] Q: Assigned there?
[10] A: To the ICU.
[11] Q: To the ICU?
[12] A: That is correct.
[13] Q: So you were the anesthesiologist/critical care
[14] specialist at that hospital?
[15] A: That is correct.
[16] Q: What hospital was that?
[17] A: Rockford Memorial.
[18] Q: And when did that stop, your association?
[19] A: 1996 — 1995.
[20] Q: Why did it stop?
[21] A: Contractual. They wished us to become
[22] employees. We did not wish to become employees.
[23] Q: Who does their anesthesia?
[24] A: They have hired people from the outside. It's

Page 40

[1] a vertically integrated system.
[2] Q: And did I understand you to say before to me
[3] that at Swedish American and Saint Anthony's where your
[4] group works with the heart surgeons, you are the only
[5] anesthesia group?
[6] A: That is correct.
[7] Q: That's contractually with the hospital?
[8] A: That is correct.
[9] Q: You are with Rockford Anesthesia Associates?
[10] A: Yes, I am.
[11] Q: You are the president, is that correct?
[12] A: Yes, I am.
[13] Q: How long have you been the president?
[14] A: Since I believe it was March of 1995.
[15] Q: What are your responsibilities as president of
[16] your group?
[17] A: I am responsible for the business end of the
[18] group, and I am also responsible — I run all the risk
[19] management seminars and new technology seminars. I have
[20] been the one that's brought the new technology to the
[21] group as far as cardiac anesthesia, different ways of
[22] doing cardiac anesthetics, transesophageal echo. I was
[23] the first person in Rockford to do transesophageal echo
[24] among all physicians including the cardiologists. And I

Page 41

Page 43

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

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

[7] Q: This is Dr. Chang?

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

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

[15] A: That is correct.

[16] Q: How many different groups are there?

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

[19] Q: And you are the head of the cardiac group?

[20] A: Yes.

[21] Q: Someone else has the pain group?

[22] A: I also have the pain group.

[23] Q: So you are the head of both groups?

[24] A: That is correct.

Page 42

Page 44

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

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

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

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

[20] Q: So you are the president of your association?

[21] A: Yes.

[22] Q: You are the head of the two groups within the
[23] association?

[24] A: That is correct.

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

[5] A: That is correct.

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

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

[11] Q: Are you — do you receive compensation for
[12] these positions?

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

[18] Q: You do it during your workweek then, the
[19] business?

[20] A: That is correct.

[21] Q: How much time does that take you?

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

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

[4] A: 15 to 20 hours a week.

[5] Q: That's an average?

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

[10] Q: How high can it get for you?

[11] A: It can get to 30 hours a week.

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

[14] A: That is correct.

[15] Q: What does that mean? What does that position
[16] entail?

[17] A: I am chairman of the board or president of the
[18] board of the freestanding surgery center.

[19] Q: Is that where we are right now?

[20] A: No. This is the RAA business office.

[21] Q: RAA meaning?

[22] A: Rockford Anesthesiologists Associates business
[23] office.

[24] Q: The Ambulatory Surgery Center is what?

Page 45

[1] A: An outpatient, free-standing, surgical
[2] treatment center.
[3] Q: You are the president of that facility?
[4] A: Yes, I am.
[5] Q: Are you also an owner in that facility?
[6] A: Yes, I am.
[7] Q: How many owners are there? Is it your
[8] anesthesia group, or are there other owners?
[9] A: There are other owners.
[10] Q: You are one of how many?
[11] A: Well, I am one of — my group has about 20
[12] percent total ownership, and then one of the hospitals
[13] owns 40 percent; and the rest are owned by other
[14] physicians in town.
[15] Q: So the 20 percent is your anesthesia group owns
[16] that?
[17] A: That is correct.
[18] Q: You don't personally own a —
[19] A: I have a small share. I believe it's —
[20] Q: Above and beyond that?
[21] A: Yes.
[22] Q: How much do you own?
[23] A: I am trying to think. Maybe 1 percent.
[24] Q: You are an owner of Rockford Anesthesia

Page 46

[1] Associates?
[2] A: Yes, I am.
[3] Q: How much of that do you own?
[4] A: 1/37th.
[5] Q: 37, meaning you have 36 partners?
[6] A: That is correct.
[7] Q: What are your responsibilities as the president
[8] of Rockford Ambulatory Surgery Center?
[9] A: To make sure my administrator does a good job,
[10] and that requires — other than around contract time,
[11] that requires maybe a couple 10-minute phone calls a
[12] couple times a week.
[13] Q: What type of surgeries are done at the —
[14] A: Strictly outpatient.
[15] Q: Give me an example.
[16] A: Knee arthroscopy, D&Cs, tonsillectomies.
[17] Q: What type of a volume does Rockford Ambulatory
[18] Surgery Center do? How many patients a week?
[19] A: I believe a good number would probably be about
[20] 150.
[21] Q: Per week?
[22] A: Yes.
[23] Q: And it's your responsibility as president to
[24] see that all that runs smoothly?

Page 47

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

Page 48

[1] A: Enough time to grab a copy of the OR schedule
[2] and a Diet Coke.
[3] Q: How about before that?
[4] A: Last Thursday.
[5] Q: How long?
[6] A: About the same amount of time.
[7] Q: Operating schedule, Diet Coke?
[8] A: Breakfast of champions.
[9] Q: Medical Pain Management Services, you are the
[10] president of that organization, also?
[11] A: Yes.
[12] Q: And what is Medical Pain Management Services?
[13] A: It's a free-standing facility that does
[14] advanced and interventional pain techniques.
[15] Q: Who owns that?
[16] A: RAA.

Page 49

[1] quality issues are there.
[2] Q: Where is Medical Pain Management Services
[3] Pl located?
[4] A: About 250 feet from the Surgery Center in
[5] Rockford, Illinois.
[6] Q: How much time do you spend there in a week?
[7] A: Probably a day and a half.
[8] Q: Are you compensated for your position as
[9] president of Rockford Ambulatory Surgery Center?
[10] A: Yes, I am.
[11] Q: Are you compensated for your position as the
[12] president of Medical Pain Management Services?
[13] A: I receive the honor and the privilege.
[14] Q: Of being compensated or of having the title?
[15] A: Of having the title.
[16] Q: Does that mean that you are not compensated?
[17] A: There is no direct compensation for that. I
[18] might get a meeting out of it a year.
[19] Q: They pay your way to some seminar. What does
[20] Talen Consulting mean?
[21] A: Talen Consulting is a consulting business that
[22] I solely and wholly own.
[23] MS. TOSTI: Doctor, if you need to —
[24] MR. JACKSON: Go ahead, Doctor. So the record

Page 50

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

Page 51

[1] plan.
[2] Q: When did you set up the Talen Consulting, Inc.?
[3] A: I'd have to look back, probably five or six
[4] years ago.
[5] Q: How many employees does Talen Consulting, Inc.,
[6] have?
[7] A: No regular employees. I contract out if I need
[8] other things, keeps the overhead low.
[9] Q: It's located in Rockford, but what's the
[10] physical location, the address?
[11] A: Oh, I have a place in Chicago. Lake Zurich is
[12] the physical address of the — I have someone there that
[13] grabs my mail for me because it's closer to Chicago, so
[14] if I need to meet someone .
[15] Q: You have it set up in Chicago?
[16] A: Well, halfway.
[17] Q: I am sorry, Doctor. I don't understand.
[18] Explain that for me again. I missed your point there.
[19] A: I have it set up so that it is halfway between
[20] here and Chicago; and if I need to meet someone from
[21] Chicago, it's a halfway meeting point since it's almost
[22] 100 miles from downtown out to here. And what I do is
[23] have my mailbox set up there and someone grabs my mail.
[24] And if I need to meet, I can meet in the office building

Page 52

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

Page 53

111 more on others.

[2] Q: What would be the average?

[3] A: Probably eight to ten.

[4] Q: Do you in terms of expert witness consultation
[5] and testimony channel all that through Talen Consulting?

[6] A: I channel the income through Talen Consulting,
[7] yes.

[8] Q: How about for your partners, do you do that for
[9] your partners also?

[10] A: What do you mean?

[11] Q: Well, do your partners here at Rockford
[12] Anesthesiologist Associated act as experts in medical/
[13] legal matters?

[14] A: No; none of them have any interest in doing it.

[15] Q: Are you the only one in the group of the 37
[16] doctors that does medical/legal expert testimony?

[17] A: That is correct.

[18] Q: You are the only one?

[19] A: That is correct, that I know of. There may be
[20] some that are doing it that I don't know of, but I don't
[21] know of any of them that are doing it.

[22] MS. TOSTI: Can I interrupt?

[23] (Discussion held off the record.)

[24] BY MR. JACKSON:

Page 54

[1] Q: Does Talen Consulting set up experts for —
[2] strike that.

[3] I am trying to determine if you use Talen
[4] Consulting as a vehicle whereby you help people who want
[5] to be experts in their dealings with lawyers and — do
[6] you understand the gist?

[7] A: I am not a broker if that's what you're asking.
[8] All the work for Talen is solely provided by myself.

[9] Q: You don't have any other doctors that you
[10] channel through Talen or help get consulting work on
[11] medical/legal matters through Talen?

[12] A: I do not.

[13] Q: The fees that Talen charges, who sets those?

[14] A: I do.

[15] Q: And your fee for depositions is \$1,500?

[16] A: \$500 an hour. My review fee is \$350 an hour.

[17] Q: The \$500 per hour with a minimum of \$1,500,
[18] where does that come from? Where did you come up with
[19] that?

[20] A: We do depositions.

[21] Q: We meaning you?

[22] A: We meaning two of my partners do depositions as
[23] treaters from the pain clinic; and according to Illinois
[24] law, the depositions can run three hours. And so we set

Page 55

[1] our fees appropriately.

[2] Q: How do you come up with \$500 per hour as an
[3] appropriate fee?

[4] A: That's what the fee schedule is in this area.

[5] Q: How long has it been that?

[6] A: As long as I have been doing depositions since
[7] '93 or '94. Neurosurgeons charge more. The orthopedic
[8] spine surgeons charge more.

[9] Q: So for anesthesiologists in your area here as
[10] long as you have been doing this, they charge \$500 an
[11] hour; is that for depositions?

[12] A: Yes.

[13] Q: How long has the \$350 per hour for review been?

[14] A: Probably the last two years. Prior to that it
[15] was 250.

[16] Q: What do you charge for trial time?

[17] A: Depends if it's in state or out of state.

[18] Q: Give me both then.

[19] A: Well, if I can get there quickly, I charge the
[20] hourly rate; but usually it's \$8,500 a day plus my
[21] expenses.

[22] Q: That's in state or out of state or both?

[23] A: Well, that's if I have to travel. If I can
[24] testify in town here, it's just my time.

Page 56

[1] Q: Okay. So if there's traveling involved, it's
[2] 8,500 plus expenses. If it's in town meaning Rockford?

[3] A: Yes.

[4] Q: That would be 500 an hour?

[5] A: That is correct.

[6] Q: How long has that fee, \$8,500, been in place?
[7] Again the same length of time since you have been doing
[8] this?

[9] A: About two years.

[10] Q: What was it before that?

[11] A: 7,500.

[12] Q: How many cases do you currently have pending
[13] where you're acting as an expert in a medical/legal
[14] matter?

[15] A: I believe five or six.

[16] Q: Where are they venued?

[17] A: Two are in Oklahoma. I'm the defense expert in
[18] both of those. Two are in Chicago where I am the
[19] defense expert in both of those. One is — I am not
[20] sure where one is going to be. One is in federal court,
[21] and I am the plaintiff's expert in that one.

[22] Q: But you don't know the state?

[23] A: Well, I don't know which federal court it's
[24] going to be in because sometimes they can go to Indiana;

Page 57

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

Page 58

[1] thought he had a cardiac anomaly.
[2] Q: You're testifying in both of those on behalf of
[3] an anesthesiologist?
[4] A: One on behalf of an anesthesiologist and one on
[5] behalf of CRNA.
[6] Q: Which one involves the CRNA?
[7] A: The eyeball case is the CRNA, and then the
[8] other case is the anesthesiologist.
[9] Q: I take it that you are testifying that the
[10] anesthesiologist did not negligently induce this child?
[11] A: That is correct.
[12] Q: The two in Chicago, what's the — who are you
[13] working for there?
[14] A: DiFalco is her name. I have just —
[15] Q: D-e?
[16] A: D-i-F-a-l-c-o.
[17] Q: Same attorney for both cases?
[18] A: No. The other attorney I don't know the name
[19] of. I haven't heard anything on the case, and it's been
[20] like three years.
[21] Q: And what is the nature of the case with
[22] Ms. DiFalco?
[23] A: You know, I don't remember.
[24] Q: What about the other case?

Page 59

[1] A: I'd have to pull that. I thought the case was
[2] dead, and I called a couple weeks ago; and they said oh,
[3] no, we are doing something, so .
[4] Q: You can't tell me on either one of those?
[5] A: I can't, no.
[6] Q: What about the federal court case?
[7] A: That's a products liability case.
[8] Q: What product are you critical of?
[9] A: I'd rather not discuss that right now since
[10] it's coming up. It's something that was used in a
[11] patient right after a cardiac cath.
[12] Q: Is that a drug or a device?
[13] A: Device.
[14] Q: What was the device?
[15] A: It was a part of respiratory therapy equipment.
[16] Q: And of whom are you critical?
[17] A: Of the device.
[18] Q: Not the caregivers?
[19] A: No.
[20] Q: What was the device?
[21] A: I'd rather not talk about it if that's okay.
[22] Q: Have you been deposed in the case?
[23] A: Not yet. I have been disclosed but not
[24] deposed.

Page 60

[1] Q: Have you written a report?
[2] A: I have written a report.
[3] Q: Okay. Then it's basically public then, Doctor,
[4] if you have been identified and you're part of the case.
[5] I am not going to explore your opinions. I just want to
[6] know what the device is.
[7] A: It's a PEAP valve.
[8] Q: Who is the attorney for whom you are working?
[9] A: I believe — it's the Office of Ken Chessick.
[10] Q: C- —
[11] A: C-h-e-s-s-i-c-k.
[12] Q: Who is the attorney in Mr. Chessick's office
[13] with whom you are working?
[14] A: That's what I am trying to think of. There's
[15] three attorneys I have talked to on the case. I don't
[16] know who the lead one is. It may be Joan Stohl,
[17] S-t-o-h-l.
[18] Q: Is Mr. Chessick venued — is his office located
[19] in Chicago?
[20] A: Chicago suburb.
[21] Q: But in Illinois?
[22] A: Yes.
[23] Q: Is a company a named defendant or a
[24] manufacturer?

Page 61

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

Page 62

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

Page 63

[1] A: Probably about four years ago, three years ago.
[2] Q: Was that because you weren't asked by
[3] plaintiffs to do it or because you chose not to review
[4] plaintiff's cases, or was there some other reason?
[5] A: After I testified a few times, a few of the
[6] plaintiff's attorneys asked me if I would review cases.
[7] And I said if I think it has merit — I mean, I will
[8] review the case. If it has merit, I can tell you one
[9] way or the other.
[10] Q: How many times have you testified? Let's talk
[11] by way of deposition first of all.
[12] A: As a treater or as an expert?
[13] Q: Either and both.
[14] A: As an expert in court, maybe four or five
[15] times.
[16] Q: Four to five times in court?
[17] A: In court. In depositions —
[18] Q: Let's talk about treater in court.
[19] (A brief recess was taken.)
[20] BY MR. JACKSON:
[21] Q: I think we were talking about your trial
[22] testimony, Doctor. You said you testified four to five
[23] times as an expert in court in medical/legal matters.
[24] Then you said you testified also as a treater. Now, the

Page 64

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

Page 65

Page 67

[1] two in Chicago are different cases than the ones we
[2] talked about a little bit ago, the pending cases; is
[3] that true?
[4] **A:** I am a little bit confused.
[5] **Q:** All right. I asked you earlier, do you have
[6] any pending cases where you are medical/legal expert;
[7] and you said five roughly?
[8] **A:** That is correct.
[9] **Q:** We went through those. There were two in
[10] Oklahoma, two in Chicago, one in federal court.
[11] **A:** That's correct.
[12] **Q:** Now I have asked you how many times have you
[13] actually testified as an expert in court, and you said
[14] one in Oklahoma and two in Chicago. My question is,
[15] those are different cases, I assume?
[16] **A:** Yes, that is correct.
[17] **Q:** In the Oklahoma case, what were you testifying
[18] on — the nature of the case?
[19] **A:** That there was no malpractice.
[20] **Q:** What was the nature of the case?
[21] **A:** Needle injury to the eye.
[22] **Q:** So that is the same case we talked about
[23] before?
[24] **A:** Yes, but that case went up on appeal; so it's

[1] **MS. TOSTI:** No, he is not going to be adding
[2] all types of information to the depo. If he doesn't
[3] recall, he doesn't recall.
[4] **MR. JACKSON:** Fine. Then we'll sit here and
[5] figure it out.
[6] **MS. TOSTI:** If you don't recall, Doctor, tell
[7] him that; and we'll move on.
[8] **A:** It would be hard because after a case is done,
[9] I send everything off to Shred-X.
[10] **BY MR. JACKSON:**
[11] **Q:** So you don't remember for whom you testified or
[12] what the allegations in the case were?
[13] **A:** I don't.
[14] **Q:** How about depositions, Doctor, how many times
[15] have you been deposed in medical/legal matters?
[16] **A:** In medical/legal matters? Well, I would say I
[17] have been deposed for every case that I have reviewed.
[18] That's, you know, the 15 to 20. And then I have been
[19] deposed as a treater.
[20] **Q:** How many times as a treater have you been
[21] deposed?
[22] **A:** It would probably average once a month.
[23] **Q:** In terms of your deposition testimony for
[24] medical/legal matters, how frequently are you deposed?

Page 66

Page 68

[1] still open. I guess it's the same case, but that's the
[2] one that's up on appeal.
[3] **Q:** The two in Chicago, what were the nature of
[4] those cases? What were the claims in those?
[5] **A:** You know, I'd have to go back and look. I
[6] don't remember.
[7] **Q:** You don't remember the nature of the case. Do
[8] you remember who you worked for?
[9] **A:** I'd have to go back and look. The guys in
[10] Chicago move around so much.
[11] **Q:** Do you remember when you last testified in
[12] trial as an expert in a medical/legal matter?
[13] **A:** I believe it was December 11th. It was the day
[14] we had the big snowfall two years ago. December 11th,
[15] 2000.
[16] **Q:** Was that in Chicago or Oklahoma?
[17] **A:** Yes. It was at the Daley Center on the 27th
[18] floor.
[19] **Q:** And as we sit here, you can't tell me what that
[20] case was about, is that what I understand, or for whom
[21] you testified? Doctor, if you can't, I'll accept that.
[22] **A:** I can't.
[23] **Q:** And again is that information that you'd be
[24] able to find easily and you could add to your —

[1] **A:** Well, the cases I would get, I would get
[2] deposed once.
[3] **Q:** When were you last deposed in a medical/legal
[4] matter?
[5] **A:** Last year.
[6] **Q:** Is that in one of the cases we have already
[7] talked about?
[8] **A:** Yes, it is.
[9] **Q:** When were you last involved in actually giving
[10] anesthesia to a patient in the operating room?
[11] **A:** About 24 hours ago.
[12] **Q:** How about a cardiac patient, when was the last
[13] time you were in an operating room with a cardiac
[14] patient as an anesthesiologist?
[15] **A:** 36 hours ago, maybe 40 hours.
[16] **Q:** Do you teach?
[17] **A:** Yes, I do.
[18] **Q:** Can you explain your teaching experience for
[19] me?
[20] **A:** Teach medical students and family practice
[21] residents, critical care nurses and **OR** nurses as well as
[22] other physicians.
[23] **Q:** Where do you teach and what method do you use?
[24] What type of teaching do you do?

Page 69

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

Page 70

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

Page 71

[1] was going on with the patient, communication.
[2] Q: So it's monitoring and communication?
[3] A: That is correct.
[4] Q: With those issues in mind, are any of your
[5] presentations presentations which would deal with those
[6] type of issues?
[7] A: Well, I think starting at Page 6, "Invasive
[8] Hemodynamic Monitoring and Its Applications," I gave
[9] grand rounds on that. "Use of Inotropes" —
[10] Q: Excuse me; that's the one in October of '86 at
[11] University of Nebraska?
[12] A: Yeah.
[13] Q: "Use of Inotropes in Cardiac and Noncardiac
[14] Surgical Procedures."
[15] Q: Again in '87 and that was at —
[16] A: Yes. "Review of Inotropic Drugs," '87.
[17] Q: The second one was at the University of
[18] Nebraska, and the third one was Denver Anesthesiology
[19] Society?
[20] A: Yes; that's correct. "Use of Antihypertensives
[21] in Anesthesia."
[22] Q: What page are we on?
[23] A: Page 7, June of '87 at the Nashville,
[24] Tennessee State Society Meeting.

Page 72

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

[4] correct?

[5] **A:** Yes. The second from the bottom or bottom

[6] "Advanced Techniques in Transesophageal Echo," Kenora,

[7] Ontario.

[8] **Q:** In October of '94?

[9] **A:** That's correct.

[10] **Q:** Again that says course director, does that mean

[11] you monitored?

[12] **A:** I monitored, moderated and gave some of the

[13] talks. That's about it.

[14] **Q:** Okay. Did you keep — did you make

[15] presentations by way of handouts or anything in any of

[16] those courses?

[17] **A:** Oh, I am sure I did.

[18] **Q:** Would you *still* have them?

[19] **A:** I probably don't.

[20] **Q:** How about your publications, there are three

[21] chapters in books. Do those in any way relate to this

[22] case? Four chapters, excuse me.

[23] **A:** Monitoring Critical Care.

[24] **Q:** That's the —

Page 74

[1] **A:** Last one.

[2] **Q:** Edited by Popovich?

[3] **A:** Yeah.

[4] **Q:** Has that been printed?

[5] **A:** You know, it was supposed to be. I got a rough

[6] copy of it. And I don't know. I stopped getting my

[7] royalties. So I don't know if it's still in press or

[8] not.

[9] **Q:** When you say in press, that means it's been

[10] printed?

[11] **A:** Well, I don't know if they all the way went

[12] through with it. They had some financial problems, that

[13] was good old El Sedvire (phonetic).

[14] **Q:** So you don't know whether that was published?

[15] **A:** That is correct.

[16] **Q:** Do you have a copy of that?

[17] **A:** I may somewhere.

[18] **Q:** Where would one get a copy if it wasn't in

[19] publication?

[20] **A:** Well, it may have been printed. I don't know.

[21] It could be in the warehouse somewhere.

[22] **Q:** Let's assume it **was** not published. Where would

[23] I get a copy of that other than asking you for a copy?

[24] **A:** I can call El Sedvire to see if they have it.

[4] never got any more; but then it's also the time I moved.

[5] **Q:** When was that put in press?

[6] **A:** I'd have to go back and look.

[7] **Q:** There's no dates on any of those chapters,

[8] that's why I ask you.

[9] **A:** Well, like I said, I'd have to go back and

[10] look.

[11] **Q:** Were any of your chapters actually published?

[12] **A:** I submitted them to the publisher. I got a

[13] letter saying that they were going to press, and they

[14] enclosed one royalty check; and that was it, and then I

[15] moved.

[16] **Q:** So this was how long ago?

[17] **A:** Well, I moved about six, seven years ago. So

[18] may be a little bit more than that.

[19] **Q:** So if I understand you correctly, these four

[20] chapters and books were written six or seven years ago

[21] or more?

[22] **A:** That is correct.

[23] **Q:** And you don't know whether they were ever

[24] published or not?

Page 76

[1] **A:** No. When I left academics, publishing lost a

[2] lot of its importance.

[3] **Q:** I am just curious as to whether you know they

[4] have or have not been published.

[5] **A:** I know I received a rough copy or a printed

[6] copy and then a royalty check, and that was it.

[7] **Q:** But whether these are in press — or in

[8] publication anywhere, do I still understand you don't

[9] know?

[10] **A:** You know, I am not sure if they're still in

[11] press — or if they're still in publication.

