The State of Ohio,)
) SS:
County of Cuyahoga.)

Doc. 356

IN THE COURT OF COMMON PLEAS

Lester Weitzel, Administrator, etc.,)
)
Plaintiff,)
)
vs.) No. 226946
)
St. Vincent Charity Hospital, et al.,)
)
Defendants.)

- - - -

Deposition of HOWARD C. PITLUK, M.D., called by Defendants St. Vincent Charity Hospital, St. Vincent Charity Hospital and Health Center, Dr. Jayne, Dr. Mohlay, Dr. Onyekwere and Dr. Mayha, taken as if upon cross-examination, before Marie L. Larbig, a Notary Public within and for the State of Ohio, at the offices of William J. Coyne Co., L.P.A., 1240 Standard Building, Cleveland, Ohio, on Friday, March 19, 1993, pursuant to notice.

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I N D E X

WITNESS:

Howard C. Pitluk, M.D.

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APPEARANCES:

For the Plaintiff:

Charles Kampinski, Esquire
Charles Kampinski Co., L.P.A.
1530 Standard Building
Cleveland, Ohio - 44113

For Defendant St. Vincent Charity Hospital:

William J. Coyne, Esquire
William J. Coyne & Associtates
1230 Standard Building
Cleveland, Ohio - 44113

For Defendant Cleveland Clinic Foundation:

Mary M. Bittence, Esquire
Baker & Hostetler
3200 National City Center
Cleveland, Ohio - 44114

For Defendant Prem Varma, M.A.:

Lynn L. Moore, Esquire
Gallagher, Sharp, Fulton & Norman
Sixth Floor, Bulkley Building
1501 Euclid Avenue
Cleveland, Ohio - 44115

APPEARANCES Continued:

For Defendant G. A. Moasis, M.D.:

Robert C. Seibel, Esquire and

Curtis Bailey, Esquire

Jacobson, Maynard, Tuschman & Kalur Co., L.P.A.

1001 Lakeside Avenue, Suite 1600

Cleveland, Ohio - 44114

For Defendant Robert J. Steele, J.D.:

John V. Jackson, II

Jacobson, Maynard, Tuschman & Kalur Co., L.P.A.

1001 Lakeside Avenue, Suite 1600

Cleveland, Ohio - 44114

For Defendant Central Radiology Consultants:

Robert D. Warner, Esquire

Reminger & Reminger Co., L.P.A.

The 113 Building

Cleveland, Ohio - 44114

For Defendant Prem Varma, M.D.:

Sanjay K. Varma, Esquire and

Fred Carmen, Esquire

Chattman, Sutula, Friedlander & Paul

6200 Rockside Road

Cleveland, Ohio - 44131

HOWARD C. PITLUK, M.D., of lawful age, called as a witness on behalf of Defendants St. Vincent Charity Hospital, St. Vincent Charity Hospital and Health Center, Dr. Jayne, Dr. Mohlay, Dr. Onyekwere and Dr. Mayha for the purpose of cross-examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, was examined and testified as follows:

CROSS-EXAMINATION OF HOWARD C. PITLUK, M.D.

BY MR. COYNE:

Q Now, Doctor, I am going to ask you some questions. If I ask you a question you do not understand or that might tend to confuse you, bring it to my attention. I will try to clarify the question for you.

Will you do that, Doctor?

A Yes.

Q You understand that everything you say here is under oath?

A Yes.

Q In front of you is the original hospital chart from St. Vincent Charity Hospital. In the event you need to refresh your recollection by looking at that chart, please feel free to do so.

You may also review any notes or anything you may have incurred at the time of your practice

Would you state your complete name for the record?

A Howard Charles Pitluk.

Q And what is your resident address?

A 60 Basswood Lane, Cleveland, Ohio.

Q And what is your professional address?

A 6801 Mayfield Road, Cleveland, Ohio.

Q And do you have more than one office address?

A Presently, no.

Q Are you a member of any group?

A Yes, I am.

Q And I am talking about professional association. What's the name of your group?

A Sampliner and Pitluk, M.D., Incorporated.

Q And that's spelled?

A S-a-m-p-l-i-n-e-r.

Q And you are a physician licensed to practice medicine by the State of Ohio?

A Correct.

Q And what is your area of specialty?

A General surgery and vascular surgery.

Q And you are on the staffs of what hospitals?

A I'm on the staffs of Meridia Hillcrest Hospital,

the Deaconess Hospital of Cleveland, Marymount Hospital, Mt. Sinai Medical Center, and I have a teaching appointment through the Case Western Reserve University School of Medicine at the Veterans Administration Hospital.

Q And how many, is there a certain number of hours per week that you involve yourself in the teaching position?

A Usually it's one day a week; on Mondays.

Q Is that while you are working at the VA Hospital?

A That's the reason I am at the VA Hospital, to teach.

Q And what are you teaching there?

A Vascular surgery.

Q I take it Dr. Sampliner is a vascular surgeon, is he?

A He is a general surgeon also, like myself, correct

Q Does he have a subspecialty in vascular?

A No, just general surgery.

Q Doctor, when did you first become aware of the Weitzel Case?

A Approximately the time that I dated the letter. Within that month I would imagine.

Q The letter that you wrote to Mr. Kampinski is dated November 30, 1992. So it was around

November when you first became aware of the case, is that correct?

A I believe that's right.

Q And who made contact with you initially concerning that matter?

A Mr. Kampinski.

Q Okay. Have you ever reviewed any case before or done any work before for Mr. Kampinski?

A No, I haven't.

Q You have never testified in any respect, be it deposition or an expert in a trial or any other case that Mr. Kampinski held?

A No.

Q Tried?

A No.

Q I take it you are not related to Mr. Kampinski or Mr. Elk?

A Not that I'm aware of.

Q And are you a friend socially of either Mr. Kampinski or Mr. Elk or any member of Mr. Kampinski's firm?

A No.

MR. KAMPINSKI: I'm going to object. Do you want to ask him if he's friends with everybody in the room or --

MR. COYNE: Well, I can ask him.

Q Are you friends, you know, socially with anybody in this room?

MR. KAMPINSKI: Or any members of their firms.

MR. COYNE: I'll just ask the question.

A I occasionally socialize with Mr. Kampinski at the Country Club we belong to. I have been out with Mr. Elk and his wife. We live in the same neighborhood. On one or two occasions.

And I also have relationships, social relationships with other lawyers who are members of some of the firms represented here.

Q Just to clarify, have you been out to dinner with any of the other lawyers that are here?

A I don't think -- no, I guess not.

Q Your first contact with Mr. Kampinski regarding this case, was that by letter, phone call or how did it come about?

A I believe it was a phone call explaining some of the particulars of the case.

Q And were you provided with certain materials to review to reach your professional opinions?

A Yes.

Q And what did you review?
A As I stated in my letter, basically those are the materials I reviewed to form any opinions.
Q And were those documents delivered to you at your office or your home?
A No; to my office.
Q How much time did you spend in reviewing those documents prior to reaching your professional opinions?
A Oh, probably in the neighborhood of eight to ten hours.
Q In your particular practice do you treat many patients that have been involved with cardiac arrests?
A Yes.
I mean, I don't necessarily treat them, but I have occasion to come into contact with them in acute settings.
Q What percent of your practice would you say is involved with patients who have been involved in cardiac arrest incidents?
A Well, it's not a percentage. It's just the incidents that have happened where patients have cardiac arrests when I am present, so it's a very small percentage, thank goodness.

Q In regard to Mrs. Weitzel, I take it on your review of the case, which you indicated you reviewed the Samaritan Hospital records, you learned that she had suffered a cardiac arrest on February 11, 1991 while at work, correct?

A [redacted] at work.

Q Or at the Samaritan Hospital?

A Right.

The arrest didn't happen at Samaritan Hospital, so we simply assume that's what happened to her, that she had a cardiac arrest while at work.

Q Is there any question in your mind that she suffered a cardiac arrest while at work?

A I have no reason to question it. I don't have any information that she had a cardiac arrest versus an arrhythmia versus a seizure.

They say it was a cardiac arrest and I have to assume that's what it was.

Q Based on your review, were there any fellow workers or anybody in the area following her arrest at work that were able to render any assistance to her before the EMS squad got there?

A I'm not aware of that.
Q After she was received at the Ashland Samaritan Hospital she was resuscitated a number of times; is that true?
A What do you mean, resuscitated a number of times?
Q Well, she was resuscitated at the hospital, put on a ventilator, was she?
A She was put on a ventilator, right.
Q And did they also have to defibrillate her a number of times while she was at the --
A She was defibrillated.
Q Did you note how many times she was defibrillated while she was at Samaritan Hospital?
A I don't recall.
Q Was it in the area of fifteen to seventeen times?
A I don't know. I have no recollection.
Q Now what condition calls for fibrillation?
A Fibrillation.
Q Yes.
A That's the condition, fibrillation. Ventricular fibrillation or atrial fibrillation.
Q Okay. What happened in this case?
A Well, I would assume, ventricular fibrillation.
Q And what does that cause in the system of an individual? Breathing?

A No. It's an inefficient contraction of the ventricles of the heart.

Q Does the heart stop pumping at that point?

A It pumps, but inefficiently.

Q And what are the hazards or risks of a heart that is not pumping sufficiently on its own?

A Death.

Q That would be the ultimate risk, correct?

A Yes, the ultimate bad risk.

Q And have you treated patients who have been defibrillated more than twelve times within thirty-six hours that have survived?

A I have no idea.

I don't count the number of times people are defibrillated. I don't know what that means, twelve times.

Q Twelve separate acts of defibrillation.

A You mean they come back twelve different times, the patient?

Q Yes.

A I am not a cardiologist. I am not in rooms when patients are arrested for the most part.

Q Do you carry or have any opinion relative to whether or not a patient being defibrillated, say, fifteen to seventeen times, whether that would

lead to any permanent damage on the heart itself?

A I have no way of knowing.

Q In your review of the records you learned I'm sure that the patient was life-flighted from Samaritan Hospital then to Charity Hospital in Cleveland, correct?

A Yes.

Q And during that life-flight the patient was still intubated all the way?

A That's my understanding, yes.

Q And following the patient's arrival now at Charity Hospital on February 12, 1991, based on your review of the records and expertise have you reached any opinion as to the patient's prognosis for survivability on, say, February 12 when she arrived at Charity Hospital?

A Yes.

Q And what was that?

A I believe she would survive and she should continue to survive.

Q And as she arrived at the hospital you believe that she had a better than fifty percent chance of survival?

A Yes.

Q Better than eighty percent chance of survival?

MR. KAMPINSKI: Objection.

What's the difference?

Do you want to ask him about fifty-one, two, three, four, five?

MR. COYNE: I just want to ask about eighty percent.

MR. KAMPINSKI: Why?

MR. COYNE: Background information General information. I think it's relevant material.

MR. KAMPINSKI: Why?

MR. COYNE: When you're deposing people, you ask all these people --

MR. KAMPINSKI: All right. Look, I don't want to argue with you.

A I don't know.

Q After she arrived at the hospital on the 12th did she have to be defibrillated again?

A I don't believe she did, but I am not sure.

Perhaps you could refer me to the area in the record.

Q You have the whole records in front of you. If you want to look at any part of them, you may.

A I don't recall. If you want me to look through them, I will.

Q Is defibrillation one of your areas of expertise?
A Defibrillation is not an area of expertise.
Do I know how to defibrillate, yes.
Q The record I believe indicates that after she was transported to Charity Hospital, shortly after she had to be defibrillated with a maximum 400 jewels.
What does that indicate to you medically, if anything?
A Standard fibrillation technique.
Q All right. She was in a life-threatening condition at that time, correct?
A Any fibrillation is life-threatening I think, yes.
Q Are you familiar with the survival rate for out-of-hospital ventricular fibrillation arrest?
A Not offhand, no.
Q Do you yourself as an expert in this case have any medical opinions regarding the survival rate for an out-of-hospital ventricular fibrillation arrest patient such as Sharon Weitzel?
A I'm not sure I understood the question
Do people survive? Yes.
Rate of survival? I don't know.
Q Have you based on your review of the records in this case and your professional expertise arrived

at any opinion whether or not Mrs. Weitzel suffered any anoxic brain damage prior to February 26th of 1991?

A Prior to February 26th?

Yes.

Q And what is your opinion?

A She did not have any significant anoxic brain damage.

Q That's your opinion?

A Yes.

Q When you say she didn't have any significant anoxic brain damage, did she have any anoxic brain damage?

A I can't say for sure.

She was paralyzed and sedated for the majority of the time she was -- and prior to the time actually she was in the hospital until her death, so it would be very difficult to ascertain whether or not she had any brain damage from anoxic cephalopathy.

Q She was actually on a ventilator from the time she was admitted to Ashland Samaritan until the time she died, correct?

A That's true.

Q And the need for a ventilator is what?

A Assisting in breathing.
Q On her own she couldn't breathe, correct?
A Well, that's not true, no.
She could breathe on her own and did breathe on her own, but the reason she was paralyzed and sedated was because most people, including Mrs. Weitzel, who are awake and not anoxic and cephalopathic cannot tolerate a tube down their throat, they would choke on it, just as you would choke on it. So in order to tolerate that, she was sedated.
Q But was there any time -- you indicated she was breathing on her own and maybe I misunderstood you -- was there any time from the time she was admitted to Ashland Samaritan Hospital until she passed away that she was not on a ventilator that she was able to breathe on her own?
A You don't understand the term. Breathing on your own doesn't mean that you can't be on a ventilator. It's called "Assist Control". The ventilator assists your breathing. You still initiate your own breathing, breathing on your own. She was doing it, breathing on her own with the assistance of a ventilator, but it became, for her, too much of a difficult situation, so they sedated her.

Q I understand she was sedated.
A That's the reason they sedated her. She was trying to do it on her own. They didn't feel that she could effectively do it without the breathing tube and the ventilator for assistance, and so they sedated her. As opposed to her breathing on her own, she was assisted by the machine.
Q Do you have an opinion as to whether or not she could have survived without the assistance of a ventilator?
MR. KAMPINSKI: Do you mean while she was in the hospital?
Q While she was in the hospital.
A Yes.
Q What is your opinion?
A My opinion is that towards the very end, according to your medical records and notes and nurses' notes, they wanted to wean her off the ventilator. In other words, the doctors that were caring for her felt she could survive on her own, without a ventilator.
Q Sometime in the future?
A Yes. Getting towards that, right before her demise.
Q Okay. All I want to know is, do you have an

opinion as to whether or not she could have been taken off the ventilator at any time between the time she was admitted to the hospital on February 11th and, say, March 15th and survived without a ventilator? At any time during that --

A No, I don't have an opinion.

I mean, that's the doctor's decision.

Q How was she being fed during this period of time?

A She was getting intravenous feeding.

Q So she couldn't be fed in a conventional by mouth method, she had to have an I.V. feeding?

A Yes. Her G.I. tract was working. I think she had a tube feed also.

Q On February 28th she had a tracheostomy. That was also for purposes of assisting in her breathin , correct?

A Correct.

Q Are there any hazards relative to the pulmonary function of an individual who is on a ventilator for, say, four weeks' period of time?

A The major hazard -- there are hazards to answer your question.

Q And what are those?

A A major hazard would be infection, because you are having to enter a foreign body into the

tracheotomy for the bronchial tube, you could create positive pressure problems by, when you are on a ventilator, you're actually forcing the air into the lungs, and if that pressure becomes too great, you can cause a collapse of the lung, blow it up and causing it to burst. Those are your primary problems that affect the pneumothorax, with the lungs we are talking about.

