THE STATE of OHIO, :
: SS:
COUNTY of CUYAHOGA.:

- - - - - -

IN THE COURT OF COMMON PLEAS

- - - - - -

Doc. 379

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

vs.

SAINT VINCENT CHARITY HOSPITAL, et al.,
defendants.

Case No. 226946

- - - - - -

Deposition of MICHAEL B. ROLLINS, M.D., a defendant herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Frank P. Versagi, a Registered Professional Reporter, a Certified Legal Video Specialist, a Notary Public within and for the State of Ohio, at Saint Vincent Charity Hospital, 2351 East 22nd Street, Cleveland, Ohio, on Tuesday, the 11th day of September, 1992, commencing at 1:30 p.m., pursuant to notice.

APPEARANCES:

ON BEHALF OF THE PLAINTIFFS:

Charles Kampinski, Esq.
Christopher M. Mellino, Esq.
Donna Kolis, Esq.
Charles Kampinski Co., L.P.A.
1530 Standard Building
Cleveland, Ohio 44113.
and
David J. Elk, Esq.
Elk and Elk
Chagrin Richmond Plaza
25550 Chagrin Boulevard - Suite 204
Beachwood, Ohio 44122.

- - - - -

ON BEHALF OF THE DEFENDANT SAINT VINCENT CHARITY HOSPITAL:

William J. Coyne, Esq.
Standard Building
Cleveland, Ohio 44113.

- - - - -

APPEARANCES: (continued)

ON BEHALF OF THE DEFENDANTS DRS. ROLLINS, KITCHEN, STEELE, KHADDAM:

John V. Jackson, II, Esq.
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue
Cleveland, Ohio 44114.

- - - - -

ON BEHALF OF THE DEFENDANT DR. VARMA:

Lynn L. Moore, Esq.
Gallagher, Sharp, Fulton & Norman
Sixth Floor - Bulkley Building
Cleveland, Ohio 44115.

- - - - -

ON BEHALF OF THE DEFENDANTS RADIOLOGY CONSULTANTS, INC. and DRS. J. PORTER, SMITH, WIRTZ:

Robert D. Warner, Esq.
Reminger & Reminger
The 113 Saint Clair Building
Cleveland, Ohio 44114-1273.

- - - - -

APPEARANCES: (continued)

ON BEHALF OF DEFENDANTS CENTRAL ANESTHESIA of CLEVELAND, INC. and DRS. SOPKO, MOASIS, STEFFEE:

Robert C. Seibel, Esq.
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue
Cleveland, Ohio 44114.

- - - - -

ON BEHALF OF DEFENDANTS DRS. MAGIERA, CHMIELEWSKI, VAIDYA:

Anna Moore Carulas, Esq.
Jacobson, Maynard, Tuschman & Kalur
1001 Lakeside Avenue
Cleveland, Ohio 44114.

- - - - -

ON BEHALF OF DEFENDANT CLEVELAND CLINIC FOUNDATION:

Ronald S. Okada, Esq.
Baker & Hostetler
3200 National City Center
Cleveland, Ohio 44114.

- - - - -

I N D E X

WITNESS: MICHAEL B. ROLLINS,M.D.

- - - - -

(NO EXHIBITS MARKED)

- - - - -

INDEX of OBJECTIONS

BY MR. JACKSON:	PAGE/LINE	PAGE/LINE
	56/10	121/6
	73/4	121/13
	84/5	121/24
	84/14	122/1
	88/44	122/7
	89/2	123/8
	103/5	125/12
	103/13	127/12
	110/1	128/25
	110/10	132/22
	119/13	133/21
	120/17	134/23
		143/9
		149/19
		152/24
		153/7

- - - - -

BY MR. WARNER:	PAGE/LINE
	65/21
	66/12
	72/22
	73/5
	107/13

INDEX of OBJECTIONS (continued)

MICHAEL B. ROLLINS, M.D.

of lawful age, a defendant herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, being first duly sworn, as hereinafter certified, was examined and testified as follows:

- - - - -

CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Doctor, would you state your full name, please?

A. Michael B. Rollins.

Q. Doctor, I'm going to ask you a number of questions this afternoon. If you don't understand any of them, tell me and I will be happy to rephrase any question you don't understand. When you respond to my question, please do so verbally. The court reporter is going to take down everything you say. He can't take down a nod of your head, okay?

A. All right.

Q. Doctor, why did you leave the Cleveland Clinic in 1985, I guess?

A. I had an opportunity to join a group in private practice, thought I had a better opportunity.

Q That would have been what, July of '85?

A. corrects

Q. What group was that?
A. Drs. Kitchen, Steele, and Aber at the time were an association of cardiologists, and I joined them.
Q. When you say "An association," what does that mean?
A. Well, we're not a group in terms of an employee/employer relationship, we're four independent practitioners who all may have separate practices and cover for each over.
Q. So you misspoke a second ago when you said you saw an opportunity to join a group?
A. We're considered a group in terms of we're a group of cardiologists.
Q. But you don't practice together?
A. We cover for each other. We each have our own separate practices.
Q. So you decided to go out on your own and associate with three other cardiologists?
A. Correct.
Q. Did they offer you some form of compensation or incentive to do this?
A. No, there was no money given directly to me to join their group.
Q. How were you compensated?
MR. JACKSON: What are you

asking, in terms of --

MR. KAMPINSKI: How did he earn a living.

MR. JACKSON: What he was paid? If you are going to ask him how much he made and that kind of thing, he is not going to answer that question.

MR. KAMPINSKI: I didn't ask him that

MR. JACKSON: You clarify it for him. I am not sure what you are trying to ask him.

MR. KAMPINSKI: How he was paid,

MR. JACKSON: You mean by whom he was paid?

MR KAMPINSK3: Sure. That would be good.

A. I received money for the services that I had performed. It takes two or three months for the billings for you to -- on July 1st to come due, so in that period of time I got an interest free loan, and I have repaid that.

Q. From who?

A. Dr. Kitchen

Q Personal loan?

A I assume so.

Q. You got a loan from him, from his corporation, or from him personally?
A. I think it would be from his corporation.
Q. And then did you set up a separate billing facility?
A. Right from the first day I billed under my own numbers,and received those monies to me.
Q. That's what you have done since that time?
A. No. That was only for the first couple months until the billings came in. Since that time I have been totally independent.
Q. I think that's what I meant when I said that's what you've done since that time, you bill on your own since that time and received monies through your corporation?
A. Yes -- no, I am not incorporated. I am a sole proprietor.
Q. So you practice under Michael B. Rollins, M.D.?
A. Correct.
Q. And that's how you bill?
A. Yes.
Q. Who does your billing?
A. We have a billing service but --
Q. When you say "We," what do you mean "We"?
A. The three physicians that are together in the

association use a billing service. We have a corporation called Cleveland Cardiology Associates, which does our billing. The girls run the office and do the billing via billing service.

Q. Are you a shareholder of that corporation?

A. Yes.

Q. When did you become a shareholder of that corporation?

A. I can't remember the exact date that the corporation came into being. I think approximately 1987.

Q. After you came with these other two or three individuals?

A. Yes.

Q. In your loose association?

A. Yes.

Q. So you do your billings through that corporation?

A. No. The billings are done in my name, but the corporation exists to employ the girls that do the billing; but it's billed under Michael B. Rollins, not Cleveland Cardiology Associates.

Q. You bill then for your services?

A. Yes.

Q. That you render to patients?

A. Yes.

Q. Did you receive some type of incentive to leave the Clinic in terms of number of patients that you would be seeing, types of patients, anything like that?

A. No.

Q. What did you anticipate you would be doing when you left the Clinic?

A Practicing cardiology.

Q Where?

A. Here at Saint Vincent Charity Hospital.

Q. Anyplace else?

A At the time I started I had privileges nowhere else.

Q. How about now?

a. I have privileges here and at Lutheran Hospital.

Q What percentage of time do you spend at Lutheran?

A. Zero percent.

Q Why did you get privileges there?

A. Well, at the time I thought it might be nice to have another hospital in case I wasn't busy enough or I had more time to spend. There was -- were also some orthopedic surgeons that were going to Lutheran that I thought I might be -- you know, see their patients

but it turned out that I was doing fine at Charity and I didn't need any of the extra income, to spend more time going to another hospital.

Q You are married and you live in Beachwood, correct?

A. Yes.

Q When did you make up this CV?

A. The date may be on the second page, It's a couple years old.

Q. Do you have any publications that you have authored or been involved with?

A Yes, there's about five of them. I don't have a list right with me,

Q Because they're not on here.

A That would be a separate page.

Q Was that page removed from here?

A. No.

Q. You don't know what they were?

A. They were -- there was an article in Lancet, approximately 1978, there were a couple articles in American Journal of Cardiology, there was an article in Canadian Journal of Anesthesiology.

Q And of these five, are there any that you remember specifically the name of them?

A The one in Lancet was a short report about the

use of DDAVP in people with Alzheimer's disease.

Q Okay.

A The one in the Canadian Journal of Anesthesiology was something to the effect of hemodynamic results of epidural anesthesia in patients with congestive heart failure, at least that was the body of the article, I don't remember the --

Q. What's the dates of that article?

A That would have been approximately 1984 or '83.

Q That's while you were a resident or Fellow?

A The article -- I would have been a clinical associate staff, so it would have been I guess '84

Q What would have been your role in that article?

A. Collaborative. Article was mostly written by anesthesiologists at the Clinic, but I took care of the patient that they wrote the article about, and I reviewed the cardiology parts of it and made comments.

Q It was a case report then?

A Case report and a little expounding on that.

Q This patient had congestive heart failure?

A Yes.

Q. And underwent some type of surgery?

A I think it was an orthopedic surgery.

Q Had the patient had a myocardial infarction?

A. I don't remember offhand.

Q. The paper discussed the effects of epidural anesthetic on such a patient?

A. Yes.

Q. As contrasted with a general?

A. Well, not contrasted. It was a patient that had congestive heart failure and we tuned the patient up and the patient underwent surgery and they used epidural anesthesia, and the article showed that using epidural anesthesia was less of a strain on the heart; but it wasn't contrasted, per se, with general anesthesia.

Q. When you say "Less of a strain," it's got to be less of a strain than something?

A. Well, I don't remember if I made a distinction like that or not.

Q. Well, is there a risk associated with a patient who has a heart problem, of course in that case it was congestive heart failure, let's deal, for example, with a patient who had a myocardial infarction; is there a higher risk associated with such a patient undergoing surgery, undergoing a general anesthesia?

A. I think you asked two questions.

Q. Maybe I did.

A. Which --

Q. I thought I asked one.

A. Is there a risk, you're asking a risk associated with surgery in persons who had a myocardial infarction, the answer is yes.

Q. Does such a person have a higher risk of undergoing surgery let's say within a month of the myocardial infarction than someone had who had not had the myocardial infarction?

A Yes.

Q. Does risk decrease the farther away you are from the infarction?

A. Yes.

Q. That's pretty well documented in the cardiology literature; is it not?

A. Yes. Cardiology and anesthesiology, I would think.

Q. Do you know what the numbers are, for example, within a week of a myocardial infarction if anybody undergoes a general anesthesia?

A. I think you can say it depends on other things, other organ systems that are involved. I can't give you a number.

Q. Do the studies then differentiate between other systems that might also be affected or do they merely indicate the numbers, morbidity numbers for such people?

A. I don't know if different studies do things different. I am sure some have done both.
Q. How about the other papers that you've been involved with, Doctor?
A. I think one of the other ones involved use of stress testing to diagnose coronary artery disease. Again, I was a collaborative author on that.
Q. Any others?
A. There were five altogether. I can't remember what the fifth one is.
Q. You say you do have a list of those?
A. Yes.
Q. Is it here in the hospital somewhere?
A. Probably in my office.
MR. KAMPINSKI: Before we leave here today, could we get that?
MR. JACKSON: Sure.
Q. Doctor, you're listed on your CV as section head of non-invasive cardiology?
A. Correct.
Q. What is that?
A. The cardiology division here is divided into four areas, there's invasive cardiology, there's cardiac rehab, there's non-invasive cardiology, there's EKG. I am a non-invasive cardiologist. I

think I am the only one that actively practices here. I am section head of non-invasive cardiology.

Q. When it says "Section head," what are you -- for example, how many people are you the head of?

A. Well, I don't manage other -- any people that work at the hospital. I am not employed by the hospital. My job would be to make sure that policies or procedures that involve non-invasive cardiology, like echocardiology, Holter monitoring, that we're doing the right things, or that if there's a problem with the techs or something, that they can come to me and discuss it with me.

Q. How many cardiologists are on the staff here?

A. I can't give the exact number, but it's probably over 20.

Q. And you say you are the only non-invasive cardiologist that you are aware of?

A. That's actively practicing. There's some older cardiologists who by the route of their training never learned catheterization that would technically be non-invasive. Most of the people are not practicing.

Q. And non-invasive means that you don't insert anything, it's done --

A. I don't do cardiac catheterizations and angiography.

Q. How about other catheterizations?
A. Swan-Ganz catheterization, yes.
Q. What training did you undergo to allow you to do, for example, Swan-Ganz catheterization as opposed to cardiac catheterization?
A. Well, Swan-Ganz catheterization is training that you would receive as part of your internal medicine residency. Cardiac catheterization would be obtained through specialized cardiology training.

When I was at the Clinic there were two tracks of cardiology Fellowship, invasive and non-invasive track. Now there is only one track and people lean more towards one way or the other, but you learn how to do catheterizations in your cardiologist Fellowship if you so desire to go that route.
Q. So what you're telling me is anybody who undergoes internal medicine training is subjected to learning how to do, for example, the insertion of a Swan-Ganz catheter?
A. Yes.
Q. Are there any other catheters that can be inserted into a body?
A. There are.
Q. For example, to monitor blood pressure?
A. Yes.

Q. We're going to be talking about one of those today, correct, that's what Dr. Varma did on the 26th of February?

A. I assume so.

Q. What kind of training would you need to undergo for that?

A. Internal medicine residency would train you for insertion of arterial catheters.

Q What year of your residency?

a. All years, depending on the program.

Q When did you learn it at the Clinic?

A. Second and third year.

Q What year was Dr. Varma in when he came here?

A Second year.

Q Had he learned it at the Clinic?

A I am not aware of what he learned or didn't learn at the Clinic.

Q. Were you involved at all in the deeision to allow him to insert a catheter into Mrs. Weitzel?

A. No.

Q. Do you know whose decision was?

A. No.

Q. While you were covering for Dr. Steele, were you responsible for Dr. Varma's actions?

A. Not in total.

Q. What were you responsible for and what weren't you responsible for?

A. Well, Dr. Varma being a resident on that particular case would talk to me about the case on a daily basis, and we would discuss treatment plan and options.

Q. I am not sure -- I don't know whether you answered my question or not.

What was originally asked you was if you were responsible for his conduct, and you said not in total. So then I asked you what you were responsible for and what you weren't responsible for. I am not sure you answered me.

A. I am not sure what you need from me other than what I answered.

For example, there was a senior medical resident there who would be somebody who'd also be responsible for his training or his conduct. There would be other physicians involved with this particular case, for example, that he would be talking to regarding her treatment, I was one of those physicians.

Q Wha was the attending during the time that you were covering for Dr. Steele?

A. The primary attending would be me.

Q. And the senior resident, was that Dr. Jayne?
A. I can't recall at the time. There might have been more than one. They might have been changed, somebody may have been covering on a weekend. I am not sure.
Q. Whoever they were, they reported to you, did they not, as the attending?
A. Not necessarily. They would discuss the case with me if -- if need be. On a daily basis I can talk to the second year resident, or second year residents, or I can talk to third year residents separately, sometimes together, or not at all, depending on what the case needed.
Q. What did you perceive your role as pertains to this patient?
A. In this particular case when I was covering for Dr. Steele I perceived my role to be that of the cardiologist on the case.
Q. Cardiologist in addition to being the attending?
A. Well, the cardiologist on the case, because in a patient like Mrs. Weitzel who's very sick, has multiple organ systems failure, different attending -- different groups of doctors would be taking care of different parts of the patient.
Q. Let's get our terminology right.

Those different groups would be consultants, would they not, there's only one attending?