[12] **Q:** Were they ever published?

[13] **A:** I assume they were. I got a copy of it.

[14] **Q:** Which one, just the second one?

[15] **A:** They're all chapters. They have to be in a

[16] book.

[17] **Q:** I mean, which one was published. You said you

[18] got one check.

[19] **A:** No; no; no. I got a copy of the book that was

[20] published.

[21] **Q:** Oh, I see what you're saying.

[22] **A:** But I don't know if they went and ran 50,000

[23] copies is what I am saying.

[24] **Q:** All right. Do you know which book it **was**,

Page 77

[1] which of these four?
[2] **A:** Those were chapters in a book.
[3] **Q:** I understand that. One book?
[4] **A:** There was one book with about 110 chapters in
[5] it. It was a thick book.
[6] **Q:** And you edited four of those chapters or
[7] wrote —
[8] **A:** I wrote four of those chapters.
[9] **Q:** Okay. Do you have any other training or
[10] education or experience that you believe qualifies you
[11] as an expert in this case that we haven't talked about?
[12] **A:** I think we have covered it.
[13] **Q:** Do I understand that to be board certified in
[14] pain management, you need to devote over 50 percent of
[15] your time to pain management?
[16] **A:** Nowadays you do. I received my board
[17] certification in pain management prior to them having
[18] fellowship.
[19] **Q:** When were you board certified in pain
[20] management?
[21] **A:** October of 1993.
[22] **Q:** And the current requirement is that you need to
[23] devote more than 50 percent of your time to pain
[24] management to **qualify** for board certification, is that

Page 78

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

Page 79

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

Page 80

[1] front of me.
[2] **BY MR. JACKSON:**
[3] **Q:** So you don't know whether they would **qualify**
[4] operative time as pain management?
[5] **A:** It depends what you're doing in the operation.
[6] There's a lot of overlap there. It's not a cut-and-dry
[7] thing.
[8] **Q:** All right. So I just want to understand this
[9] issue, Doctor. **If** someone does just OR anesthesia, from
[10] what you're telling me, they would **qualify** —
[11] **A:** No.
[12] **Q:** They could **qualify** —
[13] **A:** No; that's not what I said.
[14] **Q:** Okay. Well, then clarify for me because I
[15] don't understand what you're saying.
[16] **A:** I am not sure what you're asking. I think that
[17] if you're doing pain management, you're doing pain
[18] management. You can anesthetize a patient; and if you
[19] do an epidural on him afterwards for postoperative pain,
[20] that's pain management. **So** where do you draw the line
[21] at?
[22] **Q:** I have to ask you that question. If you give
[23] anesthesia to a patient intraoperatively —
[24] **A:** That's correct.

Page 81

[1] Q: — is that considered pain management in your
[2] opinion?
[3] A: Depends what you do to them. I mean —
[4] Q: Depends what the procedure is you mean?
[5] A: Depends on the procedure, depends if you're
[6] putting in an epidural for postoperative pain
[7] management. I think we're splitting hairs.
[8] Q: I am just trying to understand that because I
[9] don't understand it. That's why I am asking.
[10] MS. TOSTI: Doctor, if you need to take it, go
[11] ahead.
[12] A: Thanks. Well, I think that, you know, they
[13] have certain guidelines.
[14] BY MR. JACKSON:
[15] Q: They meaning?
[16] A: The American Board, and they may have changed
[17] over the years. I haven't looked — it's a ten-year
[18] certification, and I haven't really looked at the new
[19] guidelines.
[20] Q: So you can't answer that question as we sit
[21] here?
[22] A: Not without having the actual statute and new
[23] rules in front of me, no.
[24] Q: Have you ever other than this case acted as an

Page 82

[1] expert for the Becker, Mishkind firm?
[2] A: I have not.
[3] Q: Or anyone in the firm?
[4] A: I have not.
[5] Q: Other than the states you have already
[6] described for me, have you ever been an expert in a
[7] medical/legal matter in any other states?
[8] A: I don't believe so.
[9] Q: So it's been Illinois, Oklahoma?
[10] A: That is correct.
[11] Q: Do you know any of the doctors or nurses or
[12] other experts in this case?
[13] A: I do not.
[14] Q: Do you know anyone associated with this case,
[15] any of the caregivers?
[16] A: I do not.
[17] Q: Did you review the deposition testimony of
[18] Dr. Smith, plaintiff's expert?
[19] A: I believe I looked at it.
[20] Q: When?
[21] A: Well, obviously sometime after he did it, but I
[22] can't give you the exact date and time.
[23] Q: Well, has it been in the last — within the
[24] last week?

Page 83

[1] A: I am trying to think. Let me see if I have the
[2] date on this here.
[3] Q: I will tell you it's not in the pile of
[4] depositions you have in front of you, Doctor.
[5] A: No, but I'm just trying to think. I'm trying
[6] to think if that was one I looked at at my cabin or not.
[7] Q: I'm sorry. I didn't understand what you just
[8] said.
[9] A: I am trying to think if I reviewed it at my
[10] cabin or not.
[11] Q: And at your cabin was where you reviewed
[12] depositions preparing yourself for the deposition today?
[13] A: Well, that's where I do most of my work. You
[14] don't get 100 pages a day.
[15] Q: Pardon me?
[16] A: You don't get 100 pages a day.
[17] Q: I don't know what you mean by that.
[18] A: Distractions.
[19] Q: Oh. I thought you were talking about
[20] deposition pages. You mean being paged by someone.
[21] A: Yeah. It may have been in the last week.
[22] Q: But you can't tell me for certain?
[23] A: Because I was re-reviewing the depositions I
[24] have here. I am not sure if it was or if I just glanced

Page 84

[1] at it. I don't want to tell you the wrong thing.
[2] Q: But you have reviewed his deposition at some
[3] time?
[4] A: I believe I have.
[5] Q: You think that was in the last week?
[6] A: It may have been.
[7] Q: Would you have reviewed it before you wrote
[8] your report?
[9] A: No, I would not have.
[10] Q: How do you know that?
[11] A: Because I wrote my report after I did my
[12] initial review, and — I'm trying to think — no, I know
[13] I didn't do that.
[14] Q: That meaning review his deposition before your
[15] report?
[16] A: That is correct.
[17] Q: So it was sometime between the time you wrote
[18] your report and today?
[19] A: That is correct.
[20] Q: And when did you receive it?
[21] A: What's that?
[22] Q: The deposition of Dr. Smith.
[23] A: You know, I'd have to look. I may have an
[24] envelope. I may not.

Page 85

[1] Q: Well, it was represented to me earlier, Doctor,
[2] that the correspondence there was all the correspondence
[3] that we had in the case, that you had received from
[4] plaintiff's counsel?

[5] A: It is.

[6] Q: And when did you get — how did you get
[7] Dr. Smith's deposition?

[8] A: I don't think I'm following you.

[9] Q: Well, if you'll go back to those four
[10] letters — and by the way, I'd like a copy of those
[11] before we leave today. You can copy those here for me?

[12] A: That shouldn't be a problem.

[13] Q: Okay. There's no listing of Dr. Smith's
[14] deposition there, is there?

[15] A: There is not.

[16] Q: And Dr. Smith's deposition is not in the stack
[17] of depositions or copies of depositions sitting in front
[18] of you, is it?

[19] A: It is not.

[20] Q: And so I assume you have a copy of it
[21] somewhere, but you didn't bring it with you; and there's
[22] no record that you received it?

[23] A: I think, Mr. Jackson, I received three
[24] depositions approximately a week ago, the last three

Page 86

[1] depositions of Hernandez, Hearn and Koch.

[2] Q: Okay. You got those three a week ago?

[3] A: I had those. Those are the ones I took up
[4] north with me. That's why when you mentioned the name,
[5] if that was the plaintiff's expert, you caught me off
[6] guard because I went and looked and thought one of these
[7] might have been that name. So if that's the case, and I
[8] don't see it here and I don't have it in front of me, I
[9] don't believe I have reviewed the plaintiff's expert. I
[10] reviewed — I have the list here of the following
[11] materials. I also have these three here; and for a
[12] split second when you asked me that, I thought I might
[13] have reviewed it. But I have not reviewed it. These
[14] are the ones that I have reviewed.

[15] Q: Do you know who Dr. Smith is?

[16] A: I do not.

[17] Q: Never heard his name before I mentioned it
[18] here?

[19] A: Quite honestly if I have, I don't remember it
[20] because a lot of the names have flown together on this
[21] case. So I do not have that recollection.

[22] Q: As to who he is?

[23] A: That is correct.

[24] Q: Have you been aware before I said that, just

Page 87

[1] said his name, that Dr. Smith was involved in this case
[2] at all?

[3] A: I have another case where there's a Smith
[4] involved, and it may have run together; but I do not
[5] have Dr. Smith's complaint letter with me nor have I
[6] looked at it here.

[7] Q: I am talking about his deposition, Doctor.

[8] A: Well, I haven't looked at that then.

[9] Q: We're not sure if you've looked at it or not?

[10] A: No; that's not what I said. I said when you
[11] first asked me that — let's get this real clear so
[12] there's no attempt at any misperception or deception.

[13] Q: I'm not — Doctor —

[14] MS. TOSTI: Let him finish.

[15] MR. JACKSON: No, I am going to finish,

[16] MS. TOSTI: Let him finish his answer, John.

[17] BY MR. JACKSON:

[18] Q: I am not attempting any misperception or
[19] deception here. I asked you a very straightforward
[20] question, and you hesitated for a long time; and then
[21] you told me you had reviewed the depo. So please don't
[22] suggest that I am trying to mislead or cause any
[23] deception here because that's not the case.

[24] A: Well, I am also not trying to mislead or

Page 88

[1] deceive; but when you said Smith, there's Hernandez,
[2] there's Hern, and there's Koch which you mispronounced
[3] Koch. It's Koch in German. And when you said that, I
[4] thought for a minute did I or did I not, and I looked
[5] through this. And I don't necessarily identify them by
[6] their last names. I said this was a fellow, this was
[7] the person taking care of it. So no, I have not
[8] reviewed that. And if I stated that I reviewed it, I
[9] misspoke; and that's why when I looked at these names
[10] here, I wanted to make sure that I didn't have something
[11] here that said I did review it because I didn't remember
[12] reviewing it. That's why I hesitated.

[13] Q: What's your understanding of who the experts in
[14] this case are?

[15] A: I know I am one of the experts. I know there's
[16] a cardiac surgeon.

[17] Q: Who?

[18] A: I am not sure.

[19] Q: On whose side, plaintiff or defense?

[20] A: Well, I would assume there's one on each.

[21] Q: Okay. Where do you get this understanding?

[22] A: Well, usually if you have different physicians
[23] in the case, you usually have different experts.

[24] Q: Understood. But did you have some discussions

Page 89

Page 91

{1} with plaintiff's counsel about the experts in this case?
{2} A: I have not.
{3} Q: None?
{4} A: Not that I recall other than that there was
{5} expert — other experts.
{6} Q: Did you ask who they were?
{7} A: I didn't.
{8} Q: So your understanding is there are cardiac
{9} surgeon experts?
{10} A: There are other experts period.
{11} Q: What are they or do you have any understanding?
{12} A: I don't have the understanding.
{13} Q: Did you ask for their names?
{14} A: I did not.
{15} Q: Did you ask to see their depositions?
{16} A: I don't believe I have.
{17} Q: Did you ask to see their reports?
{18} A: I have not seen their reports.
{19} Q: Did you ask to see their reports?
{20} A: I don't believe I did.
{21} Q: Why not?
{22} A: Because in most cases, they want your opinion
{23} to be your opinion and not something that you build it
{24} on someone else's report. So my opinion is based on my

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

Page 90

Page 92

{1} review not a summation of someone else's.
{2} Q: Did you read Dr. Lyons' deposition, it's listed
{3} in your —
{4} A: I believe I did.
{5} Q: Do you know Dr. Lyons?
{6} A: I do not.
{7} Q: Do you disagree with his comments in his
{8} deposition?
{9} A: If you want to show me what you're referring
{10} to, I'd be more than willing to give an opinion on it.
{11} Q: In general.
{12} A: I don't like generalities. People make
{13} mistakes.
{14} Q: You don't remember — do you know who he is?
{15} A: I believe Dr. Lyons is an anesthesiologist, but
{16} I am not sure. Let me check.
{17} Q: He is an anesthesiologist. We'll save time,
{18} Doctor. Do you know his role in this case? Do you know
{19} Dr. Lyons' role in this case?
{20} A: Let — I'm just refreshing myself again on his
{21} deposition.
{22} Q: Okay.
{23} A: He was a cardiac anesthesiologist.
{24} Q: Do you know his role in this case? And so the

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

[1] doesn't have a number on it because they just recently
 [2] came. This one was in stack one.
 [3] Q: Which one?
 [4] A: The Hrobat.
 [5] Q: Those don't have numbers either, though.
 [6] A: I know that. One, two, three. This was a new
 [7] group. I never really got a chance to mark these.
 [8] Q: The new group are which?
 [9] A: Hernandez, Hern, and Koch.
 [10] Q: How would you distinguish stack one from stack
 [11] two from stack three?
 [12] A: Which ones I reviewed so I don't review them
 [13] twice for the same thing.
 [14] Q: There's no marks on stack one, so how do you
 [15] know —
 [16] A: If it's not marked, it's stack one.
 [17] Q: Okay. I was asking about Nurse Zilka, what was
 [18] her role?
 [19] A: She was one of the nurses, and I think one of
 [20] the other preceptors for Ms. Young.
 [21] Q: Have you ever been sued?
 [22] A: Yes, I have.
 [23] Q: How many times?
 [24] A: Once.

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

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

[1] Q: And what did you do with the rough draft?
 [2] A: What I do with all confidential medical
 [3] information: you know, I corrected the time — or not
 [4] the time, the date. I tend to put things in military
 [5] time, and other people like regular time. I like
 [6] military time.
 [7] Q: I am not understanding you. In other words,
 [8] you did a draft of this report, correct?
 [9] A: Yeah.
 [10] Q: And then at some time — what did you do with
 [11] the draft? You called Mr. Becker or sent it to him?
 [12] A: No. I just — we talked on the phone, and I
 [13] did my thing.
 [14] Q: Well, that's what I am trying to understand.
 [15] A: I don't like 6:00 p.m. to 9:00 p.m. I like
 [16] 1800 to 2100.
 [17] Q: So your initial draft had —
 [18] A: And I had my date 11 June 2001, and they had
 [19] June 11, 2001. It was like I dictated it, signed it,
 [20] and that was it.
 [21] Q: You're talking about the draft?
 [22] A: No. The thing. I mean, it was one thing. It
 [23] wasn't like it was sent back and forth.
 [24] Q: That's what I am trying to understand. You did

Page 97	Page 99
<p>[1] a draft?</p> <p>[2] A: Yeah, I dictated it.</p> <p>[3] Q: And then you talked to Mr. Becker about it?</p> <p>[4] A: The only thing we changed was I wanted military</p> <p>[5] time, so I won out on that.</p> <p>[6] Q: Initially there was other than military time</p> <p>[7] there?</p> <p>[8] A: It was 6:00 p.m. to 9:00 p.m.</p> <p>[9] Q: So initially you drafted it in the 6:00 p.m. to</p> <p>[10] 9:00 p.m.?</p> <p>[11] A: No. I drafted it like this. This is my</p> <p>[12] letter. This is my letter the way I wanted it. And lay</p> <p>[13] people like 6:00 p.m. They like those types of things.</p> <p>[14] That was it.</p> <p>[15] Q: What I am trying to understand is the process.</p> <p>[16] You received the materials —</p> <p>[17] A: This was not a collaborative effort. It was my</p> <p>[18] effort upon my review, dictated, transcribed, put on my</p> <p>[19] letterhead, boom, it was done.</p> <p>[20] Q: That's what I am trying to understand. You got</p> <p>[21] the materials, you reviewed them, correct?</p> <p>[22] A: That's correct.</p> <p>[23] Q: You drafted a letter, correct?</p> <p>[24] A: That is correct.</p>	<p>[1] A: That is the extent, that is correct.</p> <p>[2] Q: Now, since you have authored this report, you</p> <p>[3] have reviewed some additional depositions, correct?</p> <p>[4] A: That is correct.</p> <p>[5] Q: And you did that when?</p> <p>[6] A: After I received them. I received them about a</p> <p>[7] week ago.</p> <p>[8] Q: Did those in any way change your opinions,</p> <p>[9] alter your opinions, make any type of corrections to</p> <p>[10] your opinions as stated in your June 11th report?</p> <p>[11] A: They did not.</p> <p>[12] Q: Did you review any other materials other than</p> <p>[13] those three depositions which you received after your</p> <p>[14] deposition or after your report?</p> <p>[15] A: I did not.</p> <p>[16] Q: Did you do any research for this case?</p> <p>[17] A: I did not.</p> <p>[18] Q: Did you make any reference to any medical</p> <p>[19] textbooks or journal articles in preparing your opinion?</p> <p>[20] A: I did not.</p> <p>[21] Q: Have you asked to review any additional</p> <p>[22] materials in this case?</p> <p>[23] A: I have not.</p> <p>[24] Q: Do you intend to?</p>
Page 98	Page 100
<p>[1] Q: You spoke with Mr. Becker?</p> <p>[2] A: Well, the letter was done, but I spoke with</p> <p>[3] him.</p> <p>[4] Q: And then there were some things that you wanted</p> <p>[5] changed, like you talked about these numbers of military</p> <p>[6] time, and you made those changes; correct?</p> <p>[7] A: Well, I kept them the way I wanted it.</p> <p>[8] Q: Okay. And then you finalized your report and</p> <p>[9] sent it to him?</p> <p>[10] A: It was finalized. There was nothing to</p> <p>[11] finalize.</p> <p>[12] Q: You didn't make any changes in your report from</p> <p>[13] the time you first drafted it to the time you sent it to</p> <p>[14] him?</p> <p>[15] A: No; that is correct.</p> <p>[16] Q: So this is the only draft then of this report;</p> <p>[17] is that what I now understand you to say?</p> <p>[18] A: That is correct.</p> <p>[19] Q: Correct?</p> <p>[20] A: That is correct.</p> <p>[21] Q: When you say all Cleveland Clinic Foundation</p> <p>[22] records as being some of the materials that you</p> <p>[23] reviewed, is that the three-ring binder that you're</p> <p>[24] talking about?</p>	<p>[1] A: I don't intend to.</p> <p>[2] Q: You are not a surgeon; you're not an expert in</p> <p>[3] cardiac surgery, are you?</p> <p>[4] A: I am not.</p> <p>[5] Q: You are not an expert in cardiology?</p> <p>[6] A: I am not a cardiologist.</p> <p>[7] Q: How much time have you spent on this case to</p> <p>[8] date not including our depo time here?</p> <p>[9] A: Probably have to pull my tax records.</p> <p>[10] Q: You can't give me an estimate?</p> <p>[11] A: 16, 20 hours, give or take whatever.</p> <p>[12] Q: How much of that time was time spent preparing</p> <p>[13] for this deposition?</p> <p>[14] A: None.</p> <p>[15] Q: Did you spend any time preparing for this</p> <p>[16] deposition?</p> <p>[17] A: Yes, I did.</p> <p>[18] Q: How much?</p> <p>[19] A: Couple hours.</p> <p>[20] Q: 'What's that mean?</p> <p>[21] A: Three hours, maybe four.</p> <p>[22] Q: 'What's your understanding of the term standard</p> <p>[23] of care, Doctor?</p> <p>[24] A: The standard of care is the care rendered by an</p>

Page 101

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

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

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

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

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

[24] Q: Okay. So Dr. Cosgrove did not breach the

Page 102

[1] standard of care in your opinion?

[2] A: I have no problems with Dr. Cosgrove or his
[3] care.

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

[8] A: Well, I believe Dr. Muehlbach didn't stay
[9] adequately on top of the patient.

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

[19] A: Dr. Muehlbach, the nurses involved directly
[20] with the care.

[21] Q: Give me their names.

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

Page 103

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

[4] **MS. TOSTI:** It was in the medical records.

[5] **A:** Okay. I have mentioned Dr. Muehlbach, Nurse
[6] Young, Nurse Hrobat, Zilka, and Hernandez.

[7] **BY MR. JACKSON:**

[8] Q: You mean Dr. Hernandez?

[9] **A:** That is correct.

[10] Q: Anyone else?

[11] **A:** I believe that's what I set forth.

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

[16] **A:** That is correct.

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

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

Page 104

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

[3] Q: **So** you believe Dr. Muehlbach did what wrong?

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

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

[18] **A:** That is correct.

[19] Q: Is there anything else you think Dr. Muehlbach
[20] did wrong?

[21] **A:** I believe he did not transfer the information
[22] in a timely basis to Dr. Cosgrove.

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

Page 105

Page 107

[1] A: That is correct.
[2] Q: Anything else you believe Dr. Muehlbach did
[3] wrong?
[4] A: I believe I stated my concerns.
[5] Q: You have covered them?
[6] A: For Dr. Muehlbach.
[7] Q: You have covered them?
[8] A: Yes.
[9] Q: Let's go to Dr. Hernandez, what do you believe
[10] Dr. Hernandez did wrong? Or let me be more specific,
[11] Doctor. In what way do you believe Dr. Hernandez fell
[12] below the standard of care?
[13] A: I also believe that, one, he should have been
[14] more directly involved with this patient based on the
[15] hemodynamic parameters that were presented to him and
[16] that were charted on the patient's chart.
[17] Q: What is your understanding of Dr. Hernandez'
[18] position at the clinic?
[19] A: He was a surgical resident on the thoracic
[20] service. I believe he was an HO-2.
[21] Q: You say he should have been directly involved
[22] in the patient's care? Anything else in which — in a
[23] manner in which you believe Dr. Hernandez fell below the
[24] standard of care?

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

Page 106

Page 108

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

[1] it just the one you're referring to then?
[2] A: There's nothing charted where she notified
[3] Dr. Muehlbach.
[4] Q: But is it just one incident or was there more
[5] than one which you were —
[6] A: This is just with regards to the chest tube out
[7] drainage.
[8] Q: That's what I was talking about. The
[9] impression I got from your first comment regarding
[10] drainage from the chest tube suggested to me that you
[11] felt that there was more than one occasion when she did
[12] not notify Dr. Muehlbach.
[13] A: Of events with the patient.
[14] Q: Of a discharge from the chest tube, is it just
[15] the one incident with the chest tube?
[16] A: This is one episode where the patient dumped
[17] 250 acutely.
[18] Q: Okay. Then let's move on. There was something
[19] you were going to talk about about inotropes after that?
[20] A: Then the inotropes were instituted as well as
[21] the Amicar was instituted, and the decision — it was
[22] not clear in the orders who ordered it, but obviously
[23] she was the one that increased it. She increased the
[24] amount of sedation on the patient who is having trouble

Page 109

[1] supporting their blood pressure, knowing that the
[2] propofol infusion will necessarily decrease the
[3] patient's blood pressure. So you're increasing a drug
[4] as an inotrope at the same time you're increasing the
[5] drug that lowers the blood pressure.
[6] Q: And you believe that's below standard of care?
[7] A: Absolutely.
[8] Q: Anything else in your opinion that Nurse Young
[9] did that fell below standard of care or failed to do?
[10] A: We talked about the charting.
[11] Q: You have talked about poor charting, that was
[12] your first,
[13] A: And lack thereof of charting.
[14] Q: Any other ways in which you believe Nurse Young
[15] fell below the standard of care?
[16] A: Right here at Level T, if you have a patient
[17] who is bleeding, is hypotensive, the last thing you
[18] would do would give them 250 micrograms of Fentanyl
[19] because its sympatholytic effect will eliminate any
[20] blood pressure that they have or significantly impair
[21] it.
[22] Q: So let me understand what your criticism of her
[23] is. You're saying that at Level T, which is what time?
[24] A: Well, there's no time there.

