

<p>1 COURT OF COMMON PLEAS 2 LORAIN COUNTY, OHIO 3 --- 4 J. TERRY ROBINSON, : 5 ADMINISTRATOR OF : 6 ESTATE OF ELSIE A. : 7 ROBINSON, : 8 Plaintiff, : 9 vs. :CASE NO. 99 CV 122855 10 DR. LYNN CHRISMER, JR. : 11 et al., : 12 Defendants. : 13 --- 14 Deposition of RONALD SACHER, M.D., 15 a witness herein, taken by the defendant as 16 upon cross-examination, pursuant to the Ohio 17 Rules of Civil Procedure and pursuant to 18 agreement by counsel as to the time and place 19 and stipulations hereinafter set forth, at the 20 offices of Hoxworth Blood Center, 3130 Highland 21 Avenue, Cincinnati, Ohio, at 12:30 p.m. on 22 Wednesday, the 15th day of August, 2001, before 23 Valerie Jones Conn, Registered Professional 24 Reporter, a Notary Public within and for the 25 State of Ohio.</p>	<p>1 APPEARANCES: 2 On behalf of the plaintiff: 3 JOHN BURNETT, ESQ. (Via telephone) 4 of Becker & Mishkind Co., L.P.A. 5 134 Middle Avenue Elyria, Ohio 44035 6 On behalf of the defendant North 7 Ohio Heart: 8 ANNA MOORE CARULAS, ESQ. 9 of Roetzel & Andress 10 1375 E. 9th Street One Cleveland Center-10th Floor Cleveland, Ohio 44114 11 On behalf of the defendant EMH 12 Regional Medical Center: 13 COLLEEN PETRELLO, ESQ. (Via telephone) 14 of 100 Franklin's Row 15 34305 Solon Road Cleveland, Ohio 44139 16 On behalf of the defendants Lynn 17 Chrismer, Jr., M.D.: 18 MICHAEL HUDAK, ESQ. (Via telephone) 19 of Roetzel & Andress 20 222 South Mai Street Akron, Ohio 44305 21 --- 22 23 24 25</p>
<p>1 STIPULATIONS 2 It is stipulated by counsel for the 3 respective parties that the deposition of 4 RONALD SACHER, M.D., a witness herein, may be 5 taken at this time by the plaintiff as upon 6 cross-examination and pursuant to the Ohio 7 Rules of Civil Procedure, all other legal 8 formalities being waived by agreement; that the 9 deposition may be taken in stenotypy by the 10 Notary Public-Court Reporter and transcribed by 11 her out of the presence of the plaintiff; that 12 submission of the deposition to the witness for 13 examination and signature is expressly waived. 14 --- 15 16 17 18 19 20 21 22 23 24 25</p>	<p>1 INDEX 2 3 BY MR. BURNETT PAGE 4 Cross 5 5 6 EXHIBITS 7 8 PAGE 9 NO EXHIBITS MARKED 10 11 --- 12 13 14 15 16 17 18 19 20 21 22 23 24 25</p>

<p style="text-align: right;">5</p> <p>1 (Prior to the deposition beginning 2 Ms. Petrello, Esq. requested her objections be 3 noted at the same time other counsel entered 4 objections.) 5 ROBERT SACHER, M.D., 6 a witness herein, of lawful age, having been 7 first duly sworn, as hereinafter certified, was 8 examined and testified as follows: 9 CROSS-EXAMINATION 10 BY MR. BURNETT: 11 Q. Doctor, I'm John Burnett. I 12 represent the Estate of Elsie Robinson in this 13 case. Can you hear me, sir? 14 A. I can, yes. 15 Q. Sir, you understand this is a 16 question and answer session under oath, right? 17 A. Yes. 18 Q. Doctor, if I ask you a question 19 that you don't understand or is unclear I hope 20 you will tell me and I will do my best to 21 rephrase the question or make it clearer. Is 22 that fair enough? 23 A. It is. 24 Q. Okay. Doctor, if you give me an 25 answer to my question I'm going to conclude</p>	<p style="text-align: right;">6</p> <p>1 that you have understood it and you are giving 2 me your best answer. Is that fair enough? 3 A. Yes. 4 Q. So my understanding is you've been 5 designated as an expert in this case on behalf 6 of Dr. Hulyakar and his professional group, 7 North Ohio Heart Center; is that right? 8 A. Correct. 9 Q. And in looking at your report 10 dated May 21, 2001 is that the only report 11 you've authored in this case? 12 A. It is, yes. 13 Q. Did you have any drafts of this 14 report that were revised over a period of time? 15 A. No, I don't recall that I had one. 16 This is the final and only one. 17 Q. Okay. Doctor, tell me a little 18 bit about -- I don't have your Curriculum Vitae 19 in front of me. Tell me, give me a thumbnail 20 sketch of your career starting with medical 21 school, where you've been and what your areas 22 of practice have been in. 23 A. I was educated medical school in 24 Johannesburg, South Africa. And following 25 training there, internship, I did a rotating</p>
<p style="text-align: right;">7</p> <p>1 internship in internal medicine surgery and 2 subsequently pediatrics as well as military 3 service, which was compulsory. I went off 4 after that to specialize in hematology in South 5 Africa as a pathology discipline. So I 6 actually did pathology training in anatomic 7 pathology and hematology and subsequently 8 specialized in hematology. 9 Q. Okay. 10 A. In 1976 I went to McMaster 11 University in Hamilton, Ontario, Canada where I 12 continued my training in hematology but also 13 did some training in laboratory medicine. And 14 in 1977 I was recruited to Georgetown 15 University Medical Center in Washington, D. C. 16 to complete a fellowship in hematology joining 17 the faculty in July of 1978. 18 I remained on the faculty as a 19 clinical hematologist as well as the director 20 of the blood bank and laboratory quality 21 control at Georgetown until 1993 when I became 22 department -- chairman of the Department of 23 Laboratory Medicine at Georgetown University 24 Medical Center. 25 I rose through the ranks from</p>	<p style="text-align: right;">8</p> <p>1 assistant professor to full professor in 2 internal medicine and pathology and was 3 tenured, I believe, in 1984. I stayed at 4 Georgetown until November of last year when I 5 left Georgetown to become the head of the 6 Hoxworth Blood Center at the University of 7 Cincinnati and a tenured professor in internal 8 medicine and pathology. 9 I am also a member of the 10 hematology/oncology division here in 11 Cincinnati, as I was in Washington, D. C., as 12 part of the Lombardi Cancer Center in 13 Washington, and I'm in the process of setting 14 up my practice here in Cincinnati. I had an 15 active practice in Washington, D. C. both 16 initially in and outpatient and subsequently 17 predominantly outpatient. 18 I think that summarizes my 19 education and appointments. I have written and 20 edited 15 books. I have published, all in all, 21 over 200 papers and I'm a member of many 22 professional societies and given talks both 23 internationally and nationally probably about 24 five hundred times. 25 Q. Do you consider yourself,</p>