A. Well, an attending can be used in more than one way. The person whose name is on the plate as primary physician.

Q. Primary physician, we'll use that.

Were you then the primary physician while you were covering for Dr. Steele?

A. Technically, yes, since I was covering for him.

Q. What is the role then of the primary physician on such a patient as Mrs. Weitzel?

A. In such a patient, again, it would be if the primary physician was a cardiologist, if -- in this particular case the primary physician would be functioning as a cardiologist. Some of the other consultants might or might not discuss the case with the primary attending, depending on their needs; otherwise, they would be doing what they need to be in consultation with the residents.

Since she was a teaching case in the -- in any event, the residents would be taking care of her moment by moment, day-to-day.

Q. Who coordinated the care that was given to Mrs. Weitzel, would that be part of the primary's

responsibility?

A. Not necessarily.

Q. Well then, who did?

A. Probably the residents would be coordinating her care.

Q. You will excuse my confusion, Doctor.

The residents, at least as I understand it, are still in training, correct?

A. Correct.

Q. They are responsible to report what they do to some physician?

A. Some physician, correct.

Q. What physician would be the person that the resident would go to if he had a problem with a patient, would it be the primary?

A. Not necessarily. Depending on what the problem was, what level it needed to be taken care of.

For example, a second year medical resident would report to third year medical resident with a problem, depending on the organ system that was involved that -- those two people could report to the primary attending or they can report to one of the consultants regarding what needed to be done.

Q. They could report to their mother or father.

MR. JACKSON: You don't have to

respond to that kind of comment.

Q. Who are they supposed to report to, what is the chain of command as it relates to residents who are undergoing training?

MR. JACKSON: I think he just answered that question for you. Do you want it answered again?

MR. KAMPINSKI: I do.

A. The resident reports to the physician that was appropriate for their needs at the moment.

Q. These residents, Dr. Varma, for example, he was a rotating resident from the Cleveland Clinic; you are aware of that?

A. Yes.

Q. And I assume that was a standard practice here at Saint Vincent?

A. Yes.

Q. How long do these residents rotate through?

A. In their second year they would be here approximately eight weeks.

Q. And during that eight-week period of time where would they spend their time, would it be different parts of the hospital?

A. For four weeks usually they will spend their time on the seventh floor, and for the -- which is the

general medical floor. On the other four weeks they spend their time in the medical and cardiac intensive care units.

Q. Where was Mrs. Weitzel?

A. She was I believe in the cardiac intensive care unit.

Q Would that be an area, the cardiac intensive care unit, that would be attended by the cardiologist?

A. They would make rounds on their patients, but they wouldn't be there all day long.

Q. Is the reason a person is in the cardiac intensive care unit because they have a cardiac problem?

A. In most cases that's correct.

Q was that the case with Mrs. Weitzel?

A. She had cardiac problems, but also had other problems that necessitated her being in the unit,

Q Well, if she had had problems other than cardiac problems, is there an intensive care unit other than a cardiac intensive care unit?

A. Well, depends on the attending. Dr. Steele being a cardiologist would tend to admit his patients to the cardiac care unit as opposed to the medical intensive care unit.

Q So Mrs. Weitzel was his patient?

A. Yes.
Q. I am not mistaken about that?
A. No.
Q. While he was gone she was your patient?
A. I was covering for Dr. Steele, correct.
Q. So she was your patient?
A. I was covering for Dr. Steele. She was Dr. Steele's patient. I was covering for him for the week he was gone.
Q. So that made her your patient for that week, correct?
A. If you use those terms, that would be correct.
Q. What was your, and I say this generically, I guess I mean it to refer to yourself, Dr. Steele, and Dr. Kitchen's, relationship with the residents who would rotate through the cardiac intensive care unit for that month? I mean, I don't want to make this more complicated than it ought to be.

What would you do when the residents would come through in terms of either training or ensuring their competence to do various procedures?
A. Individuals do things differently. You would discuss your particular cases with those residents on the daily basis if you had patients in the unit, you would teach them at other times, either didactically

or just general discussion of cases.

There are C.C.U. rounds twice a week, which I am the attending for, where I talk to the residents about generic cases or just topics of interest in cardiology that come up.

Q. If you wanted a resident to do a special or specific procedure on one of the patients, what would you do to ensure yourself of the resident's competency to do that procedure, for example, insert a blood pressure catheter?

A. Certain procedures that residents do are assumed by thair level of training that they're competent in doing it.

If there was something that you weren't sure the resident was able to do, in my case I will ask the resident if he is comfortable doing the procedure or if he is capable of doing it. Based on his answer I would know whether or not anything else needed to be done.

Q. At what level would you assume that residents could insert a blood pressure catheter?

A. Depending on the institution and what cases they had, either the first, second, or third years of medical residency.

Q. Well, in this case the institution is Saint

Vincent Charity Hospital, he came frown the Clinic, and you told me that he is a second year resident, so would you or would you not assume that he could insert a blood pressure catheter?

A. I would assume he can insert a blood pressure catheter.

Q At what point in the second year did you receive training to do such an insertion?

A I don't recall.

Q When you were there?

A. I don't recall,

Q Welk, you told me that you got the training in the second or third year?

a. Correct.

Q. Why would you assume that he had already received such training?

A. Because I said that they have the training in the first or second or third year.

Q. So why would you assume that he would have gotten it?

A. I would have no reason to make an assumption one way or the other whether he can insert an arterial catheter, but the residents in the Clinic rotate through units in their years and they are exposed to these procedures and theoretically they're supposed to

do them.

Q. Tell me if this question is unfair, because I know you didn't give the order for him to do it.

Were you involved in his placing the arterial catheter in Mrs. Weitzel?

A. No, I was not.

Q. Were you involved in that decision-making process at all?

A. No.

Q. Are you aware of how that decision-making process took place?

A. No.

Q. Did you have any discussion with Dr. Steele subsequently to determine how that decision-making process occurred?

A. No.

Q. Did you have any discussion with Dr. Jayne or whoever else the resident might have -- senior resident might have been, as to how the decision was made?

A. No.

Q. Did you have any discussion with Dr. Varma after you found out that wire -- wires had been left in Mrs. Weitzel, as to who had allowed him to do that procedure?

A. No.
Q. Who did allow him to do that procedure?
A. I don't know.
Q. Well, since Dr. Steele was the primary -- well, who wanted it, do you know; do you know that?
A. I don't know.
Q. Do you know why it was done?
A. I assume that it was done to monitor -- measure blood pressure and make it easier to get blood gases and get blood from her. That was -- would be a standard reason in a patient with her particular medical problems. That's why it would be fairly common practice to put an arterial catheter in a patient such as Mrs. Weitzel.
Q. Can you do that in different places? In other words, can you put it in the subclavian?
A. Subclavian vein, that's not subclavian artery.
Q. Right.
A. No. You wouldn't put it in the subclavian artery, an arterial catheter would be put in the brachial or femoral artery.
Q. What's the difference between putting it in the brachial or the femoral?
A. Its location. One's the arm, one's the leg, it depends.

Q. Why would you choose one over the other?
A. Unknown reasons. It could be ease of placement of the catheter, or it could be the -- that she had had I.V. in the arm before and they were harder to get too, or a lot of other reasons which I am unaware of that would make a decision one way or the --
Q. Who would make that decision?
A. The physician who was putting in the catheter.
Q. Was there an order for the insertion of the catheter, Doctor?
A. I have no knowledge.
Q. Have you reviewed the chart?
A. Other than my own notes, no.
Q. So you don't know if anybody ordered that or not?
A. I don't know.
Q. What was your first involvement with Mrs. Weitzel?
Anytime you need to look at the charts, please go ahead and do so.
A. My first involvement with her would have been a note that I wrote when I was covering for Dr. Steele on a weekend, and I will try and find the date.
February 23rd.
Q. Why don't you read it for me.

A. Normal sinus rhythm, off anti-arrhythmics, major problem now is respiratory.

Q. Right above that is a note by Dr. Varma.

A. Yes.

Q. You say that was a weekend?

A. I think February 23 would have been a Saturday.

Q. And you had been on duty that weekend?

A. Correct.

Q. When would your involvement have begun and when would it have ended, is this Friday night to Monday morning?

A. Well, we're on call a week at a time, so I would have been making rounds on Saturday morning. If there had been -- we will cover the patients during the day -- if there had been any problem at night, if the resident would have called that week preceding, they would have gotten me. The weekend after the five days we had been on call, and you make rounds on Saturday and Sunday, so I would have come in that Saturday morning and made rounds and made a note then.

Q. You would have been seeing all your patients in the unit?

A. All of the patients that were Kitchen's or Steele's or mine.

Q. You wrote this note, does that tell you what you

did that morning, did you review the charts in order to write this note or what did you do?

A. I review the chart and I reviewed the patient.

Q. That would be typical of what you would do when you were on duty?

A Yes.

Q When you say reviewed a patient, what, physical examination?

A Physical examination.

Q. Why was she off of anti-arrhythmias?

a. Anti-arrhythmics.

Q. I'm sorry.

A. She had had a rhythm problem and they had been caused by certain things. After a while you will stop them to see if the rhythm problems would return.

Q Did they?

A Not while I was taking care of her.

Q. So it appeared that that problem had been taken care of?

A. At that point, yes.

Q When is the next time you saw her?

A. I would have talked to residents about her, briefly seen her the next day, this would have been the 24th.

Q. Do you have a note for the 24th?

A. No.
Q. Why not?
A. Because I would have talked about her with the resident and they -- I would have looked at their notes and would have said that's fine and gone on,
Q. Is this what you normally would do?
A. Yes
Q You assumed that you did what you normally would do, right?
A I made rounds in the unit on Sunday, yes.
Q I mean the only reason I phrased it that way, we have nothing in the charts to reflect that you were there or what you did, right?
A. Nothing in the notes. Now, sometimes, not always, but sometimes the nurse writes in their notes whether there was a doctor around, but I was there,
Q. Did you review the nurse notes to see if you were mentioned in there?
A. No.
Q If there would have been anything significant that was occurring with Mrs. Weitzel during your stay that weekend, the 23rd and 24th, I assume you would have written a note?
A If there had been anything different than what was in Dr. Varma's notes, I would have written

something.

Q. Is it typical for a physician to countersign a resident's note to show that he had read it and agreed with it?

A. It's done on occasion. I don't always do it. Sometimes I do, depends on how I feel at the time or the situation.

Q. For example, if you look at the note of the 23rd by Dr. Jayne, this is right after your note, Doctor. Well, there is an infectious disease note by Dr. Chmielewski, I guess, right?

A. Yes.

Q Then there's another note, do you see the next note 2-23, that's signed by Dr. Jayne?

A. Yes.

Q And it's countersigned by you?

A. Yes.

Q. So that you did countersign her notes on the 23rd, meaning you read it and you agreed with it?

A. I read it and countersigned it, yes.

Q. Well, that does mean you agree?

A. Yeah, in general that's right.

Q I don't see where you countersigned any notes on the 24th?

A No, there is no counter signature here,

Q. That doesn't mean that you didn't read them or that you weren't there, just means you didn't sign them?
A. Correct.
Q. When is the next time you saw her?
A. March 4th.
Q. Now, correct me if I am wrong, but would you have seen her in between the 23rd and the 4th?
A. No.
Q. When you would have been seeing your other patients on the floor, you wouldn't have looked in on her?
A. No.
Q. Why, because she wasn't your patient?
A. She had multiple doctors looking at her. I wasn't involved with her care when I wasn't covering for Dr. Steele.
Q. So you saw her on the 4th?
A. Correct.
Q. Next time you saw her?
A. Yes.
Q. When did you take over for Dr. Steele?
A. On the 4th.
Q. So between the 25th and 4th Dr. Steele would have been attending her?

A. Yes.
Q. And your notes are somewhat recognizable in that there is a heart right after the date, I have noticed that on a number of notes, that's your trademark?
A. I had gotten in the habit of doing that when I was training and I just kept it, you know, that way somebody knows it's a cardiology note.
Q. I was going to ask that.
If you were a nephrologist you'd probably draw a kidney?
A. If I could.
Q. So from the 4th until when were you then the primary physician in charge of Mrs. Weitzel?
A. Well, I covered for Dr. Steele through the 8th, which was Friday that week. The week of the 4th Dr. Kitchen was on call. So he would have been called at night if there had been any problem that they needed him, and he would make rounds the subsequent weekend, which would have been the 9th and the 10th.
Q. Where was Dr. Steele?
A. I believe he was out of town.
Q. Where?
A. I don't recall.
Q. Was he in touch with you at all during that week?

A. No, not with me personally.
Q. Well, or with anybody on your behalf?
A. Not that I know of.
Q So when he left, he left you in charge of Mrs. Weitzel, correct?
A. I was covering for Dr. Steele, As I have said before, in cases like this "In charge" applies to several people, but --
Q. You being one of them at a minimum, correct;?
A. Right.
Q. And I assume that you did what you did on the 23rd, and that is reviewed the record and examined the patient, right?
MR. JACKSON: When?
MR. KAMPINSKI: On the 4th.
A. Yes.
Q. When you tell me that you reviewed the record, what does that mean, Doctor, what do you look at when you review the record?
A. Usually look at the notes that were written by other consultants or residents, and I go to the computer and punch up the labs, if they're not written in the nurses' notes or on the daily sheets they have for unit patients.
Q When you say "The labs," you are talking about

the computer printout that shows the labs going back to when they were admitted, or the most recent labs?

A. You can get it different ways. I looked at the ones that were most recent.

Q. What about x-rays, do you look at those?

A. No, not routinely.

Q. How about interpretations, do you look at those?

A. Not routinely.

Q. Did you look at them as it pertains to Mrs. Weitzel?

A. No.

Q. As the primary would you also look at the notes of the other consultants?

A. Yes, in general.

Q. To make sure you know what they were doing with the patient?

A. Correct.

Q. Doctor, at the bottom of your March 4th note you put down -- well, before I get to that, what did you have as her problem?

A. Atherosclerotic heart disease, status post intercept M.I. on 2-12-91, pneumonia/ARDS, adult respiratory distress syndrome.

Q. Before you get to number two, there is a sentence after that says echo showed something?

A. Echo showed decreased anterior wall but overall LV looked okay, no overt congestive heart failure.

Q. What does that mean as it relates to the status of her heart?

A. Well, she had had a heart attack, that's the primary reason that she had been admitted to the other hospital, she had chest pains and collapsed at work, something like that, and when you have -- you have a heart attack, usually that part of the heart muscle stops contracting, and when you look at it on ultrasound, echocardiogram, you can see the -- that part of the heart muscle that is not contracting. You get a very general idea of the overall function of the heart in terms of how far it contracts. That's what the echocardiogram was meant for.

Q. So she wasn't in congestive heart failure, correct?

A. Not overtly. Congestive heart failure is a clinical symptom, it's not a lab test, it's these CHF's that --

Q. But there was no evidence of it at that point in time that you examined her?

A. That's correct

Q. Number two was what?

A. Pneumonia, question mark/ARDS, adult respiratory

distress syndrome. No real change despite multiple antibiotics/peep/anti-viral agents.

Q. Go ahead.

A. Number three was history of supraventricular tachycardia. That symbols mean she was having none of that.

Q. Would it be correct in assuming, Doctor, that her primary problem at least from looking at this part of the note, we'll get to the rest of it in a minute, was her lungs?

A. That was my opinion.

Q. That was being followed by whom?

A. Pulmonary consultant on the case.

Q. Who that was?

A. I believe was Dr. Sopko.

Q. And you had pneumonia, question mark, why did you have a question mark?

A. Well, in a case like this where people have severe lung dysfunction, the thought was that she had aspirated, that she had vomited and swallowed the contents, and you -- you don't know whether the damage to the lungs was due to bacteria that are in the contents or whether it's due to the damage from the acidic substances from the stomach, and what you do is usually treat for infection and there are certain

antibiotics that are given presumptively when somebody aspirates.

Q. Could you show me where it says she aspirated?

A. There is nothing in the charts that would show that. That would have been -- happened at a different hospital.

Q. You think she aspirated somewhere else before?

A. That's what people thought, she had aspirated before she had been transferred.

Q. Can you get pneumonia without aspirating?

A. Yes.

Q. How does that happen?

A. Infectious process, you inhale germs.

Q. Did she have an infectious process?

A. They were not sure. She was being treated as if she had one. That's why the infectious disease consultant was on the case.