Page 110

[1] Q: So at Level T —
[2] A: But it's written in Level T, but it looks like
[3] it's a continuation of Level S.
[4] Q: What time is Level S?
[5] A: 2340.
[6] Q: At 2340 —
[7] A: But it may be earlier. I am just saying this
[8] is all clumped in here. There's a 5 cc or 250 microgram
[9] bolus of Fentanyl that's given.
[10] Q: And you are critical of the administration of
[11] Fentanyl at that time?
[12] A: 250 microgram in a patient who is hypotensive?
[13] Absolutely.
[14] Q: So do I understand you to say that another
[15] criticism of Nurse Young is that at 2340 or thereabouts,
[16] she gave 250 micrograms of Fentanyl; and you believe
[17] that fell below standard of care, is that correct?
[18] A: Absolutely.
[19] Q: Any other manners in which you believe Nurse
[20] Young fell below standard of care?
[21] A: I believe I have covered it.
[22] Q: Okay. Let's talk now about Nurse Zilka then.
[23] Nurse Zilka, Doctor, how do you believe she fell below
[24] standard of care?

Page 111

[1] A: She was the coordinator on the shift that Nurse
[2] Young was on; and if I have my name correct for her, she
[3] was the one — her resource person.
[4] Q: In what way do you believe Nurse Zilka fell
[5] below standard of care?
[6] A: Nurse Young —
[7] THE WITNESS: I have to take this.
[8] (A brief recess was taken.)
[9] BY MR. JACKSON:
[10] Q: What's the NTB mean, just for my information?
[11] A: Oh, need to bill.
[12] MR. JACKSON: There should be one more.
[13] THE WITNESS: I have three. I have three
[14] pages, three originals plus yours.
[15] MR. JACKSON: There's one more, there was a
[16] fourth. It was a longer letter.
[17] MS. TOSTI: You know what it is, it's the one
[18] that has to do with the deposition being scheduled.
[19] That's the one that's not here. That's from me. It was
[20] one that said your depo was being — it was this one;
[21] there you go.
[22] MR. JACKSON: Okay. You got a copy of it?
[23] MS. TOSTI: No. Did you make a copy of this
[24] one? Do you have the original?

Page 112

[1] THE WITNESS: I have the original.
[2] MR. JACKSON: I have got four. All right.
[3] There's a letter of November 28, 2001, letter of
[4] February 14, 2001, January 22nd, 2002, and August 23,
[5] 2000.
[6] THE WITNESS: Somebody must have —
[7] MR. JACKSON: All on Becker, Mishkind
[8] letterhead.
[9] MS. TOSTI: Yeah, those are the four.
[10] BY MR. JACKSON:
[11] Q: Let's move on, Doctor, because I know you have
[12] a time concern and so do we, I'd like to move through
[13] these. Ready?
[14] A: I'm ready.
[15] Q: Nurse Zilka.
[16] A: Nurse Zilka was the supervising nurse for
[17] Ms. Young, and she hadn't completed her orientation.
[18] And on a case like this, I believe that Ms. Young should
[19] have been chatted a lot closer.
[20] Q: So what did Nurse Zilka do that fell below the
[21] standard of care, in your opinion?
[22] A: Well, I believe that she didn't provide her
[23] with adequate supervision.
[24] Q: Anything else for Nurse Zilka?

Page 113

Page 115

[1] A: Well, she does have some understanding of the
[2] basic pharmacology of some of the medicines that they
[3] were administering.
[4] Q: Do you believe that falls below the standard of
[5] care for her?
[6] A: If you're administering them, you should know
[7] them.
[8] Q: Do you believe that falls below the standard of
[9] care for **Ms. Zilka** not to know the pharmacology of some
[10] of these drugs that you just described?
[11] A: Yes, it does.
[12] Q: Okay. Anything else for Nurse Zilka?
[13] A: I believe that's it.
[14] Q: Nurse Hrobat? In what way do you believe Nurse
[15] Hrobat fell below the standard of care? What are you
[16] looking for, the deposition?
[17] A: Yes.
[18] Q: You know, it's okay to say she didn't fall
[19] below the standard of care; you do understand that? Did
[20] you ignore me, or you just didn't hear me?
[21] A: What was that?
[22] Q: I said it's okay to say she didn't fall below
[23] the standard of care; you understand that, don't you?
[24] A: Well, I wouldn't want to give you the wrong

[1] Nurse Young? And let me make sure that I'm clear. You
[2] didn't highlight anything in Nurse Hrobat's deposition
[3] that you can just go to, correct?
[4] A: Well, I am looking. That's why I am looking.
[5] Q: Did you highlight anything in her depo?
[6] A: I didn't see anything highlighted in her depo.
[7] Q: I didn't see anything highlighted in any of
[8] those depositions. Would you confirm that for me?
[9] A: Oh, I would disagree.
[10] Q: Show me. Who are you looking for? Who do you
[11] have there now?
[12] A: Nurse Zilka. The one I had just before —
[13] Q: You are trying to locate a highlighting or
[14] something in there?
[15] A: There is one. Who were we talking about just
[16] before?
[17] **MS. TOSTI:** Nurse Hrobat.
[18] **BY MR. JACKSON:**
[19] Q: Nurse Zilka and then we went to Nurse Hrobat.
[20] I am counting, Doctor. That's three times you went
[21] through it.
[22] A: Well, I will just have to take my time and do
[23] it right then because I know that there are highlighted
[24] spots in here. And you stated that I did not do that.

Page 114

Page 116

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

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

Page 117

[1] has no effect on the GI tract whatsoever.

[2] Q: It is not a paralytic type drug?

[3] A: It is a paralytic type drug for skeletal
[4] muscle. The gut is smooth muscle which is not affected
[5] by the neuromuscular drugs.

[6] Q: So you are interpreting what she said there
[7] that the vecuronium would have a direct relation on the
[8] bowel sounds, and you disagreed with that?

A: That is correct.

[10] Q: Now, we were talking about Nurse Hrobat. You
[11] didn't highlight anything in her deposition, correct?
[12] And are you able to tell me as you sit here without
[13] going back through her deposition yet another time what
[14] you believe she did or didn't do that fell below the

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

[22] received from Dr. Muehlbach, Dr. Yared.

[23] Q: Are you completed with your answer?

[1] Q: What did she do that fell below standard of
[2] care in your opinion or failed to do?

[3] A: Well, the patient was — became hypotensive
[4] during the infusion of the medications, and the
[5] medications were not slowed down; i.e., the propofol.
[6] And —

[7] Q: And you believe — I am sorry. I didn't mean
[8] to interrupt you.

[9] A: And this ultimately necessitated the starting
[10] of the inotropic drugs.

[11] Q: So what did she do or failed to do that fell
[12] below the standard of care?

[13] A: I believe the continued administration of the
[14] propofol despite the falling pressure necessitated other
[15] things to occur. Propofol does lower the blood pressure
[16] and would be one of the **drugs** that one would turn off
[17] when the pressure dipped.

[18] Q: That's your answer?

[19] A: Yes.

[20] Q: I still don't understand what you're saying
[21] Nurse Hrobat did or failed to do that fell below the
[22] standard of care?

[23] A: If you have a drug that lowers blood pressure
[24] and the patient experiences a drop in blood pressure,

Page 119

[1] one would not continue administering a drug that will
[2] continue to lower the blood pressure.

[3] Q: So you're saying Nurse Hrobat did what; she
[4] continued to administer —

[5] A: The propofol infusion was continued.

[6] Q: So Nurse Hrobat fell below the standard of care
[7] in your opinion because propofol was continued to be
[8] administered?

[9] A: That is correct.

[10] Q: What time frame is that?

[11] A: Well, the propofol was started when the patient
[12] came back. The patient dipped at Time E as in echo to
[13] 75/46. The nitroprusside was off, but the propofol was
[14] not turned off.

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

[21] golf

[22] Q: So it's time E as in Edward that you're talking
[23] about?

[24] A: That is correct.

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

[4] A: Yes, I have.

[5] Q: Let me go back to Dr. Muehlbach. You said
[6] there was some physiological changes that **was** evidence
[7] of an indication that this patient should be taken back
[8] to the operating room sooner. That was your first
[9] comment about Dr. Muehlbach?

[10] A: That is correct.

[11] Q: And what physiological changes are you talking
[12] about, and what time do you say this patient should have
[13] been taken back sooner? Excuse me. What time do you
[14] say the patient should have been taken back?

[15] A: I think that if you look at the trends, the
[16] heart rate is going up, started off at 99. At Point G
[17] it goes to 107. At Point H it's 110. At Point I it's
[18] 104. At Point J it's 110. At Point K it's 110. At
[19] Point L it's 110. At Point M it's 110. At Point N it's
[20] 116. When the heart rate stayed up from G to H, H to I,
[21] he remained tachycardic, the pressure dropped systolic,
[22] it went 93 to 88 to —

[23] Q: Excuse me, Doctor. You don't need to list all
[24] those for me. I am just asking you what physiological

Page 121

Page 123

[1] changes. The physiological change was the increase in
[2] the heart pressure?

[3] **A:** The sustained tachycardia, the drop in systolic
[4] blood pressure. And what makes it very difficult
[5] after —

[6] **Q:** That's between G and H on the chart?

[7] **A:** G and J is that time period.

[8] **Q:** G and J, okay.

[9] **A:** Okay. One looks at a decreasing systolic blood
[10] pressure, an increasing heart rate which is a
[11] compensatory tachycardia, and the fact that the patient
[12] is requiring more and more inotrope. They have started
[13] Amicar because the patient continues to bleed. And then
[14] what makes it very difficult because it's obfuscated is
[15] that at Point K is the last pulmonary artery pressure
[16] reading that is obtained. If the patient — on a Bently
[17] procedure, these patients can be labile because of the
[18] nature of the surgery in and of itself. This patient
[19] had had one problem intraoperatively where they had to
[20] go back on bypass to fix the proximal suture line.

[21] **Q:** Is that significant to you in this case?

[22] **A:** Well, he rebled from the distal suture line;
[23] but the most common complication of a root replacement
[24] is bleeding.

Page 122

Page 124

[1] **Q:** My question was: Is that significant to you in
[2] this case, what you just commented on having to go back
[3] in and stitch that?

[4] **A:** Well, they were in there already.

[5] **Q:** Thank you. Having to go back and stitch that,
[6] is that significant in this case?

[7] **A:** Well, you had a leak, you repaired it because
[8] the suture pulled out. That means that the tissue
[9] probably isn't as firm as one would hope for or like;
[10] however, they had to go back. And a patient that starts
[11] hemodynamically deteriorating such as this with a
[12] sustained tachycardia, one has to continue to follow the
[13] PA pressures and also follow other parameters, i.e., how
[14] much blood has come out the chest tube.

[15] **Q:** Was the fact that they had go back and resuture
[16] the distal line significant to you in this case?

[17] **A:** I think you're asking two different questions.

[18] **Q:** I tried to ask you one question three times.

[19] **MS. TOSTI:** You said distal.

[20] **THE WITNESS:** You said distal.

[21] **BY MR. JACKSON:**

[22] **Q:** I thought you said distal.

[23] **A:** I said proximal.

[24] **Q:** Forgive me then. I meant to say proximal. Was

[1] the fact that they went back in and stitched the

[2] proximal significant to you in this case?

[3] **A:** Only inasmuch as it indicates that the tissue
[4] they had to sew to may not have been as good as they
[5] liked. Did it change what happened to him? Was it
[6] significant in terms of outcome? No.

[7] **Q:** Okay. Let's go on. In terms of these
[8] physiological changes, you're talking about increased
[9] heart rate, sustained tachycardia, decreased systolic
[10] blood pressure. You're saying that Dr. Muehlbach should
[11] have seen these things as an indication, and Mr. Long
[12] should have been taken back to surgery sooner, correct?

[13] **A:** That is correct.

[14] **Q:** When? When was sooner? When should he have
[15] been taken back in your opinion?

[16] **A:** Well, I think I state in my letter here, I
[17] believe that if — beyond a reasonable degree of
[18] certainty that if Mr. Long had been taken back at L or
[19] prior to L, he would not have sustained the injuries he
[20] did.

[21] **Q:** So it is your opinion that there was
[22] physiological changes that indicated that he should be
[23] taken back at Time L at the latest, is that correct? Is
[24] that what you're saying?

[1] **A:** Yes.

[2] **Q:** Now, you said earlier that Dr. Muehlbach should
[3] have, as a result of these changes, either returned him
[4] to surgery or warranted closer care. What do you mean
[5] closer care?

[6] **A:** Well, one of the things that could have been
[7] done would have been a transesophageal echo on the
[8] patient. The patient had a history preoperatively in
[9] the cath report of severe left ventricular dysfunction.
[10] He had an aortic gradient. I believe the square surface
[11] area was .57 square centimeters which is critical aortic
[12] stenosis. Patients like that when you unload the
[13] ventricle by putting a homograph valve in there
[14] oftentimes need some inotropic support. However,
[15] there's also some evidence of dysfunction after being on
[16] the bypass machine.

[17] They raised the inotropes up, the pressure was
[18] going down, the CVP — if you look at the central venous
[19] pressure here from Time A all the way to Time R only
[20] went up maybe at one point to 20 at J. In classic
[21] tamponade one oftentimes sees a higher CVP but not
[22] always. If the patient has left ventricular
[23] dysfunction, it may be masked. There is no way to tell
[24] that without actually looking at the heart how the heart

Page 125

[1] is beating.

[2] If this patient had your heart and my heart,
[3] and hopefully we both have normal ventricular function,
[4] as the CVP — as the heart was getting tamponaded, if it
[5] went up, you would see a rise in CVP, a decrease in
[6] systolic blood pressure.

[7] In a patient who has a compromised heart such
[8] as this patient, all bets are off. So just the pressure
[9] number on the Swan is not indicative of what's
[10] happening. You really need to see — and there's two
[11] ways to see. One is by doing a transesophageal echo
[12] which tells you that the heart is beating fine but it
[13] could be empty or there might be a mass behind it; or
[14] two is to expose the heart to the night air and under
[15] direct vision look at the heart.

[16] And that's the problem with this care. If this
[17] had been a normal ventricle, totally different story;
[18] but this is an impaired ventricle with decreased
[19] function. And **so** one has to be somewhat — I don't want
[20] to say skeptical but highly suspicious of these numbers,
[21] and I would expect someone at Dr. Muehlbach's level of
[22] training to be cognizant of that. Because certainly
[23] when these parameters — when they persisted and were
[24] presented to Dr. Cosgrove, Dr. Cosgrove says meet you in

Page 126

[1] the OR. There was no questions.

[2] But nothing changed from this initial point all
[3] the way down. It was just more of the dwindles; and yet
[4] they went up on the drugs, the inotropes. So they were
[5] supporting it, but you can only beat a heart so hard and
[6] then it doesn't perform. And that's exactly what
[7] happened in this case.

[8] There **was** a lack of **PA** pressure readings, I
[9] suspect because they were very high. And those in and
[10] of themselves — but there's critical information that's
[11] not in here; but just based on what —

[12] Q: Critical information being the **PA** readings?

[13] A: That's exactly right.

[14] Q: Okay. Anything else?

[15] A: But looking at this —

[16] Q: Anything else other than the **PA** readings?

[17] A: The **PA** readings are very important.

[18] Q: Anything else?

[19] A: Well, they didn't do a wedge pressure. I don't
[20] know if they follow wedge pressures there. A wedge
[21] would have been nice. That would tell you what the
[22] other side of the heart is looking at.

[23] Q: Anything else?

[24] A: There **was** no attempt to investigate the degree

Page 127

[1] of myocardial dysfunction.

[2] Q: Okay. That's information that's not there you
[3] say?

[4] A: There was no attempt to do like a
[5] transesophageal echo.

[6] Q: Okay. Anything else that's not there, any
[7] other information?

[8] A: There's a chest x-ray that was done, showed
[9] some perihilar fullness at I believe 6:30 or so. The
[10] radiologist said a repeat **film** would be warranted. If
[11] you're suspecting tamponade or myocardial dysfunction,
[12] one of the easiest ways to **do** that would be a repeat
[13] chest x-ray. Because if there's some more fullness,
[14] that would be helpful. Was there a liter of blood in
[15] this man's chest? No. But you don't need a liter to
[16] cause the symptoms in a heart that has dysfunction.
[17] And what happened is clearly evident. When he
[18] dropped that last 250 of blood, he precipitously tanked.
[19] He lost his pressure and everything. At the same time
[20] they're increasing his propofol which will drop it even
[21] more. It's incongruous.

[22] I mean, it's like you got a gallon of gas in
[23] your tank, and then you drill a hole in your tank at the
[24] same time. You're going to run out of gas faster, and

Page 128

[1] that's exactly what happened in this patient.

[2] Q: Have you discussed all of your criticisms and
[3] the basis for your criticisms against Dr. Muehlbach?
[4] You also told me he didn't notify Dr. Cosgrove. When
[5] should he have notified Dr. Cosgrove?

[6] A: While he was taking him to the OR about an hour
[7] before he did go, two hours before.

[8] Q: He should have notified him —

[9] A: He should have told him that this patient needs
[10] to **go** back to the OR.

[11] Q: Excuse me; I'm trying to get the time that you
[12] say that should have happened.

[13] A: It should have happened back when I stated
[14] before around L.

[15] Q: Dr. Muehlbach should have notified Dr. Cosgrove
[16] at around Level L on the chart that this patient
[17] Needed to go to the OR, is that your criticism of
[18] Dr. Muehlbach?

[19] A: Yes.

[20] Q: Anything else about Dr. Muehlbach that you wish
[21] to say now?

[22] A: I believe he should have been present at the
[23] bedside with this patient. Bentyls can be unstable, and
[24] I don't think it's prudent that a second-year resident

Page 129

Page 131

[1] baby-sits a pump.
[2] Q: When should he have been at the bedside?
[3] A: Until he was sure the patient was stable
[4] postoperatively. He could have —
[5] Q: He could have what?
[6] A: He could have been there. He had — obviously
[7] we all have to make rounds, but he left.
[8] Q: When did he leave?
[9] A: I'd have to look, but he was not present for
[10] some of this information.
[11] Q: And is it your position, in your opinion, that
[12] Dr. Muehlbach not being at this patient's bedside was
[13] below standard of care?
[14] A: I believe it's below the standard of care that
[15] this patient **was** unstable and he was not present.
[16] Q: My question to you is, so I want to understand
[17] it: The fact that Dr. Muehlbach was not at this
[18] patient's bedside, in your opinion, was below standard
[19] of care?
[20] **THE WITNESS:** Could you repeat that?
[21] (The pending question was read by the court
[22] reporter.)
[23] A: I would qualify that saying he was not at the
[24] bedside between H and M.

Page 130

[1] **BY MR. JACKSON:**
[2] Q: What times were those, Doctor?
[3] A: 1950 would be at the end of H to M when the
[4] decision or prior — just prior to M should have been
[5] made to take this patient back.
[6] Q: What time was M?
[7] A: M is 2150. L which would have been the
[8] preceding time 2110.
[9] Q: So between 1950 and —
[10] **MS. TOSTI:** I think it's 2130. I think N is
[11] 2150.
[12] **BY MR. JACKSON:**
[13] Q: So between 1950 and 2130 it is your opinion
[14] that the fact that Dr. Muehlbach **was** not at the bedside
[15] **was** below standard of care?
[16] A: Yes.
[17] Q: That's a new one, isn't it? You didn't say
[18] that earlier.
[19] A: No; this patient was unstable.
[20] Q: No. The business about Dr. Muehlbach not being
[21] at bedside, you hadn't mentioned that earlier. That's
[22] one you just mentioned for the first time just a moment
[23] ago, is that correct?
[24] A: My point was that Dr. Muehlbach was not

[1] present, that was my criticism, directing his care.
[2] Q: My question to you was — well, the record will
[3] speak for itself. We'll see what it said earlier. You
[4] didn't say that earlier. You don't recall that, or do
[5] you?
[6] A: I don't recall it.
[7] Q: Is it your opinion that Dr. Muehlbach's
[8] breaches in standard of care caused some harm to Mr.
[9] Lung?
[10] A: I believe it delayed the time for which
[11] Mr. Long got back to the OR.
[12] Q: Did that cause harm to Mr. Long?
[13] A: The delay in him going back to the OR I believe
[14] **was** directly attributable to his anoxic injury.
[15] Q: I still don't have an answer to my question, I
[16] don't think. Do you believe that the delay which you
[17] think was caused by Dr. Muehlbach's breach of the
[18] standard of care caused Mr. Long injury or harm?
[19] A: Yes.
[20] Q: And what harm did it cause Mr. Long?
[21] A: I believe that Mr. Long would have had more
[22] reserve had he gone back to the OR later — sooner than
[23] later.
[24] Q: Let's talk about Dr. Hernandez. Your comments

Page 132

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

Page 133

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

[6] I don't believe that Dr. Hernandez kept a
[7] running dialogue with Dr. Muehlbach in all these
[8] changes.

[9] Q: That's show you believe he fell below the
[10] standard of care?

[11] A: Yes.

[12] Q: Did that cause harm to Mr. Long?

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

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

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

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

[24] A: Poor charting.

Page 134

[1] Q: And lack of charting?

[2] A: And lack of charting.

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

[4] A: Yes.

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

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

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

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

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

[20] A: Well, the standard of care — the delivery of
[21] the standard of care — there is a standard of care for
[22] charting. You have to have certain things, just like
[23] there's a standard of care for my charting in an
[24] anesthetic in the OR.

Page 135

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

[6] A: Well, these aren't quite — G corresponds to
[7] 1930.

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

[11] A: Right. She raised the PEAP and at the same
[12] time decreased the FIO2.

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

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

[20] Q: Out of how many weeks?

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

Page 136

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

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

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

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

[12] A: I believe we talked about the vecuronium.

[13] Q: Any others?

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

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

[22] A: Vecuronium.

[23] Q: Any others?

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

Page 137

Page 139

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

Page 138

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

[1] most institutions that's the way it is. Name an
[2] institution where that's not a surgical decision.
[3] A: Well, at Texas Heart they have full-time
[4] intensivists there. And if they think someone is
[5] bleeding or tamping, they will call the surgeon back
[6] in.
[7] Q: Who decides to take the patient back to the
[8] operating room under those circumstances?
[9] A: Well, obviously the person with the knife in
[10] their hand is going to make the final decision.
[11] Q: Are there any institutions where that's not the
[12] case that you can tell me that you're aware of?
[13] A: Well, you can't make somebody go back if they
[14] don't want to go back, but the surgeon is the one that
[15] has the ultimate decision.
[16] Q: It's a surgical decision to return to the
[17] operating room, isn't it?
[18] MS. TOSTI: I think he's answered that about
[19] three times now.
[20] BY MR. JACKSON:
[21] Q: Is that a yes or no?
[22] A: I think I said yes.
[23] Q: And do you feel as an anesthesiologist that
[24] you're qualified to make that decision and to criticize

Page 140

[1] that decision?
[2] A: Oh, in certain cases, yes.
[3] Q: In this case you think you are?
[4] A: I think the decision to go back to the OR was
[5] the appropriate one, and it was just made too late.
[6] Q: But my point is, Doctor, do you feel as an
[7] anesthesiologist that you're qualified to make — to
[8] criticize the surgical decision as to when a patient
[9] should be taken back to the operating room?
[10] A: I think I can in this case.
[11] Q: So you feel qualified to make that decision in
[12] this case?
[13] A: I think I have made the decision in many cases
[14] I have been involved with and will sit down with the
[15] surgeons, and they say do you think the patient needs to
[16] go back.
[17] Q: Please, Doctor, I am asking you in this case,
[18] do you feel qualified to make a criticism of the
[19] decision as to when this patient should go back to the
[20] operating room; is that what you're saying?
[21] A: I do.
[22] Q: Let me go to your report. Do you have it in
[23] front of you? First page at the bottom you have two
[24] bullet points there. Those are just comments on facts.