Q Right.

A The other thing that you have, a problem with the actual trachea, mechanical problems when you have a tube in the trachea. You can cause mechanical erosion, fistula, tracheoesophageal.

Q Is that one of the reasons they do the tracheostomy?

A That's one of the reasons. But the tracheostomy also has a tube with a balloon on it and it can cause some problems.

Q Now you learned during your review of the records in this case that the patient was also suffering from adult respiratory distress syndrome, ARDS as you call it, is that correct, Doctor?

A At some point during hospital admission.

Q All right. Did you arrive at an opinion as to when that was first diagnosed?

A I don't recall. It was reasonably early in the hospitalization she had there.

Q Prior to February 26th of 1991, correct?

A Yes.

Q And are you familiar with the survival rates for patients that have adult respiratory distress syndrome?

A Yes.

Q And what are those survival rates?

A It depends on the etiology of the syndrome.

Q With a patient such as Mrs. Weitzel?

A She had greater than fifty percent survival I think.

Q Do you have any authoratative sources that back up your opinion if you do?

A I don't recall any offhand.

I am sure there are articles of literature that would talk to and speak to that.

Q Have you reviewed any prior to reaching your opinion in this case?

A Not specifically for this case.

Q If prior to the trial you do review any authoratative sources that support that opinion, would you give them to Mr. Kampinski?

A Yes.

MR. COYNE: And I'll ask Counsel to forward them to us, if there is any such generated prior to trial.

MR. KAMPINSKI: Sure.

Q Based on your review of the records in this case did this patient also have multiple organ failure?

A I'm not aware of that, no.

Q What is an organ failure?

A Failure of an organ to function properly.

I assume that's what you mean.

Q Would ARDS be an organ failure?

A No.

Q Would cardiac arrest be an organ failure?

A For the time that the -- the heart is in arrest, that's a failure.

After it's not in arrest anymore, you're either alive or you're not. When you're dead, that's the ultimate failure.

Q So it's your professional opinion that in this case Mrs. Weitzel did not have multiple organ failure then?

A Correct.

Q Regarding the discovery of the two wires in Mrs. Weitzel, I believe that's noted in the chart on March 8th of 1991, correct?

A Not exactly.

It was noted before that, when the radiologist spoke of some strange foreign body in the patient or on the patient, I am not sure, as early as March 2nd.

Q Okay. I agree that's in the radiological report.

Other than radiology noting it in some of the reports they generated, the first other note in the chart is on March 8th of 1991, correct?

A By a physician.

Q By a physician, other than radiology.

A What's his name?

Q I think Dr. Varma became aware of it that day.

A Okay.

Q And I assume that we can agree that leaving two wires in a patient such as this is substandard care as far as the opinion you generated here, correct?

A Oh, most definitely.

Q All right. Relative to the two wires that were left in Mrs. Weitzel, have you reached any opinion regarding what damage the wires themselves did, if any, to her physical condition between February 26th and prior to the surgery, say, of March 14th?

In other words, I'm not including the surgery of March 14th at this time.

MR. KAMPINSKI: I object to the question because I don't understand it.

Are you saying what damage the wires did in and of themselves as opposed to the effect of leaving them in?

I just don't understand your question.

MR. COYNE: Okay.

Q My question to you, Doctor, and if you don't understand, you can tell me, did the leaving of the wires in Mrs. Weitzel, say, between February 26th and March 13th, did they cause any additional injury to her person, systems or anything else?

A The wires themselves you said.

Q That's right.

A I really don't know.

She had some positive blood cultures, whether it was because of the wires is difficult to say, so I can't really answer the question specifically.

I don't think that was the issue here, in my opinion.

There is a possibility that the wires in and

of themselves did cause some damage to her.

MR. WARNER: Object; move to strike. Possibility.

MR. COYNE: All right.

Q I'll ask you if you have any opinion to a reasonable degree of medical probability that the wires in and of themselves caused any injury to Mrs. Weitzel between February 26th and March 13th.

A No.

Q No? Now on March 13th --

MR. JACKSON: Is his answer no, he doesn't have an opinion or no, it didn't cause any injury.

A No, I don't have an opinion.

Q On March 13th, Doctor, you are familiar that Dr. Steele went in and did a removal of one of the wires, correct?

A Yes. He didn't go in, he did a transcutaneous method.

Q Is it called percutaneous?

A Same --

Q Same thing?

A Same level.

Q Okay. I take it you don't have any criticism of

Dr Steele removing the one wire in the percutaneous method on March 13th?

A No.

Q I would assume further that you don't have any criticism of the fact that the wires at some time had to come out?

A Correct.

Q Okay. So I suppose medically one of the decisions that had to be made with this patient by the attending physician is when they should be removed, correct?

A I think that is fair to say, yes.

Q There was another issue I think raised in your report concerning a right-sided pneumothorax that developed on March the 8th, or was discovered at least on March the 8th of 1991, correct?

A I think it was created on March the 8th of 1991.

Q Created.

A Discovered, I think it was discovered the day it happened.

Q March 8th.

And do you have an opinion to a reasonable degree of medical probability as to the cause of that right-sided pneumothorax?

A Yes, I do.

Q And what caused that?
A The attempted introduction of the subclavian catheter for the purpose of hemodynamic monitoring by Dr. Varma.
Q And on what do you base that professional opinion?
A The records.
Q And how did it occur? How did he do that in your professional opinion?
A He punctured the pleural lining aroung the lung with a needle used to enter the major veins in the upper chest, subclavian veins.
Q Is a pneumothorax such as Mrs. Weitzel had on the right side of her, is that a risk in the procedure of the introduction of a swan ganz, is that a recognized risk?
A Yes.
Q In other words, that can happen to a physician even of reasonable talent, training and expertise, correct?
A Correct.
Q Can a pneumothorax such as the ones that Mrs. Weitzel had, can they develop spontaneously, that is, a patient that has ARDS, on a ventilator, can pneumothoraxes develop spontaneously also?
A Yes.

Q And that's from the pressure of the ventilator itself, coupled with the disease of the lungs, is that correct?

A You don't have to couple it with anything. The ventilator can cause it, the lungs can cause it.

Q All right. A pneumothorax I believe was on the left side that was noted on March the 7th of 1991.

Have you reached any opinion as to the cause of that particular pneumothorax?

A I don't recall.

Q Let me ask you, you don't recall the pneumothorax that was discovered on March 7th or you don't recall what caused it?

A I don't recall what caused it.

Q You did note that one was present on the 7th on the left side though?

A I believe that's correct, yes.

Q Do you believe that the pneumothorax that --

A I would like to find -- since you are going to keep asking me questions about a pneumothorax I'd like to find, I'm not sure, the records from March the 8th and the 7th -- is that what you say?

Q Yes.

(Witness examining records.)

Q Doctor, in fairness, you wanted to check the

records?

A Correct.

Q Is there anything that you wanted to say regarding the pneumothorax questions after looking at the record that we haven't covered?

A No, I think we have been pretty straightforward with it.

Q Do you have an opinion to a reasonable degree of medical probability as to whether or not patients who survive ARDS and several weeks on a ventilator usually have some pulmonary function impairment thereafter?

A Yes, I do.

Q And what is that?

A For the most part they do not.

Q They do not?

A In my experience.

Q The decision to remove the wires, I take it that would be the decision reached by the treating physician, correct?

A Yes. The attending physician.

Q Right.

A Yes.

Q Now reviewing your report here that you provided Mr. Kampinski on November 30th, I believe you

indicate that it's your professional opinion that on March 14th Mrs. Weitzel was not a candidate for invasive surgery.

A Correct.

Q And what is the basis for that particular opinion?

A The basis was her antecedent one-month medical history, as well as the obvious outcome.

Q And that's because on March 14th she had ARDS is one of the reasons?

A No. Well, that was not the major reason, no. Actually the major reason was that she was just in a perimycardial infarction period within the previ- out 30 days, she was, as I pointed out, septic, most likely, she had a positive blood culture two days earlier of Pseudomonas, she had a decrease in platelet count, she was becoming thromocytopenic indicating marked risk for bleeding, she was febrile. She was not a candidate to have a major operation.

Q Did you reach any opinion as to whether or not Mrs. Weitzel -- well, first of all, you learned from the autopsy that there was some internal bleeding after the surgery, correct?

A At the arteriotomy site, yes.

Q Have you reached any opinion as to whether or not she was closed by the physician? Was she bleeding

at that time or did the bleeding develop after the surgery and after the closure?

A Closure of what, sir?

Q After the surgery where the wire was removed.

A Closure of the artery? Closure of the incision? Closure of what?

Q Closure of the incision.

A Yes.

Q And what is your opinion?

A That it occurred after the closure of the incision

Q Okay. How long after? Do you have any opinion?

A Well, when she began becoming hypotensive is when it's happening.

Q And what hour was that, if you recall?

A I don't recall. I can look it up.

It's within a few hours of the operation, within two, three hours of the operation. She remained hypotensive for a prolonged period, I think it's twelve hours, before she died.

Q I think she went into cardiac arrest approximately 1:14 A.M. on the 15th.

A And the operation terminated --

MR. KAMPINSKI: 4:30.

THE WITNESS: Yes.

A So it was about ten hours.

Q Do you have an opinion as to whether or not the surgery itself directly and proximately contributed to cause her demise?
A Well, yes.
Q Okay. And what is that opinion?
A Yes, the surgery itself proximately caused her demise.
Q Was the timing of the surgical removal -- strike that.

Was the removal of the wires an elective procedure?
A Yes.
Q Now you indicated earlier in your testimony that there was notations in the radiological records and reports that the wires had been observed by the radiologist or one or more of the radiologists as far back as March 1st of 1991, correct?
A March 1st or 2nd I think is what I said.

MR. KAMPINSKI: So it might have been the 1st?

THE WITNESS: But I did say the 2nd.

Q You would not have recommended any surgical removal of the wires between March 1st and March 14th even if they were noted by the attending, say on March 1st, would you?

A No, not an open surgical procedure. That's correct.

Q I got you.

Have you seen any evidence or in your review of this case that the delay in the removal of the wires caused any additional injury or complications to the patient?

A I'm not aware of any, no.

Q Have you -- I don't know, I don't think it is in your report, but I want to cover this -- have you reached any opinion regarding the relationship of the steroids that Mrs. Weitzel was on and her infection? Have you reached any opinion on that, as to whether the steroids caused infection or are you going to render any at the time of trial on this issue?

A I don't believe I will. I mean, I haven't been asked that.

Q But you have no opinion one way or the other at this point?

A No.

Q In your letter I observed some comments regarding the cover-up of the wires by Dr. Varma and I'm familiar with your theory on Dr. Varma; have you reached any opinion as to whether or not

there were any other persons involved in any cover-up of the wires, other than Dr. Varma I am talking about.

A Yes.

Q And what is your opinion?

A Well, my opinion is that there was another resident present with Dr. Varma, according to the records. Whether she knew what was going on or not, I don't think it's relevant, so to answer your question, there may be somebody else who knew about it, but I don't have an opinion as to whether she covered it up or didn't.

Dr. Varma I felt did, and Dr. Varma was the only person that was involved in it.

Q In your professional opinion to a reasonable degree of medical probability, did the ARDS condition that she had directly and proximately contribute to cause her demise?

A No, I don't believe it did.

Q Did the cardiac arrest that she suffered on February 11th of 1991, did that directly and proximately contribute to cause her demise?

A I think it indirectly and proximately caused her demise.

Is that possible, to indirectly cause it?

Q Well, I'll give you a chance to explain it.

Why don't you tell me.

A What I mean is that she had a heart that was weakened by a cardiac arrest, myocardial infarctic, the fact that she underwent an operation in that condition was an extremely risky procedure, coupled with the fact that she then subsequently bled, causing more strain on a diseased heart led to her cardiac arrest and her death.

So it was all tied together.

Had she had a -- if it would be one of us in this room who had a five hundred or so or a thousand cc blood loss, it wouldn't bother our hearts. But this woman had a compromised heart already, and that's why she had the arrest. So in that respect it did directly contributed to indirectly contributed to her death.

Is that clear?

Q I understand.

I have one question because I'm not really familiar with the term, and that was your comment earlier on her developing thromocytopenia.

A Yes; decreased platelet count.

Q Okay. What is it, first of all?

A Decreased platelet count.

Q Okay. And what was causing that condition? If you know.

A I would assume it was her sepsis that she had. She was developing sepsis on the 14th.

Q And that was, I believe you said, another reason why surgery should not have been attempted on March 14th? Is that correct?

A That's correct.

Q Do you have any opinion as to what the cause was or origin of the sepsis and the developing thromocytopenia? If you do.

A I don't really have an opinion.

I have an opinion, but I don't know if it's, how accurate it is.

I can say that we know she had a positive blood culture a few days earlier, the 10th I believe they cultured Pseudomonas on the tip of one of the catheters that were in her bloodstream.

So that in and of itself could have been the source of -- she was on a ventilator, Pseudomonas is one of the most common organisms that develop an infection on ventilators.

So those are the -- but I can't tell you which one it was or something else also.

Q Let me ask you this, Doctor.

If you have reached any such opinion, have you reached any opinion to a reasonable degree of medical certainty as to whether or not in your opinion if the wires had not been left in Mrs. Weitzel, would she have been able to return to work following a course of treatment by her attendings while she was at St. Vincent Charity Hospital?

A Yes, I have.

Q What is your opinion?

A My opinion is that within a reasonable degree of medical probability she would have been able to resume her lifestyle eventually had the wires not been left in her and she underwent the unfortunate procedure she did that led to her death.

Q What type of work did she do?

A She worked in a factory. I think she was a press operator, some sort of press or machine.

Q And on what do you base that opinion, that she would have been able to return to work eventually?

A Based on my past experience and having practiced surgery for, as man and boy, for about twenty years, having had similar patients who had undergone simliar problems with myocardial infarction in a younger woman. I consider forty-seven years

FORM

old a very young woman, and the way these people have responded to appropriate therapies by their doctors and their ability to return to work.

Q Have you had other patients of approximately her age who have undergone a myocardial infarction such as her history of being defibrillated some fifteen to seventeen times, plus adult respiratory distress syndrome, plus being on a ventilator for over four weeks, plus having a history of Pseudomonas, pneumonia and sepsis that have returned to work?

A Yes.

Q You have?

A I don't know about fibrillation fifteen times.

Your question though is critically ill patients on ventilators for long periods of time, a month, two months, myocardial infarction, yes, the answer is yes. And you say "How many?". I would say anywhere in the neighborhood of -- thank goodness, most young women don't have this problem, but I had three or four that I can think of.

I can think of three offhand right now. I am sure there are one or two more.

Q Have you lost some patients having similar

historical background?

A There's been one or two that died I'm sure.

Again, as I say, it's not common for forty-seven-year-old women to come in with this kind of problem.

MR. COYNE: I have no further questions.

CROSS-EXAMINATION OF HOWARD C. PITLUK, M.D.

BY MS MOORE:

Q Doctor, my name is Lynn Moore, and I represent Dr. Varma.

A What firm are you with?

Q Gallagher, Sharp, Fulton & Norman.

Doctor, have you, yourself, inserted guide wires?

A Many times.

Q And what types have you inserted?

A Perhaps you could explain the question.

Q There are various types of guide wires, correct?

A What do you mean by 'types'? Lengths? Glide wires? Side wires? Lubrication? Arterial? Venous? Angio-access?

The answer to your question is all of the above.

Q Have you given for us the various types that you,

yourself, have inserted?

A Partial list.

