THE STATE OF OHIO, :

: SS:

COUNTY of CUYAHOGA.:

Doc 318

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LESTER WEITZEL, executor of the ESTATE OF SHARON WEITZEL, deceased, and LESTER WEITZEL,
plaintiffs,

vs. : Case No. 226946

SAINT VINCENT CHARITY HOSPITAL, et al.,
defendants.

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Deposition of GHASSAN MOASIS, M.D., a defendant herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before George J. Staiduhar, a Notary Public within and for the State of Ohio, at The 113 St. Clair Building, Cleveland, Ohio, on Tuesday, the 29th day of September, 1992, commencing at 9:00 a.m., pursuant to notice.

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I N D E X

GHASSAN MOASIS, M.D.

of lawful age, one of the Defendants herein, called by the Plaintiffs for the purpose of discovery examination pursuant to the Ohio Rules of Civil Procedure, being first duly sworn, as hereinafter certified, was examined and testified as follows:

CROSS EXAMINATION

BY MR. KAMPINSKI:

Q State your full name, please?

A. Ghassan Moasis, G H A S S A N, M O A S I S.

Q I am going to ask you a number of questions this morning. If you don't understand any of them, tell me and I will be happy to rephrase them.

Please respond verbally. The court reporter is going to take down everything you say. He can't take down a nod or a shake of the head so if you could please answer verbally.

Mow, would you state your address?

A Certainly, 30799 Gates Mills Boulevard, Pepper Pike, 44124.

Q. Wow old are you?

A, 41.

Q. Date of birth?

A. February 3, '51.

Q. Where were you born?

Q And that would have been the year at the Faculty of Sciences?

A. That's correct. Only people who make it, they make it a rather difficult and challenging year. People who get accepted to go to med school, they have to go through this rather extensive screening, pass the test, and then they will be confirmed to go to medical school.

Q. Okay, That would be what, 19 - -

A. '70.

Q. What did you do after that?

A. Med school, six years; I graduated in 1976.

Q. Where did you go?

A, University of Damascus,

Q What did you do after that?

A. After that I was drafted. I had three years of military service during which time I also was allowed to practice as a general practitioner.

Q. So you were in the military from '76 to '79.

A. Correct.

Q. Were you an officer?

A. Yes, I was.

Q. What part of the military were you in?

A. I was in a tank division.

Q. And what was your position in the tank division?

A. I was what would be similar to what you see on TV

Q Did you graduate from high school?

A Yes.

Q. When was that?

A. 1969.

Q. So how many years of high school would you have undergone?

A Three years of Jr. high school and three years of senior high school.

Q. What did you do after graduation from high school?

A. I went to the Faculty of Sciences where I had one year.

Q. Where is that located?

A. In Damascus, Syria, University of Damascus.

Q. And when you say Faculty of Sciences, that would be the science school?

A That would be - - it is a college, so this is after high school; this is college.

Q. Okay.

A I was accepted to go to medical school, and when you are accepted to go to medical school, you go to the Faculty of Sciences for one year where you take sort of an extensive course in biochemistry, physics, biology.

And you take some language and history, history of medicine, and so on and so forth before you go to med school,

A. Nabk, Syria.

Q Where?

A Nabk, a, suburb of Damascus.

Q. How long did you live in Syria?

A 28 years.

Q Is that when you came to the United States?

A Correct.

Q. Have you been here ever since?

A Correct.

Q. Did you go to high school in Syria?

A. Correct.

Q. And is their high school similar or equivalent to a United States high school?

A I think it has a broader spectrum of education,

Q. So it is a better high school in Syria?

A I can't say better high school. Some aspects here are better, and over there there are some aspects there are broader.

Q When you say broader, what do you mean?

A. I mean geography and history are broader. There are broader aspects here that are probably arts, social sciences.

Driving, dancing, we don't take driving lessons in the school in Syria, but as far as geography and history, they are broader.

as the MASH Team, I was a director of a team.

I had a group of technicians, nurses, just what comprises a team in a military division and provide medical services for the members of this division wherever they go.

Q. What part of '76? When in '76 were you drafted?

A. In '76? The end of '76.

Q What month?

A February.

Q That's the end of '76?

A I am sorry. That's the beginning of '77 actually.

Q. So you were not in in '76?

A I was - - I received my notification to go, and I think I joined the beginning of '77 to recall exactly.

a. So you were in until 1980?

A No.

Q You said three years.

A. Roughly three years, In 1979.

Q When in '79 did you get out?

A June of '79.

Q. What did you do after your discharge from the military in Syria?

A. I took my ECFMG exam and I applied - - I came to the United States.

What did you bo when you came here?

A I worked in St. Elizabeth Medical Center.

Q Where is that?

A. In Youngstown, Ohio.

Q. Do you have a CV?

A Yes.

Q. Do you have it with you?

A. No.

Q Would you provide us with a copy of the C V.

MR. SEIBEL: Is that a request.

MR. KAMPINSKI: Yes.

MR. SEIBEL: Yes, I I will. It is the first time it has been requested, but I will be happy to oblige.

BY MR. KAMPINSKI:

Q. When did you start at St. Elizabeth?

A. October of 1980,

Q. What did you do from June of '79 to October of '80?

A. June '79 to October of '80 - - I came to the United States July 24th, 1979.

Q. Okay. What did you do from July 24th until October of '80?

A. Nothing specific. I was just studying.

Q. Where did you live?

A. I lived in St. Louis, Missouri for one month, and

then I moved to Youngstown, Ohio.

Q And so you were there from what, August of '79 to October of '80 before you got a job at St. Elizabeth?

A. Let me recall the events a little bit.

Q Sure.

A 1 moved to - - from St. Louis, Missouri to Youngstown July 24th.

Q '79?

A August 24th. I was in St. Louis on July 24th, and then I went to Youngstown after a month.

Q 1979, correct?

A. That's correct.

Q. All right, Go ahead.

A, And I stayed there and I was preparing for my exam. During this time, I applied for a job at St. Elizabeth hospital, and I was accepted as a surgical assistant.

I thought this would give me a chance to be familiar with the hospital, the hospital systems and also get familiar with the language and at the same time prepare for my test.

I worked there for a few months. Then I took my exam and 1 passed it, And when I passed my exam, I applied to the same hospital to be a resident, which I was accepted, and that was October 13th, 1981 when I

started my residency. Sorry for the - - I lost track.

Q. That's okay.

A. I didn't expect to be asked these questions, but it is okay, feel free to ask them. Thank you,

a. Okay.

A I am just trying to recall.

Q Sure. I appreciate your consideration.

So that from July of '79 until October of '81, how many months would you say that you worked while you were preparing for your test and you got accepted into the residency program?

A. Five months, something like that.

a. Okay. So that for 19 months you would have spent studying and waiting to start your residency?

A Probably.

Q What test was it that you took?

A The ECFMG.

Q So you took that after you got here as opposed to before you came?

A Right.

Q. What were the circumstances of your coming to the United States from Syria?

A. I took a visa to come to the United States.

Q Well, I mean, was it with the intention of immigrating here, or was it with the intention of

studying here and then returning to Syria, or under what circumstances were you allowed to leave the country?

A. I was allowed to go to the country of the United States to seek further education.

Q Okay.

A I wasn't sure what was going to happen later,

Q Well, I mean, was the purpose of that from the Syrian standpoint so that you could come back and, you know, do your medical work in Syria?

A I wasn't sure.

Q. Was it an exchange type of program?

A. No.

Q. How did you support yourself for that 19 month period of time when you were not working?

A, I saved quite a bit of money during the three years that I worked in Syria, and I got some money from the family.

Q. How long did you work at St. Elizabeth as a resident?

A From October - -

a. - - of '81?

A - - of '81 until June of '81.

Q June comes after October so you don't mean June of 81.

A. Till June of '82.

Q And was that in any type of specific residency program or was it just rotating - -

A General surgery.

Q. Had you specialized at all in Syria before coming here?

A No.

Q What did you do after that residency at St. Elizabeth?

A I moved to Cleveland.

Q. Why?

A. I started in St. Elizabeth in Youngstown in October. When I started, they told me, "you are going to be a resident, but we are not sure whether we will give you a full - - credit for a full year in June."

Q All right.

A. "So in July you will probably start over, and that way, the five years of training will start.''

As the year went by, I realized I am doing as well or even better than people who started in July, which was three months before I did.

So I approached the Chief of Surgery in about the second or third quarter of the year, and I said, "you know, I think I am doing fine. I don't think I need to repeat the first year."

Re said, "we will see."

But at that time I decided to apply at different hospitals, and one of the hospitals I applied to was Huron Road or Meridia Hospital as it is called now.

And I came to Cleveland and I was interviewed, and the end of the interview, the Chief of the Surgery at Huron Road told me, "I don't see any reason why I don't accept you as a second year. If you are interested, the position is yours.

"However, we might have to deal with this three months short of the 60 months required to complete general surgery later. We will see how the American Board of Surgery reacts to that."

Sure enough, I moved and I started at Huron Road in July of '82 as a second year resident, and I completed my residency in '85.

Sure enough, when I applied to take the board, they said you are three months short. So I was allowed to stay in the hospital an extra three months until I completed my residency.

Q. Who was your Chief of Surgery - -

A Helmut Schreiber, Chief of Surgery right now at St. Luke's Hospital.

Q And at St. Elizabeth?

A Rashid Abdul.

Q. Where was Mr. or Dr. Abdul from?

A. He originally is from Yemen.

Q. And who did you interview with when you went to Huron Road?

A. Helmut Schreiber.

Q. Chief of Surgery?

A. Correct.

Q. Did you rotate at all through your residency at Huron Road and at any other hospital?

A. Yes.

Q. What other hospital?

A. Metra General.

Q. Any others?

A. No.

A. But I used to attend conferences at Case Western regularly on Saturdays.

Q. Okay. After you completed your residency - - I am sorry, you said 1985. Is that correct?

A. Yes.

Q. All right. What did you do then?

A. I was applying to compEete my training in cardiovascular and thoracic surgery.

And during that time, 1 started moonlighting as a house officer, surgical house officer or as an emergency room physician at various hospitals in

the suburb of Cleveland while I was waiting to hear from all the places I applied to.

Then I was called to the Cleveland Clinic, and I was interviewed by Dr. Stewart and then by Dr. Loop, and I was accepted to take the position there as a fellow in cardiothoracic surgery, so I did.

Q. When was that?

A That was the end of '86.

Q. Okay, And how long did you do a fellowship there?

A A year.

Q. Did you moonlight during that year?

A. Yes. Sometimes over the weekends.

Q. Where would you moonlight?

A I went to - - I used to go to - - there is the Immediate Medical Care on the west side by Dr. Mitchell. He has four centers. I used to take some shifts there, and there is a place, a hospital Dunlap Hospital in Orville. This is just next to Akron. I used to go there on the weekend and practice as the emergency room physician.

Q Would the Clinic allow you to do that?

A Nobody said anything. Everybody did it and nobody said anything, as long as it didn't interfere with your working hours.

Q. So your fellowship was over when?

A The end of '87.

Q And when did it start?

A. The end of '86.

Q What did you do after you completed your fellowship?

A After that, among the places I applied to was Alberta, Canadian - - actually it was Dr. Loop who called my attention to this place.

He called me to his office and asked, "what are you going to do next year?"

I said, "I am going to complete my training, trying to find a place I can do congenital. heart and transplant."

At the Cleveland Clinic, their places were booked until 1990, residents already applied for that. He said, "where did you apply?"

And I mentioned different places, and I said among them was the University of Alberta.

He said, "I know the guy there. If you are interested, I will be happy to help you get the spot there, We grabbed the phone, called, talked to Dr. Elliot Gelfand and told him about me.

And so I went there, and I was interviewed, but they said you still have to take the same test you took as in the United States.

They changed the rules which is a test compatible with the ECFMG, but it is given by the Canadian - - the Royal College of Medicine in Canada.

Needless to say, it has been six years since I sat down and read or studied. I had been doing general surgery, but this test required that you go back and review biochemistry and anatomy and gynecology and everything in medicine from A to Z.

So I decided to sit down and accept the challenge, and I started studying and I went to Toronto and took the test and I passed.

Q. When did you do that?

A That was in March of '87. It was about three months after I left the Cleveland Clinic. And then they told me, you got accepted. You can start in July.

Q When had you taken the test before?

A. Pardon me?

Q When had you previously taken the test? You said it was similar to the test you had taken?

A Right. I took the test in 1980 when I was in St. Elizabeth and that was six or six and a-half years later.

I didn't have any contact with the details of like the basic sciences and the clinical sciences and just a small part of it was general surgery.

It was quite a task to go back and sit

down, and for three or four months I was reading like 16 hours a day in order to refresh my memory about what I learned in medical school and go back and take the test and pass it. It is a very difficult test,

Q Did you read various text books in conjunction with that?

A Yes.

Q Any authoritative text books dealing with cardiology?

A. No. The test doesn't require you to go into knowledge and sub specialty per se, *so* reading a chapter on cardiology from the text book of medicine would be quite sufficient.

And I can give you a name which is Harrison, this is a text book of medicine. The chapter there on cardiology is more than enough for you to know to pass this test. This is not a sub specialty test. It is passing to get you an MD or equivalent,

Q All right. So you passed the test, is that correct?

A. I passed the test. I got accepted at the University of Alberta, and by this time I got married, I got married at the end of '86. And when we were ready to travel, we just - - my wife was seven months pregnant and she had some problems.

We went for a check up and realized she was having twins and went into premature labor and got to the intensive care unit, and we were there for five weeks.

I called the University of Albsrta and told them what happened, and they said, "do what you have to do. The spot is yours." a week after that, I went and I joined the program. I finished two years there, full training.

I need to tell you that - - probably this will be relevant to you - - that the University of Alberta program is fully accredited by the American Board of Thoracic Surgery.

Q. And that's - -

A And will qualify me for the American Board of Thoracic Surgery.

Q So this fellowship was in cardiothoracic surgery?

A That's correct.

Q. And you finished it when?

A I finished it in August of '89.

a. All right. What did you do after that?

A. Right after that, I joined a guy in Kansas City, Kansas in cardiothoracic surgery.

Q. Who was that?

A. Thomas Thomas. He worked in the Providence

Hospital and Bethany Hospital.

Q. When you say you joined him, did he have a private practice?

A. Yes. He has another guy working with him and I was the third guy.

Q. What was the name of his practice?

A. Well - -

Q. Was it a corporate practice, or do you know?

A No, just practiced.

Q. Were you an employee of his, then?

A Yes.

Q And how long did you work for Thomas Thomas?

A. 44 days.

Q. Why?

A Because I didn't get along with him,

Q Did you interview with him?

A. I interviewed extensively. He asked everybody about me. Do you want me to give you the responses of the people.

Q. Oh, sure, I would love to know that.

A He checked with three people Lurie Sturns, Professor of Cardiothoracic Surgery in Alberta University and asked Patricia Pakowski, Head of the General Surgery there, and I can't recall whether he asked Dennis Modry who is the Educational Director of the program. I got

excellent recommendation.

I said, "I am going to be honest with you, Dr. Thomas, don't call Patricia Pakowski because she has a bad temper," and I didn't get along with her.

He called her anyway, and she said, "me and Ghassan never got along, but he is honest and careful."

And he said, "that's why I decided to take you," but I never asked anybody about him because I am just out of residency, and I am, you know, saving money, the saving account was dropping quickly with the family and two kids and residency, and I just wanted to take a job.

I didn't bother, to be honest with you, to check out the guy, but I realized I just couldn't work with him, even though I told him, "I am not a medical student, a technician; I am supposedly your colleague, You can not swear and scream and yell at me in the OR."