Q. Were they able to culture anything out of the lung sample that they took?

A. I wouldn't be able to tell you unless I saw the culture reports.

Q. Why don't you take a look.

A. The way the labs are, you have to look at more than one area for the cultures.

She had, for example, on March 13 she

had a culture from her trach which showed heavy Pseudomonas, and which would have been infection possibly. She had blood cultures that were positive.

Q. Give me the dates that you're talking about.

A. 3-13 blood culture, positive.

Q. Had you already looked at the labs prior to the 26th, February 26th?

A. No. The way the labs go, they print out a week at a time, so unless -- there is usually a final copy, so.

Q. Keep going.

A. Okay. On 3-10-91 there was a culture showing Pseudomonas growing on the Swan-Ganz tip. Also methicillin resistant, staph epid, two different bugs.

She also had viral cultures, too. One of these results says positive, result suggests recent collective infection with Epstein-Barr virus.

Q. What's the date of that one?

A. The date of specimen was 3-6-91.

Q. Okay.

A. There is a date of specimen 2-19-91, this looks like the legionella antibiotic.

Q. Did he find any?

A. Antibodies, no, that would have been negative.

So I have to go back and see if there

were any others. I don't see --

MR. JACKSON That Is all right, Doctor.

A. I don't see any others, other than the ones I told you.

Q So what you told me is that the only positive cultures were those that were grown, at least from I heard you tell me, after you came on duty?

A. No. What I told you is that based on the lab slips that I saw, these were the positive cultures that were there. She could have multiple positive cultures from early-on.

Q. Did she?

A. I don't know. I don't have those results in front of me.

Q. Where are they?

A. They would be in one of several different places. Sometimes not all the culture results are printed out. I mean, this blue and white copy is not the final lab copy. The final lab copy is green and white. I don't see a green and white copy in here, so there's maybe other culture results that are not there.

Dr. Chmielewski's notes would be able to tell you whether or not there was positive

cultures.

Q. So you are telling me we don't have the entire chart in front of you?

A. I am saying I don't have the final lab copy. The final lab copy is green and white. This is not green and white. I don't know if it's in another location. I don't see it in the chart, but Dr. Chmielewski was the infectious disease expert.

MR. ELK: Aren't these green?

THE WITNESS: No. It would look like this.

Q. So someone has the final lab copy other than us?

A. It's not in this chart.

MR. KAMPINSKI: Anybody in this room have it?

MR. JACKSON: Chris, do you have it?

He is **not** answering, so I guess we can't find out.

MR. KAMPINSKI: All right.

Q. Doctor, you were reading your March 4th note for me, will you continue?

A. Now normal sinus rhythm, around 112 a minimum; blood pressure was 130 to 140 over 70 to 80, no

jugular venous distention, no wet rales; heart, E-4; no murmur; abdomen distended, slightly decreased bowel sounds; examination of the extremities, no edema, full pulses.

Q. Just keep going.

A. Labs, BUN, creatine, potassium, okay; magnesium, okay; high white count with left shift; Swan-Ganz reading, pulmonary capillary wedge approximately 21 inspiratory/expiratory; cardiac output/cardiac index, systemic vascular resistance I have noted; note, intake greater than output, 4.7 liters since 2-28-91.

Impression, one to three as above, no clear source of sepsis despite multiple antibiotics; pulmonary capillary wedges slightly up; decrease I.V. Lasix to 10 to 18 range again; change nitro patch to 10 milligrams a.m. to p.m.; PAS stocking is not enough; Dig 25 milligrams I.V. q.d.; antibiotics per Dr. Chmielewski; pulmonary weaning per Dr. Sopko; Lasix, 40 milligrams I.V.

Q. What is pulmonary weaning?

A. Dr. Sopko was in charge of her pulmonary status.

Q. What is the pulmonary weaning?

A. Trying to get her off the ventilator, have her breathe on her own.

Q. What's Versed here, I don't think you read that?

A. I believe she was on Versed at that time.
Q. Why?
A. The kind of ventilator that she was on, you kind of -- the kind of setting that she was in, she had to be sedated and paralyzed so she wouldn't fight the respirator.
Q. So her inability to respond at that point in time was due to the medication that she was being given; is that correct?
A Yes.
Q Was that true when you had seen her back on the 23rd and 24th?
MR. JACKSON: Meaning her inability to respond?
MR. KAMPINSKI: Yes.
A. I can't tell you, Dr. Chmielewski had her on a Versed drip back then too.
Q. All right. Doctor, from your note then she appeared --
MR. JACKSON: Are we back on 3-4?
MR. KAMPINSKI Yes.
Q. You were giving her antibiotics, that was as a result of what, Dr. Sopko's orders?
A. She was on antibiotics. I wasn't giving them to

her. She had been on antibiotics I assume since shortly after admission, that was being controlled by the resident and Dr. Chmielewski.

Q. That was for presumptively infection, although it was noted the source was unclear?

A. Correct.

Q. All right. Dr. Chmielewski's note, is that right after yours, correct?

A. Yes.

Q. March 4th. He noticed some swelling of the right neck, is that something that you noticed in your examination?

A. No.

Q. Is there a reason why he would have noticed it and you wouldn't have?

A. He would be looking for sources of infection, being an infectious disease doctor, and she could have had punctures from I.V. before and he would be looking for areas of redness or swelling or pus.

Q. Did you have any discussions when you came on duty with the residents to determine her status prior to reviewing the chart and examining her?

A. In general I would have talked about her with them to see how she was doing, what they were doing.

Q. Do you remember who you talked to?

A. No, not offhand. I probably would have talked to Dr. Varma as one of the -- them that was her resident assigned to her case, but could have been more than one person.

Q. What was his background or training in cardiology?

A. His cardiology training would come via that which he was going through in his internal medicine training. He wouldn't have had any separate cardiology training being an internal medicine resident.

Q. How about infectious disease?

A. Same with that.

Q. How about pulmonology?

A. Same with that. They're exposed to all the medical subspecialties in the course of their three years of internal medicine training.

Q. So I assume then it wouldn't have been appropriate for him to have been primarily responsible, would I be correct in assuming he would basically just be taking orders from certain specialists and following them?

A. No, that's not correct. He would be managing this patient in consultation with his senior medical residents, and the consultants would be talking to him

about their areas that needed things done.

Q. Who was the senior medical resident?

A. I am not sure at the time. If Dr. Jayne was writing notes then, writing SMR's, it would be her.

Q. Why don't you take a look.

A That also could have changed. They change it, not necessarily at the same time,

Senior medical resident on March 2, the note of the senior medical. resident is signed by Brooks Jayne, so at that time I assume she was the senior.

Q Where was she from?

A. Cleveland Clinic.

Q. And what year was she, what year resident was she?

A. Third year medical resident.

Q. Were you told by Dr. Varma or Dr. Jayne on March the 4th that Dr. Varma had attempted to insert a catheter, an arterial. catheter and left two guide wires in Mrs. Weitzel?

A. No, I was not.

Q Did you subsequently find out that that's what did in fact happen?

A. I was told on March 8th by Dr. Varma that there appeared to be guide wires in Mrs. Weitzel.

Q Did he tell you how they gat there?
A. He did not.
Q Did you ask him?
A Yes.
Q What did he say?
A He said he didn't know.
Q Well, did he tell -- you just said March 8th?
A Yes.
Q What time approximately?
A Nine o'clock at night.
Q. Is there a reason that between March the 4th and March the 8th you didn't become aware of that yourself?
A. I was not aware that they had guide wires in her at that point.
Q. I assumed you weren't.
The question was: Why weren't you?
A. I don't understand the nature of your question.
Q. You were the primary physician, as primary physician is it incumbent upon you to be aware of what is going on with the patient?
A. In a general sense aware of what is going on with the patient is true. In terms of specific things like catheters being left inside or guide wires being left inside, there was no way I would have any

knowledge of that.

Q. Did you ever look at any x-ray reports?

A. Had no need to look at any x-ray reports in that period of time.

Q. Dr. Varma wrote a note of March 5th where it says "JMR"; do you see that March 5th note?

A Okay.

Q. That's two pages; is it not?

A. Yes.

Q Did you countersign it?

A Yes .

Q Under A/P, that's assessment and plan, right?

A. Yes.

Q. Refers to chest x-ray; do you see that?

MR. JACKSON: Talking on the 2nd?

MR. KAMPINSKI: Second page.

A. Yes.

Q. Then it's got something like an arrow?

A. Correct.

Q ARDS?

A. A-R-D-S, right.

Q. Adult Respiratory Distress Syndrome?

A. Yes.

Q. You countersigned that note?

A. Yes.
Q Did you look at that chest x-ray?
A No.
Q Did you ask him about it?
A No.
Q Did you talk to the radiologist about it?
A. No.
Q. Did the nurse ever tell you they had been told by the radiologists that there was a wire in Mrs. Weitzel that was unexplainable that had to be correlated clinically?
A. No.
Q. Did Dr. Steele tell -- did you have any discussion with Dr. Steele before he went away, wherever he went leaving you in charge, about Mrs. Weitzel?
A. Not in particular. He would have left a card with her name and her room number on there. He might have mentioned in passing that they have a lady that was in the unit, had an M.I., but I don't know any specifics.
Q. Well, did he tell you that there were guide wires left in her?
A. No.
Q. That's something you would have remembered if he

would have told you?
A. I would remember that.
Q. I assume you had some discussion with Dr. Steele subsequent to your finding out guide wires were left in Mrs. Weitzel?
A. When he returned we talked.
Q. Did he tell you he was not aware of the fact that there were guide wires left in her?
A. He said that, yes.
Q. Should he have been aware of that?
MR. JACKSON: Objection. You may answer.
A. In general I think he should have.
Q. The note I just read then from Dr. Varma referring to chest x-ray really doesn't impact upon your knowledge or your inquiring as to anything about that chest x-ray, that is just a note of his reflecting her pulmonary condition and as set forth, a chest x-ray taken?
A. Yes.
Q. When is the next note that you wrote after your March 4th note, Doctor?
A. March 5th.
Q. There's no heart on that one. I assume you were still seeing her as a cardiologist now?

A. Yes, sir.

Q As well AB the primary?

A Covering for Dr. Steele, yes.

Q And you would have reviewed the notes prior to your writing the March 5th note, right?

A Yes

Q That would have been Dr. Chmielewski's note, right?

A On March 5th the only notes written before mine was Dr. Varma's.

Q Who wrote notes on the 4th?

A On the 4th, was reading backwards, Dr. Fritz, Dr. Steffee, Dr. Chmielewski, myself, Dr. Varma, and that would be it.

Q. Who is Dr. Fritz?

A. Dr. Fritz is the third year medical resident who was doing a cardiology elective with me at the time,

Q. Resident where?

A. Cleveland Clinic.

Q. So she put hearts on there too?

A He.

Q He.

How long was he here doing his residency?

A. Well, he worked with me for a one-month period

of time.

Q. As opposed to Dr. Jayne or Dr. Varma?

A. Right. He was on elective,

Q. What does that mean?

A. That he was -- had a month where in his residency he is allowed to do what he wants, within guidelines. We can work with different physicians in different areas, he can further areas that he has interest or something that he feels he wants more competency with, so I offer an elective in cardiology.

Q. So while you were taking care of Mrs. Weitzel, made sense for him to see her?

A. correct.

Q So all the residents were getting training on Mrs. Weitzel then, right?

A. That's not a question of training on her. Everybody gets trained with me.

Q. What makes somebody a teaching patient?

A. Certain physicians who have expressed an interest in having their patients taken care of by residents are admitting to the teaching service, If their patients are deemed appropriate for residents, for example, somebody who comes in who is near death from stroke would probably not be a teaching patient, but a person with myocardial infarction and ARDS would

be deemed a teaching patient.

Q. Does the family have to consent to a patient being a teaching patient?

A. No, they don't.

Q. So it's up to the doctors to make one a teaching patient or not?

A. It's up to the doctors to make somebody a teaching patient. If the family doesn't want a resident on a particular case, they just say so and the patient becomes non-teaching.

Q. Is it up to the different physicians as to how much they allow the various residents to do on that patient?

A. Individual doctors have different levels of what they will allow residents to do.

Q. Let me ask hypothetically: If you had a patient who was not a teaching patient, for whatever reason, whether you didn't want her to be or whether the family didn't want her to be, and it is required the insertion of a catheter, arterial catheter, arterial blood pressure line, who would do that?

A. Either the primary physician or somebody that he or she could feel competent with on their comfort with the procedure.

Q. Even though you don't do invasive procedures,

that's something you can do?

A. Correct.

Q. Are there potential complications or danger from doing insertions of an arterial catheter?

A. Yes, there are.

Q. What are they?

A. One would be infection, one would be bleeding, one would be retention of guide wire, one would be dissection of an artery.

Q. Have you ever had a guide wire retained?

A. Myself personally, no.

Q Ever work on one, other than this one?

A A retained guide wire?

Q Yes, sir.

A Yes.

Q Where?

A. Saint Vincent Charity Hospital.

Q. When?

A. Approximately a month or two after this case.

Q. What happened in that case?

A. A resident had inserted a catheter for dialysis purposes and the guide wire had been retained, and when I came in to make rounds they told me and showed me an x-ray with the guide wire.

Q. What happened to the patient?

A. Nothing. I took the guide wire out.
Q. How did you take it out?
A. I used a forceps, a hemostat, and took the guide wire out.
Q. Did the resident make you or somebody else aware of the fact that it was retained?
A. Yes.
Q. So that's not something that slipped your attention?
A. No.
Q. When I say "you," I mean the person putting it in?
A. In general -- I am sorry. I don't understand your question.
Q. If somebody loses a guide wire or if it's retained, that's not something that they cannot notice?
A. I wouldn't think so.
Q. That's because you have to remove it, correct?
A. Correct.
Q. You were about to read your March 5th note.
A. Swan-Ganz reading doesn't show sepsis, want to dead end exposure, I believe; pulmonary capillary wedge approximately 18 -- I'm sorry -- approximately 15 or so; to decrease the chance of wet lungs causing

bad gases.

Q. What is the Swan-Ganz reading?

A. What are they? Which particular ones?

Q. Which ones were you referring to?

A. When you look at a Swan-Ganz catheter, there's certain numbers that you are looking at, one would be the pulmonary capillary wedge, another one is the cardiac output and cardiac index, one is the cardiac systemic vascular resistance.

Q. Your note says doesn't show sepsis, I believe?

A. Correct.

Q. Would any of these readings tell you whether or not there was sepsis?

A. Swan-Ganz can help determine that in many cases. Certainly groups of readings, if they look a certain way, suggest sepsis; others suggest other things.

Q. So these readings did not suggest sepsis?

A. In my opinion at that time, correct.

Q. Wouldn't that be an infectious disease decision?

A. No.

Q. The Swan-Ganz would be your area of expertise?

A. Correct.

Q. You a moment ago had looked at the lab slips and indicated that there was growth off of the tip of the Swan-Ganz catheter?

A. Correct.
Q. Do you recall that?
A. Yes.
Q And I think you said the date you had was the 13th. I may be wrong. You might want to look at that again.
A. 3-10-91.
Q I'm sorry. Was that the same Swan-Ganz tip that you were referring to in your March 5th note?
MR. JACKSON He didn't say the Swan-Ganz tip in his.
Q Well, Swan is from the Swan-Ganz catheter, right?
A Yes.
Q. And the tip is from the catheter, right?
A. Yes.
Q. And is that the same Swan-Ganz catheter that you were referring to on March the 5th?
A. Not necessarily. It could have been changed one or two or any number of times three times, depending.
Q At least on the 5th you don't reflect any evidence of sepsis, correct?
A Correct.
Q Since the Swan-Ganz catheter is within your area of expertise, is it therefore important for you to

ensure that its placement is correct?

A. Yes.

Q. And that it continues to remain in correct placement?

A. Yes.

Q. It goes into the lung, doesn't it?

A. It goes into the pulmonary vasculature. To the lungs, yes.

Q. And are there dangers from it becoming dislodged or displaced?

A. Well, a Swan-Ganz is in a vein, not an artery. It's connected at one end so it doesn't become dislodged and moved, per se.