Page 141

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

Page 142

[1] 2.0, and his cardiac output is 3.4.
[2] Q: Is there a 3.2 and 2.0, or is that just a
[3] misprint on mine?
[4] A: 2.0 is at E, that is the cardiac index. And I
[5] have a 3.4. Maybe it's a 3.2.
[6] Q: I am just trying to understand what's in your
[7] report. You said 3.2. Do you believe it's 3.4?
[8] A: It could be. It could be 3.4 or 3.2.
[9] Q: The next bullet point on Page 2 talks about the
[10] use of Levophed and Neo-Synephrine. Do you see that in
[11] your report?
[12] A: Yes.
[13] Q: Is the use of those two drugs unusual in this
[14] setting?
[15] A: No.
[16] Q: Your next bullet point talks about documented
[17] chest tube bleeding followed by a period of no bleeding
[18] and then the massive bleed. What period are you
[19] referring to when you say "period of no bleeding"?
[20] A: There's a period from right at G to J where
[21] there's a minimal amount.
[22] Q: Your report says no bleeding. That's why I
[23] asked you the question, Doctor. What period are you
[24] referring to when you say there's a period of no

Page 143

[1] bleeding?
[2] A: There's a time where there was no documented
[3] bleeding at period H and I. H was 1950. I was 2010.
[4] Q: When you say documented bleeding, are you
[5] referring to chest tube output?
[6] A: That is correct. Then they document at Point J
[7] as in John a 50 cc amount. Nothing at K or L, again is
[8] quiet, another 50 cc amount.
[9] Q: Is that a normal output for those periods of
[10] time, Doctor, running 50 for periods?
[11] A: Well, running 50, but —
[12] Q: Is that normal?
[13] A: This is a small bolus. They don't say that
[14] this is continuous. This is hourly.
[15] Q: Well, how else do you record it where you are?
[16] A: Well, there's time intervals. That's part of
[17] the problem with this is that there's no set intervals.
[18] Q: How often do you record those in your
[19] hospitals, Doctor?
[20] A: 30 minutes, every 30 minutes.
[21] Q: Every 30 minutes they record chest tube output?
[22] A: That is correct.
[23] Q: Swan-Gam reading is the next bullet point.
[24] You say they weren't performed often enough?

Page 144

[1] A: There is nothing performed after Point K.
[2] Q: What time was Point K?
[3] A: 2050.
[4] Q: So no Swan-Gam readings after Point K?
[5] A: That is correct.
[6] Q: Is that what you're referring to there, that
[7] after Point K they didn't do enough Swan-Gam readings?
[8] A: That was the point.
[9] Q: That's what I'm trying to understand —
[10] A: That is correct.
[11] Q: — from your report. You're talking about
[12] after 2050. How often should they have done them after
[13] 2050?
[14] A: Well, they were doing them every half hour,
[15] every 20 minutes.
[16] Q: How often should they have done them after
[17] 2050?
[18] A: Half hour would have been fine.
[19] Q: Every half hour?
[20] A: If they would have done them.
[21] O: You say "no one looked at the whole picture,"
[22] quote, end quote. What do you mean by that?
[23] A: There did not seem to be a total coordination.
[24] There was someone — they were giving propofol, and I

Page 145

Page 147

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

[4] Q: What did you mean when you said the whole
[5] picture, Doctor?

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

[12] Q: Have you ever cared for a patient like
[13] Mr. Long?

[14] A: Absolutely.

[15] Q: How many?

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

[19] Q: Did you ever have to take a patient back to the
[20] operating room?

[21] A: Yes.

[22] Q: How often?

[23] A: Depends on who the staff surgeon was.

[24] Q: How so?

Page 146

Page 148

[1] A: Some were more concerned about hemostasis
[2] intraoperatively than others.

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

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

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

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

[14] Q: That being who?

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

[23] Q: What is a cardiac tamponade, Doctor?

[24] A: Cardiac tamponade is — you can have a pseudo

[1] tamponade or real tamponade. In a nutshell, the heart
[2] is an enclosed space. Compression extrinsically on the
[3] heart by blood or something else can cause dysfunction.

[4] If you have — and as a result, there are certain things
[5] that you find oftentimes but not always. There's no one
[6] thing that's pathognomonic. And it basically inhibits
[7] the preload of the heart or it inhibits cardiac ejection
[8] via compressive effort.

[9] Q: What are the signs and symptoms of a cardiac
[10] tamponade?

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

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

[22] A: Yes.

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

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

[20] If you can't increase stroke volume which is
[21] limited, you increase the rate because the cardiac
[22] output is the heart rate times the stroke volume. So as
[23] a result of that, one then sees a tachycardia that is
[24] sustained as defined if a heart rate is sustained above
[25] 100 beats per minute. And that's been my experience in
[26] practicality and also in conversations with many
[27] coordinators of tachycardia, it's probably one of the
[28] best signs that's most reliable as long as the patient
[29] isn't Beta blocked. CVP is nice if it goes along with
[30] it. It's not one simple finding. It's what you'd
[31] called the gestalt or the constellation of findings that
[32] you see. It's the total package of the presentation.

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

Page 149

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

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

[15] Q: You're talking about the second surgery?

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

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

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

[23] MR. JACKSON: No, he hasn't.

[24] MS. TOSTI: He's told you between L and M and

[1] when he came back.

BY MR. JACKSON:

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

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

[7] Q: Give me times if you would, please.

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

[12] Q: What time is M?

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

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

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

[17] BY MR. JACKSON:

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

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

[21] Q: Please, before you do that, answer that
[22] question.

[23] A: I believe after 2150 — or Point N here which
[24] is the end of M, it is impossible to tell what was going

Page 151

[1] on inside the central perfusion pressures. There's no
[2] more things. They went up to maximum amount of drugs.
[3] The blood pressures were elevated. He was remaining
[4] tachycardic. We have no idea whether or not he had
[5] actual central pressures enough to perfuse.

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

[11] THE WITNESS: Can you reread the question back?

[12] (The requested portion of the transcript was
[13] read by the court reporter.)

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

BY MR. JACKSON:

[18] Q: Do you believe you answered the question?

[19] A: I believe so.

[20] Q: At what point was it too late to change the
[21] outcome?

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

[24] Q: Is that the point after which the outcome could

[1] not be changed?

[2] MS. TOSTI: What outcome are you referring to,
[3] the anoxic encephalopathy?

BY MR. JACKSON:

[5] Q: What were you referring to, Doctor, when you —

[6] MS. TOSTI: What are you referring to as to the
[7] outcome?

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

BY MR. JACKSON:

[11] Q: What were you referring to when you answered my
[12] question?

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

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

[17] A: That's correct.

[18] Q: Okay.

[19] (A brief recess was taken.)

BY MR. JACKSON:

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

[23] A: I believe he had hypoperfusion.

Page 153

Page 155

[1] A: When he was hypotensive or hypoperfused.
[2] Q: When was that, what point of time?
[3] A: Sometime between 2230 and when he came back
[4] from the operating room the second time.
[5] Q: Are you able to be any more specific than that
[6] time frame?
[7] A: I cannot.
[8] Q: At what point in time do you believe his brain
[9] damage could have been prevented?
[10] A: Well, I think it occurred between 2230 and the
[11] time he got back from the OR. Had he gone back to the
[12] OR earlier, I think it could have been avoided.
[13] Q: You are not critical of any of the care and
[14] treatment he received between the time he was sent to
[15] the OR and the time he returned, am I correct?
[16] A: Other than that he went too late, the care was
[17] appropriate.
[18] Q: Okay. Are you able to tell me the last point
[19] in time that he could have been sent to the operating
[20] room and not sustained brain damage in your opinion?
[21] A: I think his period — his injury occurred
[22] between 2230 and the time he came back from the OR.
[23] Q: That didn't answer my question.
[24] A: I think that's the best I can answer it.

Page 154

[1] Q: I understand that. But the question was, at
[2] what point in time before that? You say he should have
[3] been sent back earlier, correct?
[4] A: That is correct.
[5] Q: And you're saying if he had been sent back
[6] earlier, it would have made a difference in the brain
[7] damage. He wouldn't have had brain damage, correct?
[8] A: I believe so.
[9] Q: Why do you say that? What's your basis for
[10] that?
[11] A: Because I don't think he would have, to use a
[12] euphemism, crashed and burned like he did on the way to
[13] the OR that he did. He would have gone down in a more
[14] controlled fashion, hemodynamically stable. He went
[15] down to the OR hemodynamically unstable.
[16] Q: When is the last point in time, in your
[17] opinion, that he would have gone to the OR in a
[18] condition that you believe would have prevented the
[19] brain damage?
[20] A: Prior to 2230.
[21] Q: How far back?
[22] A: Just prior to 2230.
[23] Q: Are you meaning like — are you saying like
[24] 2200 or before that when you say just prior? Are you

[1] saying immediately prior, or are you saying sometime
[2] before?
[3] A: I believe that when he dumped at O, at 2210,
[4] that last 250, he became hemodynamically unstable,
[5] hypovolemic, and sent him down on the spiral curve, the
[6] slippery slope. I believe that had he been taken back
[7] prior to that 2230, he would have had enough reserve so
[8] that they could have taken him down there without him
[9] getting hypotensive and anoxic.
[10] Q: You changed your times there. You were talking
[11] 2210 and then you said 2230.
[12] A: Time O is when he dumped the last 250.
[13] Q: 2210?
[14] A: That is correct.
[15] Q: Is that the point in time before which he
[16] should have been taken to surgery in your opinion, and
[17] there would have been a different result?
[18] A: That is correct.
[19] Q: Okay. How much before 2210 do you believe —
[20] or how long before 2210 should he have been taken back
[21] to surgery where there would have been a different
[22] result in your opinion?
[23] A: Prior to that.
[24] Q: 2205?

Page 156

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

Page 157

[1] **MR. JACKSON:** It hasn't been answered. It's
[2] been asked a few.
[3] **MS. TOSTI:** Objection, asked and answered.
[4] **BY MR. JACKSON:**
[5] Q: Do you understand my question, Doctor?
[6] A: I believe that if he had gone back to surgery
[7] prior to 2210, he would have not have had the neurologic
[8] outcome and sequelae that he suffered.
[9] Q: You have said that to me. I am asking you are
[10] you able to tell me the last point in time — do you
[11] have an opinion as to the last point in time that he
[12] could have been taken back to the operating room and not
[13] suffered that sequelae?
[14] **MS. TOSTI:** Objection, asked and answered.
[15] **BY MR. JACKSON:**
[16] Q: Go ahead, Doctor.
[17] A: I would still stay with what I said, the 2210.
[18] Q: That's the last point in time in your opinion
[19] that he could have been taken back and had a different
[20] result?
[21] A: That's when he dumped.
[22] Q: My question is: Is that the last point in
[23] time? After that time, they couldn't change it?
[24] **MS. TOSTI:** His answer was prior to 2210.

Page 158

[1] **MR. JACKSON:** That's what I am trying to figure
[2] out, but he won't answer my question.
[3] **BY MR. JACKSON:**
[4] Q: At what point prior to 2210, Doctor, could he
[5] have been taken back and not had the same result?
[6] **MS. TOSTI:** Objection, asked and answered.
[7] **MR. JACKSON:** Then tell me what time he said.
[8] **MS. TOSTI:** I am just putting my objection on
[9] the record. He's answered the question about five times
[10] now.
[11] **MR. JACKSON:** He has not. He keeps saying
[12] 2210, before 2210.
[13] **BY MR. JACKSON:**
[14] Q: What's the last point in time, Doctor? And if
[15] you can't give it to me, then tell me that.
[16] A: When his inotrope was again increased and the
[17] patient's indexes went down, and the patient's blood
[18] pressure went down, that's between L and O, that's 2110
[19] to 2210. They maximally increased his inotrope at M
[20] which is 2130. Whatever that — it looks like a five
[21] but it could be a three, and M.
[22] Q: Is it your opinion that if he had been taken
[23] back at 2110, there would have been a different result?
[24] A: Yes.

Page 159

[1] Q: Is it your opinion that if he had been taken
[2] back at 2100, there would have been a different result?
[3] A: Yes.
[4] Q: Is 2110 the last point in time that you believe
[5] he could have been taken back to the operating room and
[6] there been a different result? Is that what I am
[7] understanding you to say?
[8] A: No, 2210 is. That's the point at which he
[9] dumped. That's the point where he became extremely
[10] unstable.
[11] Q: So if he had been taken back any time before
[12] 2210 in your opinion, the result would have been
[13] different?
[14] A: Yes.
[15] Q: And you say that because you believe what?
[16] A: Because I believe his hemodynamics were
[17] deteriorated to the point where he was hypoperfusing and
[18] his indexes dropped, and his heart rate proceeded to go
[19] up.
[20] Q: Doctor, have I covered all your opinions that
[21] you have rendered in this case?
[22] A: You have.
[23] Q: If there's any changes in those, additions,
[24] corrections, deletions, you will let us know?

Page 160

[1] A: I would.
[2] Q: Okay. One other — two other questions
[3] actually. How did they get to you, do you know? How
[4] did the Becker firm get to you?
[5] A: I don't know.
[6] Q: And in terms of care and treatment of a cardiac
[7] surgical patient, would you defer to Dr. Cosgrove's
[8] opinions?
[9] A: With regard to what?
[10] Q: The care and treatment of a cardiac surgical
[11] patient.
[12] A: With what aspects?
[13] Q: All aspects.
[14] A: Well, all aspects includes all the anesthesia
[15] aspects?
[16] Q: All aspects.
[17] A: I think we would have things that we would
[18] agree on. We would have things we would disagree on. I
[19] would not defer to his anesthetic management of a case.
[20] Q: During the course of a surgery you mean?
[21] A: That is correct. I would not defer to his use
[22] of the drugs postoperatively such as propofol which is
[23] typically an anesthetic drug.
[24] Q: You would not defer to his opinions in that

Page 161

{1} regard. How about his opinions regarding the other
{2} medications given to a —

{3} **A:** Well, I use inotropes just like Cosgrove does.
{4} I mean, I would definitely discuss it with him.

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

{7} **A:** Not necessarily.

{8} **Q:** Okay. Do you know who Dr. Cosgrove is?

{9} **A:** I know he is a fairly prominent surgeon at the
{10} clinic. He is the head of their cardiac program I
{11} believe.

{12} **Q:** Do you know how many cardiac surgeries he's
{13} performed in his career?

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

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

{17} **A:** Absolutely none.

{18} **Q:** You believe what he did and how he treated this
{19} patient were appropriate and within standards of care?

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

{23} **Q:** You would certainly defer to Dr. Cosgrove on
{24} surgical decisions as it relates to cardiac patients,

Page 162

{1} would you not?

{2} **A:** I would.

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

{6} **THE WITNESS:** I will reserve signature.

{7} **THE COURT REPORTER:** Ms. Tosti, will you take
{8} care of the reading and signing?

{9} **MS. TOSTI:** Yes, I will take care of signature.

{10} **THE COURT REPORTER:** Do you want this written
{11} up, Mr. Jackson?

{12} **MR. JACKSON:** Yes, with a mini and an index.

{13} **THE COURT REPORTER:** Copy, Ms. Tosti?

{14} **MS. TOSTI:** Yes, and a mini.

{15} (Whereupon, the preceding deposition concluded
{16} at 6:20 p.m.)

{17}

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{22}

{23}

{24}

Page 163

{1} **STATE OF ILLINOIS**)
{2}) SS

{3} **COUNTY OF WINNEBAGO**)
{4})

{5} **CHRISTOPHER S LONG,**)
Executor, etc ,)

{6} **Plaintiff,**)

{7} **vs**) **CASE NO 419978**

{8} **CLEVELANDCLINIC FOUNDATION,**)
{9})

{10} **Defendant**)

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

{17}

{18} **W Stephen Minore, M D**

{19}

{20} **Subscribed and sworn to**
{21} **before me this _____ day**
{22} **of _____, A D 2002**

{23}

{24} **Notary Public**

{25}

Page 164

{1} **STATE OF ILLINOIS)**

{2}) SS.

{3} **COUNTY OF WINNEBAGO)**

{4}

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

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

{23} I further certify that the signature to the
{24} foregoing deposition was reserved by the deponent.

Page 165

[1] I further certify that the taking of this
[2] deposition was pursuant to Notice and that there were
[3] present at the deposition the attorneys hereinbefore
[4] mentioned.

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

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

[11]

[12]

Tracy L. Abbott

[13] License Number 084-003182

[14] Notary public, Winnebago County,
[15] Illinois

[16]

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Lawyer's Notes

\$	100:11; 124:20; 144:15 200 164:9 2000 11:18; 12:7, 9, 10; 66:15; 112:5 2001 12:23; 95:12; 96:18, 19; 112:3, 4 2002 112:4; 164:8; 165:10	4	9:00 17:8; 96:15; 97:8, 10	164:19 Again 19:2, 18; 34:19; 36:17, 21; 51:18; 56:7; 66:23; 71:15; 73:10; 90:20; 106:1; 133:13; 143:7; 158:16 against 128:3 aggressive 41:9
\$1,500 54:15, 17 \$1,650 14:6 \$350 54:16; 55:13 \$500 54:16, 17; 55:2, 10 \$8,500 55:20; 56:6		40 45:13; 68:15; 156:18 430 20:19 4:00 17:3	A	
084-003182165:13		5	a.m 17:17, 17 Abbott 164:5; 165:12 aberrations 107:3	
1	21 150:13 2100 96:16; 159:2 2110 130:8; 158:18, 23; 159:4 2130 130:10, 13; 150:15, 16, 18; 151:14; 158:20 2150 130:7, 11; 150:23; 151:14 2150s 150:14 2200 154:24 2202 164:8 2205 155:24 2210 151:23; 152:15; 155:3, 11, 13, 19, 20 156:1, 12; 157:7, 17, 24; 158:4, 12, 12, 19; 159:8, 12 2230 151:8; 153:3, 10, 22; 154:20, 22; 155:7, 11 22nd 15:7; 112:4 23 12:9, 10; 112:4 2340 110:5, 6, 15 23rd 11:18; 12:7 24 68:11 24/7 36:3 25 20:9	50 9:20; 19:17; 77:14, 23; 78:2, 14, 23; 79:8, 11; 143:7, 8, 10, 11 50,000 76:22 500 56:4 57 124:11 5:00 17:4	153:5, 18; 156:4, 11; 157:10 Above 45:20; 148:14 absence 107:8 absent 107:4; 116:20 Absolutely 31:16, 18; 101:19; 109:7; 110:13, 18; 145:14; 161:17 academic 34:11 academics 76:1 accept 66:21 according 54:23 accreditation 37:9; 78:7 accrue 50:12 Across 5:23; 6:2 act 53:12 acted 62:13; 81:24 acting 56:13; 62:5 actual 37:2; 81:22; 151:5 Actually 21:22; 29:10; 31:21; 37:5; 47:18; 52:14; 65:13; 68:9; 70:2; 75:11; 94:11; 124:24; 145:10; 160:3 acutely 108:17 add 61:19; 62:1; 66:24 adding 67:1 addition 6:20; 9:2; 29:15	35:21; 37:10; 51:4; 59:2; 63:1, 1; 65:2; 66:14; 68:11, 15; 70:5; 75:16, 17, 20; 85:24; 86:2; 99:7; 130:23 agree 160:18 ahead 49:24; 50:2, 20; 81:11; 101:11; 157:16 air 125:14 allegation 94:15 allegations 67:12 alleged 57:22; 94:2 allegedly 92:5 allows 134:15 almost 51:21 along 148:19 alter 99:9 Although 23:20 always 21:19; 30:20, 22; 31:14; 124:22; 145:11; 147:5 Ambulatory 19:5; 44:13, 24; 46:8, 17; 49:9 American 37:7, 13; 38:15; 81:16 Amicar 108:21; 121:13 among 40:24 amount 14:1; 23:24; 33:7; 48:6; 108:24; 142:21; 143:7, 8; 151:2
1 45:23 1,000 18:14; 25:21 1/37th 46:4 10 29:2; 62:12; 72:18, 18; 135:21; 161:14 IO-minute 46: 11 100 48:17; 51:22; 79:18; 83:14, 16; 148:15 104 120:18 107 120:17 11 96:18, 19 110 77:4; 120:17, 18, 18, 19, 19 116 120:20 11:00 17:9 11th 66:13, 14; 95:12; 99:10 12 116:14; 135:21 12-bed 22:14 13 16:24 14 16:24; 20:11; 112:4; 116:13, 15 14th 12:23	16; 127:18; 135:2, 9; 155:4, 12 26 16 52:4 27th 66:17 28 112:3 287 78:12 28th 15:4; 164:7	6	6 71:7 60 19:17 6:00 17:4, 6, 15; 96:15; 97:8, 9, 13 6:15 47:23 6:20 162:16 6:30 127:9 6:45 17:5	
67:18; 116:15; 138:5 15,000 161:14 150 46:20 16 100:11 1730 141:20 18 116:14 1800 96:16 1850 116:21 1930 107:17; 135:2, 7 1950 130:3, 9, 13; 143:3 1987 94:6 1993 62:20; 64:19; 77:21 1995 37:20; 39:19; 40:14 1996 39:19 1998 35:23		7	7 71:23 7,500 56:11 75 62:15 75/46 119:13, 18 7:00 17:7, 15, 16, 17 7th 165:9	
		8	address 51:10, 12; 52:7, 10 adequate 112:23; 135:14 adequately 102:9 adjacent 22:13 adjustments 132:12 administer 119:4; 136:17 administered 119:8 administering 113:3, 6; 119:1 administers 48:24 administration 110:10; 117:17; 118:13 administrator 46:9; 47:1, 16 adult 57:10 advanced 48:14; 72:16, 18; 73:6 affected 117:4 affiliations 18:18 affixed 165:9 aforesaid 164:16, 22 afterwards 79:17; 80:19;	and/or 95:16; 114:24 anesthesia 12:5, 22; 16:5, 8, 11; 17:24; 18:2, 4; 22:5, 6; 24:13, 15, 21; 26:8, 16; 27:16; 29:15; 30:22; 31:14; 36:5; 37:17; 39:23; 40:5, 9, 21; 41:1, 14; 44:2; 45:8, 15, 24; 57:24; 68:10; 71:21; 72:4, 10, 15; 73:2; 78:19, 22; 79:17; 80:9, 23; 91:8; 94:23; 95:4, 4, 6, 8; 137:24; 160:14 anesthesiologist 18:6; 24:18, 24; 29:11; 30:20; 31:6, 8, 15; 32:23; 33:7; 35:6; 36:1; 38:18; 53:12; 58:3, 4, 8, 10; 68:14; 90:15, 17, 23; 139:23; 140:7 anesthesiologist/criti- cal 39:13 anesthesiologists 25:1; 35:14, 16; 44:22; 55:9; 91:11 anesthesiology 15:24;
2	3 72:15 3,950 14:24 3.2 141:17, 22 142:2, 5, 7, 8 3.3 141:21 3.4 142:1, 5, 7, 8 30 20:9; 44:11; 116:13; 143:20, 20, 21 30-bed 23:1 350 20:19 36 46:5; 68:15 37 46:5; 53:15	8 72:5 8,500 56:2 8.0 141:20 86 71:10 87 71:15, 16, 23 88 72:6; 94:6, 6; 120:22 8:00 17:7	9	
2 141:4; 142:9; 146:8 2.0 141:18, 23; 142:1, 2, 4 20 19:11, 12; 20:9; 44:4; 45:11, 15; 62:12; 67:18;		9 72:10, 17 9/5 14:12, 13 90 72:13, 16; 73:3 93 38:10; 55:7; 62:22; 72:20, 20; 120:22 94 55:7; 73:8 95 38:9, 10 96 37:20 98 35:24 99 47:17; 120:16		

16:3, 4; 37:7, 13; 38:4;
71:18
anesthetic 26:14; 27:4;
32:3; 134:24; 160:19, 23
anesthetics 40:22
anesthetize 80:18
anesthetizing 29:13
aneurysms 18:1
Angelique 13:3
anomaly 58:1
anoxic 131:14; 152:3;
155:9
answered 139:18;
149:22; 151:10, 18; 152:9,
11; 156:24; 157:1, 3, 14;
158:6, 9
Anthony's 18:7, 12; 19:3,
7, 16; 20:19, 22; 22:23;
23:9; 27:10; 32:20; 35:8;
36:2; 40:3
Antihypertensives
71:20
anymore 20:24
aortic 124:10, 11
apologize 19:1
apparently 10:2; 12:6,
23; 15:8
appeal 65:24; 66:2
appeared 164:8
appears 11:17; 114:13;
146:8
Applications 71:8
apply 26:18
approach 102:11
appropriate 47:13; 55:3;
101:21; 104:2; 140:5;
153:17; 161:19
appropriately 55:1;
101:20
approximately 18:14;
20:15; 85:24
April 72:16, 20; 73:3
area 55:4, 9; 124:11
areas 15:22; 16:1, 4
around 17:15; 26:21;
46:10; 66:10; 128:14, 16
arrest 152:14
arrested 57:24
arresting 132:23
artery 121:15
arthroscopy 46:16
articles 99:19
ASDs 21:3, 6
asleep 29:13
aspects 160:12, 13, 14,
15, 16
assign 114:24
assigned 24:16; 35:7;
36:1; 38:20, 23; 39:8, 9;
69:11
assist 28:7; 30:12, 14, 16;
31:4
assisting 117:21
associate 114:10