<p style="text-align: right;">9</p> <p>1 currently, a clinical hematologist?</p> <p>2 A. Yes.</p> <p>3 Q. What do the clinical hematologists</p> <p>4 do, in general?</p> <p>5 A. I'm a specialist in the</p> <p>6 evaluation, diagnosis and management of</p> <p>7 patients with diseases of the blood and blood</p> <p>8 producing organs including, of course, the</p> <p>9 coagulation tests and assessment of people who</p> <p>10 have pre-disposition to clotting and bleeding.</p> <p>11 Q. Do you manage patients on</p> <p>12 procedure when they show signs and symptoms of</p> <p>13 an internal bleed?</p> <p>14 A. Yes.</p> <p>15 Q. Who is the fellow who's the</p> <p>16 director of the -- used to be, I think -- maybe</p> <p>17 he still is -- the director of the Lombardi</p> <p>18 Cancer Institute? What is his name?</p> <p>19 A. He has left Georgetown. His name</p> <p>20 is Mark Lipton.</p> <p>21 Q. Right. I deposed Dr. Lipton last</p> <p>22 year.</p> <p>23 A. He's now the chairman of medicine</p> <p>24 at the University of Michigan Ann Arbor. I</p> <p>25 guess a lot of us have left Georgetown for a</p>	<p style="text-align: right;">10</p> <p>1 variety of reasons.</p> <p>2 Q. I keep running into Georgetown</p> <p>3 people all over the place. Small world, I</p> <p>4 guess.</p> <p>5 As of '98 -- I've got an old</p> <p>6 deposition transcript of yours -- and as of '98</p> <p>7 it appeared that you were not board certified</p> <p>8 in the United States in any specialty; is that</p> <p>9 correct and is that still the case?</p> <p>10 A. Yes. I'm board certified in</p> <p>11 hematology, pathology and tropical medicine</p> <p>12 internationally. As a matter of fact, I have</p> <p>13 board certifications from Canada but I have not</p> <p>14 been required to do board certification or</p> <p>15 board examinations in the United States,</p> <p>16 although I guess they have made me eligible to</p> <p>17 do internal medicine and pathology boards.</p> <p>18 Q. Okay. And are you going to take</p> <p>19 those?</p> <p>20 A. No. There's no reason for me to.</p> <p>21 Q. Okay. You've been doing</p> <p>22 medical/legal work for how long?</p> <p>23 A. Well, actually I think the first</p> <p>24 case I ever reviewed was probably in 1979,</p> <p>25 1980. And they -- I also was a hematology</p>
<p style="text-align: right;">11</p> <p>1 consultant to the Federal Aviation</p> <p>2 Administration and testified before</p> <p>3 Administrative Law Judges in matters relating</p> <p>4 to pilots. I guess that really is somewhat</p> <p>5 medical/legal. But I certainly have been doing</p> <p>6 it since 1979, although in the latter few years</p> <p>7 much more actively.</p> <p>8 Q. Okay. By the way, when you were</p> <p>9 in Johannesburg in the service what was the</p> <p>10 compulsory Army service, for a year?</p> <p>11 A. Correct. I actually was stationed</p> <p>12 in other cities in South Africa and also on the</p> <p>13 southwest Africa border during the war with</p> <p>14 Angola.</p> <p>15 Q. Was your occupational specialty</p> <p>16 within the Army medicine?</p> <p>17 A. Yes. Medicine and surgery.</p> <p>18 Q. Okay. Very good. In '98 you</p> <p>19 testified in a deposition that the percentage</p> <p>20 of your personal income from medical/legal work</p> <p>21 was about 15 to 20 percent of your annual</p> <p>22 income. Does that sound about right for that</p> <p>23 time period?</p> <p>24 A. That sounds about right.</p> <p>25 Q. Is it still the case, Doctor?</p>	<p style="text-align: right;">12</p> <p>1 A. It's probably closer to 20</p> <p>2 percent.</p> <p>3 Q. Okay. Have you ever testified in</p> <p>4 court for a plaintiff on a case?</p> <p>5 A. Yes.</p> <p>6 Q. Okay. How often?</p> <p>7 A. I would say the overall breakdown</p> <p>8 of the cases that I testify on is probably</p> <p>9 75 -- 70 to 75 percent defense, 25 to 30</p> <p>10 percent plaintiff.</p> <p>11 Q. And so I understand your testimony</p> <p>12 you've actually given testimony for a plaintiff</p> <p>13 in a courtroom at trial; is that what you're</p> <p>14 telling me?</p> <p>15 A. I have, yes.</p> <p>16 Q. Okay. How many times?</p> <p>17 A. I can only give you an estimate.</p> <p>18 But probably somewhere in the region of five</p> <p>19 times, maybe a little more.</p> <p>20 Q. How many times have you testified</p> <p>21 in a courtroom for a defendant?</p> <p>22 A. Probably about 15 times. I think</p> <p>23 overall, again, it's a 75 percent, 25 percent</p> <p>24 breakdown. But it may be a little more than</p> <p>25 that for plaintiffs.</p>

<p style="text-align: right;">13</p> <p>1 Q. Okay. Talking in terms of cases 2 you've reviewed, and we'll get to depositions 3 and trial testimony following this -- have you 4 ever reviewed a case with issues similar to the 5 one in this case, that is, post-invasive 6 procedure, internal bleeding, monitoring the 7 bleeding, problems with deciding whether to 8 keep the patient on anti-coagulants or not, 9 these types of issues? 10 A. Well, not exactly. Not exactly 11 the same as this. Clearly there are many 12 issues relating to the bleeding and issues 13 bleed -- related to bleeding that may or may 14 not involve invasive procedures or surgery. 15 Q. Okay. 16 A. And I do believe I've reviewed 17 cases that involve bleeding. 18 Q. Okay. Do you remember -- I'm 19 going to ask you a tough question now. I 20 should probably start -- do you keep an overall 21 master file of the cases you reviewed? 22 A. No. 23 Q. 1998 you testified there was a New 24 Jersey case that involved anti-coagulation. 25 You were deposed in the case of Ida May Evans</p>	<p style="text-align: right;">14</p> <p>1 versus Ronald Stevens, M.D. and you were 2 deposed, I think, in Washington on the 27th of 3 May in 1998. Does that ring a bell? 4 A. Vaguely. I don't recall the exact 5 elements of the case but I do remember that. 6 Q. Okay. Okay. In that deposition 7 you reference a New Jersey case that involved 8 anti-coagulation issues. Do you remember the 9 name of that New Jersey case? 10 A. I don't remember the name of that 11 case but I remember the attorney. 12 Q. You were testifying -- what was 13 the attorney's name? 14 A. Barnes, if I'm not mistaken. 15 Q. Bond? 16 A. Barnes, B-A-R-N-E-S. 17 Q. B-A-R-N-E-S. Any idea what his 18 first name was or her first name? 19 A. Timothy. Timothy. 20 Q. And he practiced in New Jersey. 21 Is that your understanding? 22 A. Yes. 23 Q. And you testified for the 24 plaintiff in that case? 25 A. I believe I did, yes.</p>
<p style="text-align: right;">15</p> <p>1 Q. Are you aware of any other cases 2 that you can name for me either by, you know, 3 the name of the case, itself, or the attorney 4 who retained you for which you've testified for 5 the plaintiff on anti-coagulation or bleeding 6 issues? 7 A. I don't recall specifically. 8 However, if I'm not mistaken, that other case 9 related to the diagnosis of Heparin induced 10 thrombocytopenia, or HIT, if I recall. 11 Q. Okay. Do you remember any other 12 cases, though, in which you represented the 13 plaintiff and they involved bleeding issues or 14 coagulation issues? 15 A. Well, that is quite a broad 16 question because I have represented a plaintiff 17 in issues relating to a disease called TTP, 18 which clearly involves coagulation and 19 bleeding. 20 Q. Okay. 21 A. But it's not pertinent to our 22 discussion to do today. 23 Q. Forget about those TTP cases. Any 24 other cases in which you testified on behalf of 25 a plaintiff involving issues involving</p>	<p style="text-align: right;">16</p> <p>1 coagulation and bleeding or managing of a 2 bleed? 3 A. And you're asking me specifically 4 for a plaintiff? I don't recall. 5 Q. That's fine. Now how about the 6 same question for the defendants? 7 A. Yes, I have testified on behalf of 8 defendants and/or reviewed cases on behalf of 9 defendants. 10 Q. Do you remember the names of the 11 cases in which you testified on behalf of 12 defendants in issues involving, again, 13 coagulation and bleeding management, bleeding, 14 those issues? I'm sorry. Did you answer me? 15 A. No. I'm thinking. 16 Q. Okay. 17 A. In fact -- 18 Q. As you're thinking sometimes on 19 these speakers phones if you answer me right 20 away I can't hear you on my end. 21 A. There is one case recently. And I 22 just can't remember. It's since, I think, 23 resolved. But I don't recall the exact name, 24 the captions. Rightly or wrongly this relates 25 to short term memory recall and I tend to</p>