The problem that you have with a Swan, if it's not in the right position, you don't get good reading, and you know, you have to re-position it.

Q. Do you continue to check the placement in terms of x-ray?

A. No.

Q. Do the radiologists continue or do they report on placement?

A. They may, depending on who is reading radiology studies on a given day. In the patient that has multiple chest x-rays, you wouldn't necessarily check the Swan every day.

Q. Do you have a good rapport with the radiologists here at Saint Vincent?

A I think sa, yes.

Q. And this isn't an enormously large hospital like the Clinic, there's not that many radiologists to know, and cardiologists, correct?

A. Fair number of each, but we know who everybody is in general.

Q. Do you have a pretty much continuing dialogue with, for example, the radiology department as relates to your patients?

A. No, not routinely.

Q. How about whether there's something out of the routine? In other words, they noticed something abnormal, would they typically pick up a phone and call you and tell you?

A. It depends on what is abnormal. If it's something that we don't suspect is there, then theoretically they would call us.

Q. In other words, if it's something unusual to them, to pick up a phone and call you?

MR. WARNER: Objection.

A. They possibly would.

Q. Has that happened to you?

A. Yes.

Q. And you want to know that as it relates to your patients; would you not --

A. Yes.

Q. -- generally? How about in specific?

A. Well, there are cases where something might be on an x-ray study, like a CAT scan or chest x-ray or ultrasound that would be pretty bad, but wouldn't prompt a phone call.

Q. Well, if they saw something that they had never seen, for example, ever on an x-ray and they wanted clinical correlation, would you expect them to pick up the phone and give you a call?

MR. WARNER: Objection.

A. Yes.

Q. When you send a patient for x-rays, they're consultants, are they not, the radiologists?

A. I am not sure what they define their role as.

Q. That's in fact, how you view them, isn't it; you seek their expertise in terms of reading the x-rays and providing you with a diagnosis so that you can then better treat your patients?

A. Yes.

Q. And your relationship with the nurses here, if they're told something by a consultant, if you're the primary, do you anticipate that they will then pass

that information on to you?

A. Yes, I would expect they would.

Q. And they might put it in the chart?

A. I would expect they would tell me.

Q. In addition to putting it in the chart?

A. I assume so.

Q. After your notes on the 5th, there is a note by the infectious disease doctor, Dr. Chmielewski, am I pronouncing that right?

A. Chmielewski.

Q. Chmielewski.

He indicates in there that he would discontinue something; do you see that?

A. Yes.

Q. What does the sentence read?

A. Discontinue Imipenen if sputum clean.

Q. What is that?

A. Imipenen is an antibiotic.

Q. Next consult is by whom, on the next note is by whom?

A. That's Dr. Sopko.

Q. The next note after that would be yours?

A. On March 6.

Q. Would you read that, please?

A. No significant changes, remains paralyzed,

sedated; blood pressure approximately 150 over 80, pulse 120, normal sinus rhythm; temp, 38.5.

Q. Keep going.

A. No jugular venous distention, lung bronchi, no rales; heart tachycardic without murmur; abdomen distended with decrease bowel sounds; extremities, no edema.

Lab today, lytes, that's electrolytes; white count 25.3 with left shift; hemoglobin, 11.7; Swan this a.m., cardiac output/cardiac index, systemic vascular resistance noted; SVR, 1,000; pulmonary capillary wedge at 9:30 a.m., approximately 17; status post, Lasix.

Impression, status post, atherosclerotic heart disease, status post, anterior M.I., with plus minus normal LV; no evidence continued ischemia.

Number two, ARDS/pneumonia, trying to keep pulmonary capillary wedge down to facilitate weaning.

Number three, increase LFT's, belly hasn't changed and CT didn't see gallbladder well; CF results, TFN and meds, can increase LFT's but wonder about cholecystitis.

Number four, history of

supraventricular tachycardia.

Q. Let me stop you there. We'll get back to the note again.

Only thing added then is this finding related to the distended abdomen?

MR. JACKSON: Excuse me?

Q. Number three was not on your previous notes?

MR. JACKSON: That's what I was asking. Added to what?

Q. Yes?

A. Correct.

Q. A different three.

A. Right.

Q. That's a description that wasn't there on the 4th?

A. Correct.

Q. What is LFT?

A. Liver function test, lab tests.

Q. There was an ultrasound ordered, as I recall?

A. Correct.

Q. Liver and gallbladder?

A. Correct.

Q. And reason for that was what?

A. To make sure she didn't have gall stones to cause any liver function abnormalities.

Q. And that was precipitated by some abnormals on laboratory study?

A. Correct.

Q. Do you know who ordered that?

A. I did.

Q. When did you order that?

A. That day, as I recall.

Yes.

Q. I'm sorry. Go ahead. You were going to read P.

A. Plan, continue to keep pulmonary capillary wedge approximately 15 to 18 with Lasix antibiotic, antibiotics per Dr. Chmielewski, try to get ultrasound of gallbladder in C.C.U., continue Nitroglycerin, Digoxin, Heparin.

Q. All right. The next note is by infectious disease, Dr. Chmielewski?

A. Yes.

Q. Can you read that?

A. Still with fever, 38.5 range, on Versed drip, chest still with rales; Cor, no real changes; abdomen, gas, distended. I don't know what he -- I don't know what EST is; stable, no evidence -- I'm sorry -- no edema.

Lab, white count 26,000 approximately, ten percent BANDS; blood culture, negative; cardiac

output, 5.4/3.9, pulmonary capillary wedge approximately 17; SVR, 1,000; LFT's still up, slowing increasing. Discussed with Dr. Rollins, asking radiology to do ultrasound gallbladder area if possible; cholecystitis as source of possible increased LFT's.

Q. Did you have any discussion with radiology?

A. About the gallbladder ultrasound, yes.

Q. Who did you talk to?

A. Dr. Porter.

Q. Which one?

A. Robert.

Q. Did he tell you anything about the existence of retained guide wires?

A. No.

Q. Who did the ultrasound?

A. The technician did it. Dr. Wirtz was the radiologist who came up to read it while it was being done.

Q. Did you have any discussion with her while it was being done?

A. Yes, I was in the room.

Q. What did the two of you discuss?

A. She showed me the finding on the ultrasound, and I think in her note of 3-6 later on she talked about

had seen and reported on x-ray?

MR. JACKSON: Excuse me. Let me understand that. You are --

A. She is doing the procedure at that time. I am not.

MR. JACKSON: Thank you. That's accurate.

A. The technician was doing it, really, and Dr. Wirtz was in the room with me watching the screen.

Q. She didn't ask you what the clinical correlation was between these wires that she had reported in an x-ray report?

MR. WARNER: Objection.

MR. JACKSON: You may answer.

A. She made no mention of wire to me.

Q. Well, had she seen retained guide wires and had

asked for clinical correlation at some point in the past and not gotten it, would you have expected her to ask you at that time?

MR. JACKSON: Objection.

MR. WARNER: Objection.

A. Yes, I would.

Q. I assume, Doctor, at any point where you would have been apprised of the existence of any foreign body that had been placed in Mrs. Weitzel and was still there, you would have done something about it?

A. Not necessarily, because -- but I would have known that it was there.

Q. Well, you would have at least examined options regarding doing something about it?

A. Yes.

Q. Which you ultimately -- which we're going to get to?

A Yes.

Q The next note was by your resident then, the one wha was going through your program?

A. No.

MR. JACKSON: Where are we now?

MR. KAMPINSKI: Right after Dr. Chmielewski on the 6th.

a. No. At the bottom of -- after Dr. Chmielewski's

note on the 6th, that note is written by Dr. William Steffee.

Q I'm sorry. Okay. The next note is by Dr. Varma?

A. Correct.

Q And then you have another note on the 6th?

A. Correct.

Q Why don't you read that.

A. Portable ultrasound of abdomen shows increased liver, increased spleen, and possibly increased pancreas, no gross evidence of stones or obstructions; portal vein is dilated. MacIntrye to see CT of abdomen 2-20 will be reviewed by Dr. Wirtz.

Q Which Dr. Wirtz?

A The radiologist.

Q What was the name of your --

A. Fritz was the name of my resident.

Q Sorry.

MacIntyre was what, gastroenterologist?

A. Correct.

Q. so you wanted consult on the increased organs that were viewed on the CT?

A. Yes, on the ultrasound.

Q. Is that the next consult?

A. The next note is written by Dr. Magiera, who is

in Dr. MacIntyre's group, apparently he wasn't available, so he did it.

Q. Says reviewed the chart, examined the patient, note would follow?

A. Correct.

Q. What part of the chart did he review?

A. I have no idea what he would review.

Q. How about x-rays, do you know if he reviewed x-rays?

MR. JACKSON: He said he had no idea.

Q. He was your consultant, did you sit down with him and review any part of the chart?

A. No.

Q. He was there for an hour and a half, apparently, 1530 to 1700, spent a long time, did he have any discussion with you about having observed any abnormalities in Mrs. Weitzel?

A. No, not at the time he wrote his note.

Q. All right. We go onto the 7th, and Dr. Varma's got a note, then Magiera?

A. Right.

Q. Then Dr. Chmielewski, right?

A. Yes.

Q. The second page of Dr. Chmielewski's note --

MR. JACKSON: Dated 3-7?

MR. KAMPINSKI: Yes.

Q. Right before your note there's a line that says would check left groin A-line; do you see that?

A. Yes.

Q. Would something?

A. Change.

Q. Change left groin A-line, what's he referring to?

MRS. CARULAS: Objection.

MR. JACKSON: You may answer.

A. Often when a line has been in place for several days, we change the lines so that there is less risk of infection.

Q. Is that A-line, the line that was monitoring the blood pressure, that's the line he's referring to?

A. Yes.

Q. So apparently he checked that line?

A. I have no idea.

Q. I guess I'll have to ask him.

MR. JACKSON: You don't have to respond to that.

MR. KAMPINSKI: Who represents him?

MRS. CARULAS: I do.

Q. Ever been sued before?

A. No.

Q. Does it cause you any concern that the same attorney that represents you, that law firm represents other physicians that are involved in this case?

MR. JACKSON: Don't answer that.

Q. Your note is next on March 7.

A. Yes.

Q. Why don't you read it for me.

A. Pulmonary capillary wedge down to 12 range this a.m., ABG's better, GI consult appreciated, but she can't at this point go down to x-ray for any procedures secondary to the I/E ratios and pulmonary status.

Number two, aspirin, one a day is indicated, should continue; number three, echo done previous, no cardiac cause for GI problem.

Plan, decrease Lasix, don't want her to drive; number two, all pulmonary capillary wedge off endo expirations or tracings; number three, hide eye CT if/when off reverse I/E ratios.

Q. Can you tell me what that last one means?

A. The hide eye CT scans are radiological procedures. The off reverse I/E ratios, I can give you a general idea. I am not a pulmonary expert, but in general if you think about one breath,

inhale/exhale most of the time you exhale, you're not inhaling most of the time when you take a breath. In people that have severe respiratory disease or ARDS, one of the things that is done is to change that where the lungs are more constantly being inflated, helps keep the airways open so that gas exchange takes place, and that's done with the special type of ventilator on a special setting; and because that's very foreign to people in terms of how they feel, that's why people on I/E ventilation are sedated and paralyzed.

The problem is that you can't move those people around the hospital, going down to the radiology department to get studies done. So if we wanted a hide eye CT scan to be repeated, I would have to wait until she was off the reverse I/E ratios.

Q Now, let me make sure I understand.

The reverse I/E ratio, she was being given oxygen; is that what you are saying?

A. Well, no. She was going -- given oxygen anyhow. She was on a ventilator, but a typical run of the mill ventilator in a patient may breathe the patient say 14 times a minute, then inflate and deflate, just like you would breathe in and out; but the reverse I/E ratios is a special type of ventilator setting where

you are more constantly inhaling, as opposed to just inhaling a short period of time in one respiratory cycle.

Again, I am not a pulmonary expert and the bottom line is, that type of ventilator setting is the type of ventilator mode that is not normal breathing mechanics, and patients fight ventilators anyway, and they fight this a lot more; therefore, so they're routinely sedated and paralyzed so they don't fight it and that gives them a chance to get their lungs better.

Q. Is that also why she was not able to be moved?

A. Correct.

Q. Now, how is the setting of this procedure maintained? I mean, is it a machine where you would actually set the amount of inspiration intake per minute, for example?

A. Well, again, you would have to ask Dr. Sopko about that, Number of inspirations per minute is one of the settings. In cases like this on this kind of ventilator there would be many settings. It would be monitored and changed, you know, minute to minute, hour by hour, day by day.

Q. That could be altered by anybody in the room?

A. No. Physically anybody could change a

ventilator setting, but no one would touch that except people who are responsible for that ventilator.

Q. How does a person develop a pneumothorax?

A. There are several ways. One way is that people have spontaneous little blebs on their lung, some -- sometimes just ruptured. A person walking down a hall can have a spontaneous pneumothorax.

Other people get pneumothoraxes because of being on ventilators or trauma or pressure of inflation can cause a small tear in the lung and pneumothorax.

Q. If the pressure of inflating the lungs is increased to a point where it shouldn't be, can that cause a pneumothorax?

A. *Yes.*

Q. Who maintains the pressure that a person is receiving in a hospital, such as Mrs. Weitzel?

A. The respiratory therapists change the ventilator settings in conjunction with the pulmonary doctor and resident taking care of the patient.

Q. In this case that resident would be Dr. Varma?

A. It would be one of the -- Dr. Jayne or whoever else was on Gala when she went there,

Q Can people die of pneumothorax?

A. They can if they are not recognized.

Q. How do you get bilateral pneumothorax?
A. Well, you have two lungs, so either lung or both lungs could have a small tear and a leak.
Q. Is that typical or unusual or don't you know?
A. I am not an expert in the pulmonary disease, but in cases that I have seen like this where there's server pulmonary problems, it's not unusual to have pneumothoraxes in the course of a hospitalization.
Q. The setting that one would set the ventilator on, is it the same for both lungs?
MR. JACKSON: Don't guess on these things. If you know.
A. That's not my area of expertise.
Q. Okay. Next note is a procedure note, chest tube for pneumo, that's short for pneumothorax; is that correct?
A. Yes.
Q. How did she develop pneumothorax, do you know?
A. I don't know.
Q. But obviously you were aware of it since you were the primary physician, right?
A. No, I was not aware of it at the time it happened.
Q. When did you become aware of it?
A. The next day.

Q. How did you become aware of it?
A. I read the note.
Q. Well, it happened at 11:15 a.m., apparently?
A. Correct.
Q. Where were you?
A. Not in the unit.
Q. Okay.
A. If you look at the note you see that Dr. Sopko was at the bedside at the time.
Q. I see that.
And he apparently was being assisted by Dr. Varma?
A. Dr. Varma didn't write that note.
Q. I didn't say he did.
A. I have no idea who was with him.
Q. Okay.
MR. JACKSON: Is there a reference to Varma's name that you were referring to?
MR. KAMPINSKI: No. I'm looking.
Q. Next note is by whom, Doctor?
A. On March 7th that Dr. Magiera's note.
Q. Then the next note?
A. Dr. Varma.
Q. There's two of them by Dr. Varma?
A. Yes.

Q. Procedure notes. Can you read that note?

MR. JACKSON: Which note?

MR. KAMPINSKI: The first one, March 7th, procedure.

MR. JACKSON: Of Dr. Varma?

MR. KAMPINSKI: Yes.

A. Swan-Ganz catheter replaced through existing introducer secondary to difficult something, existing catheter. No complications, chest x-ray to follow.

Q. Then the next note?

A. Left femoral area clean with Betadine, sterile drape and guide wire advanced. I can't read that. Guide wire removed, no complications.

Q. Can you tell what is crossed out there, chest x-ray to follow, and then it's crossed out?

A. That's what it looks like.

Q. Are you aware of his removing a femoral artery line?

A. No.

Q. Why not?

A. Because that's something that he would be doing in the course of his taking care of the patient. It's not something he would be asking me to do.