Q What are the others, if there are others.

A Yes, there are others. Sure.

Do you want me to make a list of them?

Q No, just -- you've given us some.

A There's central venous pressure guide wires for insertion of CVP's. There are guide wires for insertion of swan ganz catheters. There are guide wires for the insertion of broviac catheters. There are guide wires for the insertion of hitley catheters. There are guide wires for the insertion of portocap catheters. There are guide wires for the insertion of pacemaker arterial lines. There are guide wires for the insertion of aortic balloon pumps. There are guide wires for the insertion of angio catheters for the purpose of angiography. There are guide wires for the insertion of balloons for the purpose of angioplasties.

Do you want me to continue?

The point is, there are a million guide wires and I've put in, I'd say, ninety percent of those kinds.

Q Thank you.

A You're welcome.

Q And that's been over the course of your practice which you said was over twenty years, correct?
A Yes; residency, medical school and pursuing a practice, that is correct.
Q And how many years would that cover, about ten?
A About twenty, maybe a little more.
Q And currently in your practice do you have occasion to insert various guide wires?
A Yes.
Q And how many would you say you insert a year?
A A hundred.
Q A hundred.

Now who inserts the guidewires at the hospitals where you practice?

A Well, obviously I do.
Q You.
A Doctors, surgeons, sometimes internists, cardiologists primarily, intensivists whether they be pulmonologists, cardiologists, surgeons.

Let's see who else.

Those would be the major ones.

Q At the hospitals where you practice do residents have occasion to insert guide wires?
A Yes.
Q Okay. Do you permit residents to insert guide

wires on your patients?
A In supervised conditions if I felt it necessary, yes.
Q You say 'supervised conditions'; how would you define that?
A I feel that an attending surgeon needs to be present. That's how I define -- if I don't know the person has the appropriate expertise, then I would make sure that somebody who does is present.

If I feel that the person has the appropriate expertise, then I would allow them to do it on their own.

Q How would an attending surgeon determine if the resident has the proper expertise?
A If they've done appropriate numbers and observed them as appropriate numbers, they are designated as being qualified.
Q Would you say it would be necessary for that attending surgeon to check records or speak with the resident, or how would you ascertain that information?
A I think you ascertain it by all of the above as you mentioned, as well as by direct observation.
Q Do you also permit residents to insert swan ganz

catheters under the conditions that you enumerated for us?

A Yes.

Q And that would also include arterial lines?

A Correct.

Q Do you feel in the present case in 1991 it was in keeping with the standard of care to have a junior resident like Dr. Varma insert a guide wire while unsupervised?

A I can answer that.

Yes, I feel it's appropriate; no, not like Dr. Varma.

Q Okay. And why do you say that?

A Dr. Varma obviously didn't know what he was doing. And from the record that I saw, he didn't have the appropriate experience to know what he was doing.

Q And what records are you referring to?

A I am referring to his log of procedures.

Q You have reviewed the log?

A Since I've written my report, yes.

Q And why do you feel that was inadequate experience?

A One procedure is not an adequate experience, plus there is no indication that he had observation supervision during that one experience approximately

one month prior to him perpetrating this on Mrs. Weitzel.

MS BITTENCE: For the record, I would like to object and move to strike.

MR. KAMPINSKI: For the record, you've received the affidavit that the doctor submitted.

MS BITTENCE: It doesn't go into training on that.

Q Were there other reasons for that opinion, Doctor?

A I am sorry?

Q Other than the log, the opinion that you said that it wasn't appropriate for Dr. Varma as a junior resident to be inserting a guide wire while he was unsupervised.

A Dr. Varma specifically, I don't care if he was a senior resident or a junior resident, yes, I think the actual occurrence that occurred were the reason, the fact that multiple wires were left in this patient without anybody being told about it.

Q What should have been done with Dr. Varma specifically in these circumstances? Who should have supervised him or what should have been

done before he was permitted to insert the arterial line or the swan ganz line?

A Well, I think the general question is, what is the responsibility of whoever is supervising Dr. Varma. And it seems to me that the training program has a responsibility to making sure their residents are adequately trained.

MR. KAMPINSKI: I apologize for interjecting. Just so there is no confusion with respect to the previous objection that was made ....

The logs were provided by Mr. Fulton and Lynn Moore in response to requests that were made by me on January 14, 1993, so obviously the doctor did not have these available at the time he wrote his report.

I'm sorry.

A The training program in general would have that responsibility and I know there are appropriate guidelines set forth for medical residents insofar as certain medical procedures are concerned to make sure they have adequate training and adequate experience in doing these procedures And that's a general responsibility.

In particular I also feel that if a

resident is on somebody's service as a private patient under your service, you should make sure you know what your residents are capable of before you let them do procedures on them.

And as a surgeon, training residents, I've done so for many, many years, and I make sure that no resident touches a patient unless I'm present or I have absolute confidence in that resident, having observed him doing the procedure that I am going to do.

Q So you would say it would be necessary for the attending physician to actually observe the resident do the procedure?

A If he doesn't have any knowledge of this resident' capabilities, yes.

Q I think you enumerated the various specialists that have the right to put in lines and you went into the various specialists; and that would be true in 1991 when this occurred, would it not?

A Yes.

Q And would that be true both for the arterial line and the swan ganz type of line?

A Yes.

I forgot to mention anesthesiologists put in the lines.

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The list wasn't complete, but that's sort of a glaring omission because they put in lines a lot.

Q And that would include pulmonologists, correct?

A Yes.

Q And would it include radiologists?

A Yes.

Q And would it include vascular surgeons?

A Yes. I mentioned it.

Q And that would include a cardiologist?

A Yes. I mentioned them too.

Q Okay. Do attending physicians have any responsibilities for the conduct of residents, the way they treat their patients?

A Yes.

Q What is that responsibility?

A The attending ultimately is responsible for the people that work underneath them, whether they are residents or interns or medical students. He ultimately is going to be the one responsible I feel.

The attending physicians generally have the right to control the conduct of the residents who treat their patients; would you agree with that?

A I don't know what you mean by 'control the conduct'.

Q I think you mentioned before that they have the right to observe the resident do the procedure to satisfy themselves to the resident's competence?

A Yes.

Q Or the attending physician would also have the right to be present when the resident undertook the procedure, correct?

A Yes.

Q So in that way, they would have the right to control the resident?

A Well, I don't know how observation is control, but if you think that's control, then yes, they have control.

Q If the attending physician disagrees with the treatment that a resident has given one of his patients, the attending physician has the right to have the treatment changed?

A Not only his right; it is his responsibility.

Q And that would be true for orders given by the resident as well?

A Yes.

Q Who is responsible to set guidelines for the residents, on one from the Cleveland Clinic, as to what procedures they can or can't perform?

A I don't know.

I would assume the training program sets the guidelines that accepts you into its teaching program.

In this case I guess it's the Cleveland Clinic who accepted Dr. Varma as a resident.

They have a contractual arrangement I assume with St. Vincent's Charity Hospital to supply residents in certain fields, and therefore they do so.

Now I don't know the legalities of it. I'm not a lawyer and I can't answer who has the actual responsibility when he goes from the Clinic to Charity.

And I said, I am sure there are guidelines that the residency program has, the residency program at the Cleveland Clinic.

And after that, you guys can fight that out.

Q Would that be true for invasive procedures as well, that there should be guidelines?

A There are guidelines I'm sure in programs, including basic procedures.

Q You mean the doctor in charge of a patient has a duty to make up a guideline for what procedures the resident is able to do on his patient?

MR. KAMPINSKI: I will object. I think he has answered that already.

A Yes.

Q You have nothing more?

You're not talking about written guidelines?

A No.

Q Doctor, have you ever retrieved a guide wire that has been lost in a patient in your experience?

A No. Lost in a patient, no, thank God. I haven't seen one lost.

Q Or put into a patient that's sent somewhere in a vascular system, have you ever encountered that, not your patient, but the others?

A Yes, I have encountered that.

Q You have encountered that?

A Yes.

Q And when did that happen?

A What do you mean, when did that happen? The date?

Q Yes, like what year.

A I don't know.

Q How many?

A I have seen two or three guide wires that have sheared off. As you are trying tc withdraw them, you have a very

sharp needle that's used to introduce them into a vessel and they wind up in various and sundry places.

I recall one that a patient who had to have a thorocotomy and cardiotomy because the guide wire was stuck in the heart and it was interfering with the function of the mitral valve.

The others have been retrieved successfully by radiologists.

Two or three that I have seen through percutaneous or transcutaneous techniques.

Q What does that involve, is that used in fluorescopes, fluoroscopy?

A Yes. Fluoroscopy, direct puncture of arteries, catheters, other guide wires, other catheters and various devices to snare and trap the wire and remove it through the skin.

Q Did any of those instances that you encountered involve surgery?

A I said there was one instance of fluoroscopy. That's surgery of the heart.

Q In the heart?

A Yes.

Q Okay. And so that in some of those instances the wire was sheared off by the needle?

A Yes.
Q Is that when the wire is withdrawn?
A That's what I said, yes.
Q Pardon me.
A Well, there are a lot of people here. It is going to be a long afternoon. If we could remember what I said from one minute to the next, it might be shorter.
Q All right. And you are aware of reports in the medical literature about guide wires breaking and/or uncoiling leaving pieces in a vascular system?
A Yes. As I said, sure.
Q And you have experienced it yourself?
A Yes.
Q Now who was in charge of Mrs. Weitzel's case when Mr. Steele was on vacation?
A Dr. Kitchen, I believe.
Q Is that something that's appropriate, to leave a partner in charge of a patient?
A Absolutely.
Q And he would then be the person who would have the responsibility to supervise any residents?
A Correct.
Q Would you say that in 1991 the most widely

accepted form of retrieval of a lost guide wire in a vascular system would be by a radiologist under fluoroscopy?

A By someone trained in percutaneous techniques, usually it's a radiologist.

It can be a cardiologist.

Q It was appropriate for a femoral arterial line to be inserted in Mrs. Weitzel on February 26, 1991; would you agree with that?

A I really don't know if it was appropriate or not, to be honest.

I think a radial line would have been sufficient. Why a femoral line per se was put in, I think some other kind of a wire, another resident wasn't successful, so then they went to the groin.

I will say that you use a femoral, or certainly in my training, in my practice I use a femoral artery as a last resort for a line.

Q Why is that?

A It's just a, it's a difficult spot, complications that can occur to the femoral artery are disastrous, losing limbs.

In the groin is a small artery. The groin is a filthy area of the body, from a bacterial

standpoint at least, and if you could avoid it, you do.

Q You are aware then that another person or persons were in Mrs. Weitzel's room attempting to insert a line on the same day that Dr. Varma was there, February 26, 1991?

A A radial line, is that correct?

Q Right. You noted that in the nurses' notes I take it.

A Yes.

Q And there was no entry in the progress notes, correct?

A No, not that I'm aware of.

Q That isn't a standard practice for a physician trying to insert an arterial line, is it?

A What isn't?

Q Not make a record in the progress note?

A Not in my practice.

MR. KAMPINSKI: Show an objection.

Q Not in your practice?

A Yes. I think that anything you do to a patient should be documented just to avoid these situatio that we're sitting in now.

Q Now the chest x-ray of Mrs. Weitzel should have been read by the pulmonologist, correct?

A Did he order those?

Q I believe there was a standing order.

Assuming there was a standard order and chest x-rays were done.

A By the pulmonologist? Standing order by the pulmonologist?

Q It depends on who orders them, is that what you are saying?

A Well, I think it's the standard of care for the person who ordered an x-ray to look at his own x-rays, number one.

Number two, however, pulmonologists when they look at a chest and lungs -- that's what they deal with -- generally use x-rays as one of the most important means of gauging what is going on. So I would assume that chest x-rays were done, the pulmonologist would look at them even if he didn't order them.

If he did order them, then I would expect he would look at them.

(Mr. Elk left the conference room.)

Q And in a situation of a patient with ARDS, would it be expected that the pulmonologist would take a look at the x-rays?

A Yes. But that doesn't help him. Once you have

ARDS, you see just white. You don't see a whole lot.

It's helpful only when it gets better.

Q And would you expect a cardiologist to review the chest x-rays of a patient such as Mrs. Weitzel?

A It depends. It's hard to say. Cardiologists don't look at chest x-rays.

They look at chest x-rays, but maybe not for the same reason as a pulmonologist will.

Q Well, in this case where there was a resident who, I believe Dr. Varma, had ordered x-rays, would you expect that one of the other specialists or attending physician would have been monitoring the chest x-rays as well?

A That's correct.

Q Which specialist would be the person that would be expected to do that?

A Well, certainly the attending physician under whose careDr. Varma was charged, that doctor should look at them because Dr. Varma is his extension, if you will. He is responsible for what Dr. Varma orders.

Q That would be Dr. Steele?

A Dr. Steele and Dr. Kitchen, and then, once again,

the other corporate specialists who need the x-ray to evaluate their patients.

Q The potential complications of a retained guide wire in a patient are infection, emboli formation and possibly perforation, is that correct?

A Yes, those are the most significant complications.

Q And there was no evidence that Mrs. Weitzel had any of those complications, is there?

A She had emboli infection.

You didn't say infection, did you?

Q Yes, infection.

A Well, she had infection.

Q But that was found prior to the insertion of the --

A No, no, they did a culture of the Pseudomonas.

Q That was after?

A Yes.

Q There was no evidence of perforation of the vessels, correct?

A Correct.

Q It appears that no physician came in to see Mrs. Weitzel after the March 14, 1991 surgery; is that what you are getting from the records as well?

A Dr. Moasis' surgery?

Q Yes.

MR. COYNE: Show an objection.

MR. SEIBEL: Likewise.

A I think that no one came in. No.

There was, I think, a verbal order from a resident, but I am not aware of anybody actually, physician, seeing Mrs. Weitzel following the surgery.

Q Well, in view of the change in her vital signs, is that appropriate?

A No.

MR. COYNE: Objection.

Q What should have been done there?

A I felt that the, as soon as the vital signs changed on this critically ill patient, the attending surgeon should have been notified and/c the resident, and that person should have come in and seen his patient.

Q What caused Mrs. Weitzel's death?

A Cardiac arrest.

Q And that means what?

A Her heart stopped.

Q Why did it stop?

A Most likely from the complications of the operation and the complication of the previous

myocardial infarction about a month earlier or three and a half weeks earlier or whatever it was.

Q Did the ARDS also contribute to cause her death?

MR. KAMPINSKI: Objection; asked and answered by Mr. Coyne.

Q Isn't there a sixty percent mortality rate of persons with ARDS?

A I don't understand the question.

Forty percent in your estimation then are survivors.

Q You don't agree with that statistic?

A No.

Q There is no indication that Mrs. Weitzel died directly from the guide wires, is there?

MR. KAMPINSKI: I'll object.

A We already talked about that. Do you want me to go through that again?

Q No. You have already said all the opinions on that, correct?

A Yes.

MS MOORE: Okay, that's all I have. Thank you.

THE WITNESS: Thank you.

MR. COYNE: Mr. Carmen or Mr.

Varma?

MR. CARMEN: No.

MR. VARMA: No.

CROSS-EXAMINATION OF HOWARD C. PITLUK, M.D.

BY MR. WARNER:

Q As I understand, she was on a special type of ventilator. The name, I believe, is I.E. Reverse Ventilator.

Are you familiar with that type of ventilator

A I may be, but I don't know this particular code that you are talking about.

Q Okay. Did you read the deposition of Dr. Sopko, the pulmonologist?

A I reviewed it. I don't know the objective.