<p style="text-align: right;">17</p> <p>1 forget a lot about the case once it's over. 2 Q. All right. 3 A. I'm sure you know about that. 4 Q. That's fair enough. Have you ever 5 testified in Federal Court? 6 A. Yes. 7 Q. Tell me when, please. 8 A. It's possible it was last year or 9 the year before. I've done some testimony on 10 transfusion transmitted disease litigation and 11 some of those have been in Federal Court in 12 Washington, D. C. And if I recall it was 13 probably over a year ago. But I might have 14 been involved in a federal case that never went 15 to court that was settled about a year ago. 16 Q. You remember the name of that 17 case? And was it in Washington, first of all? 18 A. There have been a number of cases. 19 Actually that case, if I recall, was a 20 Baltimore case; it was a Maryland case. 21 Q. Was it in Federal Court in 22 Maryland? 23 A. I think that's where it was -- 24 that jurisdiction, at least. However, that 25 case didn't go to trial.</p>	<p style="text-align: right;">18</p> <p>1 Q. Did you author a report in that 2 case? 3 A. A report was authored on behalf of 4 me based on previous testimony that I'd given 5 in transfusion transmitted disease litigation. 6 Q. And as far as that report my 7 understanding in Federal Court, when a report 8 is submitted on behalf of an expert, it has to 9 list all the cases in which the expert has 10 testified as such in the past. Do you know if 11 that was done on your behalf or not? 12 A. I believe it was, yes. 13 Q. Do you know who the attorney was 14 who did that? 15 A. Thomas Cullen, C-U-L-L-E-N. 16 Q. Defense lawyer or plaintiff 17 lawyer? 18 A. Defense. 19 Q. I'm sorry? 20 A. Defense. 21 Q. Defense. Sorry. Do you remember 22 the name of the case? 23 A. Most of those were John or Jane 24 Does. 25 Q. Who were you defending?</p>
<p style="text-align: right;">19</p> <p>1 A. I was defending the plasma 2 practitioners and in this particular case it 3 was Bayer Pharmaceuticals. It was hemophilia 4 litigation. 5 Q. Okay. Now aside from that case in 6 Federal Court that we've just discussed are you 7 aware of any other cases that you've been 8 involved in that were in Federal Court? 9 A. If I recall there were perhaps two 10 or three others and I was required to try and 11 resurrect a list. But those were a number of 12 years ago. I haven't had one recently. 13 Q. So the one with the most recent 14 information would have been the Federal Court 15 case last year in Maryland, right? 16 A. I believe so, yes. 17 Q. Okay. Any idea who the 18 plaintiff's lawyer was in that case? 19 A. I don't recall. 20 Q. Okay. Fair enough. 21 Doctor, did you, in the review of 22 this case, did you generate any notes? 23 A. I, not uncommonly, jot notes down 24 as I'm reviewing it. But they are really 25 simply for the point of view of developing a</p>	<p style="text-align: right;">20</p> <p>1 chronology. I don't keep those notes and 2 generally I throw them away. 3 Q. Did you do that in this case? 4 A. I did, yes. 5 Q. Do you remember taking notes in 6 this case? 7 A. With regard to what? I don't take 8 notes. I just -- it's almost like doodling, 9 jotting down little points. But I don't keep 10 that information. I usually throw it away. I 11 highlight the record, though. 12 Q. All right. And did you highlight 13 portions of this record? 14 A. Yes. 15 Q. Okay. Do you have your file in 16 front of you? 17 A. I do, yes. 18 Q. I'm sorry. Did you answer my 19 question? 20 A. I did. Yes. 21 Q. Okay. So you don't have any 22 notes. Your file, I take it, consists of the 23 matters you identified in your May 21st report. 24 And I asked you have you looked at anything 25 since then, such as deposition transcripts,</p>

<p style="text-align: right;">21</p> <p>1 that type of thing?</p> <p>2 A. Yes, I have.</p> <p>3 Q. Okay. I take it you probably</p> <p>4 looked at the deposition of Dr. Loch and Dr.</p> <p>5 Ballard; is that right?</p> <p>6 A. That is correct.</p> <p>7 Q. I don't even know if it's been</p> <p>8 transcribed. Have you seen Dr. Solomon's</p> <p>9 deposition yet?</p> <p>10 A. I have not.</p> <p>11 Q. Do you know Dr. Solomon?</p> <p>12 A. I do, yes.</p> <p>13 Q. How do you know him?</p> <p>14 A. We were colleagues at Georgetown</p> <p>15 University Hospital.</p> <p>16 Q. Okay. To your knowledge how did</p> <p>17 Ms. Carulas get your name?</p> <p>18 A. I believe from one of her</p> <p>19 partners. I was asked to review a case by her</p> <p>20 firm. In fact, it was actually referred to my</p> <p>21 predecessor here at Hoxworth and was</p> <p>22 subsequently given to me.</p> <p>23 Q. Have you worked with Ms. Carulas</p> <p>24 before?</p> <p>25 A. No.</p>	<p style="text-align: right;">22</p> <p>1 Q. Have you worked with the firm</p> <p>2 she's with, Roetzel & Andress, before?</p> <p>3 A. Yes.</p> <p>4 Q. Okay. How many times?</p> <p>5 A. Twice before.</p> <p>6 Q. In those cases did you actually</p> <p>7 end up testifying at trial?</p> <p>8 A. I did, yes.</p> <p>9 Q. Okay. You remember the names of</p> <p>10 those cases?</p> <p>11 A. I do. Yes. One was Hannahs,</p> <p>12 H-A-N-N-A-H-S v Jain, J-A-I-N.</p> <p>13 Q. Was that here in Ohio?</p> <p>14 A. It was, yes.</p> <p>15 Q. Okay. That Cuyahoga County, the</p> <p>16 Cleveland area?</p> <p>17 A. Well, it was my first visit to</p> <p>18 Cleveland so I wouldn't say I was an expert but</p> <p>19 that's exactly where it was.</p> <p>20 Q. What was the next one, please,</p> <p>21 Doctor?</p> <p>22 A. I'm blocking on the plaintiff's</p> <p>23 name but it was versus the Cleveland Clinic.</p> <p>24 Camamassie. C-A-M-A-M-A-S-S-I-E, I think. He</p> <p>25 was a Brazilian national that sued the</p>
<p style="text-align: right;">23</p> <p>1 Cleveland Clinic and a urologist.</p> <p>2 Q. Okay. Do you remember the names</p> <p>3 of the plaintiff's counsel in either of those</p> <p>4 cases?</p> <p>5 A. No, I don't.</p> <p>6 Q. All right. Now had you ever done</p> <p>7 any work for the law firm known as Jacobson,</p> <p>8 Maynard, Tuschman & Kalur?</p> <p>9 A. No. That's unfamiliar to me. I</p> <p>10 think I might have seen the name in, perhaps,</p> <p>11 material that I've reviewed.</p> <p>12 Q. Okay. Do you know Stanley</p> <p>13 Ballard, M.D.?</p> <p>14 A. No.</p> <p>15 Q. Do you know of him by reputation?</p> <p>16 A. No.</p> <p>17 Q. Do you know Ralph Loch, M.D.?</p> <p>18 A. No.</p> <p>19 Q. How about by reputation?</p> <p>20 A. No, not at all.</p> <p>21 Q. All right. Did you do any</p> <p>22 research, Doctor, in preparation for the</p> <p>23 authoring of your report?</p> <p>24 A. No.</p> <p>25 Q. Any research in preparation for</p>	<p style="text-align: right;">24</p> <p>1 the authoring or, excuse me, in preparation for</p> <p>2 forming your opinions in this case?</p> <p>3 A. No.</p> <p>4 Q. I don't have your CV in front of</p> <p>5 me right now; it hasn't arrived yet for</p> <p>6 whatever reason. Regarding the issues in this</p> <p>7 case can you identify for me, whether it be a</p> <p>8 book, a book chapter or an article, anything in</p> <p>9 the past you've authored or co-authored which</p> <p>10 has -- that was discussed with issues that are</p> <p>11 pertinent to this case?</p> <p>12 A. Again, that's a very broad</p> <p>13 question. I've certainly written on issues</p> <p>14 relating to bleeding, its management and also</p> <p>15 clotting problems and anti-coagulants.</p> <p>16 Q. Okay. Are there any that are --</p> <p>17 any publications that are very close to the</p> <p>18 issues involved in this case, Doctor?</p> <p>19 A. Well, I would say that there</p> <p>20 probably are some in a very generic way.</p> <p>21 Again, the issues are bleeding and</p> <p>22 anti-coagulation and the justification for</p> <p>23 ant-coagulation as well as the management of</p> <p>24 bleeding. So those are fairly general. And</p> <p>25 there are articles that I've written that are</p>