Q. Well, isn't it something, Doctor -- well, you have people work for you in your practice, I mean your

office secretary?

A. Yes.

Q. If they make a mistake, are you responsible for them?

MR. JACKSON: Objection. You don't have to answer that question.

MR. KAMPINSKI: Why not?

MR. JACKSON: Because he doesn't have to. You're asking him if he's legally responsible. He is not going to answer that. He's a doctor, not a lawyer.

Q. How about morally and ethically and every other way?

MR. JACKSON: You don't have to answer that.

MR. KAMPINSKI: He doesn't have to answer that?

MR. JACKSON: No.

Q. Are you responsible for what the residents on your service do, sir?

MR. JACKSON: You may answer that?

MR. KAMPINSKI: He may?

MR. JACKSON: He may. He has answered, but he may answer it again.

MR. KAMPINSKI: He's probably going to answer it again.

A. Not in total.

Q. Go ahead.

A. I said not in total.

Q. Okay. What parts are you responsible for, what parts are you not responsible for?

MR. JACKSON: We've been through this.

MR. KAMPINSKI: I don't think he ever answered that.

MR. JACKSON: I think he has answered that. You can look back in the --

Q. How about morally and --

MR. JACKSON: We're not here to answer questions like that. We're here to answer questions --

MR. KAMPINSKI: I don't think he answered anything like that question.

MR. JACKSON: Right. And we're not --

Q. Can you answer the question?

MR. JACKSON: Go ahead. Answer it one more time about your responsibility.

Q. Can you tell me what you're responsible for and

what you're not responsible for as it relates to resident conduct?

A. In an individual case, the residents are responsible for taking care of the patient under my general direction in terms of the things that I need them to do, the studies that I need for them to get, the procedures that they would -- would be performing as directed by a specific doctor who asked them to do those; but the individual action that they do on a moment to moment basis I am not responsible for.

Q. Who is?

A. They're responsible for their own actions.

Q. Well, they are being trained by you while they're doing their residency?

A. They are being trained by many people, including myself, yes.

Q. And it's your testimony that the primary is not responsible for their conduct while they're on your service?

A. Not responsible in total.

Q. If he removed the femoral arterial line or artery line inappropriately, who would be responsible for his conduct?

A. He would be.

Q. And nobody else would be?

A. If I had told him to remove it and it was inappropriate for it to be removed, then I would share in the responsibility. If he made the decision on his own to remove a catheter, then he would be responsible for his action.

Q. What if he didn't know how to remove it and you told him to do it?

A. Then he would be responsible for telling me that he didn't know, and he would seek counsel from senior medical residents or attendings for that procedure.

Q. Then it would be wrong for you to assume that he did know without inquiring first?

A. No, it would not.

Q. Well, who would you be relying on then?

A. His --

MR. JACKSON: For what?

MR. KAMPINSKI: For assuming that be did know.

A Second year medical resident trained at the Cl veland Clinic should be able to insert and remove an arterial catheter.

Q. So that's based on your general knowledge of what a second year resident does or doesn't do?

A. Correct.

Q. So that if he didn't know how to do it, then the

Clinic would be responsible for not having trained him right?

MR. OKADA: Objection.

MR. JACKSON You don't have to answer that.

MR. KAMPINSKI: Why doesn't he have to answer that?

MR JACKSON Because it's a legal conclusion.

MR KAMPINSKI: You just --

MR. JACKSON: You're asking a legal question and --

MR. KAMPINSKI: I am not asking a legal question. I asked --

Q. Well, you are making a medical assumption that a man who is a second year resident at the Cleveland Clinic is competent to place and remove an arterial line; is that what you just told me, correct?

A. Correct.

Q. And you as a physician reay on that assumption in letting him do that, otherwise he wouldn't be there doing it?

A. Correct.

Q If he didn't know how to do that, then that would be a failure of the Clinic teaching him to do

that?

MR. JACKSON: Objection.

MR. OKADA: Objection.

A. I would assume so.

Q. Do you know, sir, if there are any certifications or, I don't know, documents that are provided here to Saint Vincent by the Clinic when the residents come over stating what they can and can't do?

A. I am not aware of any.

Q. Who is in charge of the resident program here; is that Dr. Keating?

A. I believe that's her title.

Q. And have you had discussions with her about the competence of various residents?

A. In general, yes.

Q. Prior to this situation?

A. Not particularly Dr. Varma prior to this; but about residents in general prior to this, yes.

Q. You mean whether they can and can't do what they should or shouldn't be allowed to?

A. Not necessarily specific like that. We don't talk about their competence in doing a particular procedure, but their general level of competence, their attitude.

Q. I am not sure I understand.
A. Whether a resident in general seems to be a very -- whether he cares about his patients, whether he takes orders.
Q. In other words, you would evaluate these people as they came through; is that what you're indicating?
A. Yes.
Q. We're talking cross purposes then.
My question, at least, was designed to determine to what extent you had any discussion with Dr. Keating or anybody else involved in the residency program to familiarize yourself with what these people can or can't do, or should or shouldn't be allowed to do?
A. No discussion of that type.
Q. Did you read Dr. Varma's March 7 note?
A. Yes.
Q. Do you have any recollection of when you read it?
A. No.
Q. Did it cause you any concern at all looking at it or just a normal note that you would expect to see in a chart?
A. Those are normal notes that you expect to see in charts.

Q. Were you there when it was done?
A. No, not that E am aware of.
Q Next note is what, Doctor?
A 3-8-91, Dr. Magiera's note.
Q One after that is?
A, Dr. Sopko's.
Q That's on March 8, pulmonary?
A. Right.
Q. Next one is Dr. Chmielewski?
A Yes
Q Infectious disease?
A. Yes.
Q. By the way, he says a definite improvement in temperature over the last few days, right?
A Yes.
&· Is that what it said?
A. Yes.
Q That's what I thought it said.
Next note is what?
A Dr. Varma.
Q And then tbe newt note?
A 3-8, mine.
Q Why don't you read that for me.
A She is improving, I think; ABG's much better and FIO2 is down 50 percent with greater than

90 percent SATS.

Q. Let me stop you.

That relates to her pulmonary condition; does it not?

A. She was improving, I think her -- well, right, her overall condition.

Q. And ABG's are arterial blood gases, refers to her pulmonary condition?

A. Correct.

Q. I'm sorry. Go ahead.

A. Her belly was softer with positive bowel sounds.

Q. That relates to your concern about the distended abdomen, right, that you had noted on your previous note?

A. It relates to her abdomen.

Q. Okay.

A. Stooling with very decrease NG output, blood pressure okay, pulse 100, normal sinus rhythm, no jugular venous distention; lung, scattered bronchi, no rales; heart without murmur, abdomen softer with positive bowel sound; liver and spleen enlarged; extremities, no edema.

Labs, increased BUN, creatine ratio; increased LFT; white count down a bit without a left shift.

Q. Is that a good sign for infection purposes?
A. White count decreased a bit is a good sign, but Dr. Chmielewski's note from the 8th said he doesn't know whether her temperature had been decreased because of steroids or aspergillin B.
Q. Okay.
A. Pulmonary capillary wedge 13, cardiac index in the 4's; stool, hem, negative; impression, ASHD; number two, ARDS, pneumonia; number three, increased liver/spleen/LFT's.
Q. Well, would you read the entire entry on the number two.
A. ARDS/pneumonia, definite improvement, with decreased FIO2's; improvement of ABG's.
Q. I'm sorry. Go ahead.
A. Number three, increased liver/spleen/LFT's, however, CT scan of --
Q. Would you read the entire number three?
A. Workup and progress, she's stable with improvement, hopefully her lungs will improve over the weekend so CT scan of spleen can be performed in x-ray with decreased risk.
Q. Then if you would go on to the plan?
A. Continue dig, continue nitro patch, continue p.r.n. Lasix only for greater than 20 or increase,

Would continue aspirin at q.i.d., at least unless documented GI bleeding, very elevated prothrombintime and decreased platelets; agree with Vitamin K.

Then number five, increase BUN/creatine secondary to roids, that's steroids, Lasix, catabolism.

Q What time on the 8th was that done, Doctor?

A That note?

Q Yes.

A. I have na way of knowing exactly what time, but in general I make rounds in the units in the morning.

Q. Is it typical far you to then write a note after you make rounds?

A. See the patient and I write the notes at the same time,

Q. So do you assume that this was done sometime in the morning of the 8th?

A, Yes.

Q The next note is whose note, Doctor?

A, Dr. Varma's.

Q Would you read that for me?

A. Procedure note, right Swan-Ganz, area around right IG, I think, cleaned with Betadine, sterile draped, guide wire inserted. I can't tell if that's

through existing introducer; introducer removed and new introducer placed. Swan-Ganz catheter replaced with good wave forms, CXR to follow for line placement.

18

Q. What was he doing, replacing the Swan-Ganz?

A. Changing the Swan-Ganz catheter.

Q. Per your order?

A. No.

Q. Per his own order?

A. Per his clinical judgment that it needed to be changed. I don't know if he discussed it with anybody else or whether they had determined among themselves it needed to be changed.

Q. Did you discuss every day with the residents what ought to be done with the patient and orders and to get some analysis of whether you should trust them to exercise, as you just put it, their "Clinical judgment"?

A. Well, we would discuss the patient in general, in terms of the patient's clinical condition, we would go over any appropriate labs, and the general plan for the day would be outlined, but something specific like changing catheters would not be necessarily discussed.

Q. The next note is?

A. Next note is I think Dr. Oneykwere's.

Q. Who is he?
A. He is a senior medical resident.
Q. He comes from the Clinic, too?
A. Yes.
Q. And when did he get involved in the case, do you know?
A. I don't know. He might have been covering for somebody or they might have changed residents with Magiera. I am not sure when the module ended.
Q. Next note after that is yours again?
A. I don't know for sure. I think that's Dr. Vaidya, who would be a thoracic surgery physician.
Q. Next note is who?
A. Dr. Varma.
Q. March 8, 1991?
A. Yes.
Q. JMR, junior medical resident?
A. Yes.
Q. 9:00 p.m.?
A. Yes.
Q. Would you read that, please?
A. Above something, noted patient has on chest x-ray persistent wire something, also not explainable after reviewing chest x-ray, I think it's -- the wire was not presumed on chest x-ray 2-29-91, but on

2-29-91 wire was present, or I think it's 2-26-91 wire was present.

On 2-2-691 femoral artery line was placed and something to that went something, something something. Possibly something guide wire, something is what -- what I doubt something. I did procedure myself. Is possible that sheath was left in something and something, will discuss with staff.

Then will need removal via fluoroscopy, discuss --

Q. What is "Will need removal via fluoroscopy"?

A. Fluoroscopy is an x-ray where you turn an x-ray machine on and you can see. It's like a moving x-ray.

Q. Well, how do you remove something via fluoroscopy?

A. It shows you the vasculature. So you put somebody in the lab and you use a fluoroscope.

Q. Does that assist you in the removal?

A. Yes. Fluoroscopy doesn't take anything out.

Q. Then it says discuss with Dr. Rollins?

A. Yes.

Q. This was at 9:00 p.m., were you there that night?

A. No.

Q. Where were you?

A. I was at home.
Q. Did he call you?
A. Yes.
Q. Can you tell me what was said?
A. He called me and said there seems to be a guide wire present, which was present on the date that he indicated.
Q. What date did he indicate?
A. Approximately 2-26-91. I can't remember the exact date.
I said on the phone --
Q. Go ahead, please.
A. He said looks like the wire was there on chest x-ray.
Q What did you do or what did you say?
A. I said do you have any idea how it got there; he said no.
Q. Then what?
A. I said how is the patient doing hemodynamically, and he said she was stable.
Then there were words to the effect that because she's stable and she -- there's no other evidence of bleeding or perforation, because she can't be moved, the wire will have to come out when she's stable, but doesn't look like there is a problem with

it right now where it is.

Q. Is that what he told you?

A. No. That's what we discussed. Those weren't necessarily his words.

Q. Were you upset?

A Yes.

Q Did you ask him why you hadn't been told this before?

A Well, he indicated to me he just found out about it right. then,

Q. Did you go to the hospital?

A, No.

Q. Well, first of all, was there anything else discussed in the conversation?

A. I asked him if he told Mr. Weitzel.

Q. What did he say?

A. He -- no, he said no. He would tell him the next day,

Q Anything else?

A. No.

Q When is the next time you did go to the hospital?

A. Monday morning.

Q. What day was this?

A. This was Friday night.

Q. What did you do that weekend?
A. I can't recall.
Q Well, when you got off the phone with him, did you talk to anybody else about this?
A. No, not that night.
Q. How about the next day?
A. Yes.
Q. Who did you talk to?
A. Dr. Kitchen.
Q. Is that because he was on call the next day?
A. Yes. Dr. Kitchen was on call that weekend. He would be making rounds that weekend and we know he would be coming in on Saturday.
Q. Why don't you tell me what was discussed between you and Dr. Kitchen?
A. Dr. Kitchen called me on Saturday morning and mentioned to me that he knew that there was a guide wire there, Me looked at the x-rays, and we discussed whether anything should be done at that time to remove it.
Q. What did you decide?
A. We decided that there was no reason to remove it at that point because the patient couldn't be moved because of her pulmonary status; because she wasn't having any hemodynamic consequences, bleeding,

perforation, that that could be removed safely when she was more stable.

Q. So her instability was a cause of concern in terms of the removal of this guide wire, or guide wires?

A. Well, her instability in terms of pulmonary and based on she couldn't be moved to take the guide wire out. In general her condition was improving but it wasn't good. So we wanted to wait until she was more stable since she was no having no problem with it where it is.

Q. Was there a thought about removing it surgically, was there a discussion about removing it surgically between you and Dr. kitchen?

A. Dr. Kitchen felt that this kind of guide wire could be removed in the cath lab.

Q. By a method that he had invented?

A. Well, he had develop a method to do it, he mentioned that, but there are other methods to removing guide wires in the cath lab; so some method would be used.

Q And this would involve what, entering the artery with some other type of wire, snagging the wire and pulling it out?

A. Well, I am not an invasive cardiologist, so I

can't comment specifically, but something along those lines I think.

Q. Was there any discussion about doing it surgically?

A. No. Only that he was going to have the vascular surgeon notified so that he would be available in case there was some problem in the event of a necessary surgery to remove the guide wires.

Q. Was any thought given to whether or not she was stable enough to undergo such surgery?

A. Well, she wasn't stable enough to undergo surgery on an elective basis at that time.

Q. "At that time" being on the 9th?

A. On the 9th, on the 8th.

Q. Why is that?

A. Because her pulmonary status still had not improved, and she was on the I/E ratio ventilator at the same time,

Q And that would not have allowed her to be moved?

A. Right.

Q But is that the same as saying that she couldn't undergo surgery?

A Well, when you say somebody can undergo surgery, that also involves whether or not there's risk involved in surgery, and whether the risk/benefit

ratio tilts more towards having the surgery or towards waiting.

Q. If someone dies within 24 hours of surgery, is that by definition an operative death?

MR. JACKSON: Objection.

A. I think it is.

Q. When I say "definition," where is that defined?

A. I am not sure. I think it's defined in terms of what the coroner thinks.

Q. That's what the medical community follows, is it not, in terms of their definition of operative mortality?

MR. JACKSON: Objection. You may answer.

Q. Correct?

A. I am not aware of what the surgical community does, but I think that's included in their statistics this way.

Q. When is the next time you saw Mrs. Weitzel?

A. Monday morning.

Q. On March 11, next note is of March 11?

A. Yes.

Q. Why don't you read that.

A. Rollins for Steele, overall improved, continues to make progress respiratory-wise, off I/E ratios,

decrease to 40 percent; FIO2 with SATS, around 95 percent. Cardiac-wise, had increased heart rate, possible SVT and increased blood pressure now better with Verapamil. No sinus rhythm and 106 minimum, blood pressure was 140 over 75, no jugular venous distention

Lungs with coarse bronchi, no wet rales; heart, regular rate and rhythm without murmurs; abdomen bowel sounds positive, liver very decreased in size; extremities, no edema, good pulses, I/E end, last three or four days.