Associated 53:12;
82:14; 101:18; 137:16;
148:2
associates 27:9; 40:9;
43:4; 44:2, 22; 46:1
association 39:18;
42:20, 23
assume 7:4; 12:12;
15:12, 16; 65:15; 74:22;
76:13; 85:20; 88:20; 94:7
assuming 64:24
attached 6:3; 9:21
attempt 87:12; 126:24;
127:4
attempted 38:2
attempting 87:18
attorney 5:8, 16; 6:16,
21; 10:7, 16; 57:11, 13;
58:17, 18; 60:8, 12
attorneys 6:13; 9:1;
47:15; 60:15; 63:6; 165:3
attributable 131:14
auditorium 69:6
August 11:18; 12:7, 9,
10; 14:11; 112:4
authored 99:2
authorities 70:24
availability 22:20
available 36:3
average 32:5, 18; 44:1, 5,
6; 53:2; 67:22; 101:1
avoided 153:12
aware 86:24; 138:11;
139:12

B

baby-sat 145:17
baby-sits 129:1
back 9:4, 10; 18:20, 20;
29:8; 35:17; 36:11, 13, 17,
20, 21; 42:17; 51:3; 61:24;
66:5, 9; 75:6, 9; 78:6; 85:9;
96:23; 102:12; 103:23;
104:2; 117:13; 119:12;
120:5, 7, 13, 14; 121:20;
122:2, 5, 10, 15; 123:1, 12,
15, 18, 23; 128:10, 13;
130:5; 131:11, 13, 22;
138:4, 18, 20, 21, 23;
139:5, 7, 13, 14; 140:4, 9,
16, 19; 145:6, 16, 19;
146:3, 4, 22; 149:13, 17;
150:1, 11, 20; 151:11, 16;
153:3, 11, 11, 22; 154:3, 5,
21; 155:6, 20; 156:5, 7, 13,
19, 22; 157:6, 12, 19;
158:5, 23; 159:2, 5, 11
bad 149:11
balloon 135:22
barring 36:19
based 13:20; 19:18;
23:24; 89:24; 105:14;
126:11; 148:3
basic 113:2

bed 41:12
beds 20:19; 22:19
bedside 106:22; 128:23;
129:2, 12, 18, 24; 130:14,
21
began 141:5
beginning 27:22
behalf 58:2, 4, 5
behind 125:13; 138:20
belief 104:14; 135:8
below 103:18; 105:12,
23; 106:5, 20; 109:6, 9, 15;
110:17, 20, 23; 111:5;
112:20; 113:4, 8, 15, 19,
22; 114:19; 117:14; 118:1,

Bentyls 128:23
best 148:18; 153:24
Beta 148:7, 19
bets 125:8; 147:15; 150:5
better 16:14; 35:1; 150:8
beyond 45:20; 123:17
big 20:18; 25:18; 66:14
bill 14:2; 15:2; 111:11
billed 14:5
billing 27:18
binder 4:12; 12:13; 98:23
bit 17:15; 19:13; 26:11,
13; 44:6; 65:2, 4; 75:18
blank 61:11
bleed 121:13; 142:18
bleeding 109:17; 121:24;
139:5; 142:17, 17, 19, 22;
143:1, 3, 4
block 57:23
blocked 148:7, 19
blood 107:9, 19, 24;
109:1, 3, 5, 20; 118:15, 23,
24; 119:2; 121:4, 9;
122:14; 123:10; 125:6;
127:14, 18; 133:1; 136:18,
19; 138:5, 18; 145:2;
147:3, 13; 148:4; 149:12;
151:3; 156:1; 158:17
blue 116:3

23; 38:2, 7, 11, 12, 14, 15;

16, 19, 24; 81:16
boards 78:4
bolus 110:9; 143:13
book 76:16, 19, 24; 77:2,
3, 4, 5
books 73:21; 75:20
boom 97:19
both 21:17; 27:10; 41:23;
55:18, 22; 56:18, 19; 58:2,
17; 63:13; 104:5; 125:3;
132:24; 149:6
bottom 72:2; 73:5, 5;
140:23
bowel 116:19; 117:8
box 6:11; 52:11, 12
boy 132:19
boys 31:11
brain 152:21; 153:8, 20;
154:6, 7, 19
brake 150:20
brand-new 25:10
breach 101:24; 131:17

breaches 131:8
break 10:19
BreaMast 48:8
brief 11:4; 50:3; 63:19;
111:8; 152:19
bring 42:7, 8; 85:21;
104:1
bring-back 146:5
broker 54:7
brought 40:20
brushup 137:18
build 89:23
building 6:3, 4; 51:24;
52:13, 14
buildings 9:21
bullet 140:24; 141:4;
142:9, 16; 143:23; 146:7
bunch 37:6; 42:7
burned 154:12
business 40:17; 43:16,
19; 44:2, 20, 22; 49:21;
50:6, 14, 18, 21; 52:18;
130:20
businessmen 50:19
busyness 29:4
bypass 18:16; 26:2;
29:14, 14; 31:10; 32:3;
41:2, 3, 9; 121:20; 124:16
bypasses 23:16

C

C 60:10
C-h-e-s-i-c-k 60:11
cabin 83:6, 10, 11
cadet 13:8, 12, 17;
106:23
call 14:12, 16; 21:19, 22;
34:3, 7; 43:10; 74:24;

132:19, 24; 133:2, 3, 5;
139:5
called 59:2; 96:11;
116:18; 138:17; 148:21
calls 46:11; 47:9; 132:11,
13
came 78:8; 93:2; 119:12;
149:13, 17; 150:1, 11;
153:3, 22
can 6:17; 10:8, 9, 12, 21;
11:1, 6; 17:16, 16; 18:20;
22:12; 25:14; 28:2; 29:2, 7,
21; 32:7, 8; 34:9; 41:5, 8,
11; 42:10, 15; 43:24; 44:9,
10, 11; 50:10; 51:24;
52:13; 53:22; 54:24;
55:19, 23; 56:24; 57:1;
61:9, 11; 63:8; 68:18;
70:18; 74:24; 78:4, 19;
80:18; 85:11; 94:13;
106:16; 114:8, 18; 115:3;
121:17; 126:5; 128:23;
137:13, 13; 138:16;
139:12; 140:10; 146:24;

156:20
capacity 34:8
cardiac 12:4, 4; 16:5, 8;
17:23; 18:1, 3, 15; 20:20;
21:9, 10; 22:11, 17; 23:4,
5, 8, 12; 24:15, 21; 26:9,
10, 14, 16; 27:9, 12, 14,
15; 28:4, 20, 21, 24; 31:2,
9, 23; 32:6, 7, 8; 33:1, 11,
19; 34:20; 36:8; 39:1, 6, 7;
40:21, 22; 41:1, 4, 14, 17,
19; 42:8; 57:10; 58:1;
59:11; 68:12, 13; 69:13;
71:13; 72:4, 10, 15; 73:2;
88:16; 89:8; 90:23; 91:8,
18; 94:23; 95:2, 2, 4, 5, 6;
100:3; 141:17, 17, 21, 22,
23, 24; 142:1, 4; 146:23,
24; 147:7, 9; 148:9, 11;
151:6, 7; 160:6, 10;
161:10, 12, 24
cardiologist 29:6; 100:6
cardiologists 29:6, 8;
34:22; 40:24
cardiology 100:5
Cardiopulmonary 26:2
care 13:15; 16:6, 17;
18:6; 30:22; 34:18; 35:6,
15; 36:5, 11, 19; 37:2, 5, 6,
11, 12, 15, 17, 24; 38:3,
24; 39:13; 42:15; 57:2, 3;
68:21; 69:19; 72:15; 73:2,
23; 88:7; 100:23, 24, 24;
101:3, 3, 14, 14, 16, 23;
102:1, 3, 7, 15, 20; 103:18;
104:9, 16; 105:12, 22, 24;
106:5, 10, 16, 17, 20;
109:6, 9, 15; 110:17, 20,
24; 111:5; 112:21; 113:5,
9, 15, 19, 23; 114:20;
117:15, 20; 118:2, 12, 22;
119:6, 16; 120:3; 124:4, 5;
125:16; 129:13, 14, 19;

(3) cared - Cuyahoga

CV 18:9, 24; 70:8
CVP 124:18, 21; 125:4, 5;
148:1, 19

D

D&Cs 46:16
D-e 58:15
D-i-F-a-l-c-o 58:16
Daley 66:17
damage 152:22; 153:9,
20; 154:7, 7, 19
data 42:14; 145:10;
146:18
date 14:13; 15:2, 3; 82:22;
83:2; 96:4, 18; 100:8
dated 95:12
dates 15:21; 75:7
day 17:6, 12; 24:16; 32:5,
8, 10, 13, 14; 36:14; 49:7;
52:17; 55:20; 66:13;
83:14, 16; 164:7; 165:9
days 17:4, 11, 13, 21, 22;
27:19, 24; 28:1, 2, 13, 15,
18; 34:24; 52:17; 79:13,
13, 14
dead 59:2
deal 70:10; 71:5
dealings 54:5
deceive 88:1
December 66:13, 14
deception 87:12, 19, 23
decide 33:1; 42:17
decides 139:7
decision 34:9; 101:21;
104:1; 108:21; 130:4;
137:23, 24; 138:3, 7, 10,
12, 21, 22; 139:2, 10, 15,
16, 24; 140:1, 4, 8, 11, 13,
19
decisions 161:24
decrease 109:2; 125:5;
141:11; 147:13, 16, 18;
148:4
decreased 123:9;
125:18; 135:12; 141:9
decreasing 121:9
defendant 60:23; 164:13
defendants 62:11
defense 56:17, 19; 57:11,
12; 62:7, 14, 16, 17, 23;
88:19
defer 160:7, 19, 21, 24;
161:5, 23
Define 30:14
defined 148:14
definitely 44:7; 161:4
degree 123:17; 126:24
delay 131:13, 16
delayed 131:10
delegated 35:17
Delegation 47:2
deleted 19:2

deletions 159:24
deliver 101:2
delivery 134:20
Denise 13:1, 2
Denver 71:18
department 43:23
depending 21:8
depends 21:7; 22:18;
24:16; 32:24; 33:6; 43:22;
55:17; 78:16; 79:13; 80:5;
81:3, 4, 5, 5; 135:21;
138:1; 145:23
depo 7:5; 67:2; 87:21;
100:8; 111:20; 114:7, 14;
115:5, 6; 116:9, 13
deponent 164:24
depos 55:11; 92:13;
115:8
deposed 59:22, 24;
67:15, 17, 19, 21, 24; 68:2,
3
deposition 7:23; 10:17,
17; 11:2; 13:21; 15:5, 9;
63:11; 67:23; 82:17;
83:12, 20; 84:2, 14, 22;
85:7, 14, 16; 87:7; 90:2, 8,
21; 94:8, 14, 15; 99:14;
100:13, 16; 101:9; 111:18;
113:16; 114:22; 115:2;
117:11, 13; 135:19; 136:9,
15; 162:15; 164:24; 165:2,
3
depositions 4:15, 21;
13:2; 15:13, 17; 50:12;
54:15, 20, 22, 24; 55:6;
63:17; 67:14; 83:4, 12, 23;
85:17, 17, 24; 86:1; 89:15;
92:22; 99:3, 13; 114:2
described 19:13, 19;
82:6; 113:10
designated 24:3
despite 118:14
detail 141:6
detect 148:1
deteriorate 141:6
deteriorated 141:12;
159:17
deteriorating 122:11
determination 22:15
determine 54:3
deviated 135:4
device 59:12, 13, 14, 17,
20; 60:6
devote 77:14, 23; 78:14;
79:8, 11
devoted 79:18
devout 78:16
Diagnosis 72:11
diagnostic 104:11
Diagnosticians 72:19
dialogs 26:24
dialogue 133:7
dictated 9:6, 19; 97:2, 18
didactic 69:1
Diet 48:2, 7

DiFalco 58:14, 22
differ 106:15
difference 122:17; 154:6;
156:9
differences 147:23
different 10:18; 26:8;
27:1; 40:21; 41:16; 65:1,
15; 88:22, 23; 125:17;
134:19; 155:17, 21; 156:6,
14; 157:19; 158:23; 159:2,
6, 13
difficult 121:4, 14; 149:2
difficulty 61:21
digression 135:22
diminished 116:20
dinner 17:8; 42:7
dipped 118:17; 119:12
direct 27:17; 28:11;
49:17; 69:2; 117:7; 125:15
directing 131:1
directly 102:19; 105:14,
21; 106:9; 131:14; 132:2,
16
director 18:1; 48:21, 21,
22, 24; 72:22; 73:10
disagree 90:7; 115:9;
160:18
disagreed 116:2; 117:8
disagreeing 116:3
discharge 108:14; 135:9
disclosed 59:23
discrete 6:14
discuss 12:19; 42:9;
59:9; 161:4
discussed 128:2; 141:6,
8
Discussion 53:23
discussions 88:24
dismissed 94:12, 17
distal 121:22; 122:16, 19,
20, 22
distinguish 93:10
Distractions 83:18
diuretic 147:18
Doctor 5:18; 10:5, 8, 14,
19, 23; 11:10; 13:16;
15:23; 22:1; 49:23, 24;
51:17; 60:3; 63:22; 66:21;
67:6, 14; 72:1; 79:10; 80:9;
81:10; 83:4; 85:1; 87:7, 13;
90:18; 91:1, 10; 92:9, 12;
100:23; 102:10; 105:11;
107:12; 110:23; 112:11;
114:21; 115:20; 116:5;
117:19; 119:15; 120:23;
130:2; 132:15; 134:18;
137:23; 138:21; 140:6, 17;
142:23; 143:10, 19; 145:5;
146:23; 152:5, 21; 156:10;
157:5, 16; 158:4, 14;
159:20; 162:4
doctor's 5:20
doctors 53:16; 54:9;
82:11
document 143:6

documented 142:16;
143:2, 4
dollars 101:7, 8
done 17:15; 19:7; 21:4;
23:19, 20; 32:10, 12; 34:9;
36:24; 42:6; 46:13; 67:8;
94:7; 97:19; 98:2; 101:12;
124:7; 127:8; 132:5;
133:16; 144:12, 16, 20;
156:3
door 31:13
dose 116:21; 145:2
down 23:3; 57:7; 69:23;
116:6; 118:5; 124:18;
126:3; 138:18; 140:14;
145:3; 154:13, 15; 155:5,
8; 156:2; 158:17, 18
downtown 51:22
Dr 4:6; 15:9, 9, 10; 21:8,
13; 23:10; 24:4, 17; 25:1,
5, 7, 7, 11; 26:4, 23; 27:8;
33:10, 14, 18; 35:4; 41:7;
82:18; 84:22; 85:7, 13, 16;
86:15; 87:1, 5; 90:2, 5, 15,
19; 91:6, 10, 16, 18, 19,
22; 101:19, 22, 24; 102:2,
8, 19; 103:5, 8, 14, 15, 17,
19, 21, 24; 104:3, 14, 19,
22, 24; 105:2, 6, 9, 10, 11,
17, 23; 106:2, 5; 107:11,
19; 108:3, 12; 117:22, 22;
120:5, 9; 123:10; 124:2;
125:21, 24, 24; 128:3, 4, 5,
15, 15, 18, 20; 129:12, 17;
130:14, 20, 24; 131:7, 17,
24; 132:3, 3, 10, 11, 13,
16, 17; 133:6, 7, 15, 18,
18, 20; 135:3, 9; 146:11,
16, 17, 20, 21; 160:7;
161:8, 16, 23
draft 95:19, 20, 21, 22;
96:1, 8, 11, 17, 21; 97:1;
98:16
drafted 97:9, 11, 23;
98:13
drafts 95:23
drainage 108:7, 10
draw 80:20
drill 127:23
driving 64:14
drop 47:21; 118:24;
121:3; 127:20
dropped 19:1; 94:16;
107:9; 120:21; 127:18;
156:17; 159:18
drove 64:16
Drs 21:11; 106:11
drug 59:12; 109:3, 5;
116:18, 18; 117:2, 3;
118:23; 119:1; 136:17, 17;
137:2, 3, 14, 19; 156:17;
160:23
Drugs 71:16; 113:10;
117:5; 118:10, 16; 126:4;
136:11, 11, 21; 137:4, 10,
15, 19; 142:13; 151:2;
160:22

duly 4:2; 164:15
dump 135:2
dumped 107:13, 24;
108:16; 155:3, 12; 156:1;
157:21; 159:9
dumping 107:19; 138:5
dumps 133:1
during 43:18; 57:23;
118:4; 141:12; 160:20
duties 28:18
dwindles 126:3
dysfunction 124:9, 15,
23; 127:1, 11, 16; 147:3;
148:2

E

E 119:12, 18, 22; 141:24;
142:4
earlier 17:15; 41:13; 65:5;
85:1; 103:23; 110:7;
124:2; 130:18, 21; 131:3,
4; 132:1; 153:12; 154:3, 6;
161:22
early 104:6
earned 50:8
easier 18:9, 21; 134:9
easiest 127:12
easily 66:24
easy 138:4
Ebner 6:8; 11:24; 14:12,
15, 17
echo 29:23; 30:18; 40:22,
23; 73:1, 6; 119:12; 124:7;
125:11; 127:5; 138:19;
141:24
Echocardiography
72:11, 19
echos 27:20
Edited 74:2; 77:6
education 77:10
Edward 119:22
effect 34:5; 109:19;
117:1; 147:19
effects 147:14
effort 97:17, 18; 138:14;
147:8
eight 52:24; 53:3
eighth 135:18
Either 21:7; 22:18; 23:9;
31:15; 35:17; 36:2; 38:24;
42:9; 47:15; 59:4; 62:10;
63:13; 69:5; 78:4; 93:5;
104:15; 116:19; 124:3
ejection 147:7
EI 74:13, 24
elevated 151:3
elevation 147:11
eligible 37:6, 12
eliminate 109:19
else 4:17; 7:14, 20, 22;
21:22; 35:1; 41:21; 103:2,
10; 104:19; 105:2, 22;
107:8; 109:8; 112:24;

113:12; 126:14, 16, 18, 23; 127:6; 128:20; 143:15; 147:3; 149:5 else's 89:24; 90:1	expertise 28:4 experts 53:12; 54:1, 5; 82:12; 88:13, 15, 23; 89:1, 5, 9, 10	106:5, 20; 109:9, 15; 110:17, 20, 23; 111:4; 112:20; 113:15; 114:19; 117:14; 118:1, 11, 21;	forbid 145:8 force 34:8 foregoing 164:20, 24
		103:19 fellow	
encompasses 38:4 end 23:2, 2; 40:17; 116:6; 130:3; 144:22; 150:24	extended 64:19; 107:4 extent 99:1; 151:15 extra 101:10	felt 108:11; 114:11 Fentanyl 109:18; 110:9, 11, 16	
entire 48:23 envelope 84:24 epidural 80:19; 81:6 episode 108:16 equipment 59:15 esophageal 94:2 estimate 100:10 euphemism 154:12 even 36:16; 127:20; 133:21 event 148:23; 149:21 events 108:13 everybody 95:22 everyday 137:14, 15 evidence 103:22; 120:6; 124:15 evident 127:17; 138:2 exact 15:21; 82:22; 149:1 exactly 126:6, 13; 128:1 exam 78:11 EXAMINATION 4:4; 5:3; 11:7; 18:22 examined 4:2 example 24:3; 46:15; 92:15; 107:5 except 20:23 exception 28:23 excess 161:14 excuse 13:1; 22:11; 71:10; 73:22; 120:13, 23; 128:11; 134:5 expect 13:15; 101:2; 125:21 expenses 55:21; 56:2 experience 33:9, 18; 64:9; 68:18; 77:10; 148:15 experienced 135:24; 146:9, 13 experiences 118:24 expert 4:7; 8:9, 23; 15:23; 16:2, 3, 7, 10, 16; 53:4, 16; 56:13, 17, 19, 21; 62:5, 7, 10, 14; 63:12, 14, 23; 64:9, 21; 65:6, 13; 66:12; 77:11; 82:1, 6, 18; 86:5, 9; 89:5; 91:15; 100:2, 5	extubate 34:9 extubated 33:4; 41:10 extubation 34:5, 7 eye 57:23; 65:21; 95:3, 8 eyeball 58:7 F facilitate 136:6 facility 45:3, 5; 48:13, 23 fact 42:12; 121:11; 122:15; 123:1; 129:17; 130:14; 137:9; 152:13 facts 8:17, 21; 9:3; 140:24 factual 9:9 fail 135:15; 136:8 failed 109:9; 118:2, 11, 21; 148:6 failure 133:15 fair 15:16; 61:22 fairly 41:8; 161:9 fall 113:18, 22 falling 118:14 falls 113:4, 8; 132:15 family 68:20 famine 17:16 fanfolded 102:24 far 8:24; 40:21; 116:6; 141:6; 154:21 fashion 133:18; 154:14 fast 33:2, 21; 41:2 faster 127:24 fear 61:6 feast 17:16 February 12:23; 112:4; 165:10 Federal 15:8; 56:20, 23; 59:6; 65:10 fee 54:15, 16; 55:3, 4; 56:6 feel 92:10; 114:19; 139:23; 140:6, 11, 18 fees 54:13; 55:1 feet 9:20; 49:4 fell 103:18; 105:11, 23;	6:7, 13, 14, 17; 7:2, 9, 10, 14, 15, 24; 10:7 filed 94:17 files 5:6; 6:9, 14, 15 fill 61:11, 14 film 127:10 final 138:22; 139:10 finalize 98:11 finalized 61:9; 98:8, 10 financial 74:12 find 42:19; 66:24; 147:5 finding 148:20 findings 148:21 fine 16:15; 62:3; 67:4; 125:12; 144:18 finish 5:1; 17:17; 27:15; 87:14, 15, 16 finishes 33:19 FIO2 135:12 fires 48:23 Firm 57:19; 82:1, 3; 95:17; 122:9; 160:4 first 4:2; 11:17, 18; 12:14; 14:7, 10; 17:7; 21:19, 21; 40:23; 57:6; 61:11; 65:11; 70:15; 87:11; 94:5; 98:13; 102:12, 18; 108:9; 109:12; 120:8; 130:22; 133:22; 140:23; 141:4, 10; 164:15 fit 6:17 five 28:2; 32:7; 34:24; 51:3; 56:15; 63:14, 16, 22; 64:4, 10, 18, 22; 65:7; 70:7; 158:9, 20 fix 121:20 floor 23:7; flow 107:6 flown 86:20 fluids 33:4 fog 134:11 folder 6:17, 21, 23 follow 122:12, 13; 126:20 followed 142:17 following 85:8; 86:10 follows 4:3	gradient 124:10 grand 71:9 group 17:20, 20; 18:2; 21:15; 24:16, 20, 24; 25:5, 12; 27:5, 8, 11; 40:4, 5, 16, 18, 21; 41:14, 17, 18, 19, 21, 22; 42:3; 43:8; 45:8, 11, 15; 53:15; 93:7, 8 groups 22:5; 41:16, 23; 42:1, 3, 22; 43:3; 44:3; 50:8, 15, 22; 92:23 guard 86:6 guess 8:8; 66:1 guessing 9:19 guidelines 81:13, 19 gut 117:4 guys 66:9 H H 120:17, 20, 20; 121:6; 129:24; 130:3; 143:3, 3 H-r-o-b-a-t 92:2 hairs 81:7 half 42:17, 19; 49:7; 95:1; 101:11; 144:14, 18, 19 halfway 51:16, 19, 21; 52:16 hand 12:24; 92:16, 17; handle 13:11 125:10; 149:1