<p style="text-align: right;">25</p> <p>1 generally related to that sort of scenario.</p> <p>2 Q. Are they readily apparent from a</p> <p>3 review of your Curriculum Vitae or do you think</p> <p>4 you should identify them for me as we sit here</p> <p>5 right now?</p> <p>6 A. No. I think, in the interest of</p> <p>7 time, they would be readily apparent because</p> <p>8 there would be key words in the titles of what</p> <p>9 I've written.</p> <p>10 Q. That's fine. Have you talked to</p> <p>11 Dr. Solomon at all about this case?</p> <p>12 A. No.</p> <p>13 Q. You've seen his report?</p> <p>14 A. I have, yes.</p> <p>15 Q. Anything in his report that you</p> <p>16 disagree with?</p> <p>17 A. No.</p> <p>18 Q. Doctor, in this case the likely</p> <p>19 cause of death was hypovolemic shock, right?</p> <p>20 She died from exsanguination?</p> <p>21 A. Well, certainly that contributed.</p> <p>22 I think the cause of death was cardiac arrest.</p> <p>23 Q. Okay. And what caused the cardiac</p> <p>24 arrest?</p> <p>25 A. It was her primary cardiac</p>	<p style="text-align: right;">26</p> <p>1 problem, inability to respond to the bleeding.</p> <p>2 Q. And on what do you base that?</p> <p>3 A. I base that on my review of the</p> <p>4 records and, of course, my background,</p> <p>5 education and experience.</p> <p>6 Q. What, specifically, in the records</p> <p>7 leads you to conclude that she had a cardiac</p> <p>8 arrest?</p> <p>9 A. Well, she coded and clearly she</p> <p>10 had a cardiac code. I believe that on the</p> <p>11 review of her history it is quite apparent that</p> <p>12 she had a very formidable and substantial</p> <p>13 serious medical history with many organ systems</p> <p>14 diseased and her ability to respond to a</p> <p>15 bleeding event was clearly very compromised.</p> <p>16 Q. Is that ability to respond to a</p> <p>17 bleeding event being significantly compromised,</p> <p>18 is that something you would have expected Dr.</p> <p>19 Hulyakar to be aware of?</p> <p>20 A. Yes. I'm sure he was aware of it.</p> <p>21 Q. So, in essence, her compensatory</p> <p>22 mechanisms, the way the body deals with blood</p> <p>23 loss, essentially failed her and her heart</p> <p>24 stopped. Is that a good, simple way to put it?</p> <p>25 A. Yes, I believe so.</p>
<p style="text-align: right;">27</p> <p>1 Q. Okay. Have you seen the</p> <p>2 photographs in this case which identify the</p> <p>3 area of ecchymosis on her right side?</p> <p>4 A. No.</p> <p>5 Q. Okay. Doctor, the ecchymosis</p> <p>6 around which the nurses outlined with a mark,</p> <p>7 okay, they outlined the perimeter, are you</p> <p>8 aware of that in the records?</p> <p>9 A. I don't recall. I believe</p> <p>10 certainly that the nurses were monitoring the</p> <p>11 area of ecchymosis and I think that was</p> <p>12 apparent from the record. But I don't recall</p> <p>13 the actual graphic of the perimeter.</p> <p>14 Q. All right. But I think you recall</p> <p>15 from the record they drew they used a marker</p> <p>16 and marked around the edges of the perimeter of</p> <p>17 that hematoma?</p> <p>18 A. Yes.</p> <p>19 Q. Okay. I'm sorry. That</p> <p>20 ecchymosis. I apologize. You understand that?</p> <p>21 A. I do, yes.</p> <p>22 Q. Okay. Now the ecchymosis around</p> <p>23 which the nurses outlined with a marker was</p> <p>24 identified by CT scan on 3-3-97 as a large</p> <p>25 hematoma over the anterior abdominal wall; is</p>	<p style="text-align: right;">28</p> <p>1 that right?</p> <p>2 A. That is correct.</p> <p>3 Q. So that area of ecchymosis and the</p> <p>4 flag was a visual indicator of that hematoma</p> <p>5 which was seen by CT scan, right?</p> <p>6 A. Yes.</p> <p>7 Q. I'm sorry?</p> <p>8 A. I said yes.</p> <p>9 Q. Okay. Now she had an A-V juncture</p> <p>10 intubation done on --</p> <p>11 THE COURT REPORTER: I'm sorry?</p> <p>12 Q. She had an A-V juncture intubation</p> <p>13 done on 2/27/97, right?</p> <p>14 A. Correct.</p> <p>15 Q. This procedure involved placement</p> <p>16 of an eight and a half French sheath into the</p> <p>17 right femoral vein under local anesthesia,</p> <p>18 right?</p> <p>19 A. Yes.</p> <p>20 Q. Dr. Solomon has testified that,</p> <p>21 and I'll rephrase that, more likely than not</p> <p>22 the source of the bleed seen at the large</p> <p>23 hematoma over the anterior abdominal wall on CT</p> <p>24 scan on 3/3/97 was from a punctured vein or</p> <p>25 artery near the site of the insertion of the</p>

<p style="text-align: right;">29</p> <p>1 French sheath. Do you have any reason to 2 disagree with that? 3 A. No. 4 Q. Okay. And, by the way, that's not 5 the normal standard of care for there to be a 6 puncture like that, that just happens under the 7 best of care, correct? 8 A. Absolutely. 9 Q. The autopsy report identifies a 10 huge hemorrhage, retroperitoneal space, the 11 anterior abdominal wall on the right and down 12 on the pubis into the anterior chest wall; is 13 that correct? 14 A. Yes. 15 Q. Again, Dr. Solomon testified that 16 this huge hemorrhage identified by the autopsy 17 report likely had, as its source, the same site 18 as that causing the bleed seen on CT scan on 19 3-3 of '97. Do you have any reason to disagree 20 with that? That's not below the standard of 21 care? 22 A. I'm sorry. Would you rephrase 23 that again? I didn't get all of it. 24 Q. Sure. Dr. Solomon -- and I'll 25 paraphrase his testimony -- Dr. Solomon</p>	<p style="text-align: right;">30</p> <p>1 testified that this huge hemorrhage identified 2 by the autopsy report likely had, as its 3 source, the same site as that causing the bleed 4 seen on the CT scan on 3-3-97. And I'm asking 5 you do you have any reason to disagree with 6 that? 7 A. Now specifically you're referring 8 to, of course, the retroperitoneal hemorrhage 9 swell now because that was found at autopsy? 10 Q. Yes, I am. 11 A. I really cannot agree or disagree. 12 I think that is a fact. On the other hand, 13 retroperitoneal bleeds are side effects of 14 anti-coagulation therapy under -- even under 15 the best of circumstances and even without a 16 punctured site. So while it is possible and 17 may even be probable, I don't know. 18 Q. Tell me, so I understand the 19 mechanism of this, why is the retroperitoneal 20 bleed a risk of anti-coagulation? How does it 21 happen? Explain that to me. 22 A. I don't think we know other than 23 the fact that perhaps some mechanical event 24 occurs or there may be some pre-existing 25 anatomic reason. But spontaneous bleeding into</p>
<p style="text-align: right;">31</p> <p>1 the retroperitoneal area is a concern in 2 anybody who's on anti-coagulants as it was for 3 Dr. Hulyakar and indeed that obviously prompted 4 the performance of the CT scan on the 3rd when 5 it was done. 6 Q. Okay. And feel free to look at 7 the chart as we go through this. I have the 8 luxury of having gone through this and I know 9 what my questions are. I don't want to catch 10 you by surprise. Okay? 11 On 2-26-97 at the time she entered 12 the hospital I think you'll agree with me her 13 hemoglobin was 12.5 and hematocrit 39.5; is 14 that right? 15 A. That is correct. 16 Q. March 5th, 1997 at 10:30 or so 17 p.m. hemoglobin had dropped to 6.2 and her 18 hematocrit was down to 19.4; is that correct? 19 A. That is correct. 20 Q. Okay. She was certainly anemic at 21 this point, right? 22 A. Yes. 23 Q. Is it helpful, in your capacity as 24 a hematologist, to quantify degrees of anemia 25 with regard to severe, moderate or mild?</p>	<p style="text-align: right;">32</p> <p>1 A. Not really. I don't think we use 2 the terms as severe, moderate or mild. We are 3 more focused on what is the value and the 4 clinical circumstances of the patient. I think 5 the categorization of severe, moderate and mild 6 are very arbitrary. 7 Q. Okay. As of that time on the 5th, 8 10:30 or so, when the hematocrit, hemoglobin 9 was found to be 6.2 and 19.4, the measurable 10 loss of blood, volume of blood, was more than 11 half of her entire blood volume; is that right? 12 A. Well -- 13 Q. Or about half? 14 A. -- assuming that, in fact, the 15 original value of 39.5 was an accurate one 16 because, again, hematocrit is a percentage of 17 red cells in a volume of fluid, so it is very 18 influenced by the volume of the fluid. And 19 assuming that she was -- was adequately 20 hydrated at the time and not hemodiluted, in 21 other words, having received a lot of fluid to 22 compensate for the anemia and her low blood 23 pressure, that would probably be a reasonable 24 statement. 25 Q. Do you have any reason to suspect,</p>