And he consistently did that, and I said, "I am sorry." so I wanted to leave, and I was approached by the head of the hospital in Providence and he said, "you are not leaving. We want to keep you there."

I said, "there is a covenant not to compete."

He said, "don't worry. Go to Court and we will fight it."

And I won. But by that time, imagine it is a bad experience to start, I am out of residency, I got fed up with the place, and I know a person here, a friend of mine who used to work with me in the Cleveland Clinic.

And we talked, he said talk to your colleague, his name was Dr. Toba at Southwest, and he said. there is a place available in Charity with the group there.

So I called the office and set up an appointment with Dr. Naraghipour, and I came and they accepted me and I started..

Q When was that?

A. That was in December of '89.

Q All right. When did you leave your fellowship in Alberta?

A. August - - end of August.

Q. Of which year?

A '89.

Q. Okay. And you spent 44 days in Kansas City?

A Right.

Q. Okay. Did he yell and scream at you because be didn't like what you were doing in the operating room?

A No, because - -

Q Dr., please. I am very interested in hearing your answers, obviously.

A Oh, sure.

Q But I want to make sure they are responsive to my questions?

A I just want to make sure you are not waisting your time and my time.

Q. I would never think of doing that.

A. Because, you know.

Q Everybody here is interested in your responses.

MR. SEIBEL: Let him ask the questions. Go ahead,

a. I just want to make sure you understand my question before you respond?

A. I do.

A. I am not sure you understand what I am saying.

Q I am trying. I am trying, and I want to know what happened to.

MR. KAMPINSKI: Can we have the question read back?

(Question read as follows:)

a. "Okay. Did he yell and scream at you because he didn't like what you were doing in the operating room?

A. No, because - - "

MR SEIBEL: You didn't finish your question. You haven't asked a question yet, The question was a partial question that the reporter just read back. Did did he ye11 and scream at you in the operating room?

BY MR. KAMPINSKI:

Q Because he didn't. like the way you were performing in the operating room?

A. That's up to him to answer. The way I felt, this guy was screaming at everybody.

Q. But what was his reason for screaming at you? I mean, everybody is not here. You are the only one.

MR. SEIBEL: If you know.

Q Did he tell you why he was screaming at you, or did he say, "don't put the scalpel there, that's the wrong place," that kind of thing?

A. When I approached him in the office once, I said, "I can not take this. You are screaming too much."

He said, "this is the way I am, You have to get used to it."

Q Give me an example of what he would scream at you about in the operating room?

A Like if he can not control bleeding, for instance, he would start suction, "hold this. Take your hand out of there."

So no matter what I do, he would be trying - - you know how when some people feel uncomfortable, they try to blame it on you? That's him.

Q While you assisting him in surgery, the first 44 days he would be the the lead surgeon and you the assistant surgeon?

A. Yes.

Q. And this uncontrolled bleeding, would you be the one controlling it as the assistant?

A Not whatsoever.

Q NO?

A No.

Q. And this lawsuit that you had in Kansas City, who represented you?

A Ken Rilely.

Q. Did he get - - I mean, he must have gotten very quick relief through the Courts. You were not there that Long.

A No. Et took a couple sessions. The guy didn't want me to compete with him because he felt 44 days, that's what he felt, that I could not have taken advantage of knowing the referral basis and whatever benefit I got because I worked with him.

The Judge looked at him and told him, "I don't see how this young surgeon having been there for 44

days could have taken advantage of any referral basis.

However, I am not going to let him go to Bethany Hospital," which was the bulk of his practice. "He goes to Providence Hospital, and you leave him alone," and it worked out okay at the moment because it was Providence Hospital who offered me a job with minimal guarantee and office everything.

They said, "we want to keep you here. We do not want you to go." But I elected to go because I was not happy, plus I didn't have - - I didn't know anybody in Kansas.

Q. All right. So you came here to Cleveland, then, correct?

A. Right.

Q And I am sorry. You said December of '89?

A Correct.

Q All right. And for whom did you go to work?

A Dr. Naraghipour and Beg.

a. And what kind of practice did they have?

A They have a cardiothoracic and vascular practice.

Q Were those the only two physicians?

A. And Dr. Khaddam. He is - - I mean, at that time he was an employee by them.

Q. Did they have a corporation?

A. I believe so, yes.

Q And what was the name of the corporation?

A Cardiovascular Surgeons Incorporated.

Q. And did you go to work for them?

A. That's correct. This is the third time you are asking me.

Q. That's the first time you answersd me that you went to work for Cardiovascular Surgeons Incorporated.

a. I see.

a. That's who sent you your pay check?

A No. If you want more details - -

a. I would like some more, if you could tell me?

A, Well, I worked for them so they paid me, that's correct.

a. You just said no, they didn't give you a pay check?

A. They gave me a pay check, yes,

a. Cardiovascular Surgeons, that's who you worked for?

A Right.

Q. They paid you?

A. Right.

a* How long did you work for them?

A Roughly a year.

Q Until. when?

A. Until January of '91.

Q. Okay. Was there some other corporation that employed associate physicians or house physicians?

A. That's right. You see, they are a corporation inside a corporation. I don't know how to - - why they did that. Because I was an associate with them, they have a corporation which the assistant money goes to this corporation.

Q. Which corporation?

A. Surgassist Corporation.

Q. Is that the name of it?

A. Surgassist Corporation.

Q. Wait, wait. Let's go slow, Surgassist Corporation was a separate corporation?

A. 1 don't know whether it was separate or not. I never was interested in knowing that, but they said when you assist us in surgery, the money of assistant goes to this corporation which is Surgassist. Out of this pool, we will pay you your salary and your bonus.

Q. And you couldn't figure out why they did that. I mean, was it because that would allow them to bill twice, once on behalf of you being there; once on behalf of of them being there, whereas if you worked just for them, they could only bill for their corporation?

A. I don't know. I really don't know. They said, "we are going to pay you so and so; you work for us." I

did, and that's what happened.

Q Okay. But who directed and controlled your activities? Was it Dr. Beg, Dr. Naraghipour and Dr. Khaddam, were they the ones that told you to go everyday, which patients to see?

A Pretty much.

Q Okay. Now many other doctors were employed in a capacity similar to yours, that is, surgical assistants?

A. Four.

a. Okay. And four including yourself or four others?

A Well - -

a. Just tell me their names. What were there names?

A. Phanandra, Seklon, Kalipue and Vaidya.

Q. Was that primarily a referral business?

MR. SEIBEL: Surgassist?

MR. KAMPINSKI: Yes.

A What do you mean?

Q I mean, what did you do, Dr. ? Did you go in and work with the three physicians?

A No. When there was a case, I go, I see the patient the day before, check their lab and X-rays, make sure they are okay, and next day when there is a case, I go in, I open the chest, cannulate the heart. If there is a mammary artery to be implanted, take the artery down, and then one of the surgeons will come in.

Q All right. You are talking now about a bypass procedure?

ht, for example.

Q. Would that be true for any surgical procedure? You used that as an example, but would you do the same thing for any type of surgical procedure if you were assisting?

A. It depends upon the set up.

Q. I am sorry?

A The set up. It depends upon the set up. Every group of people has a different set up.

Q. I am talking about the group you worked For.

A. The group I worked for, I don't do the same thing for every case. I told you an example of a bypass. If you want more clarification, you give me the name of the procedure, I tell you how much I do.

Q. Okay. Wow about a tracheotomy, what would you do on that?

A. Tracheotomy is a rather short procedure. Usually, the attending surgeon and the assistant are there about the same time.

Q. Well, I mean, would you go in the day before and do the same types of things, check the patient out, check out the patient's condition, the X-rays?

A. Yes.

Q And that would be your job as the assistant?

A. That's correct.

Q. And the purpose of doing that would be what? Why would you do that?

A. To make sure there is no contraindication to operate.

Q. Okay. All right. And that's the way they trained you to act as a assistant? Would that be a fair statement?

You didn't make this up, "I am going to go look at the patient the day before." They told you they wanted you to do this, right?

A. Yes.

Q. And when I say "they," we are talking about Khaddam, Dr. Beg and Dr. Naraghipour, right?

A. Right.

Q. You say you were there until January of '91, is that correct?

A, Correct.

Q. And then you were no longer employed with them after that?

A. I made the decision to split,

Q To split. What does that mean, to split?

A Split from the group and to start my own private practice because I wanted to do that. I wanted to be

independent.

Q Did they ask you to leave?

A No.

Q They were pleased with your performance?

A I am sure they were. I am definitely sure.

Q Well, you hesitated a little. Did you have a problem with one of them?

A No. I wanted to say if a commendation letter by Dr. Naraghipour would speak for my performance, I can present this as a document if you want.

Q What did you need a letter of recommendation for? Did you interview with with other people?

A Because I was applying to other places. Even though. I was working there, I was not 100 percent happy.

Q. Why not?

A We had some disagreement about doing things and rotating things.

Q. What things?

A For instance,, I can give you one instance - -

Q. Sure?

A - - like antibiotic usage,. for instance, they use antibiotic two days before surgery, five days after surgery. I didn't feel this was necessary.

Among other things, I felt like when I suggested something it didn't matter whether I am right

or wrong. There was no consideration of what you say, especially if it was a new idea.

They are tied to their routine that they have been doing for 20 years. They didn't want to change anything, In fact, I am a new graduate, trained in two large medical centers and learned quite a few new things that were new,

I believed in the clinical evaluation of the patient, the thorough evaluation of the patient, the day to day basis that will cut down on a lot of tests that we do.

There is a routine, a standard routine of post op orders that quite a few of them are not applicable any more because of the change in trends in the way we do surgery.

And over the relatively short period of time that I worked with them, I realized there was no desire to look around, see how other people were doing things to try to better what we do.

And it just got to me, so I decided I am going to go on my own and I am going to take care of the patient the way I want because this is the way I believe is the best.

Q Okay. When did you start interviewing with other people?

A I don't remember. It was like a continuing process.

Q Like, for example, within a month of your coming to the practice, did you start sending out letters seeking - -

A. No. That was a continuation of what I started doing in Kansas.

Q. So, in other words, you never really stopped looking for something else is what you are saying?

A. No, I never did, because also, remember, I worked with them as an assistant.

a. Right.

A. Okay. Because at that time they were not interested in someone joining them in a full capacity of an attending surgeon.

And I accepted this job as a sort of something to do while looking for a job like the one I found in Kansas City as an attending surgeon in the full capacity with admitting privileges.

But, you know, having been there for that time, I realized probably there is work for more surgeons there. That's my evaluation,

I sort of talked to people in the hospital, different people. You know, you talk to nurses, technicians, cardiologists, and you sort of feel

them out, sort of lobbying. "Do you think there is a place - - " I didn't mention my name.

I said, "do you think the hospital will appreciate having another choice? This group has been there for 20 years.

"What do you think about another surgeon coming and being on his own or two of us?"

And everybody said that would be great because it would be nice to have another option, and competition brings out the best in everybody. So that would be very healthy to the hospital.

With this in mind and the fact that I have full confidence in myself doing what I am doing, I am very proud of my training, I elected to do that,

Q Did you receive any offers from any of the other people that you had applied with?

A. No, not yet. No, I don't remember.

Q I mean, what was the problem? You had been sending out letters for over a year and nobody else wanted to hire you? Why do you think that was?

A. You tell me, if you know.

Q. Well, I don't know.

A, I don't know either.

a. Well, had you ever been sued before?

A. No.

Q Had you passed your boards?

A I passed my general surgery board. I am board certified, and I am qualified to take the thoracic board which I am going to do very soon.

Q. When did you pass your general surgery boards?

A. Oh, God, I don't remember the date. I can provide you with the documents.

Q. Well, I mean, within the last five years?

A. Yes. I passed my general surgery board during the time I was doing my residency and training in cardiothoracic surgery so between '87 and '88.

Q. While you were in Alberta?

A. Yes.

Q You took your general surgery boards for the United States while you were in Alberta?

A. That's correct.

Q. Did you take them more than once?

A Yes. A written one.

Q. How many times?

A. Twice.

Q. How about the orals?

A The orals, I took it twice.

Q How about the written?

A The written twice and the oral twice.

Q. All right. So you failed them both the first

time?

A That's correct.

Q Did you take them at the same time that you took the Canadian test? I mean, when you took the three months off to study after the clinic, did you decide - -

A. It was after that.

Q. It was after that?

A. Yes. I just didn't have the right time to study properly during a very extensive cardiothoracic training.

Q. Okay. So you went on your own in January of '91?

A Correct.

Q. Did you incorporate?

A. Correct.

Q. What was the name of your corporation?

A Thoracic and Cardiovascular Surgery.

Q Inc.?

A. Correct.

Q. Row many employees did the corporation have?

A Just one.

Q. Yourself?

A. Well, two meaning myself and my secretary,

Q Was there any type of non-competition clause in your relationship - - I am sorry, what was the name of the corporation that you worked for before?

A Cardiovascular Surgeons Incorporated.

Q. Right. Was there any type of non-compete clause there?

A. No, none whatsoever.

Q. So the parting was amicable, there were no problems?

A. None whatsoever.

Q They were happy to see you start up on your own competing with them?

A Very happy. Well, I say this with - - this is a sarcastic remark. No. They were not happy.

Q. I thought you said competition wax good?

A Well, not everybody believes so.

Q. Okay. Did they create any problems for you?

A, Not directly,

Q. Well, I mean, what did they do? Did they try to prevent you from getting any business?

A I don't want to get into that,

Q Well, I do.

A. I don't want to get into that.

Q It doesn't really matter because I do.

A Well, you do what you want, but I don't want to get into that.

Q. Why not?

A. Because this is what we call politics, There is no legal aspect of that. Okay? I don't see any legal

implication.

Q. Really?

A. So I am not going to answer this question.

Q. Did Mrs. Weitzel die because of politics?

A. No.

Q Okay. Well, then, why don't you tell me what the problems were?

A. With whom?

Q. With your previous group,

MR. SEIBEL: You don't have ta answer any more. Chuck, you have to get on something that pertains to this case.

MR. KAMPINSKI: I think it does pertain to this case.

MR. SEIBEL: Then I am not going to let him answer that.

BY MR. KAMPINSKI:

Q. Were you having any difficulty getting business and - - I am sorry, when in January of '91 did you leave? When did you start on your own? When in January?

A. Not actually in January. If you want to get a formal date of starting, I would assume it would be the date where the corporation was initiated.

Q. What date was that?

A. Which would be March 26th, I think, but I can

provide you with the document.

Q. March 26th. Well, when did you officially leave as surgical assistant?

A January.

Q January. When in January?

A I don't remember.

Q Beginning, middle, end?

A I don't remember.

Q. Did you have any difficulty getting patients in January, February and March?

a. Well, obviously. I left a group, and I started on my own.

Q. Fine.

A. I had been in the hospital for one year. I don't know the people there for more than one year. I built up quite a reasonably good reputation through this time, during this time.

But, remember, it is a new practice, it is a surgeon that split from a group, so I am not going to expect to have to do two open hearts a day. I had to make myself available, visible and allow the people to think about me as a new surgeon who decided to start on his own.

So I was in the doctors' lounge. I spent all my time in the hospital, and people started to

refer to me, And, as you know, it is not going -- business is not going to start booming right way. It is going to take time.

And I started getting business in March, you know. The end of February actually I got my first case. It was an associate of a pacemaker which went very well and then moved to covering an angioplasty which, thank God, went very well, and then I think I started doing open heart surgery in March.