Q Right. He indicated that the patient while she was on this I.E. Reverse Ventilator could not be moved. That was his opinion as a pulmonologist.

Would you have any comment on that or would you say that's an area outside of your expertise and you have no opinion on that?

A Well, to be honest with you, I have an opinion that because you are on a specific brand of ventilator, there's no -- I've never in my twenty years of critical care, as well as surgery, experience -- ventilator that was such that you

couldn't move the patient because of it.

The answer to that question: I would doubt that very seriously.

Q I think you indicated in this particular patient you would not have done surgery?

MR. KAMPINSKI: Look, I'm going to object because either you don't understand what Dr. Sopko testified to or you are intentionally mischaracterizing his testimony

He was discussing the type of ventilation she was receiving.

MR. WARNER: All right.

MR. KAMPINSKI: So it wasn't the make or the manufacturer of the machine.

Q I didn't intend to mean the make or the manufactur of the machine.

A That's what you said, though.

Q Right. What about the fact that she's on a ventilator --

A I don't know what you mean.

Q -- the one that's outlined by Dr. Sopko, would that make it that the patient would not be a candidate for --

A I don't understand your question so....

If you want to give me a specific reference

to a specific statement, I'd be more than happy to answer.

MR. WARNER: That's fine.

I have nothing further.

THE WITNESS: Thank you.

CDOSS-EXAMINATION OF HOWARD C. PITLUK, M.D.

BY MS BITTENCE:

Q I am Mary Bittence with Baker and Hostetler. I represent Cleveland Clinic Foundation.

A Okay.

Q I was glancing through your C.V. while other people were asking questions and under 'Hospital Appointments' you have 'Director of Vascular Laboratory' without date; is that something you are still involved in?

A Yes; at Hillcrest Meridia Hospital.

Q And then I take it the Co-Director of Vascular Laboratory at Meridia Hillcrest below, that is something you held before you became the sole director?

A Oh, I'm sorry. There are two entries. The one ahead of Hillcrest, it says --

Q Oh, Brainard. I'm sorry.

A -- Brainard. Cardiovascular Laboratory, right The other one is at Hillcrest. That's

correct.

Q What percentage of your practice is general surgery as opposed to vascular surgery?

A Maybe forty percent. Sixty percent of vascular surgery; forty percent of general surgery.

Q And do you have one of the hospitals where you have privileges where you do most of your work?

A Meridia Hillcrest.

Q Doctor, do you perform defibrillation on your patients?

A I have, yes.

Q Has that been after your residency?

A Of course.

Q And how many times have you performed defibrillation?

A I haven't got a number for you.

Numerous times. Fifteen times. Twenty times.

Q What is it in the records that leads you to the conclusion that the right pneumothorax on March 8th was caused by placement of the swan ganz catheter?

A The temporal relationship to the placement of the swan ganz catheter and the pneumothorax.

Q There's nothing in the x-ray or any indication

of a puncture, it's just a temporal relationship?

A Well, there is a procedure note by Dr. Varma indicating the placement of a swan ganz catheter and right afterwards is another procedure note about a punctured pneumothorax being done.

It's the next note in the chart. I'm looking at it right now.

Q Right. So it's that temporal relationship?

A It's a pretty good reason, yes.

Q I'm not challenging you, I just want to know.

A I know.

Q It's not an x-ray that you've seen or --

A No, I have not seen any x-ray, as I have stated.

MR. KAMPINSKI: Dr. Sopko testified that there was a temporal relationship as well.

THE WITNESS: I don't recall if I read it in the nurses' notes also.

MR. COYNE: I think Dr. Sopko testified both ways.

MS BITTENCE: Right.

MR. COYNE: It was in his deposition, I was reading it.

MS BITTENCE: On one page he said it was spontaneous.

THE WITNESS: I don't recall if there was a nurses' note that put Dr. Varma in there placing a line.

That would certainly help define this for you also.

But again, I don't recall if there was so...

Q Are you familiar with the training in the residency program for internal medicine at the Cleveland Clinic?

A No.

Q Is your basis of what training Dr. Varma had or did not have in the placing of arterial lines based solely on the logbook?

A Correct.

Q Is the procedure for placing arterial venous lines basically the same?

A No.

Q What are the differences?

A They are just totally different procedures.

One is a positive pressure procedure, the arteries have basically positive pressure in them which cause the appearance of the blood.

Venous placements were often compared to apply negative pressure to make sure you're in

the right position. So just the actual placement of the needle itself is much different. For a patient, the vessels are markedly different.

Q Once you find the vessel, is the actual placement procedure the same?

A No, usually not.

Q What are the differences in the steps?

A Well, it depends on the vein. You are cannulating on the artery. You are cannulating -- very often I won't even use a guide wire in venous procedures or arterial procedures. It depends.

If I am cannulating the radial artery, I never use a guide wire.

If I am cannulating a jugular vein, I don't usually use a guide wire either.

So it just depends on the procedure you're doing and you just have to know how to do these things.

Q When you started in your practice twenty years --

A Practice? I'm not that old.

Q You could have been a child prodigy.

A I was, but you still have to go through certain training.

Q Does your twenty years include your residency?

A Yes, it includes my residency.

Q During your residency were you able to cannulate arterial or venous lines without guide wires?

A Yes.

Q Was that part of your training, to do it without the guide wires?

A Of course. In certain instances, as I pointed out.

Q Is the procedure of the placing of an arterial line, brachial, radial or femoral, aside from finding the artery itself, step by step different from placing a swan ganz catheter?

A Yes.

Q Let me, in an abbreviated form, if I could, summarize --

MS BITTENCE: And everybody can jump on me with objections if I've done it wrong.

Q But my understanding from what other witnesses have said for placing an arterial line if you are using a guide wire is to take the needle, you find the artery, then you take the needle out, you get the needle into the artery.

A May I ask a question?

Q Yes.

A Why are you --

MR. KAMPINSKI: Why don't you just ask him.

Q Because I want you to go through the differences. If you want to go through both step by step for me, fine.

A You have -- with all due respect -- no idea what you're talking about. Just as I would have no idea if I would say legal things to you. So what, exactly, is it that you want me to do?

Q Go through step by step how you do a femoral arterial line if you are using a guide line.

A Cannulate the artery with the needle.

Q First of all, Doctor, will you explain what cannulate means?

A Stick the artery with the needle. I make sure I'm in the lumen. And I do that by making sure there is an appropriate blood flow coming back into the needle of the syringe. Then I take the syringe off, keeping my finger over the hole, because I don't want blood squirting in my face, which will happen if you don't do that. Then I take the guide wire of appropriate length. Usually if it's a femoral artery, I'll

make sure that the guide wire I'm using is short.

I don't believe in using eight-inch guide wires for a catheter that only has to be in three inches.

And I will take that wire, which usually has a soft coil tip so as not to perforate the artery once it's beyond the tip of the needle, and thread it into the artery.

At that point I will hold the wire in place once it's appropriately threaded and gently withdraw the needle over the guide wire so that the needle is no longer in the artery and the guide wire is in the artery, making sure not to dislodge the guide wire from the artery as I withdraw the needle.

I then usually will take a dilator of, usually it's a plastic material, polyethylene type of material, and over the guide wire take the dilator which basically is a catheter in the shape of the catheter lead, perhaps a little bit smaller, and over the guide wire insert it through the skin, into the artery. That's dilating a crack over the guide wire where the catheter will be placed.

Once that's done, I will withdraw that

dilator out of the artery, again leaving the guide wire in place, holding the guide wire the whole time.

I put my finger over the hole so again I don't have blood squirting all over the place.

I then take the appropriate catheter that I want to use, whether it is an angio-catheter, whether it is a subclavian catheter, and insert that over the guide wire, again making sure that the guide wire is visible -- and I am holding it, controlling it -- into the artery, through the crack that I've made with the dilator.

Once it is in, the end of the guide wire is sticking out through the hub Rulok connector of the catheter that is now lying within the artery.

I will hold the catheter in place, grab the end of the guide wire with my right hand -- usually I will hold the guide wire with my left hand -- withdraw the guide wire gently through the catheter that I just placed into the artery.

Then I take the I.V. solution tubing -- whether it is going to be a pressure bag or whatever -- connect it to the hub. And now I have an arterial line.

Q What are the [anz catheter?

And will you go through those steps and tell me what's different? Or just tell me what the difference is. Whatever is easier.

Q Well, the difference is that in order to put a catheter in, you need first of all to puncture the, I always use the subclavian vein, which is the vein right underneath the clavicle. I usually go to the right side. It's a more direct route than the left side. It's a shorter artery than the left side. And I puncture it, using negative pressure. In other words, I have to withdraw. I have a syringe attached to the needle that I used to puncture.

I withdraw on the back of the syringe so as to obtain blood flow in the vein. This is after I place the patient in a position to kill the pain. Pressure needs a gravity flow.

And once I cannulated the vein with the needle, I withdraw the syringe. I don't have to worry about blood squirting out because venous pressure is very low pressure.

But I usually put my finger over it so as to prevent sucking the air into the system.

I then take the guide wire, thread the needle, and the same procedure about placing, removing the needle slowly, making sure it's not shearing the guide wire, putting the dilator in over it.

And then at that point we use something called 'Cordes Introducer'.

Cordes Introducer is a much larger diameter tube. Through that tube, a little rubber gasket on the end of it, you place another guide, if you will, through this hole because the Cordes itself is too flimsy to put through the crack.

And now the Cordes becomes more of a rigid tube, placing over the guide wire again, guiding the guide wire with my right hand, the left hand for the catheter, pass the catheter over the guide wire into the vein.

Then I withdraw the guide wire and this introducer, of course, through the center of the Cordes, out, and the Cordes is sutured into place.

Once the Cordes is sutured into place, then I have access to the system and I can take my swan ganz catheter and insert it through the Cordes.

The Cordes is introduced in a sheath that sits in the vein, in the subclavian vein, and place the Cordes into the right ventricle, up into the pulmonary artery, obtaining the right pressure, and then I make sure that I'm in the right spot, take the x-ray, you know it's the right spot.

Q What steps, or however you want to describe it, do you feel are necessary in order for a resident to be trained to place arterial lines?

A He needs to see it, he needs to do it with somebody watching him who is proficient at it, and then he needs to do it.

Q Is there a number of times he needs to watch it?

A It depends on the individual.

Q Is that true also of the number of times he has to do it under supervision?

A Yes.

Q So there's no set number of times?

A It's more than one.

Q Always more than two?

A No, not for me. For Dr. Varma it may well have been.

Q I'm just talking in general.

In a general training program there's not some

number that necessarily says everyone has to do it 'X' amount of times under supervision before they can do it on their own, they have to watch it 'X' number of times?

A He has to do more than one for each.

Q And if in fact Dr. Varma did watch several femoral arterial line placements, and in fact did several under supervision, and the person supervising was proficient and he felt he knew what he was doing, would it have been proper then for him to do it on his own after that?

A If all those things are true, yes.

Q If a resident performs one femoral arterial line placement and four swan ganz placements and two brachial arterial line placements and does them all proficiently, would they be qualified to do femoral arterial line placements solo?

A Never having seen one or done one?

Q No, I'm sorry, I thought I said that first.

Did one femoral, three brachial, four swan ganz.

A I don't know. The question doesn't have any merit. I don't know what you are talking about.

Q Well, I'm trying to get your opinion, how many times --

A I have no opinion.

I said it depends on the resident. There is no generic resident.

Q The other part of that was to understand your opinion on if they do one type of arterial line placement and three other type of arterial line placements, in other words, femoral, brachial, are they then qualified to do the femorals, which they have only done once, but have done other arterial lines, on solo if they do them all proficiently?

A As I stated, it depends on the individual.

Q All I'm trying to do, Doctor, because you made a difference to me again how you do the second procedures.

A You asked me if there was a difference, and I said yes.

Q So then I want to know, would a resident be trained enough to do a femoral line individually, solo, if he had done only one femoral line and three brachial.

A Not necessarily.

Q But he might?

A He might.

Q So you wouldn't have to do more than one of a

specific kind of arterial line placement, just more than one arterial line placement?

A It depends again on the resident.

Q Okay. That's what I'm saying.

He might be proficient having done --

MR. KAMPINSKI: He said that now about twenty times.

MS BITTENCE: All I would like him to say is yes.

MR. KAMPINSKI: He said it over and over and over.

A I think I understand what you're trying to do, but why don't we get on with it, because my answer is my answer.

You are making a generalization for every resident, and I'm telling you there is no generalization for every resident.

Q I'm saying 'assuming'. In other words, does it make a difference.

A Yes, it does make a difference where the line goes. Does it make a difference if you do one type of one procedure and four of another type of procedure that one is sufficient is the question. And I said yes, it does make a difference, it depends again on the individual

resident.

Q So you are agreeing that that resident could be proficient to do one solo?

A That hypothetical resident could be.

Q Right.

A Yes.

Q Okay.

A Or he may not be, depending on the resident.

Q All right. I understand.

But there is no requirement in your mind that they do a specific arterial line several times.

A No I said at least once.

Q Right, I understand that.

You mentioned that in this specific case you may not have chosen the the femoral arterial lines as the location, correct?

A Yes, that's correct.

Q In your opinion did the use of a femoral location as opposed to brachial or radial in and of itself cause any damage to the Plaintiff?

A Just -- no.

Q Do you have an understanding as to why Mrs. Weitzel was life-flighted from Samaritan to Charity?

A I believe they felt that she could be better cared for at Charity than they could at this smaller hospital in Ashland.

Q And was that based on what her condition was like on the second day that she was at Samaritan?

A I would assume so.

Q Do you know whether it deteriorated overnight or stayed the same as when she was first admitted?

A I am not familiar with Samaritan Hospital and their capabilities, so I can't answer as to why specifically.

As far as her condition was concerned, it didn't appear that it was much different than when she came in, except perhaps a little more stable.

Q Is the term 'critical condition' when describing a patient a term of art in medicine; in other words, are there guidelines when they say a patient is critical or they're good or fair?

A Basically it's a subjective opinion.

There is no objective opinion on the data that I am aware of that makes someone critical versus serious versus guarded versus satisfactory versus good.

Q Do you have your own subjective guidline that

you follow for determining when you would call a patient critical?

A Yes.

Q And what, a heart patient, what would --

A What do you mean by 'heart patient'?

Q When somebody has had a myocardial infarction, what would be their overall condition for you to describe them as critical?

A Admission to the intensive care unit.

Q So whatever variables so long as long as they were admitted to intensive care?

A Correct.

Q Doctor, have you seen any x-rays for Mrs. Weitzel when she was at Charity?

A No.

Wait a minute, let me --

At Charity?

Q Right.

A I saw one x-ray, chest x-ray, that showed some wire, that showed wire in there, or a copy of the x-ray. I did see that one.

Q Do you recall what date that was from?

A No.

Well, I will recall that it was after the 26th.

Q 26th?
A Yes.
Q When you looked at, whichever one of the x-rays it was, and you looked at the actual x-ray, not the report?
A I looked at a copy of the x-ray, I do recall seeing that.
Q Could you tell if there were one or two guide wires?
A I thought there were two by looking at it.
But I did have the knowledge of hindsight.
Q Have you seen the guide wires that are at St. Vincent?
A No.

MS BITTENCE: That's all I have.

CROSS-EXAMINATION OF HOWARD C. PITLUK, M.D.