16 head 41:13, 19, 23; 42:22; 43:2; 161:10 heads 43:23 healthy 147:20 hear 36:9; 42:18; 113:20 heard 58:19; 62:8; 86:17; 116:22 Hearn 15:9; 86:1 heart 20:23; 21:1; 29:4; 40:4; 57:9; 120:16, 20; 121:2, 10; 123:9; 124:24, 24; 125:2, 2, 4, 7, 12, 14, 15; 126:5, 22; 127:16; 138:19; 139:3; 147:1, 3, 7, 11, 20; 148:2, 7, 9, 12, 14; 149:9, 12; 159:18 hearts 18:13; 19:7; 23:6; 35:15; 42:4, 5, 6; 145:17 heavily 69:17 held 53:23 help 27:22; 28:6; 50:8, 18; 54:4, 10 helped 152:16 helpful 6:10; 104:12; 127:14 Hemodynamic 71:8; 105:15; 107:2; 141:5 hemodynamically 104:6; 122:11; 152:14; 154:14, 15; 155:4; 156:8 hemodynamics 145:7; 159:16 hemostasis 146:1 Here's 18:19 hereby 164:6 hereinbefore 165:3 heretofore 164:7 hereunto 165:8 Hern 88:2; 93:9 Hernandez 15:9; 86:1; 88:1; 93:9; 103:6, 8, 15; 105:9, 10, 11, 17, 23; 106:2, 5; 131:24; 132:11, 16, 17; 133:6, 15 hesitate 133:21 hesitated 87:20; 88:12 high 44:10; 126:9; 149:10 high-risk 17:24, 24; 18:1 higher 44:7, 7; 124:21; 146:5 higher-profile 24:23 higher-risk 24:23 highlight 115:2, 5; 117:11 highlighted 115:6, 7, 23 highlighting 114:3, 17; 115:13 highlights 114:18 highly 125:20 hire 70:24 hired 39:24 hires 48:23	history 124:8 HO-2 105:20 Hold 72:17 hole 127:23 home 17:9; 52:5; 138:15, 17 homograph 124:13 honestly 23:21; 35:15; honor 49:13 hope 122:9 hopefully 125:3 hospital 17:5, 6; 18:8, 8, 18; 19:3, 3, 4, 5, 8, 22; 20:18; 21:8; 39:4, 14, 16; 40:7; 69:5; 94:4 hospitals 18:12, 13; 21:17; 22:7; 30:20; 39:1; 43:15; 45:12; 143:19 hour 54:16, 16, 17; 55:2, 11, 13; 56:4; 101:11; 128:6; 144:14, 18, 19 hourly 55:20; 143:14 hours 14:4; 44:4, 11; 52:24; 54:24; 68:11, 15, 15; 69:24; 100:11, 19, 21; 128:7; 150:3; 151:9 house 52:3 Hrobat 13:1, 2; 92:2; 93:4; 103:6, 14; 106:14; 113:14, 15; 114:23; 115:17, 19; 117:10; 118:21; 119:3, 6; 120:2 Hrobat's 114:7; 115:2 hypokinesis 148:3 hypoperfused 153:1 hypoperfusing 159:17 hypoperfusion 152:23 hypotensive 109:17; 110:12; 118:3; 153:1; 155:9 hypovolemic 155:5 I i.e 118:5; 122:13 ICU 12:22; 22:10, 13, 16; 23:5; 34:1, 13, 16, 19, 24; 36:8, 18; 37:2; 39:10, 11; 41:11 ICUs 22:12; 35:7; 36:1 idea 78:21; 151:4 identified 4:6; 60:4 identify 6:23; 88:5 ignore 113:20 Ilbawi 21:8 ill 134:15; 136:2 Illinois 49:5; 54:23; 57:3; 60:21; 64:15; 69:8; 70:3; 82:9; 164:1, 6, 9; 165:14 immediate 101:17 immediately 155:1 impair 109:20 impaired 125:18	implications 27:3, 4, 4 importance 76:2 important 126:17 importantly 29:5 impossible 150:24 impression 29:19; 108:9 improve 42:15 inasmuch 123:3 Inc 51:2, 5; 52:19 incident 108:4, 15 includes 160:14 including 40:24; 100:8 income 53:6 incongruous 127:21 increase 121:1; 136:17; 145:2; 148:9, 10, 11 increased 108:23, 23; 123:8; 156:18; 158:16, 19 increasing 109:3, 4; 121:10; 127:20 index 141:18, 21, 23, 24; 142:4; 156:17; 162:12 indexes 158:17; 159:18 Indiana 56:24 indicated 123:22; 162:4 indicates 123:3 indication 120:7; 123:11 indicative 125:9 individual 13:20; 101:2 individual's 13:7 individuals 101:13; 146:10 induce 58:10 induction 31:1; 57:24 Industrial 64:4, 6 inexperienced 136:1 information 8:7; 66:23; 67:2; 69:24; 96:3; 104:21; 111:10; 126:10, 12; 127:2, 7; 128:10; 132:10; 133:17, 19, 20; 134:10; 146:17 informed 103:24; 161:21 infusion 109:2; 118:4; 119:5 inhibits 147:6, 7 initial 26:23; 84:12; 96:17; 117:16; 126:2; 135:1; 141:20 Initially 62:23; 97:6, 9 injuries 123:19 injury 65:21; 131:14, 18; 151:22; 153:21 ink 116:3 inotrope 109:4; 121:12; 137:15; 156:17; 158:16, 19 inotropes 29:14; 33:4; 71:9, 13; 72:4; 107:22; 108:19, 20; 119:20; 124:17; 126:4; 147:15; 150:10; 161:3, 6 Inotropic 71:16; 118:10; 124:14	inside 31:12; 151:1 inspiratory 34:8 instances 107:18 instead 33:2 instituted 108:20, 21 institution 139:2 institutions 138:9, 11, 13, 24; 139:1, 11 insult 13:12 integrated 40:1 intend 99:24; 100:1 intensive 38:24 intensivist 38:11, 12, 19; 91:23; 138:16, 16 intensivists 37:8; 38:22; 139:4 interest 12:21; 53:14 interested 165:7 intermediate 41:12 Internal 38:15 interplay 33:8 interpret 79:7, 10 interpretation 13:21; 79:7 interpreting 117:6 interrupt 53:22; 118:8 interval 149:17 intervals 143:16, 17 interventional 48:14; 78:9 interventions 104:11 into 6:17; 69:18; 92:18; 95:3, 5; 135:17; 136:5 intracardiac 149:5 intraoperatively 80:23; 121:19; 146:2 introduce 41:1 intubation 31:1; 94:2 invasive 23:8, 11, 19, 21, 22; 24:3, 4, 12, 15, 19; 25:2, 6, 16; 26:4, 9, 16; 71:7 investigate 126:24 involved 19:23; 32:14; 34:23; 36:4; 37:1; 56:1; 61:20; 68:9; 69:17; 78:21; 87:1, 4; 92:3; 102:19; 105:14, 21; 106:10, 16; 132:2, 5, 17; 140:14; 146:12, 13 involvement 114:9 involves 58:6 ischemia 72:12; 149:11 issue 10:18; 70:20; 80:9; 133:13; 134:12, 13 issues 49:1; 70:11, 16, 16, 22; 71:4, 6 J J 120:18; 121:7, 8; 124:20; 142:20; 143:6	JACKSON 4:5; 5:1, 4, 18, 21; 6:1; 10:10, 14, 19; 11:1, 8; 18:23; 49:24; 50:4; 53:24; 63:20; 67:4, 10; 80:2; 81:14; 85:23; 87:15, 17; 92:11; 103:1, 7; 111:9, 12, 15, 22; 112:2, 7, 10; 115:18; 122:21; 130:1, 12; 139:20; 149:23; 150:2, 17; 157:1, 4, 15; 158:1, 3, 7, 11, 13; 162:3, 11, 12 James 101:15 January 15:7; 72:6, 13; 112:4; 164:8 Jeanne Joan 60:16 job 46:9 jobs 79:16 John 21:22; 57:16; 87:16; 102:22; 143:7 joint 138:2 journal 99:19 jump 70:18; 149:10 June 71:23; 95:12; 96:18, 19; 99:10 junior 132:6, 7, 18; 133:2, 3, 4, 4 K K 120:18; 121:15; 143:7; 144:1, 2, 4, 7; 149:3 K-o-c-h 15:10 Katherine 13:2 keep 6:10; 7:15; 43:3; 47:14; 48:22; 73:14 keeping 13:15; 37:8 keeps 5:18; 158:11 Ken 60:9 Kenora 73:6 kept 6:18, 18, 21; 26:24 98:7; 133:6 key 47:3 kids 20:24; 57:10 kind 19:23; 23:3; 114:7 Knee 46:16 knew 64:13; 146:20; 148:2 knife 139:9 knowing 109:1 known 136:17 Koch 15:10; 86:1; 88:2, 3, 3; 93:9 L L 107:6; 120:19; 123:18, 19, 23; 128:14, 16; 130:7; 143:7; 146:21, 21; 149:7, 24; 156:16; 158:18; 165:12 L/M 149:17
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

<p>labile 121:17 lack 109:13; 126:8; 134:1, 2, 5; 150:9 Lake 51:11 large 23:1; 78:19 Lasix 147:17 last 21:20; 47:22; 48:4; 55:14; 62:22; 66:11; 68:3, 5, 9, 12; 69:15, 16; 70:2, 74:1; 82:23, 24; 83:21; 84:5; 85:24; 88:6; 109:17; 121:15; 127:18; 146:7; 149:3; 153:18; 154:16; 155:4, 12; 156:21; 157:10, 11, 18, 22; 158:14; 159:4 late 140:5; 150:18; 151:20; 153:16</p>	<p>liters 151:7 little 6:17; 17:15; 19:13; 26:11, 13; 31:11; 44:6; 65:2, 4; 75:18 local 17:8; 138:1 locate 115:13 located 20:10; 49:3; 51:9; 60:18 location 51:10 locker 6:19 Long 7:3; 14:18; 32:16; 35:12; 40:13; 47:24; 48:5; 55:5, 6, 10, 13; 56:6; 62:18; 70:6; 75:16; 87:20; 91:13, 14, 20, 24; 101:15, 17; 117:20; 123:11, 18; 131:9, 11, 12, 18, 20, 21;</p>	<p>mailbox 51:23 major 35:2; 132:21; 151:15 majority 25:22 makes 18:21; 22:15; 48:24; 121:4, 14; 137:13; 138:21 making 61:6; 132:12; 141:1 malpractice 65:19 man's 127:15 manage 33:3, 5; 78:17, 18; 79:17 management 16:5, 11, 13; 17:23; 19:6; 20:8; 34:16, 19; 37:22; 40:19; 48:9, 12, 20; 49:2, 12;</p>	<p>mean 6:2; 9:20, 20; 13:9, 12, 16, 17; 14:21; 26:1; 32:1; 35:10; 38:11; 44:15; 49:16, 20; 53:10; 63:7; 72:8; 73:10; 76:17; 81:3, 4; 83:17, 20; 92:17, 20; 96:22; 100:20; 103:8; 111:10; 118:7; 124:4; 127:22; 144:22; 145:4; 146:10; 160:20; 161:4 meaning 15:1; 35:13, 22; 44:21; 46:5; 54:21, 22; 56:2; 81:15; 84:14; 154:23 means 37:14; 74:9; 92:21; 122:8 meant 122:24 meat 51:24</p>	<p>25:2, 6, 16; 26:4, 9, 15 minimum 54:17 MINORE 4:1, 6; 164:10 minute 10:3, 20; 12:24; 88:4; 148:15; 151:8 minutes 91:3; 138:6; 143:20, 20, 21; 144:15 Mishkind 82:1; 112:7 mislead 87:22, 24 misperception 87:12, 18 misprint 142:3 mispronounced 88:2 missed 51:18 missing 134:9 Missouri 72:5 misspoke 88:9</p>
<p>law 54:24; 57:19 lawyers 54:5; 94:10 lay 97:12 lead 60:16 leak 122:7 learn 18:17</p>	<p>24; 148:6, 18, 23; 150:18; 151:14, 23; 155:20; 156:12, 22; 164:12 Long's 152:21 longer 36:6; 39:5; 111:16 look 9:23, 24; 10:4, 6, 20, 24; 42:9, 14; 47:12; 51:3; 61:24; 66:5, 9; 75:6, 10; 79:14, 16, 24; 84:23;</p>	<p>12, 19, 22; 80:4, 17, 18, 20; 81:1, 7; 160:19 mandatory 36:5 manner 105:23 manners 110:19 manufacturer 60:24; 61:2 many 17:10; 20:24</p>	<p>20:1; 48:9, 12, 20, 21, 24; 49:2, 12; 53:12; 68:20; 69:6, 7, 7; 70:16; 92:10; 96:2; 99:18; 103:4; 156:12 medical/legal 53:16; 54:11; 56:13; 62:5, 10, 18; 63:23; 64:10; 65:6; 66:12;</p>	<p>mistakes 90:13 misunderstood 29:18 misuse 137:17, 19 moderated 72:24; 73:12 modify 42:10 moment 130:22 Monday 17:14, 17 11 monitored 70:19, 20; 73:11, 12 monitoring 71:2, 8; 73:23 month 67:22 months 42:6; 145:18 more 25:1; 26:11; 27:3, 5; 29:5; 32:17; 35:19; 43:13; 53:1; 55:7, 8; 69:17; 70:7; 75:4, 18, 21; 77:23; 78:14; 79:8, 11; 90:10; 101:7, 8; 105:10, 14; 106:9, 9; 108:4, 11; 111:12, 15; 121:12, 12; 126:3; 127:13, 21; 131:21; 132:1, 5, 16; 134:7; 141:7, 14; 146:1, 12, 12; 149:19; 150:4; 151:2; 153:5; 154:13; 156:4 morning 17:3; 41:10; 47:23 most 22:19; 32:10, 14; 33:10, 15; 83:13; 89:22; 121:23; 138:9; 139:1; 148:18 mostly 33:13 mouth 50:23 move 66:10; 67:7; 108:18; 112:11, 12; 114:21 moved 41:11; 75:4, 15, 17 much 8:23; 14:3, 5; 17:12; 19:9, 15; 24:20; 43:7, 21; 45:22; 46:3; 47:7, 11; 49:6; 52:18, 22; 66:10; 100:7, 12, 18; 104:8; 122:14; 155:1</p>
<p>leaves 32:21 lectures 69:2, 16, 20; 72:10 led 7:20; 137:3; 148:24 left 36:18; 76:1; 92:17; 124:9, 22; 129:7; 141:9 legal 47:14; 53:13; 94:14 length 56:7 less 26:13; 28:16; 44:8; 52:24 letter 6:11; 8:3, 4; 9:1, 8; 11:19; 12:6; 14:11; 15:4; 75:13; 87:5; 95:11, 16; 97:12, 12, 23; 98:2; 111:16; 112:3, 3; 123:16 letterhead 97:19; 112:8 letters 5:7; 6:8, 12; 7:11, 13; 8:6; 15:13, 15; 85:10 Level 107:15; 109:16, 23; 110:1, 2, 3, 4; 125:21; 128:16 Levophed 142:10 liability 59:7 License 165:13 lift 17:3 liked 123:5 likely 116:19 limit 20:23; 28:19 limited 148:11 line 80:20; 107:6; 121:20, 22; 122:16 Lines 116:13, 14, 15, 17 list 9:8, 16; 86:10; 102:17; 120:23 listed 9:12; 15:13; 90:2 listing 85:13</p>	<p>92:22, 22; 120:15; 124:18; 125:15; 129:9; 145:6, 7, 7, 8, 9, 9, 10, 16 looked 4:11; 81:17, 18; 82:19; 83:6; 86:6; 87:6, 8, 9; 88:4, 9; 102:23; 144:21 looking 20:13; 115:16; 115:4, 4, 10; 124:24; 126:15, 22; 135:5 looks 14:16; 19:1; 110:2; 121:9; 132:24; 138:19; 150:13, 14; 158:20 loop 147:18 lost 64:14; 76:1; 127:19; 156:16 lot 33:5, 6; 34:10; 43:16; 44:8; 76:2; 80:6; 86:20; 112:19; 114:22; 133:1 lots 24:10; 145:17 Loves 164:9 low 42:11; 51:8; 136:18 lower 118:15; 119:2; 136:18 lowers 109:5; 118:23 Lyons 90:2, 5, 15, 91:6, 10</p>	<p>12; 35:4; 41:16; 45:7, 10; 46:18; 51:5; 56:12; 62:9, 13; 63:10; 64:1; 65:12; 67:14, 20; 93:23; 95:23, 23; 135:20; 140:13; 145:15; 148:16; 161:12 March 40:14 mark 93:7; 114:2; 116:14 marked 93:16 marker 6:2 marks 93:14 married 16:19 masked 124:23 mass 125:13; 138:20 massive 142:18 materials 7:4; 86:11; 97:16, 21; 98:22; 99:12, 22; 20; 56:14; 62:5, 10; 66:12; 68:4; 82:7 matters 53:13; 54:11; 63:23; 64:10; 67:15, 16, 24 maximally 158:19 maximum 32:9; 151:2 may 15:2; 28:8; 30:16, 17; 31:10, 12, 13; 53:19; 60:16; 62:6; 74:17, 20; 75:18; 81:16; 83:21; 84:6, 23, 24; 87:4; 110:7; 114:4; 116:22; 123:4; 124:23; 137:19; 138:19; 147:12, 14, 15, 17; 148:1, 2; 150:8, 15, 15 maybe 6:9; 20:9; 28:12; 29:18; 44:6; 45:23; 46:11; 62:12; 63:14; 68:15; 70:15; 100:21; 124:20;</p>	<p>120:1; 48:9, 12, 20, 21, 24; 49:2, 12; 53:12; 68:20; 69:6, 7, 7; 70:16; 92:10; 96:2; 99:18; 103:4; 156:12 medical/legal 53:16; 54:11; 56:13; 62:5, 10, 18; 63:23; 64:10; 65:6; 66:12;</p>	<p>medications 118:4, 5; medicine 15:22; 37:5, 24; 38:3, 16; 69:8 medicines 113:2 meet 51:14, 20, 24; 52:13, 16; 125:24 meeting 42:16; 49:18; 51:21; 52:1; 71:24; 72:2 meetings 26:22; 42:18; 43:3 Memorial 19:4; 39:17; 94:4 mention 148:6 mentioned 86:4, 17; 103:5; 130:21, 22; 136:21; 165:4 mentoring 136:5 merit 63:7, 8 method 68:23 Michael 14:14 Michigan 95:1 microgram 110:8 micrograms 109:18; 110:12, 16 midnight 29:9 might 7:20; 29:3; 49:18; 86:7, 12; 94:6; 125:13 migrate 23:3 miles 20:14; 51:22 military 96:4, 6; 97:4, 6; 98:5 mind 12:21; 71:4 mine 47:16; 142:3; 150:8 mini 162:12, 14 minimal 142:21 minimally 23:8, 11, 19,</p>
<p>M</p>				
<p>M 120:10; 129:24; 130:3, 4, 6, 7; 149:7, 24; 150:5, 9, 12, 15, 24; 156:16, 18; 158:19, 21 M.D 4:1; 164:10 machine 26:2; 124:16 mad 61:7</p>				

Muehlbach 91:18; 102:8,
19; 103:5, 14, 17, 19;
104:3, 14, 19; 105:2, 6;
106:3, 11; 107:11, 19;
108:3, 12; 117:22; 120:5,
9; 123:10; 124:2; 128:3,
15, 18, 20; 129:12, 17;
130:14, 20, 24; 132:3, 10,
13; 133:7, 18, 18; 135:3, 9;
146:11
Muehlbach's 91:16;
125:21; 131:7, 17
muscle 116:24; 117:4, 4
must 112:6
Myocardial 72:12; 127:1,
11
myself 5:15; 16:3; 17:23;
47:11; 54:8; 90:20

N

N 120:19; 130:10; 149:12;
150:23; 156:18
name 7:1, 2; 21:19, 20,
21; 22:3; 28:8; 58:14, 18;
61:4, 19, 22; 62:1; 86:4, 7,
17; 87:1; 102:4, 11;
103:12, 13; 106:19; 111:2;
139:1
named 60:23
names 13:8; 61:5; 86:20;
88:6, 9; 89:13; 101:13;
102:14, 18, 21; 114:10
Nashville 71:23
nature 17:19; 50:5;
57:21; 58:21; 65:18, 20;
66:3, 7; 121:18
Nebraska 57:8, 9; 71:11,
18
nebulous 79:1
necessarily 78:3; 88:5;
109:2; 147:16; 161:7
necessitated 118:9, 14
need 36:20; 49:23; 50:1;
51:7, 14, 20, 24; 52:13;
69:23; 77:14, 22; 81:10;
104:10; 111:11; 120:23;
124:14; 125:10; 127:15;
138:18; 141:14; 146:18,
19
needed 35:19; 50:7, 24;
52:16; 128:17; 151:15
needle 57:23; 65:21
needs 128:9; 140:15
negative 34:8
negligently 58:10
negotiate 50:9
negotiations 50:16, 17
Neo-Synephrine 142:10
neurologic 157:7
neuromuscular 117:5
Neurosurgeons 55:7
new 40:19, 20; 42:9; 73:3;
78:5; 81:18, 22; 93:6, 8;
130:17

newer 41:1
next 6:4; 31:13; 36:14;
142:9, 16; 143:23
nice 6:17; 126:21; 148:19
NIF 34:8
night 17:8; 29:8; 41:11;
64:14, 16; 125:14
nitroprusside 119:13,
19
non-pump 27:1
Noncardiac 71:13
nonclinical 17:22
none 53:14; 89:3; 100:14;
161:17
nor 87:5; 103:24; 133:19;
165:5, 6
normal 17:1; 32:18;
125:3, 17; 141:5; 143:9,
12; 147:11
normally 29:24
north 86:4
Northwest 19:4, 24; 20:3
notarial 165:9
Notary 164:5; 165:13
note 36:13, 22, 22; 91:4;
104:4, 15, 23
Notice 165:2
notification 106:1;
107:10
notified 101:20, 21;
106:11; 108:2; 128:5, 8,
15; 132:3
notify 104:24; 107:19;
108:12; 128:4; 135:2, 9
November 15:4; 112:3
Nowadays 77:16
UTB 111:10
nuances 18:3
number 6:24; 28:1;
16:19; 70:9; 92:15, 24;
13:1; 102:22, 23; 125:9;
165:13
numbers 13:23; 14:20,
13; 62:21; 79:5; 92:13, 20;
13:5; 98:5; 125:20; 145:9,
1
nurse 13:11; 92:2, 6, 7;
13:17; 103:5, 6, 14, 14, 14;
06:13, 20, 21, 21; 109:8,
4; 110:15, 19, 22, 23;
11:1, 4, 6; 112:15, 16, 16,
10, 24; 113:12, 14, 14;
14:7, 23, 24; 115:1, 2, 12,
7, 19, 19; 116:13; 117:10;
18:21; 119:3, 6; 120:2;
33:22; 135:13, 15, 17, 24,
14; 136:4, 5; 146:13, 15
nurses 34:3, 6, 10; 36:9,
9; 68:21, 21; 69:18;
12:11; 92:3; 93:19;
01:18; 102:19; 106:14;
32:21
nursing 48:22, 23;
06:17
nutshell 147:1