And then business started to pickup very quickly and a little bit -- well, probably a lot better than was expected by me or other people who were trying to give me sort of a a prospective outlook as to what's going to happen to me if I go on me. They said, "you are going to do fine," but it went a lot faster than anybody expected.

Q. So you are doing well now?

A I am doing very well now.

Q Good. Congratulations.

Is yours a referral business almost exclusively?

A Sub specialties, 90 percent of the work you get, probably more than -- I don't have anybody coming to my office telling me "I need bypass." A patient goes to a cardiologist physician and the cardiologist approaches

me.

Q All right. Was one of the primary referral groups for Dr. Khaddam and Beg's group Dr. Steele and Dr. Rollins?

A Yes.

Q All right. Because they had their practice at St. Vincent Charity, and I assume they used the group that did the surgery there, right?

A They have their practice at St. Vincent Charity, and what was the other part of the question.

Q. I assume if they had somebody to refer a patient to for surgery, they would use Dr. Khaddam's and Dr. Beg's group before you left, is that correct?

A That's correct.

Q. Did you discuss with Dr. Steele or Dr. Rollins, and I think there is a third one.

MR. SEIBEL: Kitchen.

Q Your leaving and your desire to do surgery on their patients?

A. As I mentioned to you before, I discussed this issue and in a very casual and informal way with quite a few cardiologists from different groups, and I did not insinuate in anyway that it was me.

I said, "what would you think if another group would start here?"

Q. I heard you, and my question is, did you have that discussion with them?

A. That's part of my answer. Not specifically with them or any one of them in specific; I discussed this with probably 80 percent of the cardiologists. I wanted to know what I was getting into roughly.

Q. Sure. After you wet went out on your own - - I assume that was in January, even though you hadn't incorporated? I mean, you were available - -

A. Well, I left the group in January, but I started in sort of February, you know. You can't say, "well, it is February 20, I went to the hospital; I grabbed the microphone and said this is Dr. Moasis. I am starting my practice."

Q. Did you send out announcements?

A. Yes. I sent out announcements, and that was in February or March, something like that. Do you want the day and the time?

Q. Do you know it?

A. No. **I don't** know it.

Q. Okay. So even if I wanted it, it wouldn't help.

MR. SEIBEL: He is just curious?

A. **I love this.**

Q. Me, too.

A. All right.

Q. Did they have a higher automobile accident rate in Syria than United States to your knowledge per capita?

MR. FULTON: What's that question?

MR. SEIBEL: You don't have to answer that. He is just playing games.

MR. KAMPINSKI: No, I am not. He told me before that they didn't have - - teach driving in high school there, and he was indicating to me that it was a better school system. I am just wondering if the proof is in the pudding.

MR. SEIBEL: Don't answer that, Dr. He is being facetious.

MR. KAMPINSKI: I am not,

MR. SEIBEL: It has nothing to do with this case, Go on to something else,

MR. KAMPINSKI: He said he was very proud of his education, Mr. Seibel.

Q. I mean, that's part of your education, isn't it?

MR. SEIBEL: Don't answer him, Dr. .

BY MR. KAMPINSKI:

Q. Under what circumstances did you first see Mrs. Weitzel?

A I was in the cath lab that day.

Q. Which day is that, Dr. ?

A. I don't remember.

Q You can look at the chart anytime you need to. The original chart is right in front of you, so feel free to look at it.

A Right. But the day I was consulted by Dr. Steele, I was in the cath lab.

Q. Had he consulted you at a11 before that day? Had he ever sent you anything? We are not talking about a long period of time from the time you went out on your own until that day.

A. I don't know. I would have to go back to my records in my office.

Q. Rad they sent you anything - -

A, Yes.

Q. Before that day?

A. To be very honest, I don't remember.

Q. Could that have been the very first case you got from them?

A I don't recall.

Q. Anyway, you were in the cath lab. Was it in the morning, the afternoon, do you remember?

A. During the day, probably early afternoon.

Q. And what were you doing in the cath lab?

A. Having coffee.

Q. Okay. Where were your offices at that time?

A. My office?

Q Yes.

A It is in the medical office building across the street.

Q Well, how long have you been there? Were you there in March of '91, or did you have an office in March of '91?

A. Yes. You know, I don't have my own office actually. I subleased, It was Dr. Madidas.

Q And did you sublease from him right from the beginning?

A No, her.

Q Her. Right from the beginning?

A. Yes.

a. So in January of '91 you would have subleased some space from her?

A, I really don't remember.

a. Well, would you have been there in March of '91?

A. Yes.

Q. And where is she located?

A She is located on 2322 East 22nd Street, Apartment 210.

Q. All right. And that's where you located your practice?

A. And still.

Q. And still, Okay. So you were having coffee in

the cath lab, and Dr. Steele happened to see you there, And what happened?

A. And he said, "I would like to consult you about a case I have."

Q. Did he come looking specifically for you, or did you just happen to be there?

A. No. I think I happened to be there. He did not look specifically for me, I don't believe so. He said "Oh, you are here. Why don't we see what you think about this case?"

Q Okay, And that ties in with what you were telling me before, that is, that you wanted to be there and be visible and be available.

A, That's correct.

a. So it paid off in this particular case because you were there, available, he asked you to take a look at the case, What did he ask you to look at?

A. He briefed me about the case.

Q What did he tell you?

A, He said, "this is a patient, 46 years old, who had a cardiae arrest and she was resuscitated outside the hospital. And apparently she had a ventricular fibrillation, more than one episode, and she is in the coronary care unit. She sustained some brain damage."

Q. He told you that?

A Yes.

Q Is he a neurologist?

A What?

Q Is he a neurologist?

A No. You kriaw Dr. Steele is a cardiologist.

Q Well, I - -

A You didn't know that?

Q He is telling you about neurological status.

A. Yes. Ne is a physician.

Q. Did you notice any brain damage when you saw her?

A. When 1 went to see the patient, she was laying in bed. Wheri I examined her, she was able ta move her extremities.

But when I tried to talk to her, she just was sort of staring. I didn't get any verbal response, but I can not say by any degree of certainty how much pathologic brain damage she had because she was - - I think she was on the ventilator.

She was trached, arid she was on Versed, And if a patient is on Versed or receives Versed in the last 24 or 48 hours, sometimes you can not evaluate their neurologic status properly.

But, however, she had a better neurologic function than what I saw because she was under the - - I an not a neurolagist. I can give you my - -

Q Neither is be, but you said he is a Dr. and so are you.

A Wait a minute. I am trying to give you, to tell you that there is some brain dysfunction, but I can not be very specific about the degree of the pathologic injury.

a. Okay. He told you that she had had a heart attack; that she was resuscitated outside of a hospital; that she had brain damage, What else did he tell you?

A. And he said that one of the doctors - - actua11y, when I looked at the X-ray, I realized I could correlate right way there was one wire - -

Q. Well, let's go slow. Was he carrying the X-rays with him when you saw him?

A. Right. He had the X-ray. And he said this is one wire, and he showed me an X-ray before, and there were two wires, foreign bodies between the iliac artery and the carotid artery on the left side.

And he said, "this happened when. one of the doctors was trying to put an arterial line in and he apparently lost the wire inside." Apparently, from the way I Looked at the wires, one of them - -

Q. Let's go slow. Are you telling me now what Dr. Steele was telling you oK are you extrapolating from what you saw?

A. No. That's exactly what he was presenting to me.

Q. Anything else? That a doctor apparently lost a wire while trying to place an arterial line. Did he tell you anything else?

A. Right. And he told me that he attempted to remove the wires in a semi-invasive technique which is through the femoral stick.

And he was successful removing one of them, but he really tried and he could not get the other out. And he said, "can you get it out?"

And at that time, we were in the cath lab, and I said, "yes, probably we can do it under local anesthesia by a small incision in the neck, "because this was in the carotid artery.

He said, "okay."

I said, "is the patient stable otherwise?"

He said, "yes, she is stable. She is in the unit. She is on the ventilator."

Now, - - then I went to see the patient - -

Q. Well, before we get there, I just want to make sure we have covered everything that happened at the cath lab.

Have you told me everything that was

discussed between you and Dr. Steele, or is there anything else that you asked him or that he told you about what had happened?

I mean, specifically, for example, he showed you the previous X-ray that had two wires in there, correct?

A Correct.

Q. Okay. So you knew that two had been put in, right, by somebody?

A. Correct.

Q. Did you ask him under what circumstances that could have happened?

A Yes.

a. What did he say?

A. He said during insertion of an arterial line,

Q That two would be put in? I mean, isn't that inconceivable to you as a physician?

A It is.

a. Well, I mean, did you say that to him?

A. I said, "how in the world did this happen?"

And he said, "we11, probably the first attempt was unsuccessful," and I don't know who was this guy, this physician who was inserting the arterial line.

You would have to ask him, but apparently he grabbed another needle and another wire and

that's what I imagine happened, and he put it and lost it in probably the same way.

Q. Well, did he tell you how long the wires had been in Mrs. Weitzel?

A Yes. Roughly it was more than a week,

Q Did he tell you why nobody new about about it?

A Obviously, it was missed one way or another.

Q I mean, did he tell you that?

A. Yes.

Q What did be say specifically?

A I don't remember.

Q. What did he say generally?

A. He said, "somehow it was overlooked."

Q Did he tell you that the resident who did this didn't tell him about it?

A. Yes, he did.

Q. Did he say that the resident tried to cover up what he had done?

MR. FULTON: Objection.

A. No. We did not say that.

Q. What did he say about the resident?

A, He said - -

Q. Did he te11 you it was a resident by the way?

A. Yes.

Q. And did he tell. you who it was?

A At that time he told me and I forgot the name.

Q Dr. Varma?

A Could be,

a. Did you know Dr. Varma?

A. Never. I don't know him at all,

Q. What did he tell you about what Dr. Varma did or didn't do after he had put these two wires in Mrs. Weitzel?

A. We didn't go over the details of this conversation. This is a situation where a cardiologist shows me an X-ray, there is a foreign body in the artery, needs to be removed.

My question is, "is the patient stable? Okay, Take an anesthetic procedure from the neck." Okay?

Q You said it was in the carotid, correct?

A Correct.

Q Could you tell that from the X-ray?

A. Oh, yes.

Q. There was no question about it. You looked at the X-ray and you knew immediately it was a foreign body?

A Yes. It was a wire in the artery.

Q. You as a cardiothoracic surgeon, I mean, if you see an X-ray like this, that is something that is going to jump out at you, isn't it?

A. I am not sure what you mean by jump out.

Q. If you look at this X-ray, you are trained to see what's on that X-ray, aren't you?

A. Oh, yes.

Q. So let's say I put that X-ray just up out of the blue and you looked at it, you would be able to pick out those guide wires pretty easily?

A Sure. I should.

Q. Any trained cardiothoracic surgeon could do that?

A I don't believe it would take a cardiothoracic surgeon to figure out there were wires in the chest. It would take much less than that.

However, sometimes a patient in an intensive care unit with all kinds of monitoring devices hanging out of their body, if there is no clinical correlation, you can look and see a lot of instruments and wires and hookups, and you have to know the patient clinically in order to interpret what you see.

It is not unusual to have a center line in the patient's neck hanging out in the junction between the vena cava and the carotid.

Q. You didn't have any trouble identifying any foreign body?

A. No.

Q And what you see, anybody appropriately trained

ought to have been able to see that same wire?

A We said that.

MR. FULTON: Did we establish the date?

MR. KAMPINSKI: I think he said the same day of his consultation, March 13th?

A. March 13th.

Q. 1991?

A. Correct.

Q. Are there other specialists - - well, I am sorry. Before I get to that. You said it was in the carotid. Was it in any other portion of the arterial system? Was it into the - -

A It extended from the left iliac fossa to the - - which tells me that it is in the iliac artery, It is higher, a little higher than the common femoral artery.

Q. Higher than the common femoral?

A. Yes.

Q. So it went from the left iliac fossa to the - -

A - - to the left neck.

Q. And where did it have to go through to get there?

A. Through the femoral artery.

Q. Through the femoral artery?

A. Right. That's where they do the arterial stick.

Q. You misunderstood me. From what you saw on the X-ray, it extended from the iliac artery, correct?

A Right.

Q To the carotid?

A Right.

Q Does it go through the femoral artery from the iliac to the carotid, or does it pass the fernoral?

A Pass the femoral artery. The point to remember is that this wire has already traveled.

Q Right. It has migrated?

A Migrated.

Q. Absolutely. It has gone from the femoral where it was put in into the iliac?

A. That's correct.

Q From the iliac until the carotid, in between that area, where does it it go through **there?**

A Aorta, abdominal and then thoracic.

Q The aorta, *is* that in the heart.

MR. FULTON: He said abdominal?

A The abdominal artery and then the thoracic aorta.

Q. Where is that, in the chest?

A Correct.

Q Is that in the heart?

A It comes out of the heart.

Q Out of the heart? Well, what part of the thoracic aorta does it go in and what part **does** it come out.

MR, SEIBEL: **Does** what, the wire?

MR. KAMPINSKI: The wire, yes

A The wire?

Q Yes.

A. As I said, it started in the left iliac artery, It goes up ta the bifurcation of the aortic artery which *is* in the lower abdomen at the level of the second-third vertebrae, lumbar vertebrae, and then it goes up, and then it passes the diaphragm or goes through the aorta as it passes through the diaphragm - -

Q. Through the heart?

A No, no. This is next to the heart now. We are not in the heart yet. We are still gaing through the aorta. Now we are in the chest above the diaphragm. Now we get to the first branch *is* the subclavian artery - -

Q. So it didn't go through the heart is what you are telling me?

A. No. Actually it would have. However, it decided to take another route which is probably more of a straight route because the aorta goes up, curves, goes back to where it comes from the heart.

It went straight up in the carotid artery, probably just - - this is more of a straight line.

Q. When did it migrate?

A. I don't know,

Q. It is clear, though, that it was put into the femoral originally, or is that clear?

A. By clinical correlation, yes. By the history, I gathered from Dr. Steele, yes.

Q. How far back did you go to look at X-rays? I mean, did you just look at the ones Dr. Steele showed you, or did you go back and look at any earlier X-rays?

A. I remember going back because we had the folder there, and we looked at several X-rays.

As I told you, there was one wire, and then I saw two and they were there for a few days. I don't remember how many days. It is very obvious on the dates of the X-rays.

Q. Did you go back far enough to a point where there were no wires?

A. Yes. There was like sort of when the patient was admitted and she had evidence of ARDS.

Q. She had ARDS when she was admitted? Is that your testimony?

A. Not right away.

Q. You see, I don't know what you are talking about when you say things like that?

A. You know, she was admitted. It was intubated. She was resuscitated.

Q. Sure.

A. She was on drugs, and in this process she developed ARDS.

Q Okay. I am sure it is important for you to tell me that. My question was, did you go back to a point in time where you observed no wires?

A. Yes.

Q Okay, That wasn't hard to answer, was it? Was it?

A No. Not at all.

a. Did you ever see the wire in the femoral artery as opposed to in the iliac artery in any of the X-rays that you looked at?

A. No. I don't recall seeing that.

a. If it had remained in the femoral artery for any period of time, would it have been easier to extract?

A. I would say yes.

a. And why would that be?

A. Because you don't have to go through any depth. It would be - - it is a very easy area to get to anatomically.

Q Are you talking now from a surgery standpoint or from the attempted procedure that Dr. Steele under took? Do you understand my question, or would it be both?

A Definitely, I do. Actually, I think from both.

Q Just because it would be easier to get to?