Lab, SMA 18, decrease LFT's, white count still up with left shift, pneumonia still approximately 76; BUN down; chest x-rays still has wire in it.

Impression, number one, atherosclerotic heart disease, status post, no evidence of re-infection, LV on mild decrease.

Number two, hypertension better on Verapamil; three SVT's, still on Verapamil; and number four, respiration/ARDS, remarkable turnaround with weaning continuing. Need to wake her up.

Number five, hepatopulmonary shunt resolving, don't know cause.

Number six, guide wire retention, this

needs to be removed under fluoroscopy, no problem so far, will leave it to Dr. Steele to schedule elective removal; no evidence of vessel perforation at this point, no decrease in hemoglobin.

Number seven, nutrition, time to use gut and decrease TPN if tolerated.

Plan, number one, maybe begin half strength, check every day per her NG, at 30 cc's an hour.

Number two, decrease DIG to .25 I.V., q.d., with recheck level on March 12; number three, continue Verapamil 40 milligrams NG tube; number four, continue Nitro patch, aspirin every other day; number five, Solu-Medrol, and that's per Dr. Sopko; number six, to check Versed later and Norcuron now.

Number seven, run her fluids evenings, if I greater than O, use p.r.n. Lasix.

SMA, CBC, PT requested Monday, Wednesday, and Fridays, check DIG level Wednesday.

Q. On the first page you said chest x-ray still has wire in it?

A. Correct.

Q. Did you go look at the chest x-rays?

A. Yes.

Q. So before you wrote the note you were aware of

the fact that x-rays reflected she had a guide wire in her arterial system?

A. Well, the x-ray -- x-ray I'm referring to is one that was taken on the 11th.

Q. So you didn't look at this previous one?

A. I probably did.

Q. So you were aware of the fact that it showed up as far as back as the 28th?

A. I am not aware of what date it exactly showed up.

Q Did you go back to look to see when they first appeared on the x-ray?

A. No.

Q Did you go back and look at the x-ray report?

A No.

Q. Why not?

A. Because I knew she had a guide wire.

Q. You didn't care when it showed up?

A. It wasn't a question of caring. It was documented in the charts when it showed up There was no reason to look again.

Q. Didn't matter anymore, it was there, whether it was there a week ago, ten days ago, a day ago, wouldn't have changed what existed for you then and there?

A. It's not a question of not mattering. It's a question of that guide wire had been in far several days, her hemodynamic status was stable; therefore, if it had been a day before or day after, the actual date that it is in didn't matter, it was already in.

Q Should it have been in?

A No.

Q Should you have been told about it?

A Yes.

Q By whom?

A. Either the radiologist who saw it

MR. WARNER Objection.

A. -- or the resident.

Q Or Dr. Steele?

A. If he knew, yes.

Q. Well, you told me before he should have?

A. You asked me before if I should have.

Q. I asked you before if Dr. Steele had known?

A. Yes, he should have.

Q. Did you go back and look at the note of Dr. Varma's insertion of the arterial line?

A. No. I talked to Dr. Varma.

Q. On the morning of the 11th?

A. Again, yes.

Q. Tell me what was discussed.

A. Just in general basically about did he have any idea how the guide wire got there, and he said no, he did not.

Q. Did the two of you look at the x-rays?

A. No.

Q. Did you then look at the note as to who put it in?

A. He said he had put it in.

Q. Well, I don't understand. You just told me he said he didn't know how it got there. Now you're telling me that he said he put it in.

A. He put in the arterial line.

Q. But he didn't know how this guide wire got there?

A. Yes.

Q. Did he tell you he had removed the guide wire?

A. He said he assumed he did, or words to that effect.

Q. Anything else said in that discussion?

A. No.

Q. He was still the resident caring for Mrs. Weitzel?

A. Yes.

Q. Had Mr. Weitzel been told, by the way?

A. I assume he had, since Dr. Varma had told me he

was going to tell him as of Saturday morning.
Q. So you relied on Dr. Varma to do that?
A. Yes. He knew Mr. Weitzel. I never met him, as far as I knew.
Q. Was your opinion still the same on the 11th that the wire should not be removed at that time?
A. Yes.
Q. And your reasonings were what?
A. That she was making progress and this was going to be done electively.
Q. Is a foreign body a potential problem in someone who has sepsis?
A. Yes.
Q. What is the problem?
A. Well, foreign body can be a source of sepsis.
Q. Also prevent sepsis from clearing?
A. Not necessarily. It is possible.
Q. And we already discussed the problems in a case of doing surgery on somebody post M.I., so that the potential surgical removal of this wire, I take it, would have been a source of concern for you?
A. Yes.
Q. That would have been another reason to not do anything at that point in time?
MR. JACKSON: Objection. You

may answer.

A. It would be a reason to plan to do an elective when the patient was stable.

Q. That was a Monday, right?

A. Yes.

Q. Do you see her again?

A. Yes. 3-12-91.

Q. Is that the one with Fritz, then Rollins?

A. Yes.

Q. That was your resident who was training under you?

A. Doing an elective with me.

Q. And you countersigned it?

A. Correct.

Q. Why don't you read that.

A. Patient given .4 milligrams Robinul and four milligrams of Neostigmine over five-minute period, patient demonstrated positive doll's eye, blink reflex, and moved left arm apparently on command.

Discussing with medical residents and will restart Versed drip for sedation until Norcuron worn off. Dr. Steele will be taking over case today from cardiac standpoint.

Q. What does it mean when a patient has positive doll's eyes and blink reflexes and moved left arm

apparently on command?

A. Those are good things. That shows neurologic function is intact.

Q. In fact, there was no neurologist who was a consult here, was there?

A. Not to my knowledge.

Q. So from a neurological standpoint, she was okay, wasn't she?

MR. JACKSON: Objection. You may answer.

A She was okay as far as we knew, being sedated and paralyzed there wasn't any way to examine her higher cortical functions at that point. She was sedated.

Q. She wasn't always sedated and paralyzed when she was at your **hospital**, was she?

A No.

Q How about before she was sedated?

A. If you want a date, I'd have to look back in the records and we can tell that.

Q Why don't you **do** that,

A I wasn't on the case, but if you **look** at the neurologic exam on admission, the history and physical lists eyelid droop, took three nurses to keep patient down, motor and sensory five over five, sensitive to

pain in all extremities. No clonus.

MR. JACKSON He will ask you questions.

Q. Does that answer how was she neurologically? I know you just read it.

A. That was what her neurologic status was as documented on the chart when she came in,

Q. Does that suffice to tell you whether or not she was okay neurologically?

A No, not completely.

Q. Okay. Why don't you read on then.

MR. JACKSON: What would you like?

MR KAMPINSKI: I want him to read whatever he needs to read. He's the one who wants to go back and read. My question was, there was no neurological consult involved, which at least to me says that his service and his associates didn't see the need to get a neurologist involved in her care, in light of the fact there was nothing wrong with her neurologically.

THE WITNESS: No, I didn't say state that,

MR KAMPINSKI: I know you didn't. I was asking you to go back and look and satisfy

yourself that that is the case; if it's not, tell me if it isn't and why it isn't.

A. When I took over this lady's case on March 4th, she was sedated and paralyzed.

Q. We have gone through that. I understood you the first time you told me that, and I have no quarrel with you. I appreciate what you told me.

My question is whether or not she had any neurological impairment as evidenced by this chart?

A. On the note of 2-12-91 there was a neuro notation, patient eyes wander, patient doesn't follow command, blinks to clap, positive corneal reflex, positive reflex to sucking, that would imply she did not have normal neurologic status.

Q. Were there notes indicating that they did follow channels, that they tried to communicate or not try, but did in fact communicate and --

MR. JACKSON: Where are those? Do you want him to read them?

MR. KAMPINSKI: Well, if he needs too.

A. I have not --

MR. JACKSON: I told you he hadn't reviewed the entire chart.

Q. You just picked out that one part of it?
A. Shows that there was not a normal neurologic status on that date.
Q. Was she followed by a neurologist?
A. Not during the time I took care of her. I have to look and see if she was by anyone else.
Q. Look at 2-14, junior medical resident note, neuro, got PERM, what does that mean, PERM?
A. Where are you reading on the 14th?
Q. Probably is Dr. Varma's note.
A. Neuro. I don't think that's PERM. I think that's PERR.
Q. L?
A. R.
Q. What does that mean?
A. Pupils equal, and round, and reactive.
Q. Reactive to light?
A. If you put L there, it would be light; otherwise, it is equal, round, and reactive.
Q. Follows commands?
A. Correct.
Q. How is that neurologically.
A Better than what it had been documented earlier on. That would assume that she had a fairly normal neurologic status.

Q. How about on the 15th, JMR, awake, follows commands; do you see that?

A. Yes.

Q. Then under that says neuros?

A. Awake, moves extremities.

Q. Is that good?

A. That's good.

Q. I'm sorry. We digressed a little, Doctor. I think I had asked you if she was basically okay from a neurological status and you said you really couldn't tell other than what was set forth in your Dr. Fritz' note, right?

A Correct.

Q. But those were good neurological signs?

A. Yes.

Q. That second paragraph says discussion with medical residents?

a, Yes.

Q What medical residents?

A. Dr. Fritz discussed it With a medical resident in the unit, that may have been Dr. Varma or may have been other people there,

Q. Why in the world was Dr. Varma still taking care of this lady?

A. I don't understand your question.

Q. I don't know why he was still taking care of her. He had told you that he had put a wire in this lady and you had determined they were on x-ray back as far as February, you told me you should have been told, you weren't told; why was this man who number one, didn't do the appropriate medical thing; number two, didn't tell you about it, still talking care of this lady?

MISS MOORE: Objection.

MR. JACKSON: You may answer the question if that's a decision you made. If you know.

A. He had -- had been taking care of the patient all along, he had made a mistake in terms of a procedural mistake. That's not necessarily proving that he's a bad physician.

Q. Is it a good physician that doesn't tell somebody about mistakes that he makes to the detriment of his patient?

MISS MOORE: Objection.

MR. JACKSON: You may answer.

A. At that time I was unaware that he had known or not known.

Q. I thought you just told me earlier this is not something that you wouldn't know; in other words, if you leave a guide wire in, you know you leave it in?

A. You asked me --

MISS MOORE: Objection.

A. You asked what I thought.

Q. Yes.

A. I have no idea what he thought. In general, someone would know that they left a guide wire in.

Q. How about two guide wires?

A. I would think they would know.

Q. Dr. Steele took over for you that day?

A. He resumed care of his patient on that day, yes.

Q. Did you have any further involvement with Mrs. Weitzel?

A. No.

Q. Were you consulted with respect to the decision to remove the guide wire from her?

A. No.

Q. Were you aware of that decision being made?

A. Yes.

Q. How?

A. I knew that she had gone to the cath lab to have the guide wire removed.

Q. How did you know?

A. We make rounds in the unit. We had gone in and she was gone, getting her guide wire removed.

Q. Do you know why the decision was made to do

that?

A. Foreign body should be removed.

Q. I misspoke. I didn't ask it very artfully.

Why was it made at the time it was made, as opposed to when you had been on watch?

A. I assumed that the physicians who were taking care of her deemed it the appropriate time to do so.

Q. Why did they have her undergo surgery, do you know?

A. Apparently they go -- got one of the guide wires out under fluoroscopy in the cath lab.

Q So?

A. So they went to get the other guide wire out and they decided that she should undergo surgery to have it done.

Q. Were you consulted about that decision?

A. No.

Q. Did you agree with that decision?

A. I have no basis to make that agreement or disagreement because I wasn't aware of her clinical status at that time.

Q. What was different about them deciding to remove the guide wire on the 13th than your decision not to do it on the 9th, 10th, and 11th?

A. Her respiratory status was changed dramatically

in that period of time.

Q How had it changed?

A. She was off the I/E ratio, she was being weaned off the ventilator so that she could be moved for any procedure that she needed.

Q. So would that make it safe to have her undergo this?

A. Safer; not safe, but safer.

Q. She still would be subjected to the increased mortality that we have discussed before, about someone undergoing surgery post M.I.?

MR. JACKSON: Objection. You may answer.

A. The catheter lab removal of guide wire would not be the same kind of risk as a surgical procedure.

Q. And I meant to say surgical procedure.

A. Having a surgical procedure at that point in her hospital stay would be increased risk.

Q. And the reason she underwent that apparently was because of the retained guide wire?

A. Right. That couldn't be recovered in the cath lab.

Q. Is the standard of care for the insertion of an arterial line, the removal of a guide wire?

A. Yes.

Q So the failure to remove the guide wire **is** a breach of the standard of care?

A **Yes.**

Q. Dr. Kitchen indicated that it was unexcusable not to have brought to the attention of Dr. Steele or yourself or anybody, the failure to remove the guide wire; do you agree?

MISS MOORE: Objection.

A **Yes.**

MR. JACKSON: You may answer.

Q In light of the fact that the surgery, or this was an operative mortality following the surgery, do you agree that the placement of the guide wire and leaving it in Mrs. Weitzel contributed to cause her death?

MR. JACKSON: Objection.

MISS MOORE: Objection.

A. I can't state that with certainty. I don't have knowledge of that.

Q. Why is that?

A. Because she was ill with a heart attack, bad lungs, she could have died for a variety of reasons.

Q. She could have been hit by a bus, but she wasn't.

MR. JACKSON: Don't respond.

Q. She underwent surgery and died within 24 hours, correct?

A. Correct.

Q. Therefore it's an operative mortality?

MR. JACKSON: Objection.

A. She died of a ventricular arrhythmia following surgery.

Q. Which is an operative mortality?

A. By the decisional thinking that you were talking about before?

Q. Absolutely.

MR. JACKSON: I object, but you may answer.

A. By that definition, that's correct.

Q. Well, the ventricular arrhythmia, what caused it?

A. Don't know.

Q. What probably caused it?

A. There's no way to know. An operative procedure by itself doesn't necessarily cause a ventricular arrhythmia.

Q. But it can --

MR. JACKSON: Objection.

Q. -- post M.I.?

MR. JACKSON: Objection, but you

may answer.

A. It sure could.

Q. If in fact it did in this case, then the leaving the guide wire in Mrs. Weitzel contributed to cause her death?

MR. JACKSON: Objection.

MISS MOORE: Objection.

MR. JACKSON: Speculation. I am not going to allow him to speculate.

MR. KAMPINSKI: I don't think it is. We've gotten past speculation.

MR. JACKSON: I think he told us that he didn't know, didn't have an opinion in that regard.

Q. Why is that? Why is that, that you don't have an opinion?

A. Because there were multiple things going on with this lady at the time and there were a variety of things that could have caused her to have ventricular arrhythmias.

Q. Well, are you one of the physicians that cleared her for the surgery?

A. No.

Q. But you are not telling me that she was too bad to undergo surgery?

A. That was a decision made by the people taking care of her at that time. I have no opinion.

Q. Either she was too bad to undergo surgery and therefore she died as a result of being in such bad shape, or that she's in good enough shape to undergo surgery, you don't know which it is?

MR. JACKSON: Objection. You may answer that.

A. Those are not choices that I have, those are your words. If you'd like to rephrase it, the question, and be specific.

Q. Do you have any opinion as to whether or not she was stable enough to undergo surgery when she underwent it?

A. No, I don't.

Q. Did you have any discussion with Dr. Steele when he came back about this retained guide wire?

A. Yes.

Q When?

A. The morning that he resumed her care, which would have been on the 12th.

Q. Tell me what was said.

A. I can't remember the exact words, but I asked him if he was now aware of it, and he said yes. He said he was going to talk to Dr. Varma. Then he said

that he was probably going to go -- go ahead and try to remove the catheter under fluoroscopy at some point in the future.

Q. Did you tell him what your thought about that was?

A. About what?

Q. The removal of the guide wire?

A No, that was his decision as to when and how he would remove it.

Q. But I mean, you had the opinion not to remove it while you were taking care of her and you thought it should be removed electively and not at that point?

A. Well, things were different on the 12th than they were -- were on the 8th or 9th or 10th or the 11th; therefore, he was going to make the decision from that point onward as to whether if at all he was going to remove the guide wire,

Q I got you.

Did you discuss this retained guide wire with anybody else that we haven't already talked about?

MR. JACKSON: Of course, other than counsel.