<p style="text-align: right;">33</p> <p>1 by anything in the records or in the 2 depositions, that she was not well hydrated as 3 of 2-26-97 when her hemoglobin and hematocrit 4 was taken? 5 A. No. I think she was overhydrated, 6 so that's my point. That, in fact, value just 7 taken in isolation of 19.4 could reflect many 8 fluid shifts in the vascular system. 9 So I don't believe that you can 10 say that this happens to be in the absolute 11 half of what the red cell mass was when she 12 first came in. 13 Q. You're telling me she was 14 overhydrated on February 26th? 15 A. No. I'm just saying that 16 certainly in response to hemorrhage a lot of 17 fluid shifts occur and also in clinical 18 management of perceived hemorrhage there are a 19 lot of crystallized solutions that are given 20 which dilute the red cells. 21 Q. Okay. I guess what I'm asking you 22 is are you aware of anything, from the record 23 or the deposition testimony or anywhere else, 24 that would lead you to conclude in terms of 25 probability that the hemoglobin and hematocrit</p>	<p style="text-align: right;">34</p> <p>1 taken on 2-26-97 was not accurate? 2 A. I wouldn't say it wasn't accurate. 3 It is the value that is determined. It's a 4 calculated value based on her blood analysis. 5 But you are asking me specifically did she lose 6 half of her blood volume and I can't give you 7 an accurate answer that this represents half of 8 the blood volume because there may well be many 9 fluid changes that reflect the concentration of 10 red cells. 11 Q. In terms of probability, though, 12 more likely than not, is this about a loss of 13 about half of her blood volume as indicated on 14 the hemoglobin and hematocrit tests taken on 15 the date of 3-6-97, more likely than not? 16 A. More likely than not it is not a 17 loss of half of her blood volume but it's a 18 loss of a substantial amount of her blood 19 volume, probably more than 30 percent. 20 Q. Okay. Certainly something that 21 would cause any physician to be concerned, 22 correct? 23 A. Yes. 24 Q. Okay. By the way, if she was 25 experiencing continued active bleeding as of</p>
<p style="text-align: right;">35</p> <p>1 the time the hemoglobin and hematocrit test was 2 taken that evening on 3-5-97, the 6.2 and 19.4 3 numbers for the hemoglobin and hematocrit test 4 may not have revealed the true extent of her 5 blood loss; is that correct? 6 A. That is true. 7 Q. Okay. In fact, her blood loss may 8 have been more severe than that reflected on 9 that test if there was continued bleeding; is 10 that right? 11 A. That is possible. It's the best 12 measurement we have but we just don't know 13 because of all the fluid changes that might 14 occur. 15 Q. Okay. Is it likely that her blood 16 loss was more severe than was revealed on that 17 hemoglobin and hematocrit test that evening on 18 March 5th, 1997? 19 A. No. I don't think so. Because on 20 the basis of her response to two units of red 21 blood cell transfusions I think that this value 22 is probably a reasonably accurate value. 23 Q. I'm going to get to that. Okay? 24 I understand your testimony. 25 Okay. And I just want to walk</p>	<p style="text-align: right;">36</p> <p>1 through some facts here and then ask you a 2 question so I know on the record we make sure 3 we're on the same sheet of music here. 4 On 2-26-97 I think we've already 5 agreed her hemoglobin and hematocrit was 12.5 6 and 39.5 respectively, correct? 7 A. Correct. 8 Q. On 3-2-94 the large ecchymotic 9 area on the right flank is identified and she 10 starts complaining of pain in that area, right? 11 A. Yes. 12 Q. Okay. On 3-3-97 her hemoglobin 13 and hematocrit is 11.8 and 35.9 respective, 14 correct? 15 A. Correct. 16 Q. And then of course we know that 17 0415 on 3-4-97 her hemoglobin and hematocrit is 18 11.0 and 34, right? 19 A. Correct. 20 Q. A little lower than the day 21 before. Right? 22 A. Insignificantly. 23 Q. Okay. What was the likely cause 24 in the change from the hemoglobin and 25 hematocrit from 2-26-97 until 0415 on 3-4-97?</p>

<p style="text-align: right;">37</p> <p>1 A. I would think that this is</p> <p>2 probably related to fluid replacement and also</p> <p>3 blood tests that are drawn from people.</p> <p>4 Commonest cause of anemia in the hospital</p> <p>5 population is the blood that health care</p> <p>6 providers draw to do testing.</p> <p>7 Q. And how much blood was drawn from</p> <p>8 her during that period of time, do you know?</p> <p>9 A. Well, she had some blood drawn</p> <p>10 from her but, as I said, I also believe that it</p> <p>11 was probably fluid replacement. She had a fair</p> <p>12 amount of fluid return.</p> <p>13 Q. Would you have expected a</p> <p>14 reasonable physician to draw that conclusion</p> <p>15 relative to the drop from 2-26 to 3-4-97?</p> <p>16 A. Yes. I think that I would not be</p> <p>17 concerned about this. This is very expected,</p> <p>18 in fact, in any hospitalized patient.</p> <p>19 Q. So as of 0415 in the morning the</p> <p>20 change in her hemoglobin and hematocrit since</p> <p>21 the 26th of February was not likely a result of</p> <p>22 the large hematoma over the anterior abdominal</p> <p>23 wall later seen on the day -- on that day by CT</p> <p>24 scan, right?</p> <p>25 A. Well, I think that it may well</p>	<p style="text-align: right;">38</p> <p>1 have been some contribution of that. I might</p> <p>2 also point out that very likely when she came</p> <p>3 in symptomatic on the 26th she was probably a</p> <p>4 little hemo concentrated or a little dry and</p> <p>5 the value of 39.0 was probably a higher value</p> <p>6 than she really had.</p> <p>7 Q. Why do you say you think she was</p> <p>8 probably a little dry?</p> <p>9 A. That's not unusual for people</p> <p>10 coming in who have cardiac symptoms and she may</p> <p>11 have been breathing hard, she was short of</p> <p>12 breath.</p> <p>13 Q. Is there anything in the record</p> <p>14 that leads you to that conclusion? Is there</p> <p>15 anything you can point to to tell me that she</p> <p>16 was a little dry or are you just making an</p> <p>17 assumption?</p> <p>18 A. I'm just referring to her lab</p> <p>19 studies. Yes, as a matter of fact, her blood</p> <p>20 urinemia protein on the 25th was 38 with a</p> <p>21 creatinine of 1.9. That may be a contribution</p> <p>22 in part of her renal problems. But also she</p> <p>23 might have been a little dry.</p> <p>24 Q. Okay. I know you're telling me</p> <p>25 she might have been a little dry. That would</p>
<p style="text-align: right;">39</p> <p>1 have impacted the hematocrit. I guess what I'm</p> <p>2 asking you, on what do you base the conclusion</p> <p>3 that she might have been a little dry? Is</p> <p>4 there anything that you can point to in the</p> <p>5 records?</p> <p>6 A. Well, as I pointed out, certainly</p> <p>7 her history and the base of symptoms. And the</p> <p>8 chemical analysis of BUN and creatinine may</p> <p>9 have also given information about the status of</p> <p>10 her fluids.</p> <p>11 Q. Is it likely that these things you</p> <p>12 just discussed made her be, as you put it, a</p> <p>13 little dry, or are these just possibilities?</p> <p>14 A. No. I think it is likely. In</p> <p>15 fact, as I've pointed out, I mean, this is</p> <p>16 certainly a normal hematocrit but not</p> <p>17 uncommonly patients presenting with an acute</p> <p>18 medical problem may have a slightly higher</p> <p>19 hematocrit than is really what the true value</p> <p>20 is. And then subsequently she was given fluids</p> <p>21 and her hematocrit was a little lower. But</p> <p>22 either way I don't think the 39.5 on the 26th</p> <p>23 to the 34.6 on the 4th reflect a significant</p> <p>24 change.</p> <p>25 Q. Now she started receiving Heparin</p>	<p style="text-align: right;">40</p> <p>1 at 1,000 units an hour on 2-27-97, right?</p> <p>2 A. Yes.</p> <p>3 Q. And my understanding is -- see if</p> <p>4 you agree with me -- that this was continued</p> <p>5 until about 10:30 p.m. on March 5th, '97,</p> <p>6 right?</p> <p>7 A. Correct.</p> <p>8 Q. She started receiving Coumadin at</p> <p>9 five milligrams on 3-3-97, correct?</p> <p>10 A. Correct.</p> <p>11 Q. Now when that says five milligrams</p> <p>12 how was that administered to her?</p> <p>13 A. Orally.</p> <p>14 Q. Okay. Per day?</p> <p>15 A. Yes.</p> <p>16 Q. Okay. By the way, this was</p> <p>17 continued until her death, correct?</p> <p>18 A. Correct.</p> <p>19 Q. Okay. This wasn't stopped at, you</p> <p>20 know, 10:30 or so like the Heparin was on the</p> <p>21 5th, was it?</p> <p>22 A. Well, as a matter of fact, the</p> <p>23 Coumadin's effect -- Coumadin is given as a</p> <p>24 once daily dose. I think once they appreciated</p> <p>25 the gravity of the situation they would not</p>