BY MR. JACKSON:

Q Dr. Pitluk, I represent Dr. Steele.
Would you list for me, please, all criticisms you have of Dr. Steele's care of this patient?
A I believe Dr. Steele had responsibility as a cardiologist, specifically an internist in general, to know the condition his patient was in, to understand the possible complications due to these conditions and to exercise the appropriat

judgement in making sure that he would at least do no harm to this patient while he was trying to help her.

I think that he was successful in removing one guide wire percutaneously, and I think that's appropriate.

Q You don't have any criticism of that procedure or the decision to do that procedure?

A Correct.

My problem with him comes with the fact that there was a second guide wire left in place which he was unable to obtain, he just left it in.

He demonstrated by doing the one percutaneously, a safe and efficacious method of removing that guide wire. But then for some particular reason which to me is I believe below the standard of care -- and this is a criticism -- he did not exhaust those modalities and use those experts available to him to remove the second guide wire in this similar technique.

Specifically, he had a partner in his own practice, Dr. Kitchen, who was a self-proclaimed and I believe published expert removal of foreign body guide wires from arterial systems. He never even asked him about it. He never suggested

he help.

He had a very strong radiology department, what I understand to be Charity Hospital Radiology Department, with people capable also in percutaneously removing those guide wires, he never asked their help.

What he did do was take a patient who was in a peri-myocardial infarction period and subjected her to a major operation which ultimately helped her to her death.

So that's a strong criticism.

I believe he should have communicated better with his colleagues. I think he should not have availed himself of the operative procedure.

Finally and moreover, once Mrs. Weitzel underwent this major operation on the 14th of March, Dr. Steele never went and saw his patient afterwards.

Granted, it was Dr. Moasis who operated, but Dr. Steele, I feel, who had put so much time and effort into this young woman and really had gotten her to a point where she had survived this major myocardial infarction and all the other problems that she had, nobody saw her, including him.

You would think that the cardiologist, the heart doctor, would have been concerned about a patient who had an MI within the last month and just had a major operation would have stopped by to see her. He never did.

So I feel that's below the standard of care for a cardiologist in a major hospital with a private patient.

Q Okay. I have got then three criticisms where you believe he deviated from standard of care, first being --

A I'm not done.

Q Oh, excuse me.

A And the other criticism I have, and the final criticism, is, I feel that Dr. Varma was his responsibility. I mean ultimate.

Dr. Varma is a grown man and a physician who is practicing and so he also had obvious, his own responsibilities.

But Dr. Steele was the attending physician under whose care Dr. Varma was supposedly operating, and I feel that Dr. Steele should have much more closely supervised his resident.

I think he should have been looking at his own x-rays, as an example.

I don't know why Dr. Steele didn't see those wires. I saw them.

The radiologist did in fact point them out on March the 2nd of -- or the 3rd, one of those days. And Dr. Steele, I think, could have seen those as well.

So I feel that a lot of the things that transpired may have been avoided had Dr. Steele supervised his resident better and been more aware of what was going on.

Those are my major criticisms.

Q Are you done now?

A For now.

Q Okay. You think there may be some more, is that what you are saying?

A The way you phrased the question, I thought I might.

Q Well, I would like to know if there are any more as we sit here.

A I am not aware of any more.

Q So you have listed for me all of your criticisms of Dr. Steele then?

A Yes.

Q So that I can summarize them, I have four.

A Okay.

Q One, the decision to do the second surgery.
And you talked about another --
A Second surgery?
Which was the first surgery?
Q I'm talking about the surgery to remove the guide wire, the procedure.
A Okay. That's the only surgery she had.
Q The procedure that he used, you wouldn't call surgery?
A No. I wouldn't call it surgery, no.
Q It is an invasive procedure?
A It's invasive, yes, but so is putting I.V. in.
Q Right.
Then rather than term that as surgery, the decision to turn her over to Dr. Moasis for surgery by Dr. Moasis is your first general --
A Correct.
Q -- criticism of him?
A Correct.
Q The second one is communication with his colleagues, he should have communicated better?
A Correct.
Q The third was that he did not go in to see his patient after the March 14th operation?
A Correct.

Q And the fourth was that he was ultimately responsible for Dr. Varma and that he should have supervised Dr. Varma more closely?
A That's correct.
Q Did I cover all of them?
A Yes.
Q Then as it relates to your first criticism, that being the decision to do the surgery, you made a comment about him exhausting other modalities; what other modalities should he have exhausted before going to the surgery?
A I suggest I told you that he should have contacted Dr. Kitchen or the radiologists and used their expertise in removing the guide wire percutaneosly
Q Are those the modalities that you are suggesting?
A Yes.
Q Why should he have contacted the radiology department, what would lead you to believe that they could have done the procedure any better than he did?
A They probably do it more than he does, and that's generally who does these procedures.
Q Are you critical of a cardiologist doing the procedures?
A No.

Q And you don't have any particular or specific knowledge that they have any better expertise than he does at St. Vincent's, do you?
A 'They' being the radiologists?
Q Radiology department.
A Better expertise, no.
Q Now if in his opinion they did not, would you still be critical of him not having them perform the procedure?
A Yes.
Q So regardless of his judgement as to whether he has at least the same experience or quality obtained with performing this procedure as radiology or perhaps better, you still are critical of him for not approaching them?
A Yes, that's my second criticism, communication.
Q We'll get to that.
A Well, but this is part and parcel of it.
Q So regardless of his feelings about their abilities or what their abilities really are, you are critical of him for not going to radiology and having them attempt to remove the second guide wire?

MR. KAMPINSKI: That's the third time you have asked him. His answer is yes.

Q I am trying to clarify it in my mind.
A Yes.
Q And you believe that is a deviation from accepted standards of care?
A Absolutely.
Q Do you believe that is a proximate cause of the end of this patient, his failure to talk to the radiology department about the procedure, about doing the procedure?
A Yes.
Q What harm did that cause?
A An operation to be performed.
Q You assume they could have retrieved the guide wire?
A Within a reasonable degree of medical probability, yes.
Q That they could have done that?
A Yes.
Q What leads you to believe that?
A My experience with radiologists.
Q What was it about this particular case, what is it that you looked at or saw or reviewed that leads you to believe that the radiology department could retrieve this wire?
MR. KAMPINSKI: He just told you that.

Why do you keep asking the same question. If you don't like the answer, that's your problem, it's not his.

MR. JACKSON: I think he said his experience. I am asking about this particular case now.

MR.KAMPINSKI: What about it?

MR. JACKSON: I want to know. That's what I want to know.

A Well, he did get one wire out. It seems to me he could get the other. They weren't that far apart from each other.

So it's that simple.

Q Now as it relates to Dr. Kitchen, I know you stated in your report that Dr. Kitchen is a self-proclaimed expert in the field; were you intending to be sarcastic?

A No. I believe Dr. Kitchen said that or had discussed the fact somewhere that he had perfected a technique or had a special gimmick or some sort of instrument that he used to percutaneously remove foreign bodies.

Q So that wasn't intended as a sarcastic comment about Dr. Kitchen?

A Well, you know me better than that.

Q I'm asking.
A No. I don't write sarcasm in letters; just personally in people's faces.
Q So then not going to Dr. Kitchen, you believe that was a deviation of standard of care also?
A Yes.
Q Do you also believe that that was a proximate cause of the end of this patient?
A Yes.
Q And do you believe that Dr. Kitchen could have removed this second wire?
A Yes.
Q On what do you base that opinion?
A As I stated, Dr. Kitchen's expertise in removing foreign bodies from vessels.
Q Are there other modalities other than Dr. Kitchen and the radiology department that you refer to when you say he did not exhaust other modalities?
A The only other modality is leave the wire alone.
No. The percutaneous approach is the modality that I am referring to.
Q Did the wire have to come out?
A At the present, then, no.
Q Did it have to come out eventually?
A Yes.

Q It was a necessity that at some point in time these wires would have to be taken out, they couldn't just be left in?

A No, that's not good medical practice.

Q The comment about him communicating better with his colleagues, explain that for me, please.

A Well, I just look at everything that happened to Mrs. Weitzel. It just seems to me if people were to talk to each other more, a lot of this or all of it perhaps could have been avoided.

If the radiologist would have talked with Dr. Steele about their findings on the 1st or 2nd, and not wait until the 8th, that would certainly have made this diagnosis come forward a lot sooner.

If Dr. Varma would have told people what happened when it happened, instead of trying to cover it up or attempt to cover it up, then I think this wire could have been grabbed a little sooner.

If Dr. Steele would have talked to the radiologist, whether he thought they were good or not, or talked to his partner, Dr. Kitchen, and said, hey, look, guys, I got one out, I didn't get the other one out, what do you think,

Q How different?

A Well, she would have had the wire either left in place or removed percutaneously, she would not have had the unnecessary operation to cause her death.

Q And you feel that is in part caused by his lack of communication with these various people you just described?

A Correct.

Q And in terms of what I numbered three, because that's the third one you mentioned about not seeing her post-op; when should he have seen her post-op and why?

A Why is simply because he had a very critically ill patient who underwent a major operation and the part of her that was critically ill is the part that he was taking care of, heart, as well as her general pulmonary status, infection, and he was the internist who was running the show here. So that's why he should have seen her.

When he should have seen her? Sometime within the peri-op period, whether it's the first few hours, three or four hours usually, before he left the hospital that day would have been a good time to see her.

let's get it out, I have a lady here who has this foreign body in her, she had an MI three weeks ago, I don't want us to have to do an operation, let's get this percutaneously, somebody would have taken it out percutaneously.

And I think that when Dr. Moasis did the surgery, had Dr. Steele communicated with him about what happened about how the wire came out, personally talked with him or called him and talked with the nurses -- called up on the phone even and said, how's my patient doing, he would have found out the patient was hypotensive.

Q This is the two and three kind of overlapping each other?

A I didn't make a list for you.

Q The third one was the, not seeing the patient post-op which you just described?

A That's, yes, that's talking about, but actually seeing the patient would have even been optimal.

Q So as it relates to Dr. Steele, you don't believe he talked enough to his colleagues as it relates to the care and treatment of Mrs. Weitzel?

A I think that's correct.

I think that had he done that, the course of events would have been markedly different.

Q What would have been accomplished had he seen the patient the first three or four hours post-operatively?

A I think he would have noted some instability on her, check the cardiogram to see what was going.

Q Is there any indication in the records, Doctor, that you reviewed that in the first three or four hours post-operative that there was any instabilit on this patient?

A I believe she was becoming tachycardic, hypotensive the first four hours.

Q Should he have been notified of that?

A Somebody should be notified of it, whether him specifically, but I don't know how the hospital is set up.

Q If there's a change when you do surgery, if there's a change in a person post-op, whose obligation is it to let you know?

A The first one that notices the change, the nurses.

Q Are you required to be there at all times with a patient post-op?

A At all times?

No, only if there's significant changes going on that I would address directly.

Q And those would be changes that you should be

alerted to?

A Absolutely.

Q You said she was significantly tachycardic within three to four hours post-op?

MR. KAMPSINKI: Why don't you look at the chart. He wants a specific time.

Q Please. I would like you to point out for me the basis for that statement.

A Okay.

Q You said 'tachycardic', and there was another --

A Hypotensive.

A At 1600, that's a pulse rate of 127.

Q 1600?

A Yes.

Q When did the operation end? I believe 4:30. That would be 1630, wouldn't it?

A Well, yes. I don't see it.

Q When did the operation end?

A Let's find out. It's in the chart.

MR. KAMPINSKI: She was in her room at 4:20, returned from O.R.

Q She was in her room at 4:20.

A I don't know what this is.

This is a flow sheet. I don't know what that's from.

It says here, in the nursing progress notes, returning from the O.R. This is 4:20 P.M. Okay.

Q Now you said at some point between then and three to four hours after that he should have seen her because she was tachycardic and hypotensive.

A Yes.

Q Unstable I guess was your word.

A Yes.

Q Would you point out to me what it was in that time frame, that evidence of tachycardia, hypotension and instability?

A Well, I need to get the chart out, the records out.

Q Okay.

A Well, here is a, it says 3/14/91, so I assume this is the surgery. It gives a pulse rate at twenty hundred, which is what, 8:00 P.M? That's about three and a half hours after she's back to her room. She had a pulse of 141 and a blood pressure down from 180 over 98 at Noon to 112 over 60 at 8:00 P.M. That's three and a half hours later.

Q Well, up to that time how was she doing?

A There is no other entry up to that time, as I pointed out to you, the other one at 1600, she

wasn't in her room then, she was still in surgery. So I don't know what that entry was.

But certainly a time was appropriate for her during time of surgery, she was tachycardic and hypotensive, relative to the way she's been.

Q Okay. That's at 8:00 P.M. you are talking about?

A Yes.

Q Should he have been made aware of that?

A I think so, yes.

Q Are you suggesting he should have been there at that time?

A I'm suggesting he should have come there when she was beginning to show instability.

Q I understand that. But should he have been in the hospital at 8:00 P.M.?

No, not necessarily.

Q And unless he was notified of some instability in a patient, there is no reason you would criticize him for not coming back to the hospital?

A No. That's correct.

Q Are there any other notes?

A That's it.

Oh, yes. At 10:00 o'clock, diaphoretic. I assume this is ten -- it says 10:00 P.M. We're off military time now. We're on

American time.

And this talks about diaphoretic, range of motion.

I don't see any vital signs reported.

Oh, 1:00 o'clock.

Q That would be 1:00 o'clock A.M.?

A I would assume so.

Sinus tach. That's tachycardia again.

Unable to feel pulses. She didn't have much of a blood pressure.

V tach noted.

We have very poor documentation, but it says tachycardia and feeling no pulse means you don't have much blood pressure.

Q Okay. Again so I'm clear, these are changes in the patient's condition which he should have been made aware of by someone?

A Oh, yes, that's correct.

Q You don't criticize him for not knowing these things if he wasn't called by someone who mentioned them, do you?

A Of course not.

We're talking about Dr. Steele now?

Q Yes.

A Yes, of course not.

Q Are there any other facts from the record that you base that comment upon about coming in to see her after the operation, in the three or four hours after the operation?

A No. I mean, that's what I think good medical care would have entailed.

Q Your other criticism was as it relates to Dr. Varma.

A Yes.

Q You say there should have been much more closer supervision over Dr. Varma; is that the essence of it?

A Yes

Q Are you holding Dr. Steele responsible for Dr. Varma's medical insertion of the guide wire?

A Do I hold him responsible?

MR. KAMPINSKI: I'm going to object. That is up to the jury.

A Yes, I am not passing judgement here, to be honest with you.

Q I'm asking in your opinion then, with a reasonable degree of medical certainty, you are saying ultimately responsible, but you as a physician.

A Yes, as a physician.

Q Do you feel with a reasonable degree of medical

certainty that Dr. Steele was responsible for Dr. Varma's insertion of the guide wire?

A No. What I say is, within a reasonable degree of medical probability or certainty, Dr. Steele is responsible for the actions of his resident.

Q That's in a general sense?

A Yes.

Q He can't be responsible for every physical act of Dr. Varma, you don't suggest that?

A No.

Q How basic a procedure is the insertion of an arterial line such as this?

A Perhaps you could better --

Q Well, what level of medical training would you say someone would learn to do this?

A Oh, towards the end of his first year of residency

Q And Dr. Varma was in what?

A He was in the second year of residency.

Q The other resident that you said was with him when he inserted this, do you know what her position was?

MR. KAMPINSKI: He said she came.

Q Okay, that she came.

Do you know who that was?

A I believe it was a PG-1, a first-year, but I am

not sure.

Q Do you recall the name?

A I don't think so.

It was a woman, I know that.

Q Is there a progression in terms of, for lack of a better term, authority as it relates to residents?