MISS MOORE: Objection.

Q Other than your attorneys?

A. Other than the ones we have talked about, no.
Q. You didn't talk to Dr. Keating about it?
MISS MOORE: Objection.
A. Not at the time that this was taking place.
Q. At any time?
A. Yes.
Q. When?
A. Subsequent to her death.
Q. What was discussed?
MISS MOORE: Objection.
MR. JACKSON: I'm going to object. I'm not sure this doesn't get into a peer review type of thing, and it would not be discoverable. I don't know what -- I assume Dr. Keating was involved in the capacity as the director of that; is that the capacity in which you talked with her?
THE WITNESS: Yes.
MR. JACKSON: He is not going to answer that question then.
MR. KAMPINSKI: All right.
Q. Tell me the setting that you talked to her in.
A. I can't recall.
Q. Was it in the hall?
A. I can't recall, sir.

Q. Was it in your office?
A. I don't know if it was in my office.
Q. Was it in her office?
A. I don't think.
Q. Was anybody else present?
A. Not that I recall.
Q. So it was just the two of you?
A. Yes.
MR. KAMPINSKI: Can he answer the question?
MR. JACKSON: No.
MR. KAMPINSKI: Why not?
MR. JACKSON: I think I have stated my reason. In fact, I know I did. If the judge determines that that's a discoverable item, he will answer those questions.
Q. Did you discuss it with anybody else?
MISS MOORE: Objection.
A. Not that I can recall.
Q. Did you ever have any further discussion with Dr. Varma?
A. No.
Q. How about anybody at the Cleveland Clinic?
A. No.
Q. How about the resident that trained with you,

Dr. Fritz?

A. Subsequent to this, no.

Q. Did you talk to Dr. Fritz while it was going on?

A. Well, he knew there was a guide wire in, too. He was writing notes on the chart on the 12th, so he knew then.

Q. What was the purpose of your discussion with Dr. Keating, did she request a meeting with you or did you request a meeting with her or was it a chance discussion; how did it come about?

MR. JACKSON: You don't have to answer that.

MR. OKADA: Objection.

MR. KAMPINSKI: He doesn't.

MR. JACKSON: He does not have to answer that.

MR. KAMPINSKI: As to how the meeting came about?

MR. JACKSON: Yes.

MR. KAMPINSKI: If the judge is going to rule, Mr. Jackson, on what the purpose or the nature of this meeting was --

MR. JACKSON: He testified that that's the capacity in which he spoke with Dr. Keating.

MR. KAMPINSKI: He didn't.

MR. JACKSON: You asked him if that was the setting in which he talked with her, and the reason that he talked would be in her capacity as director; he said that was correct.

Is that correct, that's the capacity that you talked with Dr. Keating?

THE WITNESS: Yes.

Q. What capacity is that, that you asked, now that you told him what to say?

MR. JACKSON: I didn't tell him what to say.

MR. KAMPINSKI: You always do. Go ahead and tell him what to say.

MR. JACKSON: Don't get excited. I'm trying to clear up this.

Q. In what capacity was she acting when you talked to her?

A. As the director of the residency program.

Q. She's also a physician?

A. She was a physician.

Q. Did you rely upon her to provide you with competent people in the residency program?

MR. JACKSON: Objection. You may answer that.

A. Per individually, you mean?
Q. Yes. As opposed to collectively, yes, her individually?
A. No, not her individually.
Q. Who did you rely on?
A. Cleveland Clinic.
Q. Who at this hospital was responsible for providing residents?
A. The Cleveland Clinic provides us with residents.
Q. Yes?
A. The monitoring of their -- where they are put and how many there are and the particular names is Dr. Keating's job. She does not go out and get residents. The Clinic provides them.
Q. Who ensures that they're competent to be accepted here at this hospital for purposes of assisting you in your treatment of patients?
A. They're presumed via the fact that the Cleveland Clinic sends them to us to be competent.
Q. I see. Well, so if I understand then, any review of Dr. Varma and his competency in terms of peer review would have been done by Cleveland Clinic personnel as opposed to anybody here?
A. I don't understand your question.
Q. Yes. I mean if we're talking about a peer

review, that is reviewing his ability to get through his residency program at the Clinic, that would have been done by Clinic personnel, correct?

A. Up to the point until he came here, that's correct.

Q. Did you ever talk to Clinic people about his competency or lack thereof?

A. No.

Q. So you didn't get involved in any type of peer review done though the Clinic, right?

A. I am not involved with the Cleveland Clinic.

Q. Then the answer to my question is you did not?

A. The answer is I did not.

Q. Then what was the basis of your discussions with Dr. Keating since he wasn't a resident -- there is no residency program at Saint Vincent Charity Hospital, right?

A. We combine with the Clinic in terms of how the program is set up.

Q. But your discussions with Dr. Keating would not have, or would it have determined whether or not Dr. Varma could proceed in his residency program at the Cleveland Clinic?

MR. OKADA: Objection.

MR. JACKSON: You may answer, if

you know.

A. Discussions as to his clinical competence from that point on would have been made between Dr. Keating and myself, but we'll not determine whether or not he was competent to continue at the Cleveland Clinic.

Q. I see. So would you now answer my question as to what was discussed with her?

MR. JACKSON: No, he won't.

MR. KAMPINSKI: Why don't we take about a two-minute break.

- - - - -

(Brief recess had.)

- - - - -

BY MR. KAMPINSKI:

Q. Doctor, who put in the guide wire that you removed approximately a month after this incident?

A. Can't recall the resident's name. It wasn't Dr. Varma, it was a different resident.

Q. From the Clinic?

A. Yes.

Q. What year resident?

A. Second year resident.

Q. Do you still allow second year residents from the Clinic to insert arterial catheters?

A. Yes.

Q. Did you have any discussions with Dr. Jayne regarding the retained guide wire?
A. No.
Q. None at all?
A. No.
Q. Why not?
A. I had no idea she was involved.
Q. She was the senior medical resident, wasn't she?
A. When the guide wire was put in I wasn't on the case. I had no idea who was involved in putting it in.
Q. Who was the senior medical resident when you were involved?
A. Well, there were more than one. Oneykwere, I think, and Jayne and --
Q. Who was that first one?
A. Oneykwere. None others that I can recall.
Q. Did you have a discussion with Dr. Oneykwere?
A. No.
Q. How much insurance coverage do you have?
MR. JACKSON: You don't have to answer that. We'll provide that for you.
MR. KAMPINSKI: We have asked for it in interrogatories.
MR. JACKSON: I know. That's my

fault.

MR. KAMPINSKI: What's the answer.

MR. JACKSON: Not his place. I will get you the answer.

Q Do you know the answer?

A Yes.

Q What is it?

A. One million, threa million.

Q. How much excess do you have?

A. I am not sure.

MR. KAMPINSKI: Do you know?

MR. JACKSON: Not as we sit here I don't, but I will see that you are provided with that information.

Q. Is the reason you don't have an opinion as to whether or not the operation caused or contributed to cause the death because the same law firm that represents you, represents the person who did the operation?

MR. JACKSON: You don't have to answer that question.

MR. KAMPINSKI: If that's the reason, why doesn't he have to answer?

MR. JACKSON: Do you have a question?

MR. KAMPINSKI: I'd like an answer to that one.

MR. JACKSON: He is not going to answer that question.

MR. KAMPINSKI: On the grounds it might tend to incriminate.

MR. JACKSON: Incriminate, did you say?

MR. KAMPINSKI: Yes, him.

What is the reason that he can't answer that?

MR. JACKSON: Because I think it's contentious, I think you are trying to be cute or whatever the word is.

MR. KAMPINSKI: I am really not. I am being very serious.

MR. JACKSON: It's not a real issue as relates to the issues that we're here for. He is not going to answer.

Q. Doctor, would you had been concerned with the answer if I was being contentious, which I was not?

MR. JACKSON: He is not going to answer that question.

What else do you have to ask?

MR. KAMPINSKI: If you won't let

him answer valid questions, I suppose it's silly for me to ask anymore questions.

MR. JACKSON: It's silly for you to continue asking silly questions.

MR. KAMPINSKI: I guess we're just going to have to continue this deposition until such time as the court allows me or indicates that he needs to answer the questions that are appropriate.

MR. JACKSON: Did you have any other questions you wanted to ask today?

MR. KAMPINSKI: I might, but they would depend upon me getting an answer to these questions.

MR. JACKSON: To that last question?

MR. KAMPINSKI: No. There's a couple that you haven't let him answer.

MR. JACKSON: There's one about Dr. Keating and what kind of conversation, that's the --

Q. Were there any minutes kept of that meeting, by the way?

A. No.

MR. JACKSON: Ef you know.

Q. I'm sorry?

A. No.

MR. KAMPINSKI: I'm sorry. I interrupted you, you were talking.

MR. JACKSON: Anymore questions.

MR. KAMPINSKI: On those that would pertain to questions you haven't allowed him to answer. If he's allowed to answer the questions, I can probably conclude with him.

MR. JACKSON: Okay. With the exception of those questions, you have no other questions today.

MR. KAMPINSKI: For the moment.

I'd like to say there would be others, depending on the answer to those.

Does that answer your question, Mr. Jackson?

MR. JACKSON: No other questions, thank you.

Does anyone else want to inquire?

MR. KAMPINSKI: There are, but you won't let me.

MR. JACKSON: Other than the questions that I instructed him not to answer, are there any other areas you wish to inquire into?

MR. KAMPINSKI: Yes, depending

upon the answers of those questions.

MR. JACKSON: Well then, why don't you go on to anything else that doesn't depend on the answers to these. If there is anything else, you can get that done today. If there isn't, we'll assume only questions related to those I instructed him not to answer will be permitted in the future.

MR. KAMPINSKI: You can assume what you wish. I'd like answers to the questions I asked him.

Will you allow him to answer them, yes or no?

MR. JACKSON: No.

MR. KAMPINSKI: That's all I have. Anybody have any questions?

MR. COYNE: No questions here.

MRS. CARULAS: No.

MR. SEIBEL: No questions.

MISS MOORE: I represent Dr. Varma. I'm Lynn Moore. I just want to make sure that I had all of your notes here.

- - - - -

CROSS-EXAMINATION

BY MISS MOORE:

Q. Your first note was on February 23, correct, in

the Saint Vincent chart?

A. Yes.

Q. Then your next note is on March 4?

A. Correct.

Q. Then you have a note on March 5th in the chart; is that correct?

A. Yes.

Q. Then you made two notes in the chart on March 6th, correct?

A. Yes.

MR. JACKSON: Wait a second. You said two notes.

A. Yes.

MR. JACKSON: Okay.

Q. And you made another note on March 7th, correct?

A. Yes.

Q. And you made another note on March 8th; is that correct?

A. Yes.

Q. Then your last note comes on March 11th, correct?

A. Yes.

Q. That's your last one?

MR. JACKSON: Yes, that is.

A. Yes.

Q. Those notes are accurate; are they, Doctor?

A. Yes.

MISS MOORE: Thank you.

MR. OKADA: Hi, I'm Ron Okada. I represent Cleveland Clinic. I just have a couple of questions, too.

- - - - -

CROSS-EXAMINATION

BY MR. OKADA:

Q. You don't have any personal knowledge regarding the type or extent of training Dr. Varma received at the Clinic during his first two years in the medical residency training, do you?

A. I do not.

Q. Or throughout his training at the Clinic?

A. Correct.

Q. So you don't know what type of training Dr. Varma may have received regarding the femoral arterial catheterization procedure, correct?

A. Correct.

Q. When Dr. Varma was here at Saint Vincent, to the best of your knowledge did he report to any Clinic physicians?

A. Did he report to any Cleveland Clinic physician?

Q. Correct.

A. Not that I am aware of.

MR. OKADA: Thank you, Doctor.

MR. WARNER: I'm Rob Warner. I represent the radiology group.

- - - - -

CROSS-EXAMINATION

BY MR. WARNER:

Q. When you saw the patient on February 23, was the patient on a ventilator at that time?

A. I'm looking to see.

Yes, she was.

Q. This is the same type of ventilator that she had been on before, this I/E type of ventilator?

A. I am not aware of what kind of ventilation she was getting on the 23rd.

Q. In looking at the charts can you tell us?

A. I can't tell you what type of ventilation she was on on that day.

Q. Why is that?

A. The notes that I am looking at don't say for sure what kind she is on. She is -- she is on a ventilator, but it doesn't say what type she is on.

Q If you kook at it, either forward or backward, can you make a determination, either earlier in time or later in time, as to what kind of ventilator?

MR. JACKSON: He already talked about later in time,

Q. That goes to the 4th of March when he took over. I'm talking either 24th of March, 25th, going that way?

MR. JACKSON: Do you have something specifically you would like him to look at?

MR. WARNER No, I don't. He's probably more familiar with the chart and where that information would be located at than I would be.

A Are you asking me a question as to when she was put on I/E ventilation?

Q. Yes. If you can tell.

A. I have to look through the chart, I'll see if I can find it for you.

There is a note on 3-1-91 that says she was on I/E ratios of 1.5 to 1. So I know that on 3-1-91 she was on that type of ventilator management. I can't be sure she was -- I can't be sure if she was on before or Not, but I can tell you she was on it March 1st.

Q. Would there not be an order in the chart for a particular physician, Dr. Steele or whatever, ordering that, or would that be maybe a pulmonologist?

A. If there was such an order written, would be --

probably be written by the pulmonologist or the resident taking care of her.

Q. Would that be Dr. Sopko or one of the residents under him?

A. Yes.

MR. SEIBEL: Objection.

Q. Would that resident also be Dr. Varma or he would also be a -- could have been written by him?

A. It could have or -- well, could have been written by him.

Q. Why was, if you can tell me, why was this type of particular patient put on I/E ventilation versus something else?

A. I am not an expert in pulmonary medicine. That would be a question for the pulmonary people.

Q. As I understood, you indicated before that this patient being on this I/E ventilator made this patient not a candidate to be moved, and also not a candidate in your opinion at the time that you were taking care of her for surgery?

A. Correct.

Q. Would that opinion hold true as of even March the 1st?

A. Yes.

Q. So if you had been informed even on

March 1st the guide wire had been present, your determination as to -- realizing you weren't involved with the patient -- even if you'd been informed on that day, your determination as to what was going to be done with the patient would have remained the same?

MR. JACKSON: I'll object, but go ahead and answer.

A. Your question assumes an assumption that I can't necessarily agree to.

I wasn't taking care of the patient on the 1st. She may have had other clinical characteristics that might have been present on that day that would have made a difference. Those might not be the same as when I got her.

What she had on the 1st from what I had known and what I got, I would not have changed the way I managed the patient.

Q. Even going to the 4th, March the 4th, had you known about the guide wire, would you have done anything differently than what you did?

A. No.

Q. You still would have felt she was unstable to be moved and not a candidate for surgery at that time, that's primarily because of the ventilator and other -- also her medical condition?

A. Correct. Also the fact she was hemodynamically stable and not having any problems with the guide wire being where it was.

Q. Are you familiar with the radiologist reports, as to where they go in the hospital.

A In general, yes.

Q. Are you aware that a copy goes into the chart?

A. Yes.

Q. Copy that is at the radiology department itself?

A. Yes.

Q. And a copy also given to the attending of the -- the doctor who ordered the x-ray?

A. That's not always the case; but in general, yes.

Q. You have received copies of x-ray reports in the past delivered to your office; have you not?

A. Not -- not delivered to the office. They're put in the hospital mail box.

Q. Do you have a particular box somewhere in the hospital?

A. Yes.

Q. Do all the doctors have it?

A. No.

Q. Do you, yourself, and Dr. Steele have those boxes?

A. Yes.

Q. How often do you use or someone from your office check the boxes?

A. I check the box daily

Q Do you know if Dr. Steele also checks his daily?

A. I have no idea.

Q When you were covering for Dr. Steele that time he was out of town and you were covering for him, would you also check his box since you were covering for his patients?

A No.

Q Why not?

A Because the x-ray reports get to the doctors' mail boxes about two and a half weeks after you had something done, there would be no reason to check it then.

Q. Do you know when they get into the chart?

A. Approximately a week to ten days after the study is done.

Q You're indicating that the hospital doesn't deliver them until two and a half weeks later?