<p style="text-align: right;">41</p> <p>1 have given Coumadin that next day. But you're</p> <p>2 absolutely right, on the 5th it was given.</p> <p>3 Q. Okay. Do you have any idea what</p> <p>4 time of day it was given?</p> <p>5 A. I don't recall the time of day. I</p> <p>6 don't think that's very important.</p> <p>7 Q. Okay. She started receiving</p> <p>8 aspirin, one tablet per day, on the 5th, as</p> <p>9 well; is that correct?</p> <p>10 A. Yes.</p> <p>11 Q. Okay. Now the CT scan revealed</p> <p>12 the large hematoma over the anterior abdominal</p> <p>13 wall on 3-4-97, correct?</p> <p>14 A. Correct.</p> <p>15 Q. Okay. If this had been your</p> <p>16 patient after you discovered the large hematoma</p> <p>17 over the anterior abdominal wall and having</p> <p>18 learned of the hemoglobin and hematocrit test</p> <p>19 that morning, 0415, and recognizing she was on</p> <p>20 the anti-coagulants we just discussed can we</p> <p>21 agree you would have ordered hemoglobin and</p> <p>22 hematocrit tests to be done every six to eight</p> <p>23 hours throughout the rest of the day on March</p> <p>24 4th?</p> <p>25 A. I don't know that I would have</p>	<p style="text-align: right;">42</p> <p>1 ordered it every four to six hours.</p> <p>2 Q. I'm sorry. I said six to eight</p> <p>3 hours?</p> <p>4 A. I'm sorry, six to eight hours. I</p> <p>5 would probably have repeated the hematocrit but</p> <p>6 I'd be certainly observing the patient.</p> <p>7 Q. When would you have repeated it?</p> <p>8 MS. CARULAS: Just note a</p> <p>9 continuing line of objection as to what one</p> <p>10 particular doctor did. Go ahead. Did you hear</p> <p>11 that?</p> <p>12 Q. I'm sorry. I didn't hear it.</p> <p>13 MS. CARULAS: Just put in my</p> <p>14 standard objection, as I did with Dr. Solomon,</p> <p>15 as to what this one particular doctor would</p> <p>16 have done.</p> <p>17 Q. I understand. I'm sorry, Doctor.</p> <p>18 Would you --</p> <p>19 MS. CARULAS: I'll just have a</p> <p>20 continuing line so I don't have to interrupt.</p> <p>21 A. Again, it would be my standard, as</p> <p>22 a hematologist called in a situation like this,</p> <p>23 to monitor hemoglobins and hematocrits. So I</p> <p>24 would certainly monitor that.</p> <p>25 Q. And how often would you monitor</p>
<p style="text-align: right;">43</p> <p>1 it? I mean, assuming one was done at 4:15 in</p> <p>2 the morning on the 4th when would you have next</p> <p>3 run a hemoglobin and hematocrit test?</p> <p>4 A. Probably sometime in the middle</p> <p>5 part of the day.</p> <p>6 Q. And after that had been done in</p> <p>7 this case do you have an opinion as to what the</p> <p>8 likely result would have been?</p> <p>9 A. I do.</p> <p>10 Q. And what was that? What would</p> <p>11 that be?</p> <p>12 A. It probably would have been</p> <p>13 somewhat lower. But I really don't have any</p> <p>14 opinion in terms of how low it would have been.</p> <p>15 Q. Okay. And assuming it was</p> <p>16 somewhat lower would you then continue to</p> <p>17 monitor the hemoglobin and hematocrit?</p> <p>18 A. Yes.</p> <p>19 Q. When would you run the next test?</p> <p>20 A. That clearly would depend upon the</p> <p>21 circumstances. And, of course, I now have the</p> <p>22 benefit of hindsight, which is clearly</p> <p>23 jaundicing my response to it. But</p> <p>24 prospectively I would have been guided by the</p> <p>25 clinical circumstances of the patient to guide</p>	<p style="text-align: right;">44</p> <p>1 when I'd do it, repeat the test.</p> <p>2 Q. Okay. Given the clinical</p> <p>3 circumstances of this patient on the 4th my</p> <p>4 understanding is she continued to complain of</p> <p>5 pain in the area of the ecchymosis. And</p> <p>6 assuming you would have, around the middle of</p> <p>7 the day, run a hemoglobin and hematocrit test</p> <p>8 that was somewhat lower when would you have</p> <p>9 next run a hemoglobin and hematocrit test on</p> <p>10 that day?</p> <p>11 MS. CARULAS: Note my objection as</p> <p>12 to both a factual basis and the same set of</p> <p>13 objections I've raised before.</p> <p>14 A. Well, again, the response would be</p> <p>15 the same. I think I would be really guided by</p> <p>16 the circumstances of the patient and in terms</p> <p>17 of whether I would have repeated that earlier</p> <p>18 or repeated it another time I really don't know</p> <p>19 prospectively. I might have repeated it later</p> <p>20 on in the evening.</p> <p>21 Q. Okay. By the way, we've talked</p> <p>22 about what you would have done. Can we agree</p> <p>23 given this presentation, the anti-coagulation</p> <p>24 that we've agreed this patient was on as of the</p> <p>25 4th, the CT scan result which showed the large</p>

<p style="text-align: right;">45</p> <p>1 hematoma over the anterior abdominal wall and 2 the hemoglobin and hematocrit values taken at 3 0415, can we agree that the standard of care 4 required a reasonably prudent physician to 5 repeat the hemoglobin and hematocrit tests 6 sometime toward the middle of that day? 7 MS. CARULAS: Note my objection. 8 Go ahead. 9 A. I don't know that the standard of 10 care would have required it. I think that the 11 physicians were certainly attentive and were in 12 attendance and were guided by the clinical 13 circumstances in their judgment at the time. 14 Q. In that capacity is Dr. Hulyakar 15 acting, when he's monitoring this area of 16 ecchymosis, is he acting as a cardiologist? Is 17 he acting as an internist? What hat is he 18 wearing? 19 A. I would think that he is acting as 20 a physician who has experience in internal 21 medicine with an expertise in cardiology. 22 Q. And you have experience in 23 internal medicine, as well; is that correct? 24 A. Yes. 25 Q. Now, again, if this had been your</p>	<p style="text-align: right;">46</p> <p>1 patient and you learned that a CT scan showed 2 this hematoma on the 4th would you have ordered 3 another CT scan on the 5th? 4 MS. CARULAS: Objection. 5 A. I don't know that I would have 6 ordered a CT scan on the 5th. 7 Q. Was there another way for you to 8 monitor this anterior abdominal wall hematoma 9 than by CT scan? 10 A. Yes. I think the benefit, of 11 course, of an external hematoma is that you 12 have physical signs that are available to you. 13 So I would be guided by the physical signs of 14 the patient, the nurses' monitoring of the 15 patient and the patient's vital signs. 16 Q. What physical signs would you look 17 for? 18 A. I'd look for more significant 19 anatomical change in the actual hematoma 20 externally. 21 Q. What do you mean by that? You 22 mean you would be looking to see if it expanded 23 beyond the markings they draw around the 24 monitor? 25 A. That would be one indication or,</p>
<p style="text-align: right;">47</p> <p>1 in fact, if it became more protuberant because, 2 of course, the line of least resistance is 3 external rather than internal since one has 4 muscles and other tissue that would prevent the 5 hematoma from extending internally. 6 Q. Is there any indication -- well, 7 how would you do that? Would you palpate it? 8 A. Yes. 9 Q. Okay. Is there any indication, 10 from the record and the depositions, that Dr. 11 Hulyakar or anybody else palpated this 12 ecchymotic area on the 4th or the 5th? 13 A. Well, I don't know exactly how 14 they assessed it from the point of view of 15 hands-on. But there is documentation that they 16 were looking at it quite carefully. That's 17 evident in the nurses notes. 18 Q. Is it possible that the bleed 19 which manifested itself at the area of 20 ecchymosis and which was seen on CT scan could 21 have continued to expand internally and not 22 show an expansion beyond the line drawn around 23 the area of ecchymosis? 24 A. Well, I think it is apparent that 25 this hematoma was tracking in muscle planes and</p>	<p style="text-align: right;">48</p> <p>1 tissue planes. But, again, that would, in all 2 probability, have presented a change in 3 physical signs. 4 Q. Would it have entered a change in 5 physical signs in the sense of complaint of 6 pain? 7 A. Well, certainly symptoms were 8 there and she had a complaint of pain and they 9 were monitoring it. But I was referring to the 10 physical signs of either extension of the 11 hematoma externally, in other words, becoming 12 more protuberant or perhaps extension of the 13 ecchymosis or perhaps more rigidity of the 14 muscles. 15 Q. Okay. Rigidity of the muscles, 16 did you notice -- do you note from the chart or 17 the depositions whether anybody commented on 18 the rigidity of the muscles? 19 A. Yes, I think the hematologist 20 certainly commented on the rigidity of the 21 muscles on his examination. 22 Q. And when did he examine her? 23 A. On the 5th, I believe. The 6th. 24 Q. On the 6th. He examined her after 25 she had -- after she'd had an event where she</p>