A Yes.

Q Resident, junior resident, senior resident?

What would you call Dr. Varma, a junior, senior?

A He was a second year, so he was sort of between junior and -- he wasn't a senior yet. He was sort of a mid level resident.

Q But there were senior residents on the service there?

A I'll assume there are, yes

Q Chief resident?

A There is a chief resident that covers the institution.

Q In terms of the chain of command so to speak, the junior resident would be answerable to the senior resident?

A Ultimately. The senior resident has authority over the junior resident.

Q Does the chief resident have authority over both

the junior resident and the senior resident?

A Usually.

Q Is it usually the chief resident who deals with situations involving the junior and senior residents in the absence of the attending?

Isn't that why it is set up that way?

A I don't know why it's set up that way. I've always wondered why it's set up that way honestly.

But again, as I stated before, ultimately -- not in any situation, but in serious situations where patients' lives involved, it's the attending that's involved in the charge. I don't care how many senior residents are around or how many chief residents are around. You're the guy who's got the license.

Q But in terms of, as I said, the chain of command of responsibility.

A Well, the chain of command is just that.

If there's a line to be put in, the chief resident will say, put the line in, to whoever happens to be around.

If it's the senior resident, he'll put it in.

If it's the junior resident, he'll put it in.

Q And we could assume, could we not, that the chief

resident would rely upon the individual who directed or made that direction that they could put it in properly?

A Well, he should know that.

Q He should know that?

A He should know the capabilities of his staff.

Q That being the chief resident?

A The chief resident should know the capabilities of the senior resident and the junior resident.

Q The senior resident, does he have responsibility over the junior residents?

A Usually.

Q Should he be familiar with their qualifications?

A He should be familiar with their abilities to doing their job.

Q Have you reviewed any material since you rendered your report other than there were some logs apparently you looked at, anything else?

A Yes.

Q What are they?

A Some letters, some expert opinion letters.

Q Which ones did you review?

A I saw a letter from Dr. Alan Markowitz; I saw a letter from Dr. Joel Holland; I saw a letter from a Dr. Massouh; I saw a letter from --

THE WITNESS: Tell me what I saw.

MR. KAMPINSKI: I think he saw them all.

I believe he saw the experts.

A I reviewed all the experts, letters.

Q Letters. Anything else?

A I saw the personnel file of the Cleveland Clinic of Dr. Varma.

Q Anything else?

A Those I think are the major records, the only records.

Q Did you or do you maintain a file as it relates to this case?

A Not really.

Mr. Kampinski shows me the stuff, and I read it, and that's it.

Q And you just give it back to him?

A Give it back to him, yes.

Q You don't keep a correspondence file, a folder of correspondence?

A The only correspondence I have is the expert letter I wrote, that's it.

Q How about, do you keep billing records to keep your time?

A Yes, I keep my log of the time.

Q So there would be some log.

Where is that?

A In my office.

Q You only record when you were contacted, what you did?

A Yes, I usually just write down the times, I don't write down the specific dates.

Q You don't put down dates on your billing record?

A Yes, I put down dates when I submit the bills.

Q You don't put down dates of service rendered?

A Sometimes I do; sometimes I don't.

Q I'm not talking about time, I'm talking about dates.

A Yes, dates. Sometimes I do; sometimes I don't.

Q Did you do it in this case?

A I don't recall.

Q Would you provide us with your billing records in this case?

A Sure, sure.

Q What criteria would you rely upon for when this woman's wire should have been removed?

And so we're clear, the removal that I am talking about is the surgical removal as you defined it, not including this percutaneous approach. You don't have any problems with that

or the decision to do that, correct?

A No.

Q So we're talking about the actual surgery performed by Dr. Moasis or a similar procedure, is that --

A Correct.

Q I just want to be clear, then we'll talk about surgery.

What would have been the criteria to perform that surgery, to remove the wire?

A A stable patient; not in the peri-mycardial farction period.

Q Define 'peri-myocardial infarction period'.

A Well, in this case, a month.

Q So a month out from the MI would be in your opinion the peri --

A Yes, that would be a reasonable time to do it, if the patient was stable.

Q What do you mean by 'stable'?

A They ought to be stable and not demonstrating any difficulties, ventilation difficulties with blood pressure, pulse, with sepsis.

Q Do you distinguish between anoxic brain damage and apoxic and hypoxic brain damage?

A No.

Q Do you agree that the decision to remove the wire by surgical methods is a judgement call?

A Yes.

By surgical -- I'm sorry -- you mean operative, not this other way we explained?

Q That's why I defined it earlier.

We're talking about surgery.

It is a judgement of the physician involved as to when to remove this wire; would you agree with that or not?

A We already ascertained that, but let's talk about surgical now.

Q I mean surgical in the sense that you defined surgery.

That's why I went through that a moment ago.

A As I said, there are surgery criteria that should be met, stability, where you are in relationship to the peri-myocardial infarction period. That's not judgement. That's just good medical practice.

Q Is there some medical text journal that you could refer us to that would support the comments in that regard?

A There are articles regarding surgery in the peri-myocardial infarction period, yes.

Do I have them offhand, no.

Q Are there risks attached to doing the surgery outside the peri-myocardial infarction period?

A Yes.

Q And what are those?

A Any major operation has the same risks. Bleeding, infection, anesthesia risks, complications of the procedure, bowel injuries, error injuries.

Q You indicated the cause of her death. I'm not sure I heard you tell us the mechanism of her death.

A The mechanism.

She bled, became hypotensive, had a myocardial infarction or a cardiac arrest, not myocardial infarction.

Q Had she survived this hospital stay, what would have been her life expectancy, if you know?

A I think that's an actuarial -- I think she would have had a long life expectancy at forty-seven.

Q Would it have been limited because of the disease process that she suffered?

A I would say that she would have led a reasonably normal life. I can't say she would be a hundred percent normal. But I think within a reasonable degree of probability she would have led a

reasonably normal life, able to resume working, functioning normally.

Q That is not especially good quality of life if she survived?

A Yes, I think it would have been good quality.

Q You don't feel there would have been any limitations on the quality of her life?

A Not at forty-seven, having survived this myocardial infarction.

Q What was her neurological status on the 14th?

A Well, the nearest I recall from the junior medical resident and from the nurses' notes what I can glean -- nobody really talks specifically about neurological status except to say that they were weaning her off of the neuromuscular agents, the neuromuscular blockade agents, weaning her off of the --

Q Does that give you some indication of the neurological status, that they were weaning her off of the neuromuscular blockade agents?

A Well, yes. It indicates that she had a neurological status and that they can't well assess them until they stop the paralysis that's been ongoing to see how she's doing, and also the sedation that she was under.

And so as a result, it would be difficult really to do a neurological assessment.

But the nurses' notes allude to her responding to commands at one point, lifting of her arm, blinking her eyes at one point, spontaneous motions on her part.

And again, the junior resident on the first week I believe was commenting on how they were stopping on these medications to let her come off, let her function more without her being depressed and sedated.

Q How do you assess her neurological status on the 14th?

MR. KAMPINSKI: I am going to object. You asked him that. He answered that. Why do you keep asking him the same questions over and over again?

MR. JACKSON: He listed a number of facts. He didn't assess her neurological status.

THE WITNESS: I can't assess her due to the fact I never examined her.

Q Can you assess it on the basis of the records what her neurological status was on the 14th before her death?

MR. KAMPINSKI: Do you want him to go back to the time prior to the institution of these medications when she was responding to verbal stimuli where she was trying to write but couldn't hold a pen where all these things are on record, or are you limiting them now to when she was in fact paralyzed?

Q Has he given you enough information now, Doctor, to assess --

MR. KAMPINSKI: If you want to ask a fair question, ask a fair question.

Q My question to you is, can you tell us what her neurological status was on March the 14th?

MR. KAMPINSKI: Objection; asked and answered.

A I told you what I felt her status was.

Can I tell you specifically what she was doing?

She was paralyzed, she was still under sedation, so the answer to that question is no.

Okay, is that what you want?

Q I just want a fair answer to my question, that's all.

A Mr. Jackson, I don't think it's a fair question.

Q Let me ask you, what was unfair about my question about her neurological status?

A I answered the question.

I said that she was doing certain things and responding, but she was sedated and she was also paralyzed.

Q So your answer is that you can't evaluate it?

MR. KAMPINSKI: He said that three or four times.

A Yes, I did say it three or four times.

Q Okay. How about her cardiac scan, is it possible to assess it?

A It was improving from the time she came in. She was stabilized. There was no evidence of any deterioration in her status.

Q In terms of good, bad, can you evaluate it in those terms?

A No.

Q When you were discussing her status at the time of the surgery, that she was not a candidate, I believe it was under the question from Mr. Coyne, you said she was septic on the 14th.

A Yes.

Q What's your basis for that?

A I know that her white count of thirty-three plus

thousand on the, it was either the 12th or the 13th, the last one they did, tachycardia, a fever, 38 something.

Q You said she had a decreased platelet count.

A She also had that, yes, and that very well could be an indication of sepsis.

It's not a hard indication, but it could very well have been an explanation for it.

She also had a positive blood culture done where Pseudomonas had grown.

Q When was that done?

A The 10th or the 11th.

Q How was that addressed?

A Antibiotics.

Q Do you know the status of that as it relates to the 14th?

A The status of what, sir?

Q The status of the culture.

You said she had a positive culture; had that been corrected as of the 14th?

A You don't correct cultures.

Cultures tell you there's something going on and you treat them when she was treatable.

Q Was treatment successful, excuse me.

A Well, you need to treat somebody for a week to

ten days,or a week to fourteen days usually.

In fact when you have a septicemia, as this was, you need to treat it at least fourteen days before you know whether you're successful or not.

Q Doctor, have we covered all of your criticisms of Dr. Steele?

A I believe so.

Q If you formulate any new opinions related to his care and treatment before the trial of this matter, will you notify us?

A Yes, I will.

MR. JACKSON: I don't have any further question at this time.

THE WITNESS: Thank you.

CROSS-EXAMINATION OF HOWARD C. PITLUK, M.D.

BY MR. SEIBEL:

Q Do you in your practice refer patients to cardiovascular surgeons?

A Cardiac surgeons?

Q Yes.

A Yes.

Q Who do you refer to?

A Basically I send them to the Cleveland Clinic, whoever happens to be available at the Cleveland Clinic.

Occasionally I will also send to Alan Markowitz, a doctor at Mt. Sinai.

Q And why would you refer a patient to Dr. Markowitz?

A Patient choice.

Q Do you offer the patient a documented list?

A Yes.

It depends on where their family physicians are, their private internists.

Q Does Dr. Markowitz refer patients to you?

A Not really.

Q When you send a patient to Dr. Markowitz, do you have any hesitation about his competence as a surgeon?

A No.

Q Is there any overlap between the specialities of cardiothoracic or cardiovascular surgery and your particular specialty?

A Sometimes.

Some cardiac surgeons do vascular surgery, peripheral vascular surgery; some don't. So in the sense that a cardiac surgeon does vascular surgery, that's the overlap primarily.

Q Is there anything inappropriate about a cardio-vascular surgeon doing peripheral vascular surgery

A It depends on their training.

Q Are you going to appear live at trial to testify?

A I'm not sure.

If I'm asked to, I guess I will.

MR. KAMPINSKI: I hope so.

THE WITNESS: Oh, okay.

Q During cardiac arrest what happens to the brain?

A During cardiac arrest you have an inability -- the heart isn't pumping, it arrests.

So you are not profusing the body, including the brain. So the brain doesn't receive oxygen.

And if the period of lack of profusion persists for a long period of time there can be cell death because of lack of oxygen.

Q How long does it take before there is cell death in the brain due to lack of oxygen?

A It's very variable. It depends on the individual's own tolerance, meaning their cells' tolerance to lack of oxygen versus other parameters, in ambient temperatures, things of that nature.

Kids who, you know, slip under the water and are dead or drowned for thirty minutes wake up with no cell damage.

Some people can have four or five minutes of anoxia with significant or severe brain damage.

And it's really that variable.

Q What is 'medical clearance'?

A Basically I think what you're referring to is the policy whereby a patient --

You are talking about for surgery?

Q Sure.

A A patient who is about to undergo a major operation has the internist or family practicioner or the person in charge of the basic medical care evaluate him and then tell -- usually it's the anesthesiologist, that this patient is able to undergo the operation that is proposed, physically undergo it within a reasonable safe outcome.

Q And why is that term important to you in your role as a surgeon?

A To be honest with you, in my role as a surgeon, I don't worry too much about medical clearance. It's the anesthesiologists who do.

I usually know whether my patients are capable of undergoing the operation or not.

I will never propose a patient to an operatio that I feel shouldn't have one, I don't care what the internist says.

Q Under what circumstances would you, as a surgeon, postpone surgery for a patient who has specificall received medical clearance?

A If I feel the patient is not a good risk; for instance, ongoing medical problems that developed in the period just before I operate, myocardial infarction within the first thirty days. Electiv operation certainly. I am talking about elective

For instance, I had a patient yesterday who was sent to me by his internist to have his gall bladder removed. But the patient was passing blood in his urine. I cancelled that. I felt that was an acute condition. I wanted to know what was the etiology for that and I stopped the surgery.

That patient was cleared medically.

So there's a whole host of things that can happen that I feel need to be explained before I was going to operate.

Q When we talk about this peri-MI period, that lasts for thirty days after the MI?

A There's several periods. There's thirty days and there's six months, and there's a year.

Usually they break up into those time frames

Q Without any hemodynamic instability can a patient undergo elective surgery thirty days after an MI?

A Variable.

Q When is the first time a patient can undergo elective surgery after an MI without any hemodynamic instability?

A If it's purely elective and had not been revascularized; that is to say, the heart hasn't been, they had an MI and then they had to have a coronary bypass, that is a different situation.

But somebody who has a myocardial infarction that are going to have anything done to their heart to increase pulmonary blood flow, I would wait at least three to six months before I would perform an operation.

I would wait six months. It's a purely elective operation.

Q Is the removal of the wires in Mrs. Weitzel's case purely elective or is it something different?

A I think at this point it was elective or purely elective in Mrs. Weitzel, I am sure.

Q Are you saying then that if the second wire could not have been removed percutaneously, she should have waited at least three months to have the wire removed surgically?

A Yes, provided that she was recovered from all the other things.

I probably would have waited six months if

it wasn't causing any problems.

Q Why was the time right for Dr. Steele to attempt percutaneous removal of the wires on March 13th?

A Because he got it out without any problems. And that's really -- I don't mean to be facetious about it, but that's why it was right.

I mean, given the options, I wouldn't have taken it out even that night.

But the fact of the matter is, he felt the wire needed to come out, he could do it in a minimally invasive manner, did do it, and without any sequelae, so in that respect it was right.

And there were certain negating circumstances.

I mean, she did have a positive blood culture.

And she was getting better in his estimation, according to the notes anyhow, so he thought he could safely do that.

Q What were the risks to Mrs. Weitzel of leaving the remaining wire in after March 13th?

A We talked about the infection, embolis and air pressure.

Q Any others, besides those?

A I can't really come up with any right now.

Q What is atherosclerosis?

A Hardening of the arteries.

Q What health risks does atherosclerosis pose to a patient?

A Atherosclerosis is a very general term.

We all have atherosclerosis.

They did a study on Vietnam casualties, twenty-five-year-old men. They looked at their coronary arteries of the men killed in combat and they found hardening of the arteries in fifty percent of them. Significantly measurable.

Did those people have any significant problems? No.