O

O 151:7, 22; 155:3, 12;
156:8; 158:18
o'clock 17:3
obfuscated 121:14
Objection 156:24; 157:3,
14; 158:6, 8
obligated 133:5
obligation 36:15
obligations 43:14
observation 69:2
observed 104:10; 136:3
obtained 121:16
obviously 26:11, 21, 24;
34:24; 82:21; 108:22;
129:6; 139:9
occasion 108:11
Occasionally 18:11
occasions 31:19; 62:13;
107:10, 12, 24
occur 94:3; 118:15;
152:24
occurred 153:10, 21
occurring 104:5
occurs 33:8
October 71:10; 73:8;
77:21
off 6:18; 19:2; 29:14;
33:22; 37:3; 41:2; 53:23;
57:9; 86:5; 118:16;
119:13, 14, 17, 19, 20;
120:16; 125:8; 147:15;
150:5
off-pump 18:15; 23:13;
25:23; 26:23
off-pumps 24:7
offered 50:22; 78:6, 6
office 5:20; 44:20, 23;
51:24; 52:11, 12, 12, 16,
17; 60:9, 12, 18
offices 52:15
often 36:16; 143:18, 24;
144:12, 16; 145:22
Oftentimes 34:22;
124:14, 21; 147:5
Ohio 164:11
Oklahoma 56:17; 57:4, 5,
5, 10, 20; 64:12, 24; 65:10,
14, 17; 66:16; 82:9
old 16:23; 74:13
Once 31:24; 32:1, 20, 21;
16:8, 10; 47:20; 67:22;
18:2; 93:24
one 6:11, 16; 8:4, 5; 13:5,
7; 14:10, 24; 17:8, 22;
8:14, 15, 19; 20:14;
11:15, 18, 18; 22:1, 13, 13;
13:2; 24:20; 25:1; 26:22;
18:23; 29:3, 4, 5, 21; 30:8,
13; 32:8, 10, 14; 33:10, 12,
4; 38:23; 39:1, 40:20;
13:9; 45:10, 11, 12; 53:15,
8; 56:19, 20, 20, 21;

57:22, 23; 58:4, 4, 6; 59:4;
60:16; 63:8; 64:12, 13, 24;
65:10, 14; 66:2; 68:6;
69:20; 70:21; 71:10, 17,
18; 72:1; 74:1, 18; 75:1, 2,
3, 14; 76:14, 14, 17, 18;
77:3, 4; 83:6; 86:6; 88:15,
20; 91:11; 92:3, 15, 16, 24,
24; 93:2, 2, 3, 6, 10, 14, 16,
19, 19; 94:8; 95:24; 96:22;
101:21; 103:20; 105:13;
107:21; 108:1, 4, 5, 11, 15,
16, 23; 111:3, 12, 15, 17,
19, 20, 20, 24; 114:4;
115:12, 15; 117:16;
118:16, 16; 119:1; 121:9,
19; 122:9, 12, 18; 124:6,
20, 21; 125:11, 19; 127:12;
130:17, 22; 135:3; 136:14,
24; 137:13, 17, 18, 19;
138:23; 139:14; 140:5;
144:21; 146:16; 147:5;
148:5, 5, 13, 17, 20; 149:8;
160:2
one-and-a-half 17:22
me-in-a-million 101:3
ones 15:18; 33:12; 65:1;
36:3, 14; 93:12
ongoing 36:14
only 25:5; 27:11; 28:22;
10:4; 53:15, 18; 64:22;
15:16, 19, 20; 97:4; 98:16;
116:8; 123:3; 124:19;
126:5; 148:8
Ontario 73:7
open 22:19; 23:6; 26:10;
14:21; 66:1
operates 21:8
operating 28:19; 31:11;
12:22; 35:19; 48:7; 68:10,
3; 120:8; 137:24; 138:8;
39:8, 17; 140:9, 20;
145:20; 153:4, 19; 156:6,
4, 22; 157:12; 159:5
operation 25:22; 80:5;
03:20
operations 31:20
operative 80:4
opinion 23:23; 81:2;
19:22, 23, 24; 90:10;
19:19; 102:1; 103:17;
07:20; 109:8; 112:21;
17:19; 118:2; 119:7;
20:1; 123:15, 21; 129:11,
8; 130:13; 131:7; 136:8;
37:20; 149:20; 150:19;
53:20; 154:17; 155:16,
2; 156:12, 20; 157:11, 18;
58:22; 159:1, 12; 161:5
opinions 4:8; 8:17, 18,
8, 21; 9:3, 12, 16; 10:9;
0:5; 99:8, 9, 10; 106:4;
59:20; 160:8, 24; 161:1
opportunity 102:17
opposed 22:20; 62:14
order 78:3
ordered 108:22
orders 108:22; 117:21

organization 48:10
orientation 112:17;
135:17
original 111:24; 112:1
originally 102:23
originals 111:14
orthopedic 55:7
others 52:24; 53:1;
70:21; 136:13, 23; 146:2, 6
ourselves 20:24
out 23:2; 41:11; 42:7, 8,
19; 49:18; 51:7, 22; 55:17,
22; 67:5; 78:8; 92:19; 97:5;
107:9, 13; 108:6; 122:8,
14; 127:24; 135:20, 21;
138:5; 158:2
outcome 123:6; 151:21,
24; 152:2, 7; 156:2; 157:8;
161:21; 165:7
outcomes 42:14
outlined 24:5
Outpatient 45:1; 46:14
output 141:17, 22; 142:1;
143:5, 9, 21; 147:16, 18;
148:9, 12; 151:7
outside 9:22; 39:24; 50:7
over 18:16; 64:19; 69:6;
70:1; 77:14; 81:17;
149:12; 156:10
overhead 51:8
overlap 33:5; 80:6
own 43:16; 45:18, 22;
16:3; 49:22
owned 45:13
owner 45:5, 24
owners 45:7, 8, 9
ownership 45:12
owns 45:13, 15; 48:15

P

P 151:6, 8, 8
P-a-u-l 57:17
P-o-l-i-d-o-r-i 25:15
p.m 96:15, 15; 97:8, 8, 9,
10, 13; 162:16
'A 107:5; 122:13; 126:8,
2, 16, 17; 149:8, 10
package 15:8; 148:22
page 18:24; 71:7, 22, 23;
2:5, 10, 16, 17, 18, 18;
2:14; 116:13; 140:23;
41:4; 142:9; 146:8
aged 50:1; 83:20
ages 83:14, 16, 20;
15:14; 102:24; 111:14
aging 114:13
ain 16:5, 11, 13; 17:23;
9:6; 20:1, 1, 8; 23:24;
4:15; 37:22; 41:18, 21,
2; 48:9, 12, 14, 20; 49:2,
2; 54:23; 77:14, 15, 17,
9, 23; 78:8, 9, 15, 16, 17,
0, 22; 79:8, 11, 18, 22;

80.4, 17, 17, 19, 20; 81.1, 6 painted 134:8 papers 42:8 paralytic 116.18, 117.2, 3 parameters 34 4, 7; 105:15; 122.13, 125.23; 141:5; 145.8 parcel 117 20 Pardon 83.15 Park 164 9 part 25:18; 59:15; 60:4; 92:23; 117:20; 143:16 particular 12:16, 20; 16:4; 24:17; 28:4; 69:11 parties 165:6 partners 18:3; 27:9, 19; 28:12; 29:19, 20; 37:4; 42:5; 43:4; 46.5; 53:8, 9, 11; 54:22; 69:22 partnership 41:14 parts 134:8 past 50:22; 69.17 pathognomonic 147 6 patient 13:10, 15, 22; 18:6; 22:16, 17; 25:22; 29:13; 32:21; 33:2, 4, 20, 22, 24; 34:13, 16, 19, 22, 22, 23, 23; 35:3; 36:8, 8, 10, 12, 15, 18; 37:2; 41:2; 59:11; 68:10, 12, 14; 70:19; 71:1; 80:18, 23; 101 1; 102:9; 103:22; 104:2, 5, 7, 13; 105:14; 107:2, 9, 13; 108:13, 16, 24; 109:16; 110:12; 116:17; 118:3, 24; 119:11, 12; 120:7, 12, 14; 121:11, 13, 16, 18; 122:10; 124:8, 8, 22; 125:2, 7, 8; 128:1, 9, 16, 23; 129:3, 15; 130:5, 19; 134:17; 135:16, 23; 136:2; 137.23; 138:7, 15; 139:7; 140:8, 15, 19; 145:9, 11, 12, 19; 146:22; 147:17, 21, 23; 148:18; 152:13; 156:18; 160:7, 11; 161:6, 16, 19, 20 patient's 36:10; 105:16, 22; 106:10; 109:3; 129:12, 18; 132:2, 5; 145:2; 158:17, 17 patients 20:2; 22:11, 19, 24; 23:4, 6, 24; 24:14, 14, 23; 36:4, 17; 41:9; 42:13; 46:18; 78:23; 79:14, 17; 104:9; 121:17; 124:12; 134:15; 161:24 Paul 57:16, 19 pause 91:2 pay 49:19 PCAs 78:24 PEAP 60:7; 135:11 pejorative 13:14 pending 56:12; 62:4; 65:2, 6; 129:21; 164:10 penetration 57:22 pension 50:11, 24 people 9:13; 24:20; 39:24; 42:4; 47:21; 50:21; 52:13, 15; 54:4; 78:17, 18; 79:22; 90:12; 96:5; 97:13; 102:6, 11, 14; 132:24 per 32:5; 44:1; 46:21; 47:7; 52:22; 54:17; 55:2, 13; 148:15; 151:7 percent 19:11, 12, 17; 20:9, 9; 45:12, 13, 15, 23; 47:17; 48:17; 62:15; 77:14, 23; 78:2, 14, 23; 79:8, 11, 18 percentages 19:18; 62:21 perform 101:5; 126:6 performed 104:12; 143:24; 144:1; 161:13 perfuse 26:12; 151:5 perfusion 151:1 perihilar 127:9 period 35:11, 12; 89:10; 101:17; 121:7; 141:13, 16; 142:17, 18, 19, 20, 23, 24; 143:3; 153:21 periods 107:4; 143:9, 10 persisted 125:23 person 31:14; 39:8; 40:23; 88:7; 111:3; 133:4; 139:9 ersonally 5:24; 23:19; 33:13; 38:24; 45:18; 164:8 harmacology 69:14, 22; 113:2, 9; 136:10, 16, 21; 137:4, 10, 18 hone 11:22; 46:11; 47:9; 46:12 honet 74:13 hysical 51:10, 12 hysically 31:21; 145:10 hysician 31:3, 5, 5; 40:8, 15; 101:4; 136:6 hysician/partner 47:16 hysicians 17:20; 18:16; 17:23; 40:24; 45:14; 40:18; 68:22; 88:22 hysiologic 103:21 hysiological 104:4; 20:6, 11, 24; 121:1; 23:8, 22 hysiologically 104:6 hysiology 69:14 licked 103:24 icture 134:7, 8, 9, 11; 44:21; 145:5, 6, 7 ile 83:3 ioneers 18:15 dace 48:22; 51:11; 56:6; 1:11 laced 14:16 laintiff 62:14; 88:19; 64:12 laintiff's 56:21; 61:22; 62:1, 24; 63:4, 6; 82:18; 85:4; 86:5, 9; 89:1; 94:9 plaintiffs 62:10; 63:3 plan 50:11; 51:1 play 79:5 played 92:4 Pleas 164:11 Please 10:4, 21; 21:12; 87:21; 92:10; 140:17; 150:7, 21 plus 55:20; 56:2; 111:14 point 12:20; 15:14; 26:8; 51:18, 21; 116:20; 120:16, 17, 17, 18, 18, 19, 19, 19; 121:15; 124:20; 126:2; 130:24; 140:6; 141:4, 20, 24; 142:9, 16; 143:6, 23; 144:1, 2, 4, 7, 8; 146:7, 21; 149:1, 2, 3, 9; 150:23; 151:6, 6, 8, 8, 20, 22, 22, 24; 153:2, 8, 18; 154:2, 16; 155:15; 156:8, 18, 21; 157:10, 11, 18, 22; 158:4, 14; 159:4, 8, 9, 17 points 140:24 Polidori 25:7, 9, 12 politics 138:1 poor 50:19; 107:3, 7; 109:11; 133:23, 24; 146:16 Popovich 74:2 portion 4:12; 151:12 position 44:15; 49:8, 11; 105:18; 129:11; 136:6 positions 43:8, 12 possible 41:6 post 52:11, 12 post-cardiac 161:6 post-operative 36:13 postop 35:15; 36:22 postoperative 22:8, 24; 36:22; 78:18, 24; 80:19; 31:6; 101:17 ostoperatively 24:1; 78:17; 129:4; 160:22 ostops 23:2; 132:20 racticality 148:16 ractice 15:24; 17:2, 19, 21; 25:19; 32:20; 36:7; 42:10; 50:17; 68:20; 78:5, 19, 20; 95:6; 136:2 ireceding 130:8; 162:15 receptors 93:20 recipitously 127:18 refers 25:1 reload 147:7 reoperatively 124:8; 48:4 reparation 7:5 reparing 83:12; 99:19; 00:12, 15 resence 164:18 resent 4:22; 30:21, 23; 11:8, 21; 35:24; 62:22; 28:22; 129:9, 15; 131:1; 165:3 presentation 72:23; 148:22 presentations 70:9, 10, 10, 14; 71:5, 5; 73:15 presented 8:10; 105:15; 125:24; 133:20 presents 132:8, 9 president 40:11, 13, 15; 42:20; 43:1; 44:12, 17; 45:3; 46:7, 23; 47:5; 48:10 19; 49:9, 12 press 22:1; 74:7, 9; 75:5, 13; 76:7, 11 pressure 107:5; 109:1, 3, 5, 20; 118:14, 15, 17, 23, 24; 119:2, 18; 120:21; 121:2, 4, 10, 15; 123:10; 124:17, 19; 125:6, 8; 126:8, 19; 127:19; 136:18, 19; 138:18; 145:2; 147:12, 13; 148:4; 149:5; 158:18 pressures 122:13; 126:20; 149:7, 8, 10, 12; 150:10; 151:1, 3, 5 Pretty 17:12; 24:20; 47:10 prevented 153:9; 154:18 previous 148:6 Primarily 23:5, 6 primary 106:21; 136:5; 138:10 printed 74:4, 10, 20; 76:5 prior 8:14; 39:4; 55:14; 77:17; 123:19; 130:4, 4; 154:20, 22, 24; 155:1, 7, 23; 156:3; 157:7, 24; 158:4 rivilege 49:13 robably 18:9; 27:24; 35:23; 46:19; 49:7; 51:3; 53:3; 55:14; 62:20; 63:1; 54:4; 67:22; 73:19; 100:9; 122:9; 148:17; 152:13 roblem 35:2; 36:20; 42:19; 85:12; 95:3, 9; 121:19; 125:16; 143:17 roblems 74:12; 102:2; 137:16 rocedure 23:13; 24:4; 36:6; 81:4, 5; 104:9; 21:17 rocedures 23:14; 71:14 roceeded 159:18 rocess 97:15 rocessor 19:2 roduce 10:24 roduct 5:17; 10:7, 16; 49:8 roducts 59:7 roficiant 42:5 rogram 26:20; 161:10 rominent 161:9 ropofol 109:2; 117:17; 18:5, 14, 15; 119:5, 7, 11, 3, 17, 19; 127:20; 144:24; 45:1; 160:22 proponents 26:23 protocol 34:5, 10; 35:5 provide 112:22; 135:14 provided 54:8; 146:9 provider 22:6; 30:22; 101:1 provisions 47:14 proximal 121:20; 122:23, 24; 123:2 prudent 78:10; 128:24 pseudo 146:24 public 60:3; 164:5; 165:13 publication 74:19; 76:8, 11 publications 73:20 published 74:14, 22; 75:11, 24; 76:4, 12, 17, 20 publisher 75:12 publishing 76:1 pull 8:8; 27:18; 57:20; 59:1; 100:9 pulled 122:8 pulmonary 35:3; 121:15 pulmonologist 35:2; 39:3 pulmonologists 38:14 pump 25:24; 41:6; 129:1; 135:22; 145:17 pumps 18:14; 25:21, 23 purely 29:4 pursuant 165:2 put 21:24; 50:7, 11; 75:5; 92:18; 96:4; 97:18 putting 29:12, 13; 81:6; 124:13; 158:8 puzzle 134:8	Q qualifications 37:16 qualified 139:24; 140:7, 11, 18 qualifies 77:10 qualify 38:16; 77:24; 78:13, 24; 79:3, 4; 80:3, 10, 12; 129:23 quality 42:15; 49:1 quick 34:5 quickly 55:19 quiet 143:8 quite 23:20; 35:15; 43:24; 36:19; 135:6; 136:15 quote 144:22, 22	R r 124:19 IAA 44:20, 21; 48:16 adiologist 127:10 aised 124:17; 135:11 an 35:12, 14; 76:22
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------

range 38:10
rarely 19:22; 20:3, 5
rate 42:11; 55:20; 120:16;
20; 121:10; 123:9; 146:5;
148:11, 12, 14; 159:18
rather 21:24; 26:9; 59:9,
21; 61:10
re-review 136:15, 24
re-reviewing 83:23
read 90:2; 114:22;
116:16; 129:21; 151:13
reading 91:1; 114:7, 14;
121:16; 143:23; 162:8
readings 107:5; 126:8,
12, 16, 17; 144:4, 7; 149:4;
156:17
Ready 112:13, 14
real 87:11; 147:1
really 6:9; 8:13, 14;
15:21; 21:16; 26:7; 41:17;
81:18; 93:7; 114:21;
125:10; 149:4
reason 63:4
reasonable 101:4, 4, 5;
123:17; 156:11
reasonably 101:1
reassume 36:11
rebled 121:22
rebleed 42:11
recall 8:13; 9:11, 12, 15;
67:3, 3, 6; 89:4; 131:4, 6
receive 43:11; 49:13;
84:20
received 5:7; 6:8, 12;
11:9; 12:14; 15:14; 26:15;
76:5; 77:16; 85:3, 22, 23;
97:16; 99:6, 6, 13; 116:17,
20; 117:22; 153:14
recently 37:17, 19, 19;
93:1
recess 11:4; 50:3; 63:19;
111:8; 152:19
recollection 86:21
reconvene 10:22
record 12:6; 21:24;
49:24; 53:23; 85:22; 91:1;
131:2; 143:15, 18, 21;
158:9
recorded 119:18;
134:10; 149:7
records 4:13, 21; 12:11,
17, 18; 13:21; 15:3; 27:18;
92:10; 98:22; 100:9;
102:23; 103:4
reduced 164:19
refer 92:9; 133:19
reference 99:18
referring 90:9; 107:12;
108:1; 136:11; 141:18;
142:19, 24; 143:5; 144:6;
152:2, 5, 6, 9, 11
reflux 148:7
refresher 69:18
refreshing 90:20
regard 160:9; 161:1

regarding 15:4; 36:9;
108:9; 137:20; 161:1, 5
regards 5:7; 108:6
regular 22:10; 26:6;
37:10; 51:7; 96:5
relate 73:21
related 165:6
relates 4:18, 20; 8:20;
28:4; 36:7; 106:4; 116:15;
161:24
relation 117:7
relative 95:17
relatively 136:1
relaxant 116:24
relayed 133:17
relegated 47:11, 15
relevant 70:11, 17
reliable 148:18
relied 10:9
relieving 43:14
rely 79:9
remained 120:21
remaining 151:3
remember 11:21; 58:23;
54:13, 16; 66:6, 7, 8, 11;
57:11; 86:19; 88:11;
90:14; 135:19
remove 5:16
removed 5:13; 6:5, 7, 9,
13; 10:6, 15
render 4:7; 9:17
rendered 9:13; 57:2, 3;
100:24; 159:21
rendering 18:6
rent 52:1, 14, 17
repaired 122:7
repeat 127:10, 12; 129:20
replacement 121:23
report 60:1, 2; 84:8, 11,
15, 18; 89:24; 95:11; 96:8;
98:8, 12, 16; 99:2, 10, 14;
103:13; 117:17; 124:9;
140:22; 142:7, 11, 22;
144:11; 146:8; 148:3
reported 164:17
reporter 129:22; 151:13;
162:7, 10, 13
reporting 70:24
reports 11:15; 13:1;
39:17, 18, 19
represented 85:1
requested 151:12
requests 28:23
required 104:15
requirement 77:22;
78:13
requires 46:10, 11
requiring 121:12
re-read 151:11
research 99:16
reserve 61:15; 91:8;
131:22; 155:7; 162:5, 6
reserved 164:24

resident 105:19; 128:24;
132:7, 7, 19, 22
residents 34:11; 68:21;
101:18
resistance 147:14
resolved 94:7; 95:3, 9
resource 111:3
respiratory 34:12; 36:20;
59:15; 145:8, 10
responsibilities 40:15;
43:1, 2; 46:7; 48:20;
114:11
responsibility 32:23;
33:20; 35:17; 46:23
responsible 18:2; 29:12,
16; 30:3, 7, 14, 16; 31:19;
33:22; 34:12, 15; 40:17,
18; 47:5; 132:20
rest 27:6; 34:18; 45:13;
64:22; 70:22
restaurants 17:9
result 50:21; 124:3;
147:4; 148:13; 155:17, 22;
156:6, 15, 23; 157:20;
158:5, 23; 159:2, 6, 12
results 42:10
resuture 122:15
return 104:16; 137:23;
138:7; 139:16
returned 104:8; 124:3;
153:15
revascularization
23:14, 15
revascularizations 24:7
review 6:10; 7:10, 18, 23;
8:3; 9:8, 10, 18; 12:2, 5,
17, 18; 15:3, 17; 54:16;
55:13; 61:8, 13, 19; 62:2,
19, 24; 63:3, 6, 8; 69:22,
23; 71:16; 72:8, 9; 82:17;
54:12, 14; 88:11; 90:1;
33:12; 97:18; 99:12, 21
reviewed 4:17; 7:4, 9, 18;
8:14; 15:12; 67:17; 83:9,
11; 84:2, 7; 86:9, 10, 13,
13, 14; 87:21; 88:8, 8;
93:12; 97:21; 98:23; 99:3
reviewing 50:12; 88:12;
114:7
right 18:10; 28:20; 34:20;
38:19; 44:19; 59:9, 11;
52:17; 65:5; 69:12; 70:18;
72:20; 76:24; 80:8; 92:16;
103:3; 109:16; 112:2;
114:6; 115:23; 116:4;
126:13; 132:23; 135:11;
136:6; 142:20; 148:2;
149:14; 150:20
rise 125:5; 148:1
risk 40:18
Road 52:2, 5; 164:9
Rockford 19:5; 20:16;
39:17; 40:9, 23; 44:2, 12,
22; 45:24; 46:8, 17; 49:5,
9; 51:9; 53:11; 56:2; 94:4
role 29:10, 15; 90:18, 19,
24; 91:10, 17; 92:2, 4, 8;

93:18
room 27:17, 18; 28:11,
19; 29:21, 22; 30:16, 17,
21, 23; 31:9, 11, 11, 13,
13, 21; 32:22; 35:19;
68:10, 13; 120:8; 137:24;
138:8; 139:8, 17; 140:9,
20; 145:20; 153:4, 20;
156:6, 14, 22; 157:12;
159:5
rooms 29:24; 30:11, 12
root 121:23
rotation 24:15
rough 74:5; 76:5; 95:22,
23; 96:1
roughly 65:7
round 69:9
rounds 17:4; 69:9; 71:9;
129:7
royalties 74:7
royalty 75:3, 14; 76:6
rules 78:6; 81:23
run 17:20; 30:24; 31:3;
33:3; 40:18; 41:3; 50:18;
54:24; 87:4; 127:24
running 29:14; 48:22;
133:7; 143:10, 11
runs 41:6; 46:24; 47:2;
48:23

S

S 4:1; 110:3, 4
S-t-i-e-g-l-i-t-z 21:13
S-t-o-h-l 60:17
Saint 18:7, 12; 19:3, 7, 15;
20:19, 22; 22:23; 23:9;
27:10; 32:20; 35:8; 36:2;
40:3
Same 19:23, 24; 20:22;
26:6; 27:8; 31:20; 42:3;
48:6; 56:7; 57:12; 58:17;
65:22; 66:1; 93:13;
106:15; 109:4; 127:19, 24;
135:11; 158:5
sat 78:11
Saturday 17:17
save 9:19; 90:17; 150:18
saw 137:1
saying 72:17; 75:13;
76:21, 23; 80:15; 109:23;
110:7; 117:19; 118:20;
119:3; 123:10, 24; 129:23;
140:20; 154:5, 23; 155:1,
1; 158:11
schedule 17:10, 10; 48:1,
7; 55:4
scheduled 111:18
school 69:6, 7, 7
scope 38:4
scratches 114:4
scut 132:8, 20
seal 165:9
second 23:7; 71:17; 73:5;
76:14; 86:12; 102:10;