<p style="text-align: right;">49</p> <p>1 was -- her blood pressure had dropped 2 precipitously at six or seven in the morning, 3 right? 4 A. Correct. 5 Q. I'm going to take you back to the 6 4th, comments on the rigidity of the muscles in 7 the records or depositions? 8 A. I certainly remember comments 9 about the nature and description of the 10 hematoma but I will have to refer to the 11 progress notes. On the 4th there is a comment 12 by the house officer, when she was complaining 13 of right lower quadrant discomfort, that there 14 was no apparent change in the size of her 15 ecchymosis. And there is a statement about his 16 examination, mild right lower quadrant 17 tenderness without guarding. So with regard to 18 rigidity I was referring to guarding and/or 19 rigidity. So there is a comment. 20 Q. Okay. Any indication that Dr. 21 Hulyakar or Dr. Chrismer, on the 4th or the 22 5th, ever evaluated the ecchymotic area in 23 terms of protuberance or muscle rigidity? 24 A. Well, again, I think the record is 25 self-evident in terms of evaluations by</p>	<p style="text-align: right;">50</p> <p>1 physicians and/or nurses of this anatomic site. 2 So that information would be available to them. 3 In terms of whether they did it or not I don't 4 know. 5 Q. Okay. If they didn't do it, if 6 they didn't evaluate this ecchymotic area in 7 terms of protuberance and muscle rigidity on 8 the 4th and the 5th, can we agree that they 9 both fell below the standard of care? 10 A. Well, I would say that if, in 11 fact, they didn't follow up on this issue then 12 they would have deviated from the standard of 13 care. But I think that's not facts in 14 evidence. 15 Q. And, again, I'm not clear, in your 16 testimony with regard to this bleed which 17 manifested itself at the area of ecchymosis in 18 the right flank and seen as an abdominal wall 19 hematoma by CT scan, had it continued to bleed 20 internally and not spread beyond the line, the 21 markings on the skin, is that possible for it 22 to do that? 23 A. It is possible. It could erode 24 through some tissue if it was extensive enough. 25 Q. Okay. But you're saying that if</p>
<p style="text-align: right;">51</p> <p>1 it does that it may further reveal itself in 2 terms of muscle rigidity or protuberance, 3 correct? 4 A. Right. And other clinical signs, 5 for example, signs of peritonism if it actually 6 erodes through the muscle planes into the 7 abdominal cavity. 8 Q. Signs of infection? 9 A. Peritonism. Inflammation of the 10 peritoneal cavity. 11 Q. And how does that manifest itself 12 clinically? How do you determine if that's 13 there? 14 A. Well, the patient's symptoms would 15 change. They would very likely be nausea and 16 vomiting. There would be clinical signs of 17 guarding and certainly rigidity and there may 18 well be absence of bowel sounds or what's 19 termed an ileus, I-L-E-U-S. 20 Q. Did that happen in this case? 21 A. No. 22 Q. I'm sorry. Did you say something? 23 A. I said no. 24 Q. Okay. I'm sorry. I may have 25 asked you this and I apologize. Had a CT scan</p>	<p style="text-align: right;">52</p> <p>1 been done on the 5th, that day, what would it 2 have likely revealed? 3 A. You asking me midday on the 5th? 4 Q. Yes. 5 A. I think it would have revealed the 6 same as it revealed the day before. Perhaps. 7 Q. Why do you say that? 8 A. Well, perhaps there may have been 9 some marginal change. CTs are not that 10 discriminating in terms of absolute volumes. I 11 think that her hematoma would have been 12 obviously apparent. But I don't believe that 13 her retroperitoneal bleed would have been 14 noted. I think this was an acute event. 15 Q. Okay. And we've got to talk about 16 that in a minute. All right. So I understand 17 what you're saying. 18 By the way, relative to complaints 19 of pain in the area of the ecchymosis with this 20 patient her complaints of pain, those, of 21 course, were likely a result of the hematoma on 22 the anterior abdominal wall, right? 23 A. Yes. And/or the femoral 24 puncturing that was made previously. But I 25 would agree with that.</p>

<p style="text-align: right;">53</p> <p>1 Q. Yeah. Is it likely that that</p> <p>2 puncture continued to bleed throughout the day</p> <p>3 on the 4th and the 5th?</p> <p>4 A. Well, I believe it was the origin</p> <p>5 of the abdominal wall hematoma. So it could</p> <p>6 conceivably have continued to bleed or it may</p> <p>7 have sealed off and then subsequently opened up</p> <p>8 again.</p> <p>9 Q. Tell me why you believe this was,</p> <p>10 so I understand your testimony, I think you</p> <p>11 believe this is an acute bleed. Right?</p> <p>12 A. Correct.</p> <p>13 Q. And, again, the bleed I'm talking</p> <p>14 about was the bleed that ultimately killed her</p> <p>15 and that was described in the autopsy report,</p> <p>16 correct?</p> <p>17 A. Well, it was the contributing</p> <p>18 factor to her death, yes.</p> <p>19 Q. Yes. I understand. Tell me why,</p> <p>20 each and every reason why, you believe it was</p> <p>21 an acute bleed?</p> <p>22 A. Well, based on my review of the</p> <p>23 record and the chronology of events and the</p> <p>24 vital signs something acutely happened. And</p> <p>25 this something that acutely happened was, at</p>	<p style="text-align: right;">54</p> <p>1 least by virtue of the clinical signs, not</p> <p>2 apparent for most of the day on the 5th. So</p> <p>3 subsequently towards the latter part of the 5th</p> <p>4 when she went into the -- when she dropped her</p> <p>5 blood pressure and went into the intensive care</p> <p>6 an event happened. And I believe that this was</p> <p>7 the contributing event that a hemorrhage</p> <p>8 occurred and this hemorrhage continued well</p> <p>9 into the 6th, obviously until when she coded.</p> <p>10 And by that stage, of course, she had no</p> <p>11 cardiac reserve that was able to adapt to this,</p> <p>12 or very limited cardiac reserve or very limited</p> <p>13 body reserve. And that caused her death.</p> <p>14 Q. You say that something acutely</p> <p>15 happened that was not apparent for most of the</p> <p>16 day on the 5th. And my question to you is what</p> <p>17 acutely happened? Did the bleed happen that</p> <p>18 was not apparent for most of the day on the</p> <p>19 5th?</p> <p>20 A. Well, I think the bleed started</p> <p>21 when she dropped her blood pressure.</p> <p>22 Q. And when was that?</p> <p>23 A. Certainly she had evidence of an</p> <p>24 abdominal wall hematoma. I believe that the</p> <p>25 cause of her death was the retroperitoneal</p>
<p style="text-align: right;">55</p> <p>1 hematoma because there was a massive bleed into</p> <p>2 her retroperitoneum which certainly wasn't</p> <p>3 evident on the CT scan. So it must have</p> <p>4 happened after the CT scan.</p> <p>5 Q. In terms of probability when did</p> <p>6 it start?</p> <p>7 A. I think it started at the time</p> <p>8 when she dropped her blood pressure.</p> <p>9 Q. And, I'm sorry, Doctor, when was</p> <p>10 that?</p> <p>11 A. That was on the 5th, probably</p> <p>12 around -- started around 1600 hours, I would</p> <p>13 say, as to 1800 hours, to 8:00 in the evening.</p> <p>14 Q. Until 8:00 in the evening. So</p> <p>15 2000 hours is when her blood pressure dropped?</p> <p>16 A. Well, I think there's evidence</p> <p>17 that her blood pressure did drop at 1600 hours,</p> <p>18 that's 4:00. But then 8:00 it was 79 over 48.</p> <p>19 Q. Okay. So more likely than not, in</p> <p>20 your opinion, this bleed started at about 4:00</p> <p>21 in the afternoon, right?</p> <p>22 A. Very likely; that would be the</p> <p>23 earliest time I would think that it would have</p> <p>24 started. Shortly before that.</p> <p>25 Q. And, Doctor, what, in terms of</p>	<p style="text-align: right;">56</p> <p>1 probability, was the cause of this bleed?</p> <p>2 A. Well, again, we're not totally</p> <p>3 sure. I mean, it's very easy to say that it</p> <p>4 was related to the femoral catheter and the</p> <p>5 needle stick that reopened. But I think that</p> <p>6 it's also well known that spontaneous bleeding</p> <p>7 can occur.</p> <p>8 Q. Now I want you to understand</p> <p>9 something. In Ohio here we talk in terms of</p> <p>10 probability, that is, 51 percent or greater</p> <p>11 certainty of a fact. Allows you to state</p> <p>12 things to a reasonable degree of medical</p> <p>13 probability. And that's probably how Ms.</p> <p>14 Carulas will ask you questions at trial, but</p> <p>15 I'll leave that up to her.</p> <p>16 My question to you, though, in</p> <p>17 terms of probability, is it more likely than</p> <p>18 not or to a reasonable degree of medical</p> <p>19 probability that the bleed that began at 1600</p> <p>20 on the 5th was from the puncture wound in the</p> <p>21 area of the femoral vein in the groin?</p> <p>22 A. I really can't say.</p> <p>23 Q. Okay. Can you, again, to a</p> <p>24 reasonable degree of medical probability, can</p> <p>25 you say what was the cause -- or strike that.</p>