So it's a whole gamut of possible problems and it depends on the individual.

Certainly for symptomatic, angina pain, in connection with the heart, myocardial infarctions secondary to ischemia, aneurysms, those kinds of things, those have recognized risks which are discussed in the literature and has the significance of them.

Q In terms of atherosclerosis in the peripheral vasculature, what is the risk to the patient there?

A Same thing. Carotid arteries become narrow and

you get strokes. Arteries can become aneurysmal and they can rupture. Quadriceps distally become narrowed and maybe cause ischemia -- that's lack of blood flow -- pain with walking, pain at rest, gangrene.

Q In your practice do you do a procedure called a 'carotid endarterectomy'?

A Yes.

Q What is that procedure?

A It's a removal of the disease from the inside of the carotid artery that goes up to the end, up to the forward portion of the brain whereby you open up the artery, remove the diseased material, the atherosclerosis, which is called 'plaque', and then repair the artery.

Q And why would you do such a procedure for a patient?

MR. KAMPINSKI: Can I interject and ask why you are going into these? Do they have some relationship to this particular case?

MR. SEIBEL: Yes.

We are talking about a carotid artery, aren't we?

THE WITNESS: No, we aren't.

Maybe we are.

MR. SEIBEL: Doesn't it have something to do with Mrs. Weitzel's carotid artery in some respect?

That's where at least one end of the wire was as far as I know.

MR. KAMPINSKI: I apologize. I see what you are saying.

Q Why do you do a carotid endarterectomy on a patient with atherosclerotic plaque in the carotid artery?

A To prevent stroke.

Q Well, whatis the mechanism of a stroke in a patient with atherosclerotic plaque in the carotid artery?

A If the plaque is a 501, that is to say, usually breakable, it can break off and embolize the brain and causes strokes. That's symbolic.

The other type is occlusive, the narrowing can totally thrombose the artery,leading to stroke.

Q What causes the plaque to break off and travel to the brain?

A The nature of the plaque.

Q Why would the remaining wire eventually have to come out?

A As we indicated before.
Q To avoid the risks?
A Correct. Not just the risks; to avoid the actual complications.
Q Would it have been safe for Mrs. Weitzel to begin walking with any wire in her arteries?
A I can't answer that. I don't know.
Q With respect to the risk of embolization with the wire in, what would have been the mechanism of embolization?
A Either the wire itself could embolize, meaning travel, or you could form clot on the wire. The wire is initis for clot formation. And then as a result, the clot breaks off and embolizes.
Q Is there also a risk inherent in causing plaque to break off and travel to the brain as well?
A Possibly.
Q And what about the risk of perforation? Describe that for me.
A The wire is a sharp object and it's steel, and the wire could actually erode or get into the bloodstream and travel in such a direction as to perforate through the artery, causing significant bleeding, injuring the surrounding

structures.

Q Does the aorta bend when the patient bends?

A To a small degree, yes.

Q To how many degrees?

A I don't know.

Enough that you could bend yourself in half and it won't break or occlude.

Q But it does move with the patient?

A Yes. I mean, everything moves. There is nothing to break except your bones where there is no joint.

Q By the time that Dr. Steele consulted Dr. Moasis on March 13th, was it reasonable for Dr. Moasis to conclude that Dr. Steele had exhausted percutaneous alternatives to remove this wire?

A I think he should have asked the question.

Q Assume the answer was yes; could he assume then that percutaneous removal methods had been exhausted?

A Well, if the question was asked, have you exhausted all methods of removing the wire and the answer was yes, then the answer is yes, you could assume that.

Q What was Dr. Moasis's obligation to follow Mrs. Weitzel postoperatively?

A His obligation was to make sure his patient was doing well, was stable or to have a sufficient mechanism established whereby he was notified of his patient's condition.

Q And what would have been a sufficient mechanism for that?

A Resident coverage, nursing coverage, his own calling in to the post-anesthesia care unit or the I.C.U., wherever she was, and ascertain what was going on.

Q Either one of those would have been okay?

A Any one of those would have been okay.

Q What if there's a breakdown in the nursing coverage or the resident coverage, is Dr. Moasis liable for that?

A No, I don't think so.

Q When was the first indication -- and I think you answered this, I beg your pardon if it's repetitive -- when is the first indication postoperatively in the records that Mrs. Weitzel became hemodynamically unstable?

A Postoperatively?

Q Right.

A Well, there were a very few notes postoperatively by anybody.

The nurses' notes at 2000 hours definitely indicated instability.

Q You looked at a critical care flow sheet that was dated March 14, 1991.

A Correct.

Q It had an entry at 1600 hours?

A Yes, it does.

Q Now if you assume, and I'll ask you to assume this for purposes of this question.

If you assume that those are vital signs taken upon her arrival to the coronary care unit, do those vital signs reflect hemodynamic instability?

A Not really, no.

Q What should have happened once Mrs. Weitzel became hemodynamically unstable on the evening of her surgery on March 14th?

A The attending certainly should have been called and then the person immediately available to come to the unit should have been called to come to the unit.

In this case I assume it to be the resident.

Q In your opinion, Dr. Pitluk, if Mrs. Weitzel had received appropriate care when she became

hemodynamically unstable after surgery, would she have survived?

A Yes, she would have.

Q When foreign objects are left inside the body, what tends to happen?

A We're talking about steel here?

What are we talking about?

Q This guide wire particularly.

A Three things that we talked about.

Q I'm curious about a process -- I don't know if i am pronouncing it correctly -- epitheliazation.

What is that?

A Epitheliazation is a coating of surface with epithelium, which is the lining of blood vessels, the cells, type of cell.

Q So that process can take place within an artery?

A Partially, sure.

Q How long does it take that process to happen?

A It just depends on the type of -- usually epitheliazation, in fact always epitheliazation takes place from an epithelial -- actually an endothelial surface to an endothelial surface.

That is to say, if you damage the lining of an artery, it can bridge the damage, the inside lining, by putting epithelium down.

When you put a foreign body in, however,

you don't get epitheliazation if you have a foreign body per se, unless it's sticking into the wall, the end of the epithelium -- endothelium.

It's the same thing. Epithelium is the skin. Endothelium is the lining of the artery.

So that in that part where the wire may be sticking into or immediately adjacent to the artery wall, you could get some epithelium or endothelium coating.

Usually what you get is fiber, a scar if you will, a false lining. It's not endothelium.

And that acts as an area that can cause narrowing, a source for bloodclots to form.

Q Why does the body respond that way to a foreign body?

A Because to wall it off from the area that is in circulation.

Q What factors are needed to change to make Mrs. Weitzel a candidate surgical removal of the wire?

MR. KAMPINSKI: I think they was asked and answered.

THE WITNESS: It was, but if he wants it again ....

A She needed to be further along from her myocardial infarction, six months in my estimation, she

needed to be hemodynamically stable, not to be septic, and she was, she needed to be off the ventilator I felt, just improved, recovered from this whole episode.

Q In your medical expertise what would have happened to Mrs. Weitzel if the wire would have perforated the artery it was in?

A It depends where.

Q Carotid.

A It went fifteen inches.

Q Carotid.

A Yes. She probably would have had a stroke.

Q What would have happened to Mrs. Weitzel if as a result of the wire a piece of atherosclerotic plaque had embolyzed to her brain?

A Same answer; a stroke.

Q Do you have an opinion as to the probable consequences of that stroke to Mrs. Weitzel?

A No.

Q What would have been the reasonable range of consequences?

A Death on the one extreme to neurological deficit which completely recovers over time to the other extreme, and everything in between.

Q Is there a relationship between calcific

atherosclerosis in the coronary arteries and calcific atherosclerosis in the peripheral vasculature?

A The relationship is that atherosclerosis, whether it's calcific or otherwise, affects the entire body, the arteries in the entire body, so that when you have it in one place, you always have it someplace else too.

Q Assuming that now we are six months out from the MI and that Mrs. Weitzel is no longer septic and is hemodynamically stable, and further assume that she needs surgical removal of the wire, what are the risks to her in surgery for the removal of the wire?

MR. KAMPINSKI: Objection.

A We asked that earlier.

Basically I said the risk of any operation: Bleeding, infection, possible injury to structures, all the risks, anesthesia risk, death.

Q In the one case where you were involved in a surgery to remove a guide wire, did you actually perform the surgery?

A No. That was my patient I was involved in.

It was a cardiac procedure that I did not participate in, no.

Q Do you have an opinion as to the cause of Mrs. Weitzel's thromocytopenia?

MR. KAMPINSKI: Before surgery. I think this has been asked and answered.

THE WITNESS: Yes.

A I said most likely the sepsis.

MR. KAMPINSKI: There is very little that hasn't been asked or answered.

Q The same for the fever and the positive cultures?

A Right. Well, the positive culture went to the sepsis.

Q Did Dr. Moasis choose the proper approach to reach the iliac artery?

A Yes, it's an acceptable approach. Just didn't time it right.

Q Do you have any opinion that Dr. Moasis's actual operative techniques were substandard?

A I don't have an opinion on that, no.

Q Okay. How then to a reasonable degree of medical probability did Dr. Moasis deviate from accepted standards of care for a surgeon in his specialty?

A Number one, by performing an operation that should not have been performed on this critically

ill patient in the peri-myocardial infarction period, number one. And number two, in her particular situation when she was septic, thromocytopenic, with a non-life-threatening problem being guide wires in the iliac up to the carotid artery.

And the other criticism that I have is the fact that postoperatively he could have -- should have actually followed his patient more carefully, someone as critically ill as she was and called at least, called once to see how she was doing.

Q Do you know whether or not Dr. Moasis saw Mrs. Weitzel after the surgery?

A It was my understanding that he did not.

Q Do you see any evidence in the records that you reviewed that he did not see her?

A No.

Q Did you read his deposition?

A Yes, I did.

Q And if he had gone to see her in the postoperative period before he left the hospital that evening, would that be acceptable medical care?

A Yes.

Q If the wire had become initus of infection, would that have posed a life-threatening risk

to Mrs. Weitzel?

A Possibly, yes.

Q But for the wires being left in Mrs. Weitzel's vasculature, would she have died prematurely?

A I think I've said no. I don't know if she would have.

Certainly I think she would have recovered from this episode and left the hospital and gone and lived a long time.

Q Have you stated, Dr. Pitluk, every way that you feel that Dr. Moasis breached standard of care involved in this case?

A I believe I have, yes.

Q I want to ask you a variation of the question I asked before and I apologize for not covering this aspect then.

If Mrs. Weitzel had received appropriate care from the nurses and the hospital residents in the postoperative period, would she have survived and lived a normal quality of life as well?

MR. KAMPINSKI: Why is it a variation? It's the exact same.

MR. SEIBEL: I asked survival before.

A You want quality of life now?

Q Right.

A I think I have answered that.

I thought she would have survived and lived a normal quality of life had she survived this hospitalization. So had the nurses and the residents done what they were supposed to do, I think she would have survived, and therefore she would have survived and lived a normal, reasonable quality of life, yes.

Q And is it your opinion that the hospital nurses and residents in the postoperative period were negligent?

A Yes.

MR. SEIBEL: That's all I have.

CROSS-EXAMINATION OF HOWARD C. PITLUK, M.D. RESUMED

BY MR. COYNE:

Q You indicated that had the nurses and/or residents observed this hemodynamically unstable condition at approximately 8:00 P.M., they should have notified the attendings and then if appropriate care were rendered you think she would have survived; that was one of your answers, is that correct, Doctor?

A That's correct.

Q Okay. Now the appropriate care with her bleeding internally would have been what?

Further surgery?

A Not necessarily.

The appropriate care for her would have been to give her fluids and get her blood pressure up, stabilize her hemodynamic condition and get blood into her, if that was the case, then she would have probably been transfused. And she may not have needed any more than that. That could have been enough to stabilize the condition and the bleeding would have stopped.

The problem again, as I indicated, was that in conjunction with an already severely damaged heart or I should say, the myocardial infarction, that's the reason you don't operate on these people, because small problems can lead to big disasters.

Q I understand why you don't operate on them.

But I'm saying, had they come back, if the bleeding was internal --

A Well, it was in the iliac artery.

Q Right. And had they not been able to control that with blood supplements, et cetera, then they would have had to go in and surgically

correct that condition that was causing the bleeding, correct?

A Yes.

Q That would have been another trauma to this person who was already a poor risk for surgery, correct?

A One was an emergency and one was elective, but yes, they would have had to go in.

Q And the chances of her surviving that I assume would be much less than even the initial surgery because she would have already been compromised once?

A I can't answer that. I don't know if it would be much less or the same less or --

Q Another substantial risk at least?

A Yes.

Q Just rehearsal of the chain of command, Mr. Jackson was asking you about starting at the bottom of the chain of command -- if we start at the top, the attending would be the person who is mainly responsible for the care and treatment of the patient, correct?

A As I indicated, yes.

Q Then you would go down to the consultants for their area of specialty underneath the attending?

A No; consultants aren't subservient to anybody.

If you call a consultant in, you consult with them.

There's different ways to consult people. You consult them for management. You consult them just for opinions. You can consult them for opinion and management You can consult them and say, take over.

It depends on how you consult somebody

Q But the consultants in their area say, whatever that would be pulmonary, infectious disease, would certainly be over the residents?

A Oh, yes. Any attending is over a resident

Q Okay. Relative to the radiologist, I got a little lost there and I want to ask you ...

Did the radiologist's treatment comply and comport to reasonable and acceptable radiology care?

MR. SEIBEL: Objection.

A They did the procedures and they reported it. So that's reasonable.

I feel they could have done more, but I don't think it's germane to this conversation.

What they did was acceptable.

MR. COYNE: I have no further questions.

CROSS-EXAMINATION OF HOWARD C. PITLUK, M.D. RESUMED

BY MS BITTENCE:

Q I noticed on your C.V. which I didn't see before, No. 10 I believe, 'Referred Journal Articles'.

It says accepted for the Journal of Cardiovascular Surgery.

Has that been published?

A May I see it, please?

Which one?

Q The last one.

A Yes.

Q Do you know when it was published?

A Last year or a year and a half ago, something of that nature.

Q Doctor, in the last twelve months have you testified in depositions other than this one?

A Yes.

Q And approximately how many?

A Three, four depositions, yes.

Q Have you testified in trial in the last twelve months?

A Yes.

Q How many?

A Once. I believe it was once.

Once or twice.

Q In the trial testimony had you been retained by plaintiff's counsel or defense counsel?
A In that one it was a plaintiff's counsel.
Q And was that in a medical malpractice case?
A Yes.
Q And in the deposition testimony had you been retained by plaintiff's counsel or defense counsel or both?
A Both primarily.
I think it was one plaintiff and three defense.
Q And what kinds of cases were those?
A Medical malpractice.
If I testify, that's all I testify in.
Q Throughout your career as a physician how many times have you testified in either deposition or trial, approximately?
A Twenty times.
Q And what percentage, again approximately, has that been for plaintiff or defendant?
A Ninety percent for the defense; maybe ten percent for the plaintiff.
Q And has that been here in town?
A Yes.
Q Or Greater Cleveland area?

A The majority of my work was for Jacobson, Maynard, Tuschman and Kalur.

Q Doctor, have you been asked to render an opinion with respect to the training at the Cleveland Clinic in the trial of this case?

A No.

Q Do you intend to render such an opinion?

MR. KAMPINSKI: Other than what he's testified to.

I don't understand your question.

MS BITTENCE: Well, his original report didn't touch on training at all with respect to the Cleveland Clinic's program, so from his original report we don't know clearly who he is talking about there.