149:15, 18; 153:4
second-year 128:24
sedation 108:24
Sedvire 74:13, 24
seem 64:23; 144:23
sees 47:2; 124:21;
148:13
selects 24:18
self 138:2
self-evident 13:18
semantic 79:15
semantics 78:21
seminar 49:19
seminars 40:19, 19
send 21:6; 67:9
senior 95:5; 133:5
sense 7:11; 150:14
sent 7:16; 9:3, 7; 11:12;
12:11, 24; 14:2; 15:4, 7;
96:11, 23; 98:9, 13;
153:14, 19; 154:3, 5; 155:5
separate 6:14
separated 92:18
sequelae 157:8, 13
serve 8:9; 39:5
service 91:19; 95:2;
103:20; 105:20; 132:7, 9,
19; 133:4, 5; 145:17
Services 19:6; 48:9, 12,
20; 49:2, 12; 50:22
sessions 69:21
set 50:9, 11, 24; 51:2, 15,
19, 23; 54:1, 24; 103:11;
143:17; 165:8
sets 54:13
setting 50:10; 142:14
settle 64:23
setup 22:23
Seven 17:13; 75:17, 20;
151:7
seventh 135:18
several 18:12; 32:15;
36:4; 70:5
severe 124:9
sew 123:4
shape 101:22
share 45:19
sheet 14:8; 106:24; 107:6
shift 111:1
short 41:3, 6; 141:12, 16
shortages 35:16
Show 18:18; 90:9; 91:2;
115:10
showed 127:8
Shred-X 67:9
side 88:19; 126:22
sign 34:6; 47:12
signature 61:15; 162:5,
5, 9; 164:23
signed 37:3; 96:19
significance 8:16, 20, 22
significant 121:21;
122:1, 6, 16; 123:2, 6;

				T	
137:16	14, 16; 106:23; 147:2	stating 61:18	supposed 74:5	T 109:16, 23; 110:1, 2	
significantly 109:20	speak 5:15; 131:3	status 34:13; 35:3	supra-high 149:7		
signify 13:24; 92:14	special 26:18; 37:16;	statute 81:22	sure 13:10; 14:22; 46:9;	table 41:3; 116:7	
signing 162:8	38:6; 78:2	stay 102:8; 157:17	47:1, 12, 13, 14; 48:21, 24;	tachycardia 121:3, 11;	
signs 107:4, 8; 116:19;	specialist 35:7; 39:14	stayed 120:20	56:20; 61:7; 73:17; 76:10;	122:12; 123:9; 148:8, 13,	
141:11; 147:9; 148:18	specialists 35:18	stenographically	80:16; 83:24; 87:9; 88:10;	17	
simple 148:20	specialty 12:20	164:18	18; 90:16; 107:23; 115:1;	tachycardic 120:21;	
simultaneously 29:23;	specific 20:12; 94:22;	stenosis 124:12	116:10; 129:3; 137:17;	151:4	
30:2	105:10; 149:19; 150:4;	step 145:6	149:6; 161:14	tailor 25:21	
sit 66:19; 67:4; 69:23;	153:5; 156:4	Stephen 164:9	surface 124:10	Talen 49:20, 21; 50:5, 14;	
78:3, 11; 79:3; 81:20; 91:9;	specifically 36:1	sternotomy 26:10, 10;	surgeon 25:5; 33:1, 7;	51:2, 5; 52:7, 18; 53:5, 6;	
117:12; 140:14	speed 114:7	27:2	34:21, 21; 35:18; 41:4;	54:1, 3, 8, 10, 11, 13;	
site 6: 18	Spell 21:12; 25:14	Stieglitz 21:11, 12; 25:11	88:16; 89:9; 94:9, 16;	101:7	
sitting 27:17; 85:17;	spend 14:3; 18:5; 19:9;	still 5:19; 26:14; 32:24;	100:2; 138:15, 22; 139:5,	talented 41:4	
138:14	15; 47:18; 49:6; 69:10, 24;	66:1; 73:18; 74:7; 76:8, 10,	14; 145:23; 161:9	talk 18:20; 33:9; 59:21;	
situation 104:1; 134:19	100:15	11; 78:19, 19; 79:3, 8;	surgeon's 138:9	63:10, 18; 72:24; 79:21;	
six 32:11, 15; 42:6; 51:3;	spent 14:1; 64:14; 95:1;	103:2, 3; 118:20; 131:15;	surgeons 18:15; 21:9;	106:13; 108:19; 110:22;	
56:15; 75:17, 20; 145:18	100:7, 12	145:1; 157:17	29:4; 33:6; 40:4; 42:8, 12;	131:24; 135:13, 22; 141:4	
skeletal 116:24; 117:3	spine 55:8	stipend 43:13	55:8; 138:17; 140:15	talked 14:17; 60:15; 65:2,	
skeptical 125:20	spiral 155:5	stitch 122:3, 5	surgeries 25:6; 26:5;	22; 68:7; 77:11; 96:12;	
slide 136:5	split 86:12	stitched 123:1	27:9; 29:11; 46:13; 161:12	97:3; 98:5; 109:10, 11;	
slippery 155:6	splitting 81:7	Stohl 60:16	Surgery 18:11; 19:24;	133:14; 136:12; 141:13,	
slope 155:6	spoke 14:15; 98:1, 2	stop 22:2; 39:18, 20;	20:20; 21:10; 23:9, 12;	15	
slow 29:7	spots 115:24	47:20; 102:10	25:3; 26:9, 10, 16, 23;	talking 23:4, 15; 24:2;	
slowed 118:5	Spring 52:2, 4	stopped 37:8, 10; 74:6	27:13, 14, 15; 28:4, 20, 21;	28:10, 20; 31:2, 6; 32:24;	
small 43:13; 45:19;	square 124:10, 11	storage 6:18	39:2; 41:10; 44:13, 18, 24;	34:20; 63:21; 83:19; 87:7;	
138:19; 143:13	SS 164:2	story 125:17	46:8, 18; 49:4, 9; 94:24;	96:21; 98:24; 108:8;	
smaller 19:22; 43:15	stable 129:3; 154:14	straight 78:22	95:2, 7, 8; 100:3; 103:23;	115:15; 117:10; 119:15,	
Smith 82:18; 84:22;	stack 85:16; 92:21, 23,	straightforward 2 13;	104:8, 16; 121:18; 123:12;	22; 120:11; 123:8; 141:17;	
86:15; 87:1, 3; 88:1	23; 93:2, 10, 10, 11, 14,	87:19	124:4; 149:13, 15, 18;	144:11; 149:15; 150:3;	
Smith's 85:7, 13, 16; 87:5	16; 103:3	street 5:23; 6:2; 20:11, 11	155:16, 21; 157:6; 160:20;	155:10	
smooth 117:4	stacks 92:18	strict 138:3	161:6	talks 73:13; 142:9, 16	
smoothly 46:24; 47:2	staff 18:7, 12; 28:9;	Strictly 46:14	surgical 12:4; 19:5; 20:5;	tamponade 124:21;	
snowfall 66:14	145:23	strike 54:2	27:4; 45:1; 71:14; 78:10,	127:11; 146:23, 24; 147:1,	
Society 71:19, 24; 72:5	standard 100:22, 24;	stroke 148:10, 12	18; 105:19; 138:3, 12;	1, 10	
sole 22:6	101:4, 14, 23; 102:1, 7, 15;	students 68:20; 69:9	139:2, 16; 140:8; 160:7,	tamponaded 125:4	
solely 30:3, 7, 14, 15;	103:18; 105:12, 24; 106:5,	stuff 6:10; 42:17, 18; 44:8	10; 161:24	tamponading 139:5	
32:2; 49:22; 54:8	20; 109:6, 9, 15; 110:17,	submitted 75:12	suspect 126:9	tank 127:23, 23	
somebody 92:14; 112:6;	20, 24; 111:5; 112:21;	suburb 60:20	suspecting 127:11	tanked 127:18	
139:13	113:4, 8, 15, 19, 23;	Suburban 19:4; 20:1, 3	suspicious 125:20	tax 100:9	
Someone 41:21; 51:12,	114:20; 117:15; 118:1, 12,	sudden 133:1	sustained 121:3; 122:12;	teach 68:16, 20, 23; 69:4,	
14, 20, 23; 80:9; 83:20;	2, 119:6, 16; 120:2;	sued 93:21; 94:11, 20	123:9, 19; 148:14, 14;	11, 13, 15; 70:2	
89:24; 90:1; 125:21;	129:13, 14, 18; 130:15;	suffer 148:23	153:20	teaching 18:2; 68:18, 24	
132:23; 133:1; 138:4, 14;	131:8, 18; 132:15; 133:10;	suffered 149:20; 157:8,	suture 121:20, 22; 122:8	team 101:16	
139:4; 144:24	134:12, 14, 18, 20, 21, 21,	13	Swan 125:9; 149:4;	technically 79:19	
sometime 11:18; 82:21;	13, 135:4; 141:1	suggest 87:22	150:9; 156:17	technique 42:9	
84:17; 149:1, 3, 16; 153:3;	standards 161:19	suggested 108:10	Swan-Ganz 143:23;	techniques 48:14; 72:18;	
155:1	standpoint 12:22; 32:4	suit 165:6	144:4, 7	73:6	
Sometimes 17:14; 28:16,	start 17:7; 27:22; 47:13;	Suite 164:9	Swede's 18:13	technology 40:19, 20	
16; 30:24; 34:21; 35:1;	22:24	summarized 8:11, 12	Swedish American 18:8;	TEEs 28:5; 29:19, 20	
44:8; 56:24; 57:1; 138:1, 2,	started 64:20; 119:11,	summary 9:9	19:3, 8, 10; 20:10, 18, 21;	telling 80:10	
3	20; 120:16; 121:12;	summation 90:1	21:14; 22:9, 16; 23:9;	tells 125:12	
somewhat 79:1; 125:19;	151:23; 156:2	superiors 106:1	27:10; 32:21; 35:8; 36:2;	en 32:17; 52:24; 53:3	
134:11	starting 17:5, 16; 71:7;	superstar 101:3	40:3	en-year 81:17	
somewhere 42:7; 64:15;	18:9	supervise 28:6; 30:11	switched 95:7, 8	lend 24:22; 96:4	
74:17, 21; 85:21	starts 122:10	supervising 29:16, 21;	sworn 4:2; 164:15	Tennessee 71:24	
sooner 120:8, 13;	State 20:11; 55:17, 17,	30:15, 17; 112:16	sympatholytic 109:19	erm 13:16; 25:24; 38:17;	
123:12, 14; 131:22; 146:3	22, 22; 56:22; 71:24; 72:5;	supervision 112:23;	symptoms 127:16; 147:9	78:21; 100:22	
sorry 50:20; 51:17; 83:7;	23:16; 148:24; 156:21;	135:14	system 40:1	armed 38:19	
118:7	64:1, 6, 11	supervisor 92:5; 136:4	systemic 147:13, 14	erms 18:6; 53:4; 67:23;	
sort 134:7	stated 8:24; 32:7; 88:8;	support 124:14	systolic 120:21; 121:3, 9;	94:14; 101:13; 123:6, 7;	
sounds 117:8	99:10; 105:4; 115:24;	supporting 109:1; 126:5	123:9; 125:6	149:19; 160:6	
southHearn 64:15	28:13; 136:9; 149:17;			est 37:21; 78:6, 7	
space 13:8, 12, 17; 52:1,	56:16				
	itates 82:5, 7				

testified 4:2; 63:5, 10, 22
 24; 64:7; 65:13; 66:11, 21;
 67:11
 testify 55:24; 57:7;
 164:15
 testifying 58:2, 9; 65:17
 testimony 53:5, 16;
 63:22; 64:18; 67:23;
 82:17; 164:17, 21; 165:8
TETs 21:4
 Texas 139:3
 textbooks 99:19
 Thanks 81:12
 theater 31:12
 therapy 59: 5
 thereabouts 110:15
 thereof 109:13; 165:7
 thick 77:5
 thin 6:17; 47:13
 third 71:18
 thoracic 105:19
 though 93:5
 thought 58:1, 59:1;
 78:10; 83:19; 86:6, 12;
 88:4; 122:22
 thousand 101:7, 8
 three 17:4; 20:14; 27:19,
 24; 28:13, 15, 16, 18;
 32:19, 19; 54:24; 58:20;
 60:15; 61:4; 63:1; 69:21;
 72:2; 73:20; 85:23, 24;
 86:2, 11; 91:3; 92:16, 24;
 93:6, 11; 94:9; 95:14;
 99:13; 100:21; 111:13, 13,
 14; 115:20; 122:18;
 139:19; 158:21
 three-and-a-half 17:21
 three-hour 69:21
 three-ring 4:12; 12:13;
 98:23
 throw 116:5
 Thursday 48:4
 timely 104:22; 133:18
 times 31:9; 35:4; 46:12;
 61:4; 62:9; 63:5, 10, 15,
 16, 23; 64:1, 18, 22; 65:12;
 67:14, 20; 93:23; 115:20;
 116:12; 122:18; 130:2;
 139:19; 148:12; 150:7;
 155:10; 158:9
 tipoffs 104:7
 tiresome 43:24
 tissue 122:8; 123:3
 title 49:14, 15
 titrate 34:4
 titrated 107:22
 to-wit 164:7
 today 5:11; 79:3; 83:12;
 84:18; 85:11
 together 86:20; 87:4
 told 12:3; 37:9; 43:2;
 64:20; 87:21; 128:4, 9;
 149:24
 tonsillectomies 46:16

took 37:22; 86:3; 94:8,
 14, 15; 117:16; 156:7
top 52:10; 92:13, 15;
 102:9
TOSTI 4:24; 5:2, 15, 19,
 22; 10:5, 12, 15, 23; 11:5;
 18:19; 49:23; 53:22; 67:1,
 6; 79:23; 81:10; 87:14, 16;
 92:9; 102:22; 103:4;
 111:17, 23; 112:9; 115:17;
 122:19; 130:10; 139:18;
 149:22, 24; 150:15; 152:2,
 6; 156:24; 157:3, 14, 24;
 158:6, 8; 162:7, 9, 13, 14
 total 15:2, 3; 45:12;
 144:23; 148:22
 totally 125:17
 touch 70:13
 town 39:4; 45:14; 55:24;
 56:2
 tract 1 17:1
 Tracy 164:5; 165:12
 tradeoffs 43:9, 9
 Traditionally 50:18
 trained 101:2
 training 26:15, 18; 57:5;
 59:3; 77:9; 78:2, 5, 9; 91:6;
 94:22; 101:5; 125:22;
 135:23
 trans-sternal 23:21
 transcribed 97:18
transcript 61:14, 19;
 52:2; 151:12; 164:21
transcription 164:20
transcripts 15:9
transesophageal 27:20;
 19:16, 30; 18:40; 22:23;
 72:11, 19; 73:1, 6; 124:7;
 125:11; 127:5
 transfer 104:21
 transmittal 15:15
 transplants 20:23; 21:1;
 57:9
 ravel 43:15; 55:23
 raveling 56:1
reat 91:14, 20, 24
 reated 91:13; 104:10;
 61:18
 reater 63:12, 18, 24;
 54:7; 67:19, 20
 reaters 54:23
 reatment 19:5; 20:5;
 5:2; 106:6; 153:14;
 60:6; 10
 rends 120:15
 rial 55:16; 63:21; 64:18;
 6:12; 94:8
 ried 122:18
 rouble 7:12; 108:24;
 51:15
 rue 65:3; 164:21
 truth 164:15, 15, 16
try 28:13; 33:2
 trying 13:13; 42:19;
 45:23; 54:3; 60:14; 81:8;

83:1, 5, 5, 9; 84:12; 87:22,
 24; 96:14, 24; 97:15, 20;
 114:10; 115:13; 128:11;
 142:6; 144:9; 158:1
tube 107:10, 20, 21, 24;
 108:6, 10, 14, 15; 122:14;
 135:10; 142:17; 143:5, 21
 Tulsa 57:19
 turn 118:16
 turned 119:14, 19, 20
 turning 119:17
 twice 93:13
two 6:14, 15; 8:5; 15:13;
 16:22; 18:13; 19:6; 22:7,
 12; 27:23; 28:23; 29:3, 6,
 22; 30:1, 2, 3, 4, 11, 12;
 31:20; 32:19; 41:17; 42:1,
 3, 22; 44:3; 54:22; 55:14;
 56:9, 17, 18; 57:4, 12;
 58:12; 64:12, 13; 65:1, 9,
 10, 14; 66:3, 14; 69:21;
 79:16; 92:17, 23; 93:6, 11;
 94:24; 106:8; 114:4;
 122:17; 125:10, 14; 128:7;
 132:18; 140:23; 142:13;
 150:14; 160:2
 wo-time 69:20
ype 8:6; 22:8; 46:13, 17;
 58:24; 71:6; 78:10; 99:9;
 16:18; 117:2, 3
ypes 20:20; 21:4; 23:5,
 1; 28:23; 67:2; 97:13
 ypewriting 164:19
ypical 29:15; 33:3
 ypically 160:23

U

ultimate 139:15; 156:2
 ultimately 47:4; 118:9
 under 125:14; 138:8;
 39:8
 underlined 116:8, 15
 underlining 114:3
 Understood 36:23;
 8:24; 136:16
 undetermined 164:10
 unit 22:8, 14, 18; 23:1, 6;
 8:20, 21; 132:17; 135:18;
 41:10
 units 38:24; 69:19;
 32:18
iversity 69:8; 70:3;
 1:11, 17; 95:1
ness 132:21
 nload 124:12
 nstable 128:23; 129:15;
 30:19; 152:14; 154:15;
 55:4; 156:8; 159:10
nusual 36:19; 142:13
p 17:3; 24:22; 26:24;
 3:13, 15; 30:13; 34:6;
 7:8, 17, 19; 41:2; 50:10,
 3, 11, 24; 51:2, 15, 19;
 3; 54:1, 18; 55:2; 59:10;

61:24; 65:24; 66:2; 72:2;
 86:3; 101:11; 103:24;
 107:22; 120:16, 20;
 124:17, 20; 125:5; 126:4;
 149:10; 150:10; 151:2;
 159:19; 162:11
Update 73:3
 updated 43:4
 upheld 114:12
 upon 57:24; 79:9; 97:18;
 103:24
 urine 147:16, 18
 use 25:24; 27:23; 43:16;
 54:3; 68:23; 69:1, 2; 71:9,
 13, 20; 72:4, 10; 137:14;
 142:10, 13; 154:11;
 160:21; 161:3, 6
 used 38:17, 21; 59:10;
 69:13, 16; 132:19; 137:15
usually 6:18; 17:5, 7;
 52:20; 55:20; 88:22, 23;
 101:10, 11; 132:7, 24;
 149:11

V

/vacation 29:5
/valve 23:20; 24:12, 14,
 19; 25:2; 60:7; 124:13
/valves 23:18, 18; 24:9, 10
 variable 17:18; 52:20, 23
 varies 34:21
 vascular 17:24; 147:14
 recuronium 116:18, 24;
 17:7; 136:12, 22; 137:6
 recuronium's 137:12
 vegetative 148:24
ehicle 50:7, 9; 54:4
enous 124:18; 147:12
 rent 34:3
entilation 26:12
entilator 33:3, 23
entricle 124:13; 125:17,
 8
entricular 124:9, 22;
 25:3
enued 56:16; 60:18;
 4:11
ersus 7:3; 30:14
 ertically 40:1
 ia 147:8
ideo 101:7, 9
iew 26:9
ision 125:15
ital 34:7; 107:4, 8;
 41:11
olume 46:17; 133:1;
 48:10, 12
SDs 21:3, 6

W

/ 164:9

waking 41:2
 walls 31:12
 warehouse 74:21
 warmer 42:13
 warrant 104:16
 warranted 104:8; 124:4;
 127:10
 waste 114:22
 way 10:3; 16:14; 18:9;
 26:6, 7; 49:19; 50:10, 24,
 24; 63:9, 11; 70:19; 73:15,
 21; 74:11; 85:10; 97:12;
 98:7; 99:8; 101:22;
 102:11; 105:11; 106:19;
 111:4; 113:14; 114:3;
 124:19, 23; 126:3; 135:13;
 139:1; 148:8; 150:10;
 154:12; 165:6, 7
 ways 40:21; 69:1, 70:13;
 109:14; 125:11; 127:12;
 135:3
 wean 33:2, 3, 21; 41:2
 weaned 36:10
 weaning 33:22
 wedge 126:19, 20, 20
 week 17:4, 11, 21; 19:12,
 18; 27:19, 24; 28:13, 15,
 18; 29:7, 7; 44:1, 4, 11;
 46:12, 18, 21; 47:8, 19, 19;
 49:6; 52:22; 82:24; 83:21;
 34:5; 85:24; 86:2; 99:7;
 135:18
 Neekend 43:10; 69:24
Weekends 17:15; 52:21,
 24
 weeks 29:2, 3; 43:22, 24;
 54:7, 7; 59:2; 135:20
 weights 17:4
weren't 63:2; 114:12;
 143:24
Western 91:8
what's 10:10, 21; 17:2;
 11:21; 22:23; 32:9, 18, 22;
 51:9; 57:21; 58:12; 73:3;
 14:21; 88:13; 100:20, 22;
 11:10; 114:9; 116:23;
 25:9; 142:6; 146:18;
 54:9; 158:14
 whatsoever 117:1
 whereby 54:4
wherein 164:12
whereof 165:8
 Whereupon 162:15
 thole 10:18; 95:5;
 16:11; 144:21; 145:4, 6;
 64:15
/holly 49:22
 whose 88:19; 138:7
 WILLIAM 4:1
 willing 90:10
WINNEBAGO 164:3, 6;
 165:13
 wish 39:22; 128:20
 wished 39:21
 within 20:14; 42:22; 43:8;

44:3; 82:23; 161:19; 164:5
without 81:22; 117:12;
124:24; 155:8
WITNESS 5:23; 11:3;
53:4; 111:7, 13; 112:1, 6;
122:20; 129:20; 151:11;
162:6; 164:14, 17, 19, 22
won 97:5
word 19:2; 50:23
words 30:13; 43:17; 78:3;
96:7; 106:23
work 5:17; 10:7, 16; 17:7;
21:9; 28:13; 29:24; 30:3;
33:13, 16; 35:7; 38:21;
39:1; 42:2; 54:8, 10; 83:13;
132:8, 8, 20
worked 24:11; 66:8
working 50:15; 58:13;
60:8, 13
works 40:4
workweek 17:2; 43:18
write 36:13; 78:23
writing 14:7
writings 13:5
written 13:23; 60:1, 2;
75:20; 106:24; 110:2;
162:10
wrong 61:7, 18; 84:1;
101:19; 102:5, 13, 16;
104:3, 20; 105:3, 10;
113:24
wrote 9:4; 13:6, 8; 77:7, 8;
84:7, 11, 17; 92:14, 15;
95:11; 107:1, 2

X

x-ray 127:8, 13

Y

Yared 91:22, 23; 117:22
year 18:14; 25:21; 49:18;
57:9; 68:5; 69:16; 95:5
years 32:15, 17; 35:21;
37:9; 51:4; 55:14; 56:9;
58:20; 63:1, 1; 66:14; 70:5;
75:17, 20; 81:17; 94:24
Young 13:3; 93:20;
103:6, 14; 106:6, 14, 20,
21; 109:8, 14; 110:15, 20;
111:2, 6; 112:17, 18;
115:1; 117:21; 133:22;
134:3; 135:15

Z

Z-i-l-k-a 92:7
Zilka 13:2; 92:7; 93:17;
103:6, 15; 106:14; 110:22,
23; 111:4; 112:15, 16, 20,
24; 113:9, 12; 114:24;
115:12, 19; 135:13;
146:15

Zilka's 116:13
Zurich 51:11

Lawyer's Notes