A. Right. You don't have to do any manipulation away from the site of engagement?

Q. I see. All right. Now, when you were presented with this case and asked by Dr. Steele - - I am sorry.

Did he ask you actually if you would perform surgery, or was he hypothetically asking you if surgery should be performed or could be performed? How was it presented to you? Did he say, "I want you to do this, "or did he say, "what can be done?"

A. That's exactly right.

a. Which one?

A. He said ,"what did be done from your view, the fact now that I tried and I was able to retrieve one wire, but I was not able to retrieve the other.?"

Q When did he see you in relation to his attempt to get or when he got the one out and he attempted to get the other one out? Was it within minutes? Was it hours?

How long prior to seeing you had he been doing the procedure on Mrs. Weitzel, do you know?

A. He or me?

a. No, him, Dr. Steele?

A, I don't know. I don't remember. But it was within 24 hours.

a. Okay. Did you inquire of him as to whether or not he had discussed this with any invasive radiologists or

whether he had discussed this with Dr. Khaddam or Dr. Kitchen?

A. No.

Q. Or Dr. Rollins?

A. No.

Q. Well, do invasive cardiologists - - I am sorry, invasive radiologists do these kinds of procedures, angiographic procedures?

A. Some of them are qualified to do that and expert in doing that, and, yes, they do it.

Q. Does St. Vincent have such experts?

MR. WARNER: Objection.

A. I can not - - I am not sure whether I can answer this question correctly or let me rephrase that.

Let me give you my opinion of that.

Q. Sure.

A. Being a surgeon in St. Vincent Charity hospital.

Q. Absolutely.

A. The invasive cardiologists that we have, Dr. Steele specifically among one of them, are very competent and qualified invasive cardiologists. And they do insert cardiac catheters, pacemakers, right and left heart catheterizations on a daily basis.

Even though we do have an invasive radiologist, which I don't doubt his qualifications and

expertis , I don't have any reason to think h would b more skilled to do this job than any of the invasive cardiologists, especially regarding removal of such a wire from such an anatomical location.

Q When is the last time you got a referral from an invasive radiologist?

A Invasive radiologist?

Q. Yes.

A. I am not sure. It doesn't work - - invasive radiologist - -

Q. Have you ever gotten a referral from an invasive radiologist?

A No. I don't remember. They don't refer patients to us. We refer patients to them. This is not the way it works.

Q I understand. Dr. Steele came to you seeking a consultation, is that correct?

A. That's correct,

Q When did you write up your consult report?

A The date is written.

Q What time?

A Use a time here but - -

Q When do you think you wrote it?

A Early afternoon.

Q. Read it.

A. "46 year old white female. Status post myocardial infarction with cardiac arrest and CPR, developed ARDS, pneumonia, brain anoxia, is being treated for all these conditions in CCU, remaining of" I think it should be chest X-ray, remaining of what looked like a broken guide wire. Still in iliac artery, aorta and up in the neck. Dr. Steele was successful taking the other piece out in the neck. We can't be sure at this point as to in which vessel does it lie," plus the fact that - -

Q. Just read it the way it is written.

A "that," should be "that, with a tracheostomy close by create a definite risk of infection. At this point, the best and safeest approach would be a retroperitoneal approach via a flank incision and a direct approach to the left iliac vessel."

Q Left iliac vessel?

A. "Left iliac vessel, Will schedule to do that in OR tomorrow under general anesthesia."

Q. By the way, had you ever had any contact with this patient before this consult at all?

A. No.

Q. All right. You didn't even know she was in the hospital, right?

A. No.

Q You told me a few minutes ago that you told Dr.

Steeles that you were going to do it under local and go in through the neck?

A. Correct.

Q What changed your mind?

A The patient had a tracheostomy.

Q You didn't know that?

A At the time, no,

Q Well,. you looked at the X-ray. You saw the trach in the X-ray, didn't you, especially if you saw the X-ray where you removed the one wire.

I mean the trach is there. You are a trained cardiothoracic surgeon. You know what it looks like?

A. Probably, I saw it but at that moment sometimes you are presented with a case, and then you make a preliminary decision.

Q. Okay.

A. And then you go and you look at the patient and you collect the information and you come up with a better judgment.

Q Better judgment?

A Okay.

a. That's when you went and looked at the patient?

A. Right.

Q. And your better judgment was to subject to her to

a general anesthesia. Was that your better judgment?

A Yes.

Q And that was based upon the existence of a trach?

A. That's correct,

Q You knew that she was status post MI?

A Yes.

a. Did you tell Dr. Steele of your change in plan?

A Definitely.

Q When?

A. When I went and I saw the patient.

Q Did he go with you?

A I don't remember, but I definitely talked to him.

a. How did you talk to him?

A. I came to the cath lab and I said, "Dr. Steele, I don't think it is a good idea to make another incisionincision in the neck which would probably be within one inch of the trach incision which is invariably, if not infected cauterized, and this is supposedly a clean incision, clean surgery."

So I didn't want to risk to risk causing this patient any more problem.

Q We11, what kind of problems does a patient have post MI having under gone surgery within a month, what potential problems does she have from that?

A It is a higher risk to under go hemodynamic

instability.

Q Putting her under?

A Right. However, this is particularly when you are embarking on a procedure that includes the chest or upper abdomen, and it is proportional to the magnitude of the surgical procedure you are going to be embarking on.

Q Dr., Dr. The anesthesia is one of the potential precipitators of the risk, is that correct - -

A. If during the induction of anesthesia there is hypotension. If the induction of anesthesia induces or causes hypotension, this will increase the risk of myocardial infarction after one month of a previous episode of previous myocardial infarction.

a. And what publication tells you that's where the risk occurs with the induction as opposed to being under it for a number of hours? Could you cite me to a source.

MR. SEIBEL: First of all, she was not under for a couple of hours.

BY MR. KAMPINSKI:

Q Go ahead. Cite me to a source if you remember?

A. I don't remember a source, but I can get you a source if you want.

Q Well, I mean, what do you base that - -

A. My own experience.

Q. You operate on a lot of post MI: patients?

A Yes.

Q Electively?

A Yes.

Q Under what circumstances do you do surgeries post MI electively?

A We wait for a week until, and then we operate operate. They run a higher risk, but we have to do it before they infarc again,

Q. I see. And you consider that elective?

A. I would say semi-elective.

Q Semi-elective. Was this elective surgery or semi-elective surgery, or how would you consider that?

A I would say semi-elective surgery toward urgent, not emergency surgery.

Q. I am asking about this particular surgery that you did on Mrs. Weitzel.

A Yes.

a. Characterize it %or me.

A It is an urgency.

Q Why?

A. Because this patient had a massive myocardial infarc with multiple episodes of ventricular fibrillation indicating severity of the coronary cardiac disease and with her age at 46, she carries a very significant risk of having associated significant previous vascular

diseases including carotid, including iliac and femoral.

This wire was inserted through the femoral artery and already migrated to the carotid artery which carries a very high risk of, if not stenotic enough to cause symptoms before, it will definitely have an atherosclerotic plaque against which this wire would be eroding at all times, and at any minute if the patient is moved, this wire is going to erode.

Q When you say erode, what do you mean?

A Erode through the plaque, and that will cause breaking away of fragments of this plaque and migrating only toward the brain.

Besides the fact that the wire has already migrated upward and it was going through the skull toward the cerebral arteries, this is something the patient didn't need at this point.

Besides, the patient was not on any anticoagulation, and this is a metallic foreign body laying in the blood stream with no protection against coagulation, so it is very susceptible to form clots around it.

Q Well, you could give her Heparin, couldn't you?

A Yes, we could. However, as far as I know, neurologists are reluctant to put the patient on any form of anticoagulation when they sustain a cerebral vascular

accident. They are very cautious.

Q. Who was the neurologist in this case?

A. I don't recall. I think Dr. Syed.

Q. Did you have any discussions with him?

A. No.

Q. Well, whoever the neurologist was, did you talk to him?

A. No.

Q. I am sorry. I interrupted you. You were telling me the reason that this was urgent surgery. Had you completed your reasoning?

A. Yes. I said it was a foreign body, migrated, it can clot, and it can erode into the atherosclerotic plaque.

Q. Had you done any of those things?

A. I don't know. The potential is great.

Q. I assume you looked at the chart, didn't you?

A. I looked at the chart. The patient had sustained some degree already of brain anoxia. How would we know that she didn't have any further brain damage by any further embolization from the effect of the wire.

Q. So you think that may have happened?

A. It could have happened. There is no way we can prove it.

Q. Well, I mean is - -

A In my opinion.

Q In your opinion that probably happened?

A, It could" There was a chance,

Q. Well, you understand, I assume, and maybe you don't, probability is defined legally as 51 percent. Would you say there was a 51 percent chance - -

A I can not give you this.

Q 1 percent, 80 percent? Do we know?

A. With the patient having previous anoxic brain damage, it would be almost impossible to attribute what degree of the brain damage was caused by the anoxic event and what degree was caused by further damage caused by embolization because the wire was there.

$2. Did she die of brain damage?

A, I read the report from the coroner's office, and it does not indicate that.

Q. What did she die of?

A She died apparently of massive myocardial infarction.

Q. And how did that occur?

A. It occurred after an episode of ventricular fibrillation.

Q Well, how did that occur?

A. I wasn't there when it occurred.

Q. Where were you?

A I was at home.

Q Doing what?

A You don't want to know

MR. SEIBEL: 1 o'clock in the morning?

BY MR. KAMPINSKI:

Q Yes, I do. I am just a curious kind of guy.

A Very personal.

Q. Did Dr. Steele agree to this proposed change in terms of how you were going to do the procedure?

A Yes, he did.

Q. Re didn't discuss with you any increased risks in subjecting her to anesthesia?

A. We both know that.

Q. Well, I mean, did you tell him this would be a simple, easy procedure?

A Yes.

Q. And when I say this, I mean the new procedure that you were going to do?

A, The approach through the iliac artery.

Q Did you tell him how long she would be anesthetized?

A. No. I don't remember telling him that, but I knew it was going to take somewhere between a a half hour and hour. I knew it was something very straight forward

Q Okay. Did he show you the wire that had been

removed?

MR. SEIBEL: That he had removed, that Dr. Steele had removed?

MR. KAMPINSKI: Right. That Dr. Steele removed.

A You know, I honestly don't remember.

Q Have you seen it since at any time?

A. That he removed?

Q. Yes.

A. No.

Q Okay. When did you do your surgery? Was it on the 14th, the next day?

A. Correct, as scheduled.

Q Well, when did you schedule it?

A. I mentioned in my consult sheet that it would be scheduled for next day.

Q. I mean morning, afternoon? When did you set it for'? Were you real busy, or did you have a lot of time?

A. I just will give you the time. 2:15.

a. P.m?

A. Yes.

Q. Did you have any other procedures that you did that day?

A. I would have to check my file.

Q. What file?

A. My computer at the office.

Q. Your computer would tell you what procedures you had on March 14th, 1991?

A. Could be. I don't know. I would have to ask my secretary,

Q Well, wait a minute. First you said you would have to check your computer.

A. I would have to check with the secretary so she could check the computer or the file, what have you, go back, dig and see whether there is anything I did that day or not. I don't remember.

Q. My question is, why did you have to wait until 2 o'clock in the afternoon? Was there any particular reason?

A. I don't know. I don't remember.

Q. You know, your attorney a minute ago corrected me or tried to correct me about how long she was under anesthesia. Do you want to look at the anesthesia record, Dr.?

A Yes.

Q Now long was she under anesthesia. Where it says anesthesia time, 2:15 p.m to 4:25, 2 hours and 10 minutes?

A. No, no, no.

a. No, no, no?

A You have to look at incision time. I thought you knew about this.

Q. No. I am just trying to learn.

A You have to look at the incision time and then closure.

Q. You mean you don't put her under anesthesia before you cut her?

A That's right.

Q You cut her first os - -

A. That's right. You see, this - -

a. What's right?

A. This patient had a trach, right.

a. Yes.

A. It takes 60 seconds to put her to sleep.

Q I am listening. Go ahead.

A. All right.

a. Go ahead.

A So once you induce her it takes about five minutes to prepare and to drape and make your incision.

Q I am listening. Go ahead, I want ta know how long she was under anesthesia. Do you want to answer that?

A. She was under anesthesia for about an hour.

a. Could you show me where that is in the record.

(Pause.)

Q You can answer now, Dr. ?

A I am trying to see.

Q. Sure.

A It says here, time 2:15. But I don't know whether they meant 2:15 is the time of induction or the time of the patient getting into the room.

Okay? I can not be sure. If you know anything - - I mean, if you notice anything that will indicate anything specific, let me know.

Q. Sure, I already told you. Anesthesia time, start 2:15; stop 4:25. Total 2 hours and 10 minutes. Did I read that correctly?

A. I see where you are looking at now.

Q Does that help you?

A Yes. It helps me very much, That's anesthesia time, then.

Q. Well, why did it take so long?

MR. SEIBEL: The surgery?

MR. KAMPINSKI: Sure.

MR. SEIBEL: Why don't you explain to him how long the surgery took?

A. The surgery took about an hour,

Q. Why did it take an hour?

A. Why did it take an hour?

Q. I thought you told me a minute ago you told Dr,

Steele it would be easy, quick, I think you said a half hour?

A Right.

Q So why did it take an hour?

A. We made an incision. We went in and got to the iliac artery in about 10 to 15 minutes. Now, when I looked at the X-rays and I know roughly where the wire is, I thought once I get to the artery, I will feel the artery, and if the wire is inside there, I will be able to feel it.

So all I have to do is put a clamp up,. clamp below, open the artery and pull the wire out.

But when I got to the artery, I found a piece of rock, completely and circumferntially calcified completely to the point that I was not able to oppose the two walls against each other, and I was not able to feel the wire at all.

At this point, I didn't want to open the artery blindly or do anything blindly, and I put the marker there and I called for X-ray.

That's where we had to wait until an X-ray technician, fluoroscopy machine come to the room, put the marker there, shoot an X-ray, see where the marker is related to the wire and make sure that the wire is, indeed, passing through the artery at this same

point.

So if I open the artery, in other words, I will be able to find the wire and take it out,

Q. Where did you do this surgery?

A. In the operating room.

Q And where is that from the CCU?

A The operating room is on the third floor. The CCU is on the second floor.

Q. And how was she brought up there?

A. On the bed,

Q Was she on a ventilator?

A. She was bagged.

Q. She was bagged?

A Usually when you transfer a patient, you have 100 percent oxygen and somebody bags them. That's easier and safeer.

a. Do you have X-ray capabilities in the operating room?

A. That's right.

a. You didn't have them standing by while you were doing this operation on the artery?

A, Well - -

Q. You didn't have her under fluoroscopy while you were doing this?

A No.

Q Why not?

A. Because I didn't expect since I am approaching the artery directly, I didn't think that her artery was so calcified, completely circumferentially to the point that I am not going to be able to feel the wire inside, I didn't expect that.

Q Is that in your note anywhere?

A Do you mean the operative note?

a. Yes. You are referring now to your dictated note?

MR. SEIBEL: Well, there are several.

Q Did you do a written note?

A. Yes. This is the written note. The written note is not, you know, a detailed note.

Q. It is not?

A. It is not. It gives you outlines of what you did and doesn't go through the details of the operative procedure per se.

Q But your dictated note did?

A. Pardon me?

a. Your dictated note did?

A Right.

a. And where do you mention this rock?

A. "The retroperitoneum was reached by pulling the retroperitoneum up. We reached the left iliac fossa where the iliac artery was visualized. After isolation

of the iliac artery, a marker was placed next to the exposed area." Well, it was not dictated this way.