A. You asked me when they appeared in the boxes, some cases that's the case. Now, it's not always two and a half weeks, but certainly isn't within two days, either. There's often a long delay.

Q. Do you know the personnel that delivers these;

do you know whether that's a hospital employee or not?
A. I have no idea.
Q. You're not aware that the hospital delivers them as soon as they're typed, within that day, for the delivery to the box?
A. That's not the practice that I have seen done.
Q. Has that ever occurred, you've gotten them the next day or the day of an order?
A. Never had an x-ray in my box the day the x-ray was done.
Q. I'm talking about interpretations.
A. I'm talking about interpretations.
Q. When in this case -- why were portable x-rays taken of this patient?
A. Patient was not able to be moved down to the department for radiologic studies.
Q. So portable x-rays are taken up in the coronary intensive care?
A No. Portables are done there. The radiology films will remain down in the department.
Q. Isn't it routine then they send them back up after they are developed to be viewed in the morning by the various physicians?
A. Mot to the coronary care unit.
Q. That's never done?

A. Correct.
Q. You or Dr. Steele never asked for the x-rays to be brought up to be viewed?
A. I never asked for x-rays to be brought up to C.C.U.
Q. They've never been brought up?
A. I can't say never.
Q. Isn't it routine that residents or yourself will review them?
A. Not in the C.C.U.
Q. Would you review them somewhere else?
A. If they were being reviewed, they would be reviewed down in the department.
Q. You routinely don't review them?
A. I routinely don't review them unless there's something that I need to see on the x-ray.
Q. What about when you were checking on the positioning of a Swan-Ganz catheter?
A. I was not checking on the position.
Q. Someone was?
A. Correct.
Q. Does the resident or the physician then, how does he know they're being placed properly?
MR. JACKSON: What is being placed properly.

Q. In this case the Swan-Ganz?
A. If a resident put in a Swan-Ganz catheter and a portable x-ray was done, the resident could go down, if a C.C.U. patient, could go down and look at the x-ray film.
Q. I thought you had indicated you had asked that a Swan-Ganz catheter be checked?
A. No, that's not correct.
Q. That was one of the other residents that was doing that?
MR. JACKSON: He is not a resident.
MR. WARNER: I understand that.
Q. During your testimony earlier I thought you had discussed it?
A. At one time Dr. Chmielewski asked an A-line be changed. No one ever said as far as -- you didn't need any order to change a Swan-Ganz.
Q. Are you familiar with the telephone access of radiological reports in the hospital?
A. Yes.
Q. How does that work?
A. You call up a number and put in the patient's birthday and you get a recording of the dictation that the radiologist does when they dictate the films.

Q. That can be done 24 hours a day, as I understand?

A. Yes.

Q. Have you ever done that?

A. Yes.

Q. If surgery had been done to remove these guide wires any earlier than it was, would you have an opinion as to whether or not the outcome would have been any different?

A. I can't state that as an opinion.

Q. I think you did state earlier that if surgery was done while on the I/E ventilator that your opinion was she wouldn't be able to survive that type of surgery?

A. I didn't say that.

MR. JACKSON: Objection.

Q. Well, let me ask a question.

If surgery were done while she was still on the I/E ventilator, what would be your projection or --

A. I can't answer that question. I don't think it can be done when you're on an I/E ventilator, probably you would have to change to some other mode of ventilation.

Q. Is that in your opinion, that you would probably

not be able to undergo surgery if she was on that type of ventilator?

A. Since I am not a pulmonologist, my opinion is not made from a strong point of view, but I don't think she could have surgery done on an I/E ventilator at that point.

Q. Why is that, based on your knowledge?

A. I don't think you can properly ventilate a patient during surgical procedures from an anesthesiology point of view on that type of ventilator, and probably change it -- her over to some other type of different method of ventilation.

Q. When did she start to improve to come off the I/E ventilator, you talked about it earlier?

A. During the latter part of the week that I was taking care of her.

MR. WARNER: I don't have anything further.

MR. KAMPINSKI: Just a couple questions, Doctor.

- - - - -

RECROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Do you have any type of office record as it pertains to Mrs. Weitzel?

A. No.
Q. How about your charges, your billings?
A. I am not sure that I would have billed her. I am not sure -- sure whether I would have billed her the week that Steele was gone or not.
Q. Why wouldn't you have billed her?
A. Sometimes when we're taking over for other physicians in the group we don't bill, let the physician which was in the -- physician there do the billing, and it comes out even in the long run, that Steele's taking care of a patient when I am out, when he goes out of town, I do, so it's not necessary to bill. I don't know if I did or not.
Q. How can we find out?
A. My office personnel would know that.
MR. KAMPINSKI: Can we get the billings for all of --
MR. JACKSON: Yes.
MR. KAMPINSKI: -- the physicians?
MR. JACKSON: The physicians I represent, we'll provide you with billings.
BY MR. KAMPINSKI:
Q. This telephone access to x-ray interpretations that was discussed by Mr. Warner, do you know what I am talking about?

A. Yes.
Q. When you call up, do you get an interpretation of that patient for each x-ray that was taken of her, or the last one, or what happens?
A. It depends on how it's dictated, usually you get the last x-ray that was dictated.
Q. I see.
What if you wanted more than that, can you go it through this and access them?
A. I think there is a way. I am not familiar with it though. If I wanted them at that point I'd probably go down to the department to look for them.
Q. I see.
Have you treated women 46 years old who had heart attacks?
A. I assume that in the course of my practice I have had 46 year old women with a heart attack, yes.
Q. What's the prognosis for such a woman, typically?
MR. JACKSON: I'll object, but go ahead.
A. It's not related to age. It depends on own each individual person.
Q. Are there statistics for post M.I. 46 year old women?

A. Not -- not based on age.
Q. Age doesn't matter?
MR. JACKSON: Objection. That's not what he said.
Q. Does age matter?
A. Age is one variable.
Q. Is it a good prognostic indicator or bad prognostic indicator?
A. It's unknown.
Q. So it's an unknown variable?
A. Correct. Meaning that being 46 years old doesn't mean that you have a good or bad prognosis for a heart attack.
Q. Is it better or worse than being 76?
A. There's no way to know that.
Q. Just have to live and see?
A. You have to evaluate the other medical problems that the patient has and the other status of their heart to know.
MR. KAMPINSKI: Okay. Thanks.
MR. JACKSON: Anyone else.

- - - - -

(Deposition concluded; signature not waived.)

- - - - -

ERRATA SHEET

PAGE LINE

I have read the foregoing transcript and the same is true and accurate.

MICHAEL B. ROLLINS M.D.

The State of Ohio, :

County of Cuyahoga.: CERTIFICATE:

I, Frank P. Versagi, Registered Professional Reporter, a Certified Legal Video Specialist, a Notary Public within and for the State of Ohio, do hereby certify that the within named witness, was by me first duly sworn to testify MICHAEL B. ROLLINS, M.D., the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid. I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel, or attorney of either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 17th day of September, 1992.

Frank P. Versagi, Registered Professional Reporter, a Certified Legal Video Specialist, Notary Public/State of Ohio. Commission expiration: 2-25-93.

DOC
re: 379

MICHAEL ROLLINS, M.D. deposition index

9/2. Joined Kitchen, Steel, and Aber in July of **1985.**

9/6. Not a group, four indep. pract. who cover for each other.

10/23. Initial phase of his business he got an interest free loan from Kitchen till his accounts came in.

11/19. He is not incorporated.

12/6. He is a shareholder of Cleveland Cardio. Assoc. (Their billing organization)

13/16. He has privileges at Lutheran also (0% of time)

14/12. Authored about five articles.

16/5. Participated in an authored case study showing use of a strain on heart in a M.I. patient.

17/1. Admits there is a risk in a person with prior M.I. doing surgery.

17/11. Risk decreases the further away from the surgery you are.

18/18. Head of non-invasive cardiology.

19/5. He is not employed by hospital in that capacity, his resp. is to review policy and procedures to make sure things are being done right.

19/14. Over **20** cardiologists on staff.

19/24. He doesn't do catheterizations or angioplasty.

20/20. Swan Ganz insert is learned as a res. in internal med.

21/20. He was not involved in dec. to have Varma place cath in Mrs. W.

21/25. While he was covering for Steele he was not responsible for Varma in total.

22/16. The senior would also be responsible as well as the other physicians.

22/25. He admits he was the primary attend while Steele was gone.

23/8. Sr. resident only reported to him if need by.

24/13. Some of the other consultants might or might not discuss

the case with the primary attending.

25/4. The residents would be coordinating her care.

29/2. There are CCU rounds twice a week which he is the attending for, where he talks about generic cases or topics of interest in cardiology.

29/11. Certain procedures that resid. do are assumed by their level of training.

30/5. He assumes a second yr. res. from the Clinic can insert a blood pressure cath.

31/6. He was not involved in the placement of Mrs. W's cath.

33/21. His first involvement was **2-23,** when he was covering a weekend at the hospital for Steele.

34/1. Note says normal sinus rhythm, off anti-arrhythmics, major problem now is respiratory.

35/13. Off medications to see if rhythm problem would return.

35/25. Would have briefly seen her and talk to the residents about her on **2-24.**

36/3. No note because he revised their notes.

36/19. He didn't review nurses notes to see if there were any notations that he was there.

37/5. He doesn't necessarily counter sign res.notes, it depends on how he feels at the time.

37/17. HE counter signed Jaynes note of **2-23.**

38/6. Next time he saw her was **3-4**

39/5. A **"heart"** means card. note.

39/2. He was in charge of Mrs. W from **3-4** to **3-8**

39/14. Kitchen was on call that week and would have been called at night.

41/3. He looked at the most recent labs when he took over the case

41/8. He doesn't routinely look at x-rays and didn't look at Mrs. W's.

41/21. At point he assumed her care he listed problems as atherosclerotic heart disease, status post . intercept MI, penum/ARDS

42/18. No evidence for congestive heart failure at the time he saw her.

43/11. Her primary problem at the time was her lungs.

47/4. Final lab copies are green and white (reg. cultures) and they weren't in chart.

49/10. Her inabil. to respond on **3-4** was still due to Versed.

50/13. Rollins didn't notice swelling of the right neck on the 4th although Chmielewski noted it same day.

51/1. He would have discussed the case with Varma initially.

51/23. Even though Varma had no separate training in Cardiol. infect disease, or pulmn, he would have been primarily resp for managing her case in consultation with SMR and other consultants.

52/16. He thinks Jayne was the SMR.

52/21. He was not told by Janye or Varma that two guidewires were left in.

52/24. He was told by Varma on **3-8** that apparently wires were left in.

53/6. Varma told him he didn't know how wires were left in.

54/3. He didn't know wires were in and he had no need to look at x-rays at that time.

55/1. Countersigned Varma's **3-5** note where CXR was part of plan but did not look at film.

55/12. **No** nurse ever told him that they had been told by a radiologist that an unexplained wire needed to be clinically correlated.

55/17. Steele had no particular conver. with him about Mrs. W. before he left.

56/13. In general Rollins thinks Steele should have been aware of the guidewires before he left.

57/16. Fritz was a cardiolog. elect, third year med res.

60/7. Potential complic of arterial insertions, infection, bleeding, retention of guide wires, dissec. of art.

60/21. Rollins involved in one other retained guidewire case 1 month after this. (Resid. lost wire)

61/18. He doesn't think a person could loose a guidewire and not know it.

61/22. March **5** note- read note

63/21. SWAN GANZ doesn't reflect any infection.

64/11. Problem with a SWAN is if its not in the right position you don't get a good reading.

64/19. Doesn't continue to check placement by x-ray.

65/25. Radiologist at St. Vinc have called him in the past when something unusual appears on x-ray.

66/22. Agrees that he relies on radiologist to read x-rays to assist with diagnosis.

67/23. Next note **3-6** - no sign changes, remains paralyzed-etc-long note.

69/18. **3-6** note adds increased LFTs, liver function test.

70/15. Chmieliewski **3-6** note.

71/3. "Discussed with Rollins asking radiology to do ultra sound of the gallbladder.

71/8. He spoke with rad. about the gallbladder.

71/13. He spoke with Robert Porter but no mention was made of the guidewires.

71/24. Wirtz did the ultrasound, and discussed it with Rollins.

72/5. She did not mention the retained guidewires to him.

73/6. If she had asked for a clinical correlation at some point and not gotten it he would have expected her to ask him on the 6th.

74/9. 2nd note on the 6th- regarding ultrasound results.

75/15. Mageria, gastroint. was reviewing patient and chart.

77/1. No prior lawsuits.

77/6. Next note is **3-7**

80/1. Physically anyone could change a ventilator setting, but no one would touch it except people who are responsible for the ventilator.

80/15. If pressure in inflating is increased it can cause a

pneumothoraxes.

80/18. Resp. therapists in conjunction with doctor and resident maintains the pressure.

80/25. If unrecognized they can cause death.

81/19. Develops a pneumo on **3-7.**

82/25. Two notes by Varma on the 7th.

85/5. He is not totally resp. for what the residents on his service do.

86/24. **If** he removed the line inaprop. he (Varma) would be respons. for his conduct.

87/8. He (Varma) would be resp. for telling a doctor he didn't know how to do a procedure and to seek help.

89/4. If the res. didn't know how to do a proc. it would be the Clinic's fault for not training him.

91/22. Next note **3-8,** extensive but mostly related to pulm improvement. Thinks he wrote it in the a.m.

97/22. Varma's note is at **9** p.m. that night, and says discuss with Rollins.

98/5. Varma called him at home and told him there appeared to be a guide wire present - and it looked like it was present since approx 2-26

98/16. Varma told him he had no idea how it got there.

98/21. Varma told her the patient was stable, because there's no evidence of bleeding or perforation.

99/3. Those aren't exactly Varma's words but Rollins recalls that's what they discussed.

99/6. He (Rollins) was upset.

99/15. He asked Varma if he had told Mr. W, Varma said no.

99/23. Next time Rollins went to the hospital was Monday morn.

100/9. He talked to Kitchen Sat. morn.

100/22. They decided there was no reason to remove it because the patient couldn't be moved due to pulmonary, and there didn't appear to be any hemodynamic consequences.

102/11. She was not stable enough to undergo elective surgery on

3-9.

103/24. Next note 3-11 - Rollins for Steele.

105/24. Then he looked at CXR (from the 11th)

106/19. He didn't go back and look at all the x-rays.

107/11. He should have been told about the wire either by the radiologist or the resident.

108/1. He talked to Varma again on the morn. of the 11th and again he was told Varma had no idea how it got there.

109/9. He was still of the opinion on the 11th that the wire should not come out.

110/7. He saw her again on the 12th.

110/16 Countersigned note by Fritz "moved left arm apparently"

111/2. Positive dolls eyes, blink reflexes and moved left arm means neurologic function is intact (on 3-12).

113/11. On admis. her neuro status was not normal.

114/23. By the 2-14 exam she was better neuro wise than on the date of admiss (actually fairly normal)

115/7. By 2-15 neuro signs are good.

117/20. He was not involved in the decis to remove guidewires but knew Mrs. W. was in cath lab for some because he was making rounds.

118/25. The difference in Mrs. W between 3-13 and 3-9,10, or 11 was dramatic in terms of pulmonary function/resp. statics.

119/3. She was off I/E ratio.

122/2. An operative procedure post mi could cause a ventricular arrhythmia

123/23. He did talk to Steele about the retained guidewire on the morning he came back, and Steele told him he was probably going to try to remove it.

124/8. He didn't offer his opinion at that point.

126/8. He did discuss it with Dr. Keating/ not allowed to answer per Jackson.

133/8. His coverage is 1mil/3mil.

Cross / Lynn Moore
nothing

Cross / R. Okada
nothing

Cross / Warner

143/8. **If** he had known the wires were in on March 1st he would not have changed the way he managed the patient.

144/1. **If** he know on March 4th he would not have done anything differently.

146/24. X-rays are not brought up to the coronary unit.

149/10. No opinion as to whether outcome would have been different if surg. had been done sooner.

Recross

152.5. Phone interp of x-rays is the last one done.

152/22. Prognosis for heart attack victims not based on age but depends on indiv.