MR. KAMPINSKI: Well, he's told you he just got the logs after his report.

MS BITTENCE: I simply asked him --

A Are you asking me, am I going to evaluate the Cleveland Clinic's program?

Q Right.

A No, only in the general terms that I did here.

Is that what you mean or --

Q No. I guess I don't know what you mean by in the general terms that you did here.

A Well, the questions you asked.

Q Let me put it this way.

Do you have criticism of the Cleveland Clinic's training program that you intend to render at the trial in this case?

A No more than the questions that were asked me.

I mean, that's what I mean. I'm not going to come in there and say I want to criticize the Cleveland Clinic --

Q I understand that.

A -- if that's what you are asking.

Q But I was asking the question. I didn't have any opinion.

What are your criticisms of the Cleveland Clinic training program?

MR. KAMPINSKI: Well, wait, wait. If I can interject, and I'm just trying to be helpful, you want to know what his criticisms are with respect to Dr. Varma in his particular level of training?

I mean,that's really the question.

He's not going to come in, as he said a number of times, and say the Cleveland Clinic program is good or bad, but how it applied in this case.

MS BITTENCE: Well, I was going to ask the general question and then the narrow question, criticism.

MR. KAMPINSKI: He already said no.

MS BITTENCE: Well, let the Doctor say it.

Q Do you have criticisms of the Cleveland Clinic residency program?

A No.

Q Do you have criticisms of the Cleveland Clinic residents program as it applied to Dr. Varma?

A Yes, as I specifically answered.

Q And what are those criticisms?

A That Dr. Varma should have been better trained if he were going to be doing the procedures that he was doing.

It's my understanding that when a resident leaves the second-year level and goes to another institution, he supposedly has a certain number of procedures at which he is proficient, meaning to perform these procedures. Dr.Varma didn't have that.

Now whether or not Charity should know it or not, that's something as I said, I think the individual people should know what the

capabilities of the residents are.

But certainly if the Cleveland Clinic has a standard by which after a certain time period their residents are supposed to have proficiency, he didn't have it, the Cleveland Clinic would be missing those then

Q Are you saying then that because he did this procedure on February 26, 1991 incompetently then he was not competent trained?

A That's a legal decision as far as I am concerned.

That's something you are going to have to decide and the Judge is going to have to decide

Q To find out what you are saying on the deposition?

, yes.

Q In what way was he incompetently trained?

A He did not know how to do this procedure, number one.

And number two, once he had problems he never told anybody about those problems

You own up to your mistakes. You handle your own problems. You don't cover them up

Q How do you know that he was not competently trained to do the procedure?

A Well, the logbook doesn't show me any indication that he's competently trained, not according to

the logbook anyhow, by the time he got to Charity.

Q If in fact he had done --

MR. KAMPINSKI: You already asked this.

Q What you're saying, that the logbook doesn't show he had actually done any.

A Yes.

Q If he had done some and had done them proficiently in front of a, someone who is proficient.

A I heard what you are saying.

Certainly if he had done these procedures, hypothetically, in front of somebody who was qualified to assess that and say, hey, good job done, you know how to do it, go ahead and do it, and he went there and he did it and he had a complication, that's acceptable. Complications happen.

What's not acceptable is the fact that in this procedure he lost two guide wires in the patient, which he never should have done to begin with, but he did it. But he didn't tell anybody. That's not acceptable.

It's not acceptable in anybody's training program, that kind of behavior.

Q Why do you base that behavior came from the

training program?

MR. KAMPINSKI: He just told you.

MS BITTENCE: No, he didn't.

A A training program has a responsibility of assessing their resident. Not just in their technical abilities, but in their moral character, in their cognitive skills, in proficiency, and you need to know who you're dealing with.

If you have a psychopath in there -- and this is an example, I'm not saying that Dr. Varma is psychopathic, I'm just saying, if you have somebody's who is mentally incompetent, for whatever reason, and he can be the greatest technician in the world, you get rid of that person, because being a doctor in a training program isn't just sticking in lines and spitting out answers.

Q And on what do you base your opinion that the Cleveland Clinic doesn't do that?

A I didn't say the Clinic doesn't do that. I said in Dr. Varma's case they didn't do that.

Q And on what do you base your opinion that in Dr. Varma's case they didn't do that?

A By the fact that there was no record that I'm aware of, of his having put these lines in before

January 27, 1990, by the fact that once a problem did occur where two lines are left in a patient, he never told anybody, the fact that they look at his record, there was a recent unsatisfactory evaluation by Dr. Jeffrey Olin in the peripheral vascular department about some strange behavior and some inability to comprehend what was going on and not complying with some direct orders or direct teaching that was given to him.

I mean, there was something going on here that I feel was not appropriate.

MR. KAMPINSKI: Excuse me, you said '90. You mean '92, January 27th.

THE WITNESS: No; '91.

A '91, when he was at Charity Hospital.

Those are the kinds of things I am talking about.

Q And that's what I'm asking about.

Dr. Olin's report, the fact that he didn't tell anyone about losing the guide wires.

Those are the three I heard.

A Oh, yes. The fact he lost guide wires too shows obvious poor training.

Q In your opinion is it possible to do a procedure incorrectly after being correctly trained and

just be distracted that day?

A Twice in a row, no.

Q In your opinion, the fact that he did this proves to you that he was not correctly trained?

A Within a reasonable degree of probability, yes.

Q And I think I did ask, but let me just make sure you have answered my question, that is: Are you aware of the procedures in the residency training program at the Cleveland Clinic?

A Medical residents' training?

Q Yes.

A Not specifically, no.

CROSS-EXAMINATION OF HOWARD C. PITLUK, M.D. RESUMED BY MR. WARNER:

Q As I understand, Doctor, Mr. Coyne asked you questions as far as the radiologists were concerned.

You said they could have done more, and what they did do you thought was acceptable.

A The actual procedure was acceptable. The communication I feel was unacceptable.

Q The reporting is not acceptable, putting it in the report?

A Give me a date.

Q March 1st, March 7th?

A No, that's not acceptable.

They said the wire may be on the chest, it may be in the chest or in the abdomen.

We don't know clinical correlation.

If I recall, one of the radiologists went up and did an ultrasound of Mrs. Weitzel's abdomen somewhere between the 1st and the 9th -- or the 8th, and this is a doctor I believe who had read one of the x-rays, reporting on a possible wire being inside the abdomen or on the abdomen. She got up there. There was nothing on the abdomen. I think at that point she should have realized it was in the abdomen.

Q I think you already testified that the delay in the removal of the wires did not cause any additional complications.

A That's true.

MR. WARNER: Thank you.

CROSS-EXAMINATION OF HOWARD C. PITLUK, M.D. RESUMED BY MR. SEIBEL:

Q You indicated in your report that Dr. Steele had a, quote, almost blatant disregard for Mrs. Weitzel. I want to know what you mean by that.

A Again as I said, I just feel that the -- this is a young woman -- I think she's only forty-seven,

she's looking younger all the time -- who comes in with a real serious problem and survives it, and survives it because of a lot of good care by Dr. Steele. I think they worked hard on her.

And then something's happened and then they find this disaster, there's two wires left in her that were placed in her. And she's having a lot of problems again. She becomes septic. She has one wire taken out. And he takes one out but at that point for some reason he doesn't put it all together. I mean, he's worked so hard, but he's got a woman, he knows how sick she is. He knows she had a PMI recently. He knows she's getting septic. He knows that there's another wire left in her.

I don't understand why he let the surgeon or even consulted a surgeon and said, go in and do this.

And even after a surgeon did it, he didn't even call up and say, well, how's she doing?

He said, well, it's his problem now.

That's what I mean by that.

Q Just to clarify, your comment about almost blatant disregard goes more towards the post-operative period?

A And the actual decision on his part not to pursue radiology, not to pursue Dr. Kitchen and offer an operation to a patient who I think he should know and does know shouldn't have an operation.

Q Let me put it this way then.

Your comment regarding almost blatant disregard of Mrs. Weitzel relates to Dr. Steele's care after he performed the percutaneous removal on 3/15?

A Basically, yes.

MR. SEIBEL: Then I don't have any more questions.

MR. COYNE: Do you want to waive signature?

THE WITNESS: I think I want to read it.

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ERRATA SHEET

I, Howard C. Pitluk, M.D., do hereby certify that I have read the foregoing transcript of my deposition this _____ day of _____, 1993, and believe the same to be true and correct (or, except as follows, noting the page and line number of the change or addition as desired and the reason why):

PAGE	LINE	CHANGE

Dated this _____ day of _____, 1993.

_____
Howard C. Pitluk, M.D.

CERTIFICATE

The State of Ohio,)
) SS:
County of Cuyahoga.)

I, Marie L. Larbig, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named HOWARD C. PITLUK, M.D. was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above set forth was reduced to writing by me by means of Stenotypy, and was later transcribed into typewriting by me, and is a true record of the testimony given by the witness; that said deposition was taken on Friday, the 19th day of March, A.D. 1993, in the City of Cleveland, County of Cuyahoga, and State of Ohio, pursuant to notice, and was completed without adjournment; that I am not a relative or attorney of any of the parties or otherwise interested in this action.

IN WITNESS WHEREOF, I hereunto set my hand and affix my seal of office at Cleveland, Ohio, this _____ day of March, A.D. 1993.

Marie L. Larbig, Notary Public
within and for the State of Ohio
My Commission expires July 22, 1993.

HOWARD C. PITLUK, M.D. - DEPOSITION INDEX

4) **60** Basswood Lane, Cleveland, Ohio.

5) ~~Teaches~~ Teaches, one day per week. Vascular surgery.

6) Never testified for us before.

8) Has contact w/patients who have had cardiac arrests.

11) Ventricular fibrillation is inefficient contraction of the ventricles.

12) No way of knowing if being defibrillated **15-17** times leads to permanent heart damage. She had better than **50%** chance of survival as of **02/12/91.**

15) She did not have any significant anoxic brain damage prior to **02/26/91.**

20) Greater than **50%** survival even w/ARDS.

21) No organ failure.

22) Leaving two wires in a patient is substandard care.

24) No opinion if the wires by themselves caused injury to Mrs. Weitzel between **02/26** and **03/13/91.**

26) Varma caused pnuemothorax by attempted placement of the subclavian catheter.

28) For the most part, patients who survive ARDS and several weeks on a ventilator do not have pulmonary function impairment afterwards.

29) Mrs. Weitzel not a candidate for invasive surgery on **3/14;** Major reason was she was in perimycardial infarction period most likely septic, thrombocylopenic and febrile.

30) Bleeding most likely occurred when she became hypotensive.

31) Surgery itself proximately caused her demise.

33) Varma only person involved in cover-up; ARDS did not contribute to her demise.

34) She had a compromised heart which couldn't sustain a **500** cc bleed.

36) Had the wires not been left in her, she would have been able to resume her lifestyle eventually.

37) Has had other patients critically ill, on ventilators for long periods of time, m.i. have done well:

38) Lynn Moore - Inserted many types of guide wires.

40) Inserts 100 guide wires per year.

41) Attending responsible to ensure that resident can appropriately place the guide wire.

43) Appropriate to have a junior resident insert guide wire, but not jr. residents like Dr. Varma. Varma obviously didn't know what he was doing, didn't have the appropriate experience from logs. One procedure not adequate, no indication that he had observation supervision during that experience.

44) Actual occurrence, multiple guide wires, nobody told all, indicates he didn't know what he was doing.

45) Training program has a responsibility to make sure their residents are adequately trained.

46) If somebody is on your service you should make sure you know what they are capable of.

47) Attending is ultimately responsible.

50) Never lost guide wire in patient; Seen it in other people's patients; Seen two or three guide wires shear off as you are with drawing them, patient required a thoracotary.

53) Most widely accepted form of retrieval is by fluoroscopy.

54) Radial line attempted required procedure note.

57) Potential complications of retained guide wire are infection emboli formation and possible perforation.

58) Appears that no physician came in after the surgery; as soon as vital signs changed the attending surgeon should have been notified.

59) Don't agree with 60% mortality rate from ARDS.

WARNER

61) Would doubt very seriously that she couldn't be moved because of the ventilator.

62) MARY BITTENCE

63) **60%** vascular surgery, **40%** general surgery; Tempora1 relationship between placement of Swan-Ganz and pneumothorax lead to conclusion re: causation.

73) Resident needs to see it; do one with supervision and then do it. Number of times is dependant on the individual.

74) Needs more than one time for each.

80) Saw an X-ray with guide wires-looked like two wires.

JACKSON

80) Steele had responsibility to know the conditions of his patient to understand possible complications and to exercise appropriate judgment to make sure he did no harm to patient.

81) **1.** Did not exhaust the modalities available to him to remove the 2nd guide wire percutaneously.

2. Subjected his patient to major operation in perimyocardial infarction period.

3. Should have communicated better with his colleagues.

4. Never saw patient after surgery.

83) Would think her heart doctor would be concerned about a patient who had major m.i. within a month who just had a major operation; Responsible for Varma, should have more closely supervised him.

89) 2nd wire close to first wire, if first could be extracted percutaneously, 2nd one probably could have been.

90) Wire had to come out eventually, not then.

91) If Varma would have told people what happened <u>when</u> it happened, then this wire could have been grabbed a little sooner.

93) Steele should have seen her within first **3-4** hours post-op.

94) If he saw her he would have noted she was becoming unstable. Pulse **141** BP down at **8:00** p.m., no notes between then and **4:00** p.m.

98) Don't criticize him for not being aware of changes in patient's condition which he should have been made aware of by someone else.

107) There are surgery criteria that should be met, stability and relationship to peri-myocardial infarction period. Decision to operate not a judgment call, question of good medical practice.

108) Mechanism of death was she bled, became hypotensive, had cardiac arrest.

109) Had she survived, she would have led a reasonably normal life, ask to resume working, function normally. Life would have been good quality - no limitations.

SEIBEL

115) Refers patients to Dr. Markowitz.

119) Removal of wires was purely elective.

120) Probably would've waited six months to remove wires if not causing a problem.

121) Atherosclerosis doesn't mean much unless it is symptomatic

125) Moasis should have asked if Dr. Steele exhausted all percutaneous removal methods.

126) Moasis obligated to make sure his patient was doing well, was stable or have mechanism established to notify him of patients condition. Very few notes post-operatively by anybody.

127) Notes at **1600** do not reflect hemodynamic instability.

128) If Mrs. Weitzel received appropriate care post-op then she would have survived.

132) Moasis negligent for performing an operation that should not have been performed on critically ill patient in perimyocardial infarction period when she was septic, thrombocytopenic with a non-life threatening problem of guide wires. Should have followed patient post-operatively either seen her or called once to check her condition.

134) She would have recovered and lived a long time.

135) Hospital nurses and residents were negligent in post-op period.

COYNE

138) Radiologist acted reasonably.

BITTENCE

140) Testified **20** times in his career, **90%** for Defendants.

141) Majority of his work is for JMTK.

143) Dr. Varma should have been better trained.

144) He was incompetently trained. He didn't know how to do the procedure. Once he had problems he didn't tell anybody. Opinion based on log books.

146) Training program has a responsibility of assessing their resident, not just their technical abilities, but their moral character and cognitive skills. In Dr. Varma's case the clinic did not do that.

147) Opinion also based on recent unsatisfactory evaluation by Dr. Olin.

WARNER

148) Communication by the radiologist was unacceptable.

149) Delay in removal of the wires didn't cause any additional complications.

151) SEIBEL - Comment re: "blatant disregard by Dr. Steele" relates to care after percutaneous removal on **3/15.**