Q. Well, wait a minute, wait a minute, Dr. Are you making this up as you go along?

A. No, I am not. 1 am under oath.

Q. It is a good thing that somebody remembers. You just told me that this was, when you say this, that is, your written note Wasn't detailed, I assumed you meant that because your dictated note was, right?

A Right.

a. All right. And you have just told us under oath, and I am glad you reminded me, sometimes I forget based on what I hear, that you came across this rock that covered the entire circumference of the artery?

A That's correct.

Q Very important finding?

A. That's correct.

Q And you can't see that on X-ray, so you were not ready for it?

A. No.

Q So I assume you put that in your dictated note?

A. Right, I - -

a. It is not there, is it?

A. Right, This is dictated by Dr. Parvez.

Q. It is signed by *you?*

A Well, it is an overlook,

Q An overlook?

A Could be an overlook. But if you use your common sense and what I - -

Q. Are you saying I am not.

MR. SEIBEL: Et is a hypothetical question, hypothetical answer.

A If you use you are common sense, that means you do have common sense, which means that you have to use it, and you read, and from what I described to you, then I didn't need to waist time putting the marker.

E mean, if you bring somebody from an elementary school and make him read this and then explain to him the event, he will realize there was reason we put the marker, especially when we are looking at the artery and feeling it.

And the only reason that you would gut the marker is because you didn't feel the wire there. So you don't want to be lost. You put the marker and under fluoroscopy, seeing it on TV, E saw the wire passing by the needle, and I took the wire out.

a. Did you make a film of fluoroscopy?

A. No.

Q. Why not?

A Why do I have to do that?

Q. I am just wondering why you didn't?

A. You take a fluoroscopy film, it is important for post op documentation. We know the wire is out. What am I going to take the X-ray for?

Q. Okay. Well, so you determined that that - - and by the way, where did you put the marker, right where the rock was? Is that where you put the marker?

A There was no rock there. what do you mean the rock?

Q. You are the one that called it a rock?

A. I said the artery felt very rocky. I am not sure whether you will understand, calcified.

Q You said there was a rock - -

A. No. I said - -

Q. Covering the entire circumference of the artery, That's what you testified?

A I said rocky, meaning hard, calcified.

a. You said it blocked the entire circumference of the artery, How was there blood flow getting through there?

A. Why is it blocked? I said it is calcified circumferentially. So cool down.

MR. KAMPINSKI: Let's take a minute break to go to the restroom.

(Recess had.)

BY MR. KAMPINSKI:

Q Who assisted you in this simple easy surgery?

a. Dr. Parvez and Mr. Weakland.

Q. Mr. Weakland, I assume, is not a director; a surgical assistant?

A Correct.

Q. And Dr. Parvez, where did you find him?

A We is a general surgeon and he is one of the surgeon assistants that was working in the hospital with the Phanandra, Vaidya, Seklon and Kalipue group.

Q. Did you have the ability to subcontract them to assist you?

A. No, no. Those guys basically work for a hospital, too. They are supposed to assist any cardiothoracic surgeon who comes to the hospital.

MR. COYNE: Show an objection.

Q They had a contract with the hospital to do that

MR. COYNE: Show an objection.

A Yes.

Q So when you needed to do surgery, they would be -- I mean, it would be part of their job to assist you even though you were not with the group any more?

A. That's correct. The hospital, as far as I know, pays there malpractice, their health. insurance -- KOEUPB

MR. COYNE: Show an objection.

Q Go ahead.

MR. SEIBEL: He is testifying for everybody.

MR. FULTON: I am objecting to them paying the malpractice and so forth. I am noting an objection?

A. But, you know, they are suppased to work for any cardiothoracic surgeon who works at the hospital.

Q. Where is he now?

A, I don't know,

Q. And Mr. Weakland, where did you find him at?

A He works also for the cardiothoracic surgery department in Charity hospital.

Q. He was a hospital employee?

A Yes, he is.

a. What did he do in the surgery?

A We retracts all the suction, helps with the prep,

Q Who was the anesthesiologist?

A. The anesthesiologist? I would have to look.

Q. Look at the anesthesia record, That might help, Up at the top it has line and Sevchet or Sevcheck.

MR. SEIBEL: One is the nurse anesthetist.

Q. Who is who? Is Linn the anesthesiologist?

A. Lyon, eldona Lyon.

Q And who is the other person, Sevcheck?

A Yes, could be. But this is - - I think this is a nurse anesthetist, yes.

Q. And it also shows under surgeon, it has Dr. Bacue, who is he?

MR. SEIBEL: We are looking at a different page than you. We are looking at the handwritten operative nurse's notes.

MR. KAMPINSKI: It is in the anesthesia notes.

MR. SEIBEL: Can you show us what you are looking at?

MR. KAMPINSKP: The anesthesia record. Surgeon, Moasis, Bacue, Weakland and Parvez.

Q. Who is Bacue? Where did he come from?

A I never heard this name before.

Q Was there a Bacue in the operating room?

A **No.**

a. Well - -

A Baker. Baker,

a. Who is he?

A That's another surgical assistant.

Q. Well, how many do you need for this operation?

A. Okay, Sometimes it might be the change of shift at that time. And if it is the change of shift, if one

of them - - it is like 3:30, they all go home.

Q. Even if the operation is right in the middle, is that right?

A That's right.

Q Time to go?

A. That's right. I laugh at that everyday myself,

Q That is pretty funny.

A Yes.

Q. What happened to the blood pressure at 3:30?

A Oh, do you mean because Mr. Baker left, the patient dropped the pressure?

Q I don't know. Look at the anesthesia record.

A All right. The blood pressure at 3:30.

Q Well, from 3 to 3:30, what happened? Anything?

A It is within the range of somewhere between 140 to 160 systolic.

Q. When the procedure started it was what, up around 170?

A Right.

Q. Is that good?

A. No. It is not very good, but it is not unusual.

Q It is not unusual for what? For someone who had had an MI?

A. No, for anyone.

Q For anyone. All right.

What did you tell me before you would be concern d with in terms of the induction of anesthesia for post MI patient, under what circumstances?

A If they have a hypotensive episode.

Q In other words rise i.n blood pressure?

A No.

Q. Drop?

A. Fall in the blood pressure.

Q Wow much of a drop would you be concerned?

A. If it dropped below, systolic of 80 or90, systolic,

Q What about the diastolic, that wouldn't concern you?

A. The diastolic, it depends upon the situation, The diastolic reflects peripheral vascular resistance, and it would concern me, too, So we don't like to see either one drop.

Q. Why would a drop be of concern? What is it that would cause you to be concerned about a drop in the blood pressure?

May be that's not a fair question. When I say "you, "I guess what it is i s Ghat you believe that the authorities say in terms of this being the danger?

A. When you have a patient with compromised coronary circulation, meaning that the lumen or the inside opening

of the artery is narrowed, they are more susceptible to double ischemia or infarc if the pressure drops because the resistance in the artery is already high. for obvious reasons, which is the compromised lumen.

You have to sustain a good pressure in order to overcome this resistance and maintain the circulation beyond the blockage.

Q Okay. So a drop in the blood pressure, then, is an. indication to you as a surgeon that there is a potential problem in what might even be a normal blood pressure - -

A Yes.

R. - - getting through a compromised arterial system?

A. Yes.

Q. And which you testified she had by virtue of your inability to feel the wire due to all her calcifications?

A. She did,

Q Sure. Well, there was a drop in the blood pressure, wasn't there, from the time that you started the surgery?

A. This is not a significant drop by any means.

Q. 170 to 140 is not significant?

A Right, no. You see, the? 170 is the abnormal, not the 140.

R. Okay. So you have it normal, right?

A. Right. I would say for 46 years old, you know, 140 is a very acceptable reasonable blood pressure to maintain circulation.

Q. Well, weren't you concerned about operating on somebody with a blood pressure of 170 over 100?

A. But, as I told you, she had hypertension but was controlled, blood pressure was controlled.

Q. Controlled by what?

Q. 170 over 100 was how she was being controlled? That means she was okay?

A. No, no, no, I said the patient when they come to the OR and are stimulated, they have a transient increase in their blood pressure that comes back to normal once they are induced.

Q Is that because she was worried about undergoing the surgery?

A Could be.

Q Could be. Well, she would have to be cognizant to be aware of that, wouldn't she?

A I can't answer that.

Q. Who did you get a consent from?

A, The family.

Q What family?

A The husband.

Q Did you talk to him?

A. Yes.

Q What did you tell him?

A I told him exactly what I said before; that this wire should come out.

Q Did you tell him why?

A Yes, I did.

Q What did you tell him?

A. I told him that this - - that's exactly what I mentioned, that there is a danger of leaving the wire there.

Q. Did you tell him how the wire got in?

A. No. I don't remember going through that, From what I gathered, the husband looked like he was fairly well updated and knew what I was referring to.

Q. How did you gather that, Dr.?

A. Through the conversation.

Q. What did he say? We said yeah?

A. Like, for instance - -

Q. Wait a minute. Did he say, "yeah, I know a Dr. here put two guide wires in my wife and I would love to have a Dr. take it out"?

a. I don't recall the details of the conversation. What I am sure I did, I told him who I am, what am I going to do and why.

Q Did you tell him the dangers of doing an operation

an somebody post MI?

A Absolutely.

Q Good thing. Did you tell him that a resident - -

A. No. What was I going to say?

Q. That the resident did insert the wire and lost it?

A. No.

Q. Did you think that that was important far his decision making process in terms of who would remove the wire?

A No.

Q Well, did it ever occur to you that maybe if he felt that somebody t that hospital had done it that maybe he wouldn't want somebody at that hospital to have removed it? Did that occur to you?

A He would have told me that.

Q I see.

A. Because he was very upset and Dr. Steele told me, now refreshing my memory, that the family knew everything.

Q. Dr. Steele told you that the family knew everything?

A. Yes, from what I recall now.

a. All sight, You removed the wire. Is that correct?

A That's correct,

Q. After about an hour into the surgery?

A. No. After about a half hour to 35 minutes.

Q. Okay. Then how long did it take you to clos her?

A. About 20 minutes.

Q. So why was she under anesthesia for two hours and ten minutes?

MR. SEIBEL: Chuck, just for the record, you are assuming that this anesthesia time means the time she was under anesthesia.

MR. KAMPINSKI: If you want to point something else out to me. I would be happy to look at it.

MR. SEIBEL: We don't know if these mean - -

MR. KAMPINSKI: It says anesthesia time.

MR. SEIBEL: But you are assuming that that means the time she was under,

MR. KAMPINSKI: If you want white to be black, black to be white,. you make up whatever you want.

A No, no. We are not going to make up anything. I will make it easy for you. I am definitely sure that line is going to be involved. I don't know. I suppose she should be asked. She should be the one who would give you the best answer.

a. Weren't you there?

A I was there.

Q You tell me all these things that you remember that aren't in the record, What about things that are in the record? Why don't you remember them? At least we have some idea they happened?

A. Oh, you do?

Q. Well, it says it.

A. Well, that's right. Let me tell you, I told you exactly what E did and bow long it took me.

a. All right. So why was she under anesthesia for two hours and ten minutes, Dr.?

A I don't that. I don't know.

Q If your procedure took as long as you told me it just took, were they just practicing on her for another hour?

A. That's for them to answer.

a. Should she have been under anesthesia for another hour?

A I don't believe so.

Q Why not? Because of the the risks?

A. Pardon me?

Q. Because of the the risk?

A. There is a risk for being under anesthesia no matter what you are doing,

Q. Sa under no circumstances should she have been

under anesthesia for an hour in addition to the operation?

A. You are still assuming she was anesthetized for two hours, and you don't know that. And I told you to make it easy for you ask the anesthesia person.

Q. I am asking you?

A. I don't know.

Q. You were there?

A. I was there.

Q. Are you sure you were there?

A. Of course I was there,

Q. You had a good look at your patient? You saw her?

A. She was covered with drapes,

Q. Well, did you go into the recovery room with her?

A. Of course,

Q. After the surgery?

A. Yes.

Q And when did you do that?

A. After surgery. I don't remember whether she went to the recovery room or the coronary care unit directly.

Q. Why don't you remember?

A. I don't remember.

Q What was her condition?

A. Pardon me?

Q. What was her condition?

A Stable.

Q Good condition?

A. Absolutely.

Q Terrific. Did she open her eyes on command?

A. She was not, as I told you, I was not sure about the degree of the brain damage.

Q. Did she open her eyes on command? Yes or no?

A. I don't remember.

Q What kind of a wire did you remove from her?

A. It is a guide wire.

Q How long was it?

A Probably between 15, 20 inches probably, probably longer than that. I didn't measure it, but it was, I would say, that long.

Q But, you see, he can't write down how long that was?

A. Right. I didn't measure it.

Q. All right.

Q. I have just handed you a ruler which is 12 inches long. Would it be longer than that?

A Yes.

Q Would it be somewhere - - would it be about 18 inches long to your recollection?

A. Probably, if I recall, it would be 1 and a-half.

Q. One and a-half would be 18 inches?

A Probably one and a-half the length of this ruler.
Q Okay. All right. Was it intact?
A Yes.
Q It was not broken?
A I couldn't tell that. I mean, I couldn't be sure, but it didn't look like it was broken.
Q All right. Was it frayed in anyway that you could tell?
A Well - -
Q Do you know what I mean by frayed?
A No. It was fairly intact.
Q What did you do with it?
A I just passed it on to go to pathology.
Q I mean, who did you give it to?
A To the nurse.
Q And you told her to send it to pathology?
A Absolutely.
Q For what purpose?
A It has to be documented.
Q Documented?
A. It has to be examined, of course.
Q By whom?
A By the pathologist.
Q Okay. Go ahead.
A And kept on file in the pathology lab for record

keeping

Q Well, did Dr. Steele tell you what he wanted done with it?

A No.

Q. Did you need to have it cultured to determine whether or not it was a site of infection?

A. No.

Q. Why not?

A It was in the arterial system, and there was no infection in or around the artery whatsoever.

When I took the wire out, I didn't find any evidence of infection whatsoever in or around the artery.

Q Is a foreign body a potential site for infection?

A. Yes, but in the venous system.

Q Does blood go through the arterial system?

A. Of course.

Q It does. Okay. Good,

Was Mrs. Weitzel septic at all?

A. Yes.

Q What does that mean when somebody is septic?

A. It means that they have a severe infection somewhere in their body, and this severe infection got to the point where it caused problems in other organs due to either a direct effect on these other organs or due to an

effect on the peripheral vascular resistance which caused collapse and lack of circulation to these organs.

Q How does it get from one organs to the other, these infections?

A. With the blood.

Q. I see. Does that blood circulate throughout the body?

A. Yes, right.

Q. Does it go through the arterial system?

A. That's correct.

Q So it would go past these guide wires if she was septic?

A. That's right,

Q. And getting back to an earlier question, I think you said that a foreign body can be a situs for infection.

MR. FULTON: Re said the venous system.

MR. KAMPINSKI: I heard his answer.

A Yes, but it is much Less likely.

Q. But it is not likely to have a foreign body in the arterial system, is it?

A But the chances are rare.

Q. To have a foreign body in the arterial system?

A. To have an infection happen around a wire in an arterial system.

Q. How many wires do you put into a person's system and leave them there? A lot of them?

A. Go dig in the surgery literature and find out.

Q. You are the guy that is the Dr., have all this education that you are proud of.

A You bet.

Q. Is that what this guide wire was a complication?

A It was a complication.

Q A foreseeable one?

a. No. I wouldn't say foreseeable. Complications are not foreseeable. They are probably calculated risks, and there are figures, statistics that give you a percentage.

And to insert a line in the femoral artery and lose a wire there, I would say it happens probably one in a thousand.

Q. But if it happens, you know it happens?

A. Right.

Q. It is not something that you would be unaware of, correct?

A I would say so. I can agree with you.

Q So that not telling sornebady would not be an accident; it would be intentional, would it.

MR. FWLTON: Objection,

A However, it depends upon how the party who

inserted the wire felt about it.

Q. Well, wait a minute. You have got it in your hand, right, the guide wire?

A. Right.

Q. So if you don't pull it out, you know it is in?

A. Yes.

Q. So that's not something you wouldn't know, right?

A. Under normal circumstances, that's right,

Q Under any circumstances.

MR. FULTON: Those answers may be painful but he said - -

BY MR. KAMPINSKI:

Q. Correct.

MR. SEIBEL: Correct what.

Q. Under any circumstances? I mean if you are putting a line into somebody and have a hold of the guide wires and you pull it out, you know it is inside of her?

A If it was me, that's how I would feel.

Q Any doctor, any competent doctor?

A. If it happened to me, I definitely should know what I am doing and where the wire is.

Q. And the failure to let somebody know afterwards of a wire that was in somebody, how would you characterize that?

MR. FULTON: Objection,

Q Go ahead.

A I don't know how this person felt at that time.

Q What's the difference? I mean, what about the patient?

A Absolutely. I agree with you.

Q Isn't that reckless disregard for the rights and safety of the patient, Dr.?

MR. FULTON: Objection. I have an objection,

MR. COYNE: Objection.

A Carry on.

Q. What's the answer?

MR. SEIBEL: You are allowed to answer. You can answer that. Read it back.

(Question read as follows:)

Q "Isn't that reckless disregard for the rights and safety of the patient, Dr.?"

MR. SEIBEL: What is reckless disregard.

BY MR. KAMPINSKI:

Q. Leaving the guide wires in and not telling anybody about it.

MR. FULTON: Objection.

NR. COYNE: Objection.

MS. BITTENCE: Join it.

MR. SEIBEL: Go ahead,

A. Knowingly?

Q. Yes, sir.

A. I agree with you 100 percent. If I insert a wire and the wire got lost in the artery and I intentionally didn't tell somebody who is more experienced to try to take care of the problem, I agree with you.

Q. Well, does the fact that there were two wires in there, I mean does that confirm that whoever put the first one in new he lost one and put in another one?

MR. FULTON: Objection.

A. He has to answer this.

Q. I am asking you for somebody who you are about to do surgery on.

MR. FULTON: I have an objection.

A. He has to answer this.

Q. Well, that may be. But until your attorney tells you not to answer, so do you.

MR. FULTON: If he did answer.

MR. KAMPINSKI: No, he didn't.

MR. FULTON: I thought he did.

Q. Doesn't that tell you - -

A. I think you are waisting your time and everybody else's time.

MR. SEIBEL: Dr. Moasis, from what you know, not from what you can speculate, but from what you

know, answer his question.

A I answered it already.

MR. FULTON: Objection.

A Excuse me. I answered already. What's the difference whether it is one wire or two wires or a hundred wires? I gave you the answer. Just pay attention.

Q I am trying. Sometimes I am slow.

A It is slow.

a. I am just struggling here, Dr.

A. I know. God. I don't envy you, I gave you the answer.

Q. What time did you write your written operative note?

A After I finished.

Q. What time?

A. Around 4 o'clock.

Q. Did you have any more notes after that note?

A No.

Q. Well, if you would Look at the chart, Dr., I mean, did anybody write any more notes after your surgery?

MR. SEIBEL: Do you mean in the whole entire chart?

MR. KAMPINSKI: I mean on the 14th.

MR. SEIBEL: Any other doctors?

MR. KAMPINSKI: Yes. That would be good for a start?

A I see from when I wrote my note until 2 a.m of the 15th, which is about 10 hours later, no notes.

BY MR. KAMPINSKI:

Q. Well, I mean, who was taking care of her?

A She was transferred back to the coronary care unit to the original service, the original primary service.

Q. Well, does your care of her stop when she is wheeled out of the operating room?

A, No, not whatsoever.

Q. Is it your service that continues to take care of her?

A. Well, in a way, yes, we do in regard to the operative procedure, the care for the incision, taking out of the stitches, making sure she is okay as far as the surgical aspects.

Q. How was she then from 4:25 p.m on March 14th until 2 a.m on March 15th?

A. When she left the operating room, she was stable, heart pressure didn't take any acute changes whatsoever, and from that time, I didn't know anything till I came the next morning. And when I went to make rounds, I was told that she passed away.

Q. What time did you go home that day?

A I usually go around six or seven clock, six probably.

Q How much did you bill for your procedure?

A. I don't remember.

a. When is the last time you looked at your bills?

A At what?

Q when is the last time you looked at your billing?

MR. SEIBEL: For this patient?

MR. KAMPINSKI: Yes, this patient.

A. This patient, I don't remember at all.

a. Today?

A No.

a. Yesterday?

A No.

Q Last week?

A **No.**

MR. KAMPINSKI: Could we have a copy of the bill?

MR. SEIBEL: That is an affirmative nod.

MR. KAMPINSKI: So that's a yes, you will give me a copy of his billings?

MR. SEIBEL: If they exist and we can find them, we will get them to you?

A. The billing?

BY MR. KAMPINSKI:

Q Yes, how you get paid, earn a living. You have those records, don't you?

A Yes.

Q Good.

MR. SEIBEL: I thought they have been provided to you, Chuck, in all honesty.

MR. KAMPINSKI: I have been asking for billings from everybody, and nobody wants to give me any. Their must be a secret here.

MR. SEIBEL: We will talk about it later.

MR. KAMPINSKI: Do you have them here?

MR. SEIBEL: No. We don't have them here.

BY MR. KAMPINSKI:

Q. You don't remember what time you went home?

A. No.

Q Do you have any recollection of seeing her in the cardiac intensive care unit?

A. I really don't remember.

Q. Did you talk to Dr. Steele after the surgery?

A. Yes.

Q. What did you tell him?

A. That the procedure was uneventful and we removed the wire. I told him that we had to use fluoroscopy,

something like that. But I told him the procedure was uneventful, and the wire was out.

Q. Did you tell him that it took two hours?

A, NO.

Q. Why not?

A Because it took me one hour.

Q. Could you point to something in the chart, anything, anywhere that reflects that the procedure took one hour?

A. Incision time - -

Q. What are you reading from?

MR. SEIBEL: Operating room nurse's notes. It would be either the back of that - -

MR. FULTON: What are you reading from?

MR. SEIBEL: The operating room nurse's notes page 1.

BY MR. KAMPINSKI:

Q. Go ahead?

A. Incision time, 2:55. Surgery ended, 4:05.

Q. Is that 2:35 or 2:55? It says, "patient in room, 2:20," right?

A. Right. I don't know. It is like corrected, It is 35 or 55, I don't know which one.

Q. Corrected by whom? By you?

A. No.

Q Okay. You don't know by whom?
A No, I don't.
Q. Who is G. Cunningham or the anesthesiologist and who is G. Cunningham?
A. I don't know.
Q The circulating nurse?
A. Could be.
Q. Did you have circulating nurses in there?
A. Yes, all the time.
Q. Two of them?
A Sometimes two; sometimes one.
Q And a scrub nurse?
A. That's right,
Q Wait a minute, You had yourself; you had Dr. Parvez; you had Mr. Weakland; you had Mr. Baker; you had Dr. Linn; you had nurse anesthetist Sevchick, a scrub nurse and two circulating nurses. You had nine people in there, is that right?
A. Yes, could be.
Q For this uncomplicated procedure?
A Could be.
Q. Well, was it?
A The number or the procedure.
Q. The number?
A, It could be, whatever the document says must be

right.

MR. SEIBEE: You are assuming also all those people were in the operating room at the same time.

A. No. They were not at the same time. They are not there necessarily at the same time,

Q. Right. G. Cunningham was relieved by Pam somebody, right?

A. I don't know.

Q Do you see where that is 2:35 to 2:55, so she is not even there when the times were put down. Who put them down? She is the one that signed this copy.

A. I don't know. I really don't no. I can't tell you.

Q. So what you are telling me is, it took you an hour, and what you are pointing out to me is the operating room nurse's note to confirm that. Even that tells me it was an hour and a-half?

A. It could be.

Q. Well, what was it, Dr. ? An hour, hour and a-half, two hours?

A. Wait a minute, Whatever the document tells you here.

Q Which document. I have another document that tells me it was two hours and ten minutes. Which one are we supposed to look at?

A This specifically indicates incision time and ending time of the procedure, when the surgery ended.

Q Did the anesthesiologist, how did they get paid? By the procedure, by the minute, by the hour, do you have any idea?

A I don't know.

Q. I asked you before why she died and you said because her heart stopped, something like that

A. Right.

Q Was this an operative fatality?

A. No.

Q. What is an operative fatality? How do you define that, sir?

A The operative fatality is if a fatality happened as a direct cause of the operative procedure within one month of surgery.

Q How about if the patient dies within 24 hours of surgery?

A Right, but if we, say, do bypass surgery on a patient who had an MI and arterial disease and they die within 24 hours with an MI, that's directly related to the surgical procedure.

This patient did have multiple episodes of myocardial infarction.

Q When was the last time she had any problems?

A Four weeks before, So the fact that nothing happened during the operative procedure in terms of any change in her hemodynamic status at all and within the next 12 hours, it clearly indicated that nothing happened interoperatively that would cause her demise.

Q. Did you answer my question about what happens if someone dies within 24 hours of surgery?

A. It is looked at as probably operative mortality.

Q. And that means that the death was as a result of the operation?

A Not necessarily,

Q. So operative mortality does not mean - -

A, In this incident, in my opinion, I don't look at it that way.

Q Well, that's not surprising because you are the one that did the surgery?

A Right.

a. But everybody else looked at it that way, didn't they, Dr., the coroner? Correct?

A. Probably that's what he wrote,

a. Why would he do that? Why would she do that, I should say?

MR. SEIBEL: Why would she do what?

MR. KAMPINSKI: Make it an operative mortality if it wasn't?

A, Well - -

Q Do you know?

A "Cause of death: Cardiorespiratory arrest following surgical exploration for retrieval of intravascular guide wire."

Now, it doesn't say here "caused by surgical procedure." It says "following."

Q. So that's just a coincidence, then?

MR. SEIBEL: That's sequential, not coincidental.

MR. KAMPINSI:

Q. Is that a coincidence, Dr. .

MR. SEIBEL: Is what a coincidence?

BY MR. KAMPINSKI:

Q Following the surgical exploration?

MR. SEIBEL: Her death?

MR. KAMPINSKI: Yes.

A. It could have been a coincidence.

Q Do yau think it was a coincidence?

A It could, yes,

Q. Is that what you think?

A Yes.

Q It had nothing to do with your surgery?

A. No.

Q. So if you wouldn't have done surgery, she would

have died the same time anyway, right?

A She could have.

Q. Well, would she probably have?

A I don't know.

a. Well, you just said it was a coincidence.

A. I said she could have.

Q Let's deal with probabilities. Do you have any opinion to a reasonable degree of medical certain based upon probabilities as to whether or not the surgery contributed to the cause of her death?

A, The probability exists, However, this patient did have a significant coronary artery disease - -

Q Wait, wait, Row did you start that? Did you say, did you say the probability exists?

A The probability exists. As I said before, and I am not contradicting what I said before, that her risk of surgery is higher than normal.

However, this wire that lays these also creates a risk on her life.

a. But that's not the risk that caused her death, is it?

A. The wire?

Q. Yes. But the removal?

A, It was the removal.

Q. But the removal of the wires?

A We don't know.

Q But the probability is that it did?

A The probability is that it exists, However the patient was hemodynamic stable all along during the procedure and for 12 hours afterwards which makes it very unlikely, very unlikely that she died from the removal. This patient - -

MR. SEIBEL: Wait until he asks you a question.

a. Well, when you came in the next day, who did you talk to?

A I walked in the coronary care unit, and one of the nurses said - - no. I asked. I said, "where did you put Mrs. Weitzel?"

And they said, "she passed away." I was totally shocked entirely.

I said, "when did she pass away? "

They said, "2 o'clock in the morning."

I said, "what happened?"

They said, "she was doing fine, and all of a sudden she fibrillated and passed away."

Q. What else do you remember?

A. I don't remember what else happened that day, but I really don't recall the events that day. I am sure we talked about it after that. But I don't recall any

specific events.

Q How much blood loss was there in your operation?

A I would say probably 50-75 ccs, something like that.

Q. How much did the nurse put down for blood loss?

A I don't know.

Q Wby don't you take a look?

A All right. Let's see.

A. If you have it, we will look at it.

Q **No.**

MR. FULTON: I thought it told us she lost 200 ccs.

A. **Blood** loss was estimated to be 200 ccs.

Q 200 ccs?

A This is and estimation. We did not lose 200 ccs.

Q Did you sign that?

A I signed it, but it was dictated by Br. Parvez This is estimated.

Q Sure.

A, But we did not lose that much blood.

Q. You know something, that's the last thing that is dictated right above your signature?

A. Right.

a. That's the last thing you would have read right before you signed that?

A. Right.

Q. If that wasn't right, could you have - - I don't know, - - maybe crossed it out and put in 50 whatever you are telling us now was the loss?

A. That's what I am saying was the loss.

Q. Why didn't you put it in the record?

A. I don't know*

Q. So the record is wrong?

a. No. It is only estimated. It is in his opinion estimated blood loss ccs.

Q. But you signed it. That's your signature?

A Probably overlooked it.

Q Another overlook?

A, Yes.

Q You said you reviewed the autopsy report?

A Right.

Q There was a blood clot estimated at 300 to 400 ML What does ML stand for?

A What is your question?

Q. Are you looking at the autopsy?

A. Right. 300 to 400 milliliter. So what?

Q. How much is that in *ccs?*

A. This is CRs.

a. How does a blood clot like that form? By hemorrhage?

A. Yes.

Q So she hemorrhaged?

A I don't know.

Q During her surgery?

A This is a hematoma. It doesn't describe where it came from.

Q Well, wait a minute. Sure it does. We are looking at different things, but this is right at the area of the surgery, Dr.

MR. SEIBEL: What are you looking at Mr. Kampinski?

Q. The external and internal evidence of recent therapy. Do you see that?

A. External and internal evidence of recent therapy.

MR. SEIBEL: Just take a minute to read that?

A, "An IV line remains in the right femoral area and the dorsum of the left wrist. There are multiple addional needle puncture marks....."

Q Keep going.

A. I want to draw your attention to that, needle sticks in the femoral area bilaterally.

Q Go ahead, Dr.

A And this is just 1 inch - -

Q. Just read it.

A. Below the - - listen. Let me finish my statement.

Q Go ahead.

A, Okay?

Q Sure.

A That tells you when this patient was resuscitated, she was stuck many times in the femoral region, and when you stick the artery in the femoral region, you always go toward the head

And with an artery as I described, this absolutely could have been the reason she bled and formed a hematoma at that time

a. Why don't you finish reading it?

A. Now I am going to finish. "There are bilateral tube thoracotomies with indwelling chest tubes and a Foley catheter remains in the urinary bladder.

"A bag has been attached to the anal rectal area, Defibrillator impressions are visible on the chest, There is a recent obliquely oriented surgical incision at the extreme aspect of the left lower quadrant.

"It measures up to 4 1/2" in length and correlates with the presence of a large amount of blood clot in the underlying tissues bulging the peritoneum inward.

"There is also hemorrhage extending

along the greater length of the left retroperitoneum. Volume of blood clot is estimated at 300 to 400 ml."

Q So where was that blood clot found?

A In the left retroperitoneum.

Q Where is that?

A Around the iliac artery.

Q And where did you do your surgery?

A Around the iliac artery.

Q And as a matter of fact, that's what they are describing, the? recent surgical incision?

A Right, but the surgical incision extended over 4 and a-half inches and obliquelyly upside down.

Q And correlates with a large amount of - -

A, Could be. But there could be other reasons for the blood clot, and the femoral stick is a very good reason.

Q. Is surgery a good reason?

A Yes.

Q. So that's not something uncommon or unexpected?

A. To me it was unexpected because at the time I closed this artery it was absolutely hemostatic with no evidence of leaking whatsoever.

Q. How much is 300 to 400 ccs. Mr. Fulton asked a similar question, and we have a can of 7-Up there. How many ccs would be in that one?

A This one?

a. About 200?

A About 200.

Q So it would be 1 and a-half times that can?

A Yes. Could be.

Q And that's how much bleeding there war;?

A Could be according to the description.

Q Would that be good for her'

A No.

Q Would that have caused her heart to w over time and caused a heart attack?

A It could have caused a little increase in the pulse rate, but it is not enough reason to have a heart attack since her hemodynamic status didn't change at all.

Q. Bo you mean after the surgery?

A. correct.

Q. What happened to her hemoglobin?

A Dropped.

Q Why?

A, Because of a blood loss.

Q. So her hemodynamic status did change,

A No.

Q. Hemoglobin doesn't constitute hemodynamic state?

A Well the hemoglobin dropped, but her pressure remained the same, so that means that she is profusing,

and also her oxygen saturation remained about 90 percent.

Q Was she receiving assistance in her saturation?

A Yes. She was FI02 which means provided by oxygen.

Q So wouldn't that - - well, so what does that tell you, then, in terms of her body's ability to profuse? She was being profused mechanically?

A. No. She was profused mechanically on her own because the heart was functioning, but her oxygen saturation was helped by increasing increments of FI02.

Q And if she is bleeding. If she is bleeding as a result of, say for the sake of argument, a sloppy surgery, wouldn't that cause her heart to work harder to make up for the blood lost and the lack of oxygen getting to the eissues?

A. As long as her pressure remained the same and her pulse rate didn't go too high like above 120, that will give her optimum cardiac output and maximum oxygen saturation and a lower hemoglobin and hematocrit.

Q. Well it is a good thing she had this bleeding, then?

A No.

Q If it was better for her?

A. I say a patient with with atherosclerotic occlusive disease of their arteries and carotid arteries and other arteries do better with a a lower hemoglobin

and hematocrit.

Q. What was her pulse and blood pressure after the surgery, Dr. ? Where would we find that'

A Her blood pressure was around 140 over 90.

Q Where do you find that?

A. In the anesthesia notes.

a. I mean from the time she left the surgery until she died?

A. In the CCU flow sheet.

Q Let me know when you find that?

A Here we go, flow sheet. Now, we are looking at time is 2000 hours on 3-14, and it says here 112 over 60.

Q. And what had it been at 16002

A. At 1600 it was 130 over 80.

Q. Okay. That drop in blood pressure - -

a. Right.

Q - - did that concern pow. at all?

A That would concern me, yes, literally, especially the increase in pulse rate from 127 to 141.

Q. Well, 1600 it was 127, and at 2000, which is 10 o'clock it was 141?

A. Correct.

Q. What was done about that?

A I don't know.

Q What about the respiration?

A. The respiration increased Prom 18 to 33.
Q. I mean, is that good?
A. No.
Q. What is respiration?
A. Well - -
Q. Breathing?
A. Yes.
Q. What's normal?
A. 18, 20, somewhere between 14 - -
Q. 33 is not very good, is it?
A. No. Et is high.
Q. I mean what was done about this?
A. E don't know.
Q. Here is a patient in the CCU - -
A. Right. E don't know.
Q. You have this blood pressure drop. You have this increase in heart rate, increase in respiration?
A Right.
Q. You just did surgery on her, and you are telling me you don't know what was done?
A No, I don't.
Q. Why don't you go to the nurse's note and see how your patient was being taken care of that night?
A Open eyes - -
Q What are you looking at?

MR. SEIBEL: Nurse's azote from 8 p.m on 3-14.

MR. KAMPINSKI: Do you think that's p.m?

MR. SEIBEL: It says 6 P above that. The previous page goes a.m to what looks like past noon. Axe we talking about the same page?

MR. KAMPINSKI: I see the page you are looking at. All right. Go ahead.

MR. SEIBEL: I just want to make sure we are on the same page.

Q Go ahead.

A. "Open eyes." I don't know what that is, "at name. Pupils = & R @ 4cm. Unable to move extremities. Cardiac EKG monitor intact. Alarm limits set. EKG monitor shows sinus leak at 24Q to 150. Dr. Chino notified."

Q. Dr. Who? Chin, Chang?

A. Chang, something like that,

Q. Do you know Chang?

A. No.

Q No. Is he a rotating physician from the Cleveland Clinic, a resident?

A I don't know.

A. "Blood gas to be drawn afibrile, no jugular vain extension, color pale, Three plus bilateral, radial pulses faint. Right pedal pulse, able to dopple. Left

pedal pulse, Well. Right groin triple lumen in place. TPN infusing to middle port Lidocaine to prox port. No peripheral edima. Respiratory, coarse Rhonchi. Ventilator to trachia. See front for settings - Continuous pulse shows 92 - 96 percent saturation, respiration at 33 per minimum. Dr. Chang notified."

Q. Wait a minute. I thought Dr. Chang was notified? Did somebody get a hold of you?

A. No.

Q. Should they have?

A. Yes.

Q. Go ahead. Well, why? Why should you have been notified?

A Because I am one of the physicians taking care of her.

Q. Because your patient is going down hill?

A. She is dropping her pressure and increasing her heart rate.

Q. I am sorry, Go ahead?

A. "Dr. Chang notified, Suctioned., expelled dry mucous plug with cough. Only scant clear secretions suctioned. Respiratory treatment given per resp. GI abdomen slightly distended. Blood sounds in all four quadrants, NG tube to - - " I can't read. this "left nares" probably.

Again "NG2 patent to stomach. Placement cleared with - - checked with air bolus, Right meds given per NG. No tube feeding at present. Foley draining cloudy yellow urine. Repositioned, blood gases obtained and called to Dr. Sopko per respiratory technician. 02 was increased to 45 percent. 20 pressure support added."

Q. Well, so she was not doing so good, then, after the surgery?

A. At this point she doesn't seem to be doing good. I can't say she is stable at this point. I agree with you.

Q All right. And did you finish reading the 8 o'clock note?

A Yes. I even moved up to the 9 o'clock note.

Q. Somebody called Dr. Sopko?

A Yes. It says here,

Q. And he increased the oxygen?

A. Yes

Q. That probably helped her, didn't it?. Don't put it away.

A That's the, end of it.

Q You have seen enough?

A, That's the end of it.

Q. It is the end of the patient.

MR. SEIBEL: End of the page.

MR. KAMPINSKI: Almost the end of the patient?

A. I said the end of the page.

BY MR. KAMPINSKI:

Q. Sure. Let's go to the next page?

A. 11 o'clock - -

Q. By the way, can you tell what nurse wrote that?

A No.

a. S. Thompson it looks like?

A, I don't know.

Q. You don't know who that is?

MR. FULTON: Is that 11 or 10.

MR. KAMPINSKI: The 8 o'clock was signed. There is no signature on the 9 o'clock, is there?

A, No. But to me it looks like the same writing. I am not an expert on that,

Q Okay, So you were not called, and can you tell what Dr. Chang did by the way at eight or nine, assuming he came?

A No, I can't.

Q. And we looked at the progress notes before. Is there any note from Dr. Chang?

A. I didn't see,

Q Or from Dr. Sopko?

A. No.

Q Or from any Dr. ?

A No.

Q Well, what Dr. saw her?

A I can not answer that,

Q. What Dr. is taking care of your patient after the surgery, sir?

A One of the cardiovascular fellows.

a. Fellows. Go ahead.

A. Or house surgical assistant if you want to call him that.

Q. Which one?

A, One of them should have been on call and should have been called, but he wasn't.

Q Wait a minute, wait a minute. You are the guy who did the surgery.

A. Right.

Q Isn't it up to you to make sure somebody is following your patient after the surgery?

A. Definitely.

Q. Who?

A, Well - -

a. Who was doing it?

A. Nobody notified us there was a problem.

Q. No, no. Listen to my question carefully. Who was

doing it for you? Who was following this patient?

A I am following my patient.

Q But you didn't know what was going on with her?

A Yes. I was not notified.

Q. Well, then, who was there on your behalf?

MR. SEIBEL: Do you remember who was on call that night?

A No. Somebody - - I can check the call schedule and give you the name.

Q Will you do that?

A. Yes.

MR. KAMPINSKI: Will you do that?

MR. SEIBEL: If you will do that I will communicate with Mr. Kampinski.

A But it is obvious here he was not notified because it is not Dr. Ghang.

Q Well, who whose job is it to notify him?

A Whoever was there.

Q Do you mean the nurse?

A. Yes.

Q. Okay. We will move on to 10 o'clock. How was she doing then?

MR. FULTON: Is that 10? Mine is punched off?

A. I have 11 o'clock. I don't have 10 o'clock.

MR. SEIBEL: It looks like it is 11 or mine.

MR. KAMPINSKI: Go to the original chart. Are we looking at the same thing?

MR. SEIBEL: This is a better copy,

MR. FULTON: What do we agree it is.

MR. SEIBEL: It is 10 o'clock.

A. "Diaphoretic."

Q What does that mean, seating?

A Right. "Continue to have 37.5 temp" which means temperature, "suctioned per respiratory. range of motion to all four extremities. Tears natural to both eyes."

Q. She is crying?

A. No, that means they - -

Q Is that the whole entry?

A That's it. 10 o'clock.

Q. Who wrote that?

A I don't know. It looks like the same handwriting

Q We just went through the hemodynamics at 10 o'clock, Dr. , right?

A. Well - -

a. I mean if you Look at the critical. flow care sheet, that coincides with that 10 o'clock entry. No. No. I apologize, the 2000 is at 8 o'clock. We are up to 2200, that's 10 o'clock?

A More advanced stage.

Q So, now, what was her blood pressure?

A To go back to the flow sheet, we are at what?

Q 2200.

A 140 heart rate.

Q. I asked for blood pressure.

A It is not recorded.

MR. SEIBEL: It is not legible.

BY MR. KAMPINSKI:

Q. It is not recorded?

A I mean, it is not written. I can't see it,

Q. Wait a minute. They are checking her hemodynamics, blood pressure dropped from 130 over 80 to 112 over 60, and you are telling me there is no blood pressure?

MR. SEIBEL: It is not legible on our copy.

MR. KAMPINSKI: I am representing I don't have one either. You have the original in front of you there.

A It is not written.

Q. It is not written. Well, Dr. , how in the world can you assess the hemodynamics of a patient without knowing her blood pressure? Aren't the nurses supposed to put that down?

A Yes.

Q Well, did it get better or worse from 8 o'clock that night?

A. Well, if I am there evaluating this patient and I look at this data, I assume - - and nothing has been done - - this patient is doing worse now.

Q Okay. Her heart rate is about the same, 140, right?

A. That's right. Her respiration went down to 24. That's probably because the FI02 was increased to 45 percent which compensated. The temperature stayed the same.

a. So. Do you feel better about her condition now?

A, I was not there. If I was there, I wouldn't have felt comfortable with that condition. I would have - - I don't know. There is blood pressure. It must be Lower at this point. E assume this blood pressure is Lower,

Q. Why?

A. Nothing was done about the change in hemodynamic status from 1600 to 2000 except increasing the FI02.

Q And that would not do anything for the blood pressure, would it?

A No.

Q. As a matter of fact, if she was having a blood form - - what was found in autopsy on this blood clot,

that could cause this drop in blood pressure, couldn't it?

A. Yes, it could.

Q. Well, how do you determine after a surgery if somebody is having a bleed? Just by looking?

A. He monitors their vital signs closely,

Q. Did you have some type of problem in this surgery that took you two hours, Dr. , that caused this lady to bleed afterwards?

A. No.

Q. No. Of course not, Okay.

The next reading we have is at 2400 hours, is that right?

MR. SEIBEL: Can we see your copy of the original? Ours is very load.

BY MR. KAMPINSKI:

Q Once again, no blood pressure?

A Right, Only pulse rate and respiratory rate,

Q It was probably a busy night in CCU. How often do they undertake to mark down the hemodynamics of patients?

A. If a patient is unstable, they should be monitored instantaneous and constantly off the monitor because if you have an arterial line, you are reading the pressure at any given second.

Q It is right up there to be seen, isn't it?

A. Absolutely.

Q. And if someone were there, they ought to be writing it down, correct?

A That's correct,

Q 2400, her heart right was down to 128, right?

A. Yes.

Q And can you tell me what the respirations were?

A 20, as I see it here unless it is 10.

Q. I can't tell, Dr. . Maybe you have a better copy than me, but I don't know what that is.

MR. SEIBEL: I assure you We don't have a better copy?

A. Cone on, take a look. How do you read this?

Q. You are the Dr. , you tell me?

A. It is not whether I am a Dr. or not a Dr. I want you to take a look at this and tell me how to read it. Then I will tell you,

MR. SEIBEL: Here we have a better capy.

A You are looking at the better copy. So Hook at that.

Q. I didn't give you that, did I?

A. I don't know whether you gave it to me or not. Just look at it. Okay?

Q. Now what?

MR COYNE: For the record it is

confusing?

A Is it as easy as the one you have.

Q. What's your point?

A My point is you have a much better copy. That's why I am having problems reading it.

Q Did I give you the original chart? One of the things I would like to do is assist physicians such as yourself in answering these questions.

That's why Mr. Coyne was asked by me and so graciously brought the chart here. Now take a look at it.

MR. SEIBEL: We did.

Q What were her respirations at 2400?

A. 10.

Q 10?

A. 10.

Q Is that goad?

A. That's not good at all.

Q. What's wrong with that?

A Well - -

Q She was not breathing very well, was she?

A. That's right.

Q. What was done about it?

A. I don't know. Well, read.

Q. Take a look. Bed bath given?

A 12, bed bath given - -

Q. Is that how you treat respirations at 10, give a person a bed bath?

A. Tears, natural to both eyes,

Q Do you want the answer that?

MR. SEIBEL: First you asked him to read the note.

MR. KAMPINSKI: I apologize.

MR. FULTON: Where are you at, the nurse's note, 11 o'clock.

MR. KAMPINSKI: 12:15.

A "Fluid on the left eye. Dr. Chang notified."

Q Is that appropriate treatment for - -

A. No, it is the not.

MR. SEIBEL: I assume you meant is that appropriate treatment, bed bath for low respirations.

MR. KAMPINSKE: Yes, that's what I meant.

Q And, once again, there is no listing of blood pressure, is that correct?

A That's correct,

Q. And in your opinion from the point in time that we have been reading, Dr. , that is, sometime between 1600 on March 14th and, now we are up to midnight, did Mrs. Weitzel receive appropriate care?

A No.

Q Why not?

a. She should have been evaluated by a physician who should have tried to find the specific reason why her blood pressure was dropping and her pulse rate increasing.

a. Did this failure to provide her with that appropriate care contribute to cause her death in your opinion, Dr. ?

a, Yes, I do.

a. All right, And then the last note is at what, 1:08 it looks like?

A Right.

MR. FULTON: Can I ask something? Did he identify Dr. Ghang or did E miss it?

MR. KAMPINSKI: He said, "Dr. Chang notified."

MR. FULTON: Who is Dr. Chang?

MR. SEIBEL: He doesn't know.

MR. FULTON: He didn't know?

THE WITNESS: I don't know.

Q. 1:08. Would you read that?

A "Repositioning patient. Pulse alarming. EKG monitor showing sinus attack...''

Q Or showing?

A. "Showing" or showing, could be "showing." I am sorry. Yes, I take this back.

"EKG monitor showing sinus attack. Unable to feel pulse, V tach noted on monitor. Express team called.'

Q Just one final question, Dr. You are going to provide us with the charges for your care of Mrs. Weitzel including the surgery?

A, sure.

Q. Do you have any idea what you would charge typically for a surgery such as this? Give me a ball park, A thousand dollars, five hundred dollars, eight hundred, somewhere between?

A I don't know. The reason I am telling you, I just came to know about a similar charge which included an accelery artery repair because of trauma, and it was somewhere between $500 and a $1,000, I am giving you this rough estimate. I don't deal with billing directly.

Q I am not asking for an exact amount. If you would have done this, your charge obviously will show haw much it was, but assuming just for the sake of argument, Dr. , you would have done this under local anesthesia and gone in through the way you originally planned to do it, what would your charge have been for such a procedure?

A About the same.

Q Probably it would have been - - it it would have been probably more because approaching the carotid artery is not as easy and - - I mean approaching the carotid artery is a much more dangerous process and tedious process than approaching the iliac.

It is a high risk. It would have been done under local anesthesia, but it has its own advantages and disadvantages.

Q. Have you ever done carotid endarterectomies?

A. Yes.

Q. How many?

A. I can't remember.

Q. A lot of them?

A. A lot of them in my training, but now the fact that. I am - - I am not merely a vascular surgeon. I do cardiac and thoracic and there are quite a few vascular surgeons in the hospital. I did probably about five. That's after I went on my own.

Q Why would Dr. Steele have consulted you as opposed to a vascular surgeon?

A. I am a vascular surgeon.

Q Just a vascular surgeon as opposed to a cardiovascular surgery?

A I really don't know.

MR. KAMPINSKI:

MR. COYNE: No questions.

MS. BITTENCE: No questions

MR. WARNER: No question.

BY MR. FULTON:

Q. I am Burt Fulton and represent Dr. Varma.

You were referred by Dr. Steele, is that correct? You were referred to the patient by Dr. Steele?

A, Yes.

Q. Did you talk to any of Dr. Steele's partners about this case before you operated, Rollins or Kitchen?

A No. I don't think so.

Q Now, after the surgery, she was returned where, to the coronary care unit?

A Correct.

Q And she was returned there for - - why there instead of any other particular place in the hospital?

A This is where she was. This is where everybody was familiar with her, and it is an intensive care unit so she would be monitored closely.

Q. And she was in the coronary care unit under Dr. Steele's care?

A. You know, I would have to look at the chart. The reason I can't answer you specifically, I would have to check the chart,

Sometimes the patient is admitted under

the primary care physician, and then the cardiologist is admitted to her and transferred to his service. And sometimes she stays on the same service as the primary care physieian, and the same specialist takes care of her while under - -

MR. SEIBEL: You can accept she was Dr. Steele's patient.

BY MR. FULTON:

Q. But Dr. Steele would normally be working out of the cardiac care unit because of his expertise, right. He is often there?

A Yes.

Q HG is what, what are the initials for? When they give a blood gas or any test, HG is shown as what, the initials.

MR. SEIBEL: How is it abbreviated?

A HG.

Q And hematocrit is shown as what?

A. HCT or HT sometimes.

Q. At what point in the RG do you as a surgeon require transfusion?

A If it goes below 9, 10, something like that.

Q In this instance it went down to 5.1. Da you know that happened?

a. Preoperatively?

Q We11, let me just ask this. I have 3-14 - -

MR. FULTON On 3-24 - -?

MR. SEIBEL Is it a CBC or blood gas? They all look the same.

A 3-14 - -

MR. KAMPINSKI: Just hold on. J 18 is the number?

MR. FULTON: Yes.

BY MR. FULTON:

Q I just wand to be sure. It appears - - that's what I am going to ask you, where it says 5.2, is that not 3-14-91. 2245 hours?

A. 2245? That's what, 6 o'clock? 6:45?

BY MR. FULTON:

Q I think that's 10:45?

A, Well, let me tell you. This is a blood gas hemoglobin. A blood gas HG, it says 5.2, but then what is this;, 8.2 at what time?

Q 21. 2115?

A. So she dropped from here to here.

Q. Let me just ask the question and be sure 3 read it right. Is that on the 14th at 2115, that's after the surgery, is it not?

A. Yes.

Q Okay. And it shows at 1240. Is that after the

surgery?

A. 1240, no, that's before. 3-14, before surgery, it was 10.20.

Q. Is it 10.1 before surgery. That's it?

A. Yes.

Q. And after surgery it goes to 8.2?

A. Yes.

Q. 2245 it goes to 5.2?

A. Yes.

Q. And the next day at 0115, which is just after midnight, 1:15 it is at 6.1?

A. Right.

Q. Which is still very low?

A. It is still low, but HG values taken of blood gas reading machines are notoriously unreliable. It can give you an idea that the HG is dropping because you check the blood under the same circumstances, but in my experience it is 2 points lower than the actual value.

We don't depend on it. I do not depend on a HG of the blood gas to determine whether this person needs a transfusion or not.

Q. But if you saw that, you certainly would have some concern?

A. Absolutely.

MR. FULTON: Nothing further.

BY MR. KAMPINSKI:

Q. Just to clear one thing out, when you answered me about endarterectomies, you said you did them before Mrs Weitzel. You didn't do them afterwards?

A. No. I have been doing them sporadically.

Q. Whenever the need arose, you would do one?

A. When I am asked to do one, yes. 1 have done probably about a hundred in my training.

MR. KAMPINSKI: Fine. That's all I have.

BY MR. FULTON:

Q. For my own edification, could you stand up and show me where the femoral abdominal aorta is on your body.

A This is here, the groin femoral? The femoral artery.

Q And iliac: is where?

A. And iliac comes up and goes to the inside.

Q Around your belly button?

A, Meets below the belly button and becomes one artery which is the aorta.

Q. The abdominal aorta?

A. Yes. Goes in the middle for - - I mean most of the time, 99 percent goes in the middle, and then it goes slightly to the left as it penetrates the diaphragm which

is the muscle layer that separates the chest from the abdomen, and it goes next to the esophagus, absolutely to the left.

And it then goes up in the chest behind and left of the heart, completely behind it and to the left of it, left side of the middle, goes up and then curves behind the upper part of the sternum and goes down to the heart. That's where it comes from. And this part right here - -

Q. The carotid?

A. Bifurcates, one is subclavian, going to the left arm and one carotid which is the left carotid goes to the left side of the head, and then there is an artery that we call - - has no name. For a short distance it has no name and then bifurcates and goes to the right carotid and right subclavian. That's the normal anatomy.

MR. SEIBEL: Well read it. You are not going to wave the seven days?

MR. KAMPINSKI: I can't do it.

MR. SEIBEL: The pressing May trial date?

MR. KAMPINSKI: He can have as long as he wants. I don't care about his changes.

- - - - -

(Deposition adjourned at 1:10 p.m.)

- - - - -

I have read the foregoing transcript from page 1 through 148 and not the following corrections:

PAGE	LINE	REQUESTED CHANGE

_____
Ghassan Moasis, M.D.

Subscribed and sworn to before me this_____day of_____, 1992.

_____
Notary Public

My commission expires: _____

State of Ohio,)
) SS: CERTIFICATE
County of Cuyahoga.)

I, George J. Staiduhar, a Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named Plaintiff, Ghassan Moasis, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to computer in the presence of said witness, afterward transcribed by me, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing captior specified and was completed without adjournment.

I do further certify that I am not a relative, counsel, or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 5th day of October, 1992.

George J. Staiduhar, Notary Public in and for the State of Ohio. My commission expires 7-3-97.

GHASSAN MOASIS, M.D., deposition index

6/18. **30799** Gates Mills Blvd. Pepper Pike

8/18. **1969-1970** Faculty of Science, Damascus College then **6** yrs med school, Univ. Damascus, grad **1976**

9/18. Three yrs of military **76-79**

10/2. served as director of a medical team.

10/23. June **79** took ECFMG and came to this country.

11/15. Worked at St. Elizabeth in Oct. **80** surg assist.

12/25. Oct. **81** accept as resid. at ST. Elizabeths

14/24. Stayed till June of **1982**

15/2. res. was in gen surgery

16/14. July **1982** moved to Huron Road, began 2nd yr of res in gen. surg. completed **1985**

18/7. Attend of **86** did a fellowship in cardiothoracic surgery at Cleveland Clinic.

18/13. Worked weekends at Dr. Mitchell's immediate care centers.

19/3. Completed fellowship - end of **87.**

20/14. Then he was accepted at Univ. of Alberta, July of **87,** and did **2** yrs of cardiothoracic surgery.

22/22. Then went to KC, Kan in Aug **89** to join a cardiothoracic surgeon Thomas Thomas.

23/12. worked there **44** days.

25/15. Then came here with Naraghipour in Dec. **89.**

28/23. Injunctive relief granted in KC.

30/24. Worked for cardil. surg Inc. till Jan **91.**

31/8. Actually employed by Surgassist

32/19. When he worked for Surg Assist his job was to see the patient the day before, check their labs and x-rays make sure they are okay. (Vaidya?).

33/24. for a tach the procedure would be the same.

39/23. took his general surg. bds twice.

40/14. his corp name is Thoracic and Cardiov. Surgery, Inc.

50/19. his first involvement with this case was meeting Steele in the cath lab. Steele told him that he had a patient who had cardiac arrest, ventricular fibrill and she had sustained some brain damage.

52/3. based on what he saw there was some brain dysfunction but he couldn't be specific about the degree of pathologic injury.

52/14. he showed him the x-rays. The before and after, one with two wires, one with one. Steele told him this happened when one of the doctors was trying to put an arterial line in and apparently lost the wire.

53/12. At that time we were in the cath lab, and I said yes, probably we can do it under local anesthesia by a small incision in the neck because this was in the carotid artery.

54/20. He claims he asked Steele how this happened and he said "well probably the first attempt was unsuccessful, . . . but apparently he grabbed another. . . and lost it the same way."

58/12. Steele told him somehow it was overlooked.

57/9. I don't believe it would take a cardiov. surg. to figure there are wires in the chest.

59/11. Wire has migrated from femoral to iliac.

62/15. It would have been easier to remove from the femoral artery

62/18. Easy area to get to anatomically.

66/10. His consult note . . . at this point, with a tracheostomy close by create a definite risk of infection, best and safest approach would be a retroperitoneal via a flanch incision. . .

66/16. Will sched. for tomorrow under general anesth.

68/3. He decided on the alt. appr. because of the trach.

68/13. He told Steele of the change in plans.

69/2. Risk to post MI patient is hemodgnomic instability.

69/8. He says the risk occurs in the induction phase of the anesthesia.

70/12. He classes this procedure as semi elective toward urgent.

70/18. Then he says it was an urgency.

71/9. He felt this was so because the wire would have been pushing on atherosclerotic plaque which could break away and head for the brain. He was also concerned with clots.

72/3. Thought Dr. Syed was the neuro on the case.

72/20. How would we know that she didn't have any further brain damage by embolization from the wire.

74/7. Steele agreed to the change.

77/22. She was under anesth. for about an hour.

78/15. read anesth. sheet and agrees it says 2 hrs. and 10 min.

78/21. says surg took 1 hr.

79/13. When he got in he found a piece of rock calcified to the point that he was not able to oppose the two walls of the artery, so he put a marker there and called for x-ray. then he waited for an x-ray tech to determine where the wire was in relation to the marker.

81/2. He didn't have her under fluoroscopy originally because he didn't expect to encounter calcification.

82/23. This event does not exist in his written or dictated note.

85/8. He did the proc. with Parvez who he claims basically works for the hospital.

85/11. Mr. Weakland who was there also works for the hospital.

86/24. Eldona Lyon was the anesthesiologist.

87/19. Baker, another surg assist was also there.

88/18. When pro. started she was 170/systolic

88/14. Dropped between 140 to 160.

89/9. He would have been concerned with a drop below 80 or 90 systolic.

92/8. He got consent from Mr. W and explained to him the danger of leaving the wire in.

93/21. Dr. Steele told him the family knew everything.

94/4. Says procedure lasted 35 minutes and it took another **20** to close her.

98/3. He removed an intact guidewire.

98/13. He passed the wire on to pathology.

99/11. When he took the wire out he saw no signs of infection.

101/10. a guidewire in the arterial system is not a foreseeable complication.

104/3. If a wire is inserted and lost and one intentionally doesn't tell someone it is a reckless disregard of the patients rights.

106/14. His service continues to take care of her regarding operative procedures, the incision, stitches status as for any surgical aspects.

106/20. She was fine when she left O.R. (stable). and he didn't know anything till next day when he was told she had died.

3-08/24. He talked to Steele after the procedure and told him it was uneventful.

109/19. Operating room nurses note; incision time 2:55 (entry appears corrected).

114/21. He thinks her death is a sequential coincidence having nothing to do with the surgery.

116/3. The probability is that if exists (meaning maybe that the removal caused her death).

117/3. He says there was **50-75** cc blood **loss** from his procedure.

117/13. Nurse wrote **200** ccs.

117/15. He says it was an estimation and **200** ccs were not Post.

117/24. However thats what op summary says and he signed it.

118/12. Probably overlooked it.

119/1. Blood clot formed by hemorrhage.

119/5. This is a hematoma. It doesn't describe where it came from."

120/9. This absolutely could have been the reason she bled

(needle sticks in the femoral area).

121/18. Admits surgery could be the reason for the clot.

121/20. To me it was unexpected because at the time I closed the artery it was absolutely hemostatic with no evidence of leaking.

124/18. Blood pressure at 8:00 112/60 at 6:00 130/80 and that would concern him since pulse increased from 127 to 141 in the corresponding time period.

128/1. Respiration increased from 18 to 33

125/21. He didn't know what was done for the patient.

126/14. EKG monitor shows sinus leak at 140 to 150- Dr. Chino (?) notified.

127/11. They should have notified him

128/5. Sopko called per resp. techn. 02 was increased to 45%

133/21. For 10P note no blood pressure is written, heart rate still 140.

134/19. Nothing was done about the hemodynamic status from 1600 to 2000 except the F102 (and that wouldn't do anything for blood pressure.)

135/18. Note at 2400 no blood pressure again, just pulse and respiration.

137/16. Respiration was 10 at 2400.

138/12. 12:15 note - fluid on the left eye Dr. Chang notified.

139/3. Mrs. W did not receive appropriate cqre between 4:00 and 12:15 on 3-15 because she should have been evaluated by a physician to see why her Bp was dropping and pulse increasing.

139/10. Lack of care contributed to death.

140/1. 1:08 am note - Pulse alarming, EKG showing sinus attack - V tach noted on monitor. Express team called.

Fulton

144/19. HG is 8.2 at 2115 and 5.2 at 2245.

145/4. HG is 10.1 before surg.

145/14. HGs taken off blood gas machine are notoriously unreliable