<p style="text-align: right;">57</p> <p>1 What was the etiology of that</p> <p>2 bleed?</p> <p>3 A. I can't say. All I can say is one</p> <p>4 of those two possibilities. That's the</p> <p>5 differential diagnosis of that retroperitoneal</p> <p>6 bleed. But I don't know what the cause was.</p> <p>7 Q. Okay.</p> <p>8 A. I would have expected that if it</p> <p>9 was from the femoral puncture site you would</p> <p>10 have seen it on the CT scan before that because</p> <p>11 the femoral puncture was done, of course, days</p> <p>12 before that, too. And she was on</p> <p>13 anti-coagulants so I really don't know.</p> <p>14 Neither do, I think, anybody does.</p> <p>15 Q. You said something that confuses</p> <p>16 me. You would have seen what on the CT scan?</p> <p>17 A. Retroperitoneal bleed.</p> <p>18 Q. Why would you have seen it on the</p> <p>19 CT scan?</p> <p>20 A. Well, I think, obviously, there</p> <p>21 was an invasion of a blood vessel and that was</p> <p>22 done at the time of the initial puncture on the</p> <p>23 27th, I believe it was.</p> <p>24 Q. Okay.</p> <p>25 A. So if there was continued bleeding</p>	<p style="text-align: right;">58</p> <p>1 from a blood vessel to bleed into the</p> <p>2 retroperitoneum, which is an open space, either</p> <p>3 it's sealed off for some reason and then didn't</p> <p>4 -- then reopened, which I suppose it's</p> <p>5 possible, again, it's possible, or if it</p> <p>6 continued I would have expected to see blood in</p> <p>7 that space done when the CT scan was performed</p> <p>8 on the 4th.</p> <p>9 Q. Why?</p> <p>10 A. Because it is a space without</p> <p>11 resistance. It really is an open space. It's</p> <p>12 beneath the peritoneum.</p> <p>13 Q. What if the blood just hadn't made</p> <p>14 its way there yet through the tissue planes?</p> <p>15 A. Well, she was on anti-coagulants.</p> <p>16 There would be expectation that, in fact, if</p> <p>17 there was a puncture in the vessel causing a</p> <p>18 leak into that space that there would have been</p> <p>19 a substantial amount of blood there.</p> <p>20 And, again, I should point out</p> <p>21 that it is well known to hematologists that</p> <p>22 spontaneous bleeding can occur for some reason</p> <p>23 in the retroperitoneum. And I have personally</p> <p>24 seen a patient who was not punctured who has</p> <p>25 had a life threatening bleeding into the</p>
<p style="text-align: right;">59</p> <p>1 retroperitoneum.</p> <p>2 Q. Did you salvage that patient?</p> <p>3 A. Actually I've seen it several</p> <p>4 times and I've seen it cause death.</p> <p>5 Q. Okay. Of the several times you've</p> <p>6 seen it how many times has it caused death?</p> <p>7 A. I can recall one time that a</p> <p>8 patient died.</p> <p>9 Q. And how many other times did the</p> <p>10 patient survive?</p> <p>11 A. I don't recall.</p> <p>12 Q. But at least several, right?</p> <p>13 A. Yes.</p> <p>14 Q. And in those circumstances did you</p> <p>15 provide care for the patient?</p> <p>16 A. Well, I assume I was consulted</p> <p>17 because I know about the cases but I cannot</p> <p>18 remember exactly what my role was. Mostly it</p> <p>19 relates to blood component therapy, I</p> <p>20 believe --</p> <p>21 Q. Okay.</p> <p>22 A. -- and coagulation parameters.</p> <p>23 Q. You said something, again, I want</p> <p>24 to make sure I understand. The medicine -- you</p> <p>25 said something that confuses me and that is, I</p>	<p style="text-align: right;">60</p> <p>1 guess, you know, I'm thinking internally. Is</p> <p>2 there something about a -- that the route the</p> <p>3 blood would flow, that we see the collection of</p> <p>4 blood on the CT scan around the interior wall</p> <p>5 of the abdomen but we don't see it in the</p> <p>6 retroperitoneum. Are you telling me that you</p> <p>7 would, given the fact that she was on</p> <p>8 anti-coagulants, you would have expected to see</p> <p>9 blood in the retroperitoneum at the same time</p> <p>10 you saw abdominal wall hematoma?</p> <p>11 A. No. I didn't answer it exactly</p> <p>12 that way.</p> <p>13 Q. Okay.</p> <p>14 A. But given the fact that she</p> <p>15 ultimately died and was found at autopsy that</p> <p>16 she had an extensive retroperitoneal bleed, and</p> <p>17 given the fact that she was on anti-coagulants,</p> <p>18 had this been going on I would have expected to</p> <p>19 see blood in the retroperitoneum at a time when</p> <p>20 the CT scan was done because it was a puncture</p> <p>21 of her femoral vein and her artery on the 27th.</p> <p>22 Q. Okay. But it's certainly possible</p> <p>23 that -- so I understand your testimony -- it's</p> <p>24 possible that the bleed that began at about</p> <p>25 1600 on 3-5 was from that same site, correct?</p>

<p style="text-align: right;">61</p> <p>1 A. Oh, yes.</p> <p>2 Q. Okay.</p> <p>3 A. Again, I think I've explained to</p> <p>4 you that there are a number of possibilities.</p> <p>5 But I cannot tell you which, exactly, was the</p> <p>6 one that caused it.</p> <p>7 Q. And the other possibility is the</p> <p>8 spontaneous retroperitoneal bleed that people</p> <p>9 who are an anti-coagulants sometimes have,</p> <p>10 correct?</p> <p>11 A. Correct.</p> <p>12 Q. By the way, given her cardiac</p> <p>13 problems and the expectations with her limited</p> <p>14 reserve to deal with a blood loss the standard</p> <p>15 of care requires a physician to monitor very</p> <p>16 closely a patient for bleeding under these</p> <p>17 circumstances, correct?</p> <p>18 A. Yes.</p> <p>19 Q. Now had a hemoglobin and</p> <p>20 hematocrit test been run at 1600 or 1700 that</p> <p>21 evening do you have an opinion as to what it</p> <p>22 would have likely shown?</p> <p>23 A. On the evening of the 5th, you</p> <p>24 referring to?</p> <p>25 Q. On the 5th, yes, shortly after the</p>	<p style="text-align: right;">62</p> <p>1 bleed began?</p> <p>2 A. I think it would have been lower.</p> <p>3 Q. Okay. At that point in time --</p> <p>4 well, let me ask it to you this way. Is there</p> <p>5 a point in time between when the bleed began at</p> <p>6 1600 and when the patient expired the next</p> <p>7 morning when this patient was salvageable, that</p> <p>8 is, when her life could have been saved by</p> <p>9 proper medical intervention?</p> <p>10 A. I don't think this patient was</p> <p>11 salvageable.</p> <p>12 Q. Tell me why.</p> <p>13 A. Because of all the medical</p> <p>14 problems that existed in her, and I'd be happy</p> <p>15 to enumerate them.</p> <p>16 Q. Well, yes. Enumerate them for me</p> <p>17 and explain how they relate to her not being</p> <p>18 salvageable in your mind. Please tell me.</p> <p>19 A. Well, first of all, and I think</p> <p>20 certainly preeminently, this lady had heart</p> <p>21 muscle disease. She had a cardiomyopathy. She</p> <p>22 had an abnormal heart rhythm that was</p> <p>23 refractory to medical management and, of</p> <p>24 course, that's why she came into the hospital</p> <p>25 in order to attempt to control this.</p>
<p style="text-align: right;">63</p> <p>1 She also had pulmonary</p> <p>2 hypertension which, in and of itself, can be a</p> <p>3 life threatening condition. She had a history</p> <p>4 of congestive heart failure. She had poor</p> <p>5 circulation particularly affecting her</p> <p>6 peripheral circulation. She had a past history</p> <p>7 of a stroke affecting her left cerebella</p> <p>8 hemisphere. She had two previous pulmonary</p> <p>9 emboli. She had chronic obstructive lung</p> <p>10 disease. She also had hepatitis C and that may</p> <p>11 have also been playing a role to some extent,</p> <p>12 although I think minimally because her liver</p> <p>13 functions were not that bad.</p> <p>14 But this lady had multiple medical</p> <p>15 problems and, in essence, her protoplasm was</p> <p>16 such that any event which would tip the apple</p> <p>17 cart would, I don't believe, allow her to be</p> <p>18 salvaged. She really had very, very limited</p> <p>19 medical and cardiovascular reserve.</p> <p>20 Q. Given this woman with vast limited</p> <p>21 cardiovascular reserve that you discussed can</p> <p>22 we agree that the standard of care required at</p> <p>23 least one more hemoglobin and hematocrit test</p> <p>24 run by Dr. Hulyakar on the 4th and at least one</p> <p>25 more hemoglobin and hematocrit test run by Dr.</p>	<p style="text-align: right;">64</p> <p>1 Hulyakar or Dr. Chrismer on both these</p> <p>2 questions on the day of the 5th to monitor</p> <p>3 this?</p> <p>4 A. Again, I think I've answered that.</p> <p>5 And I referred to the fact that I don't believe</p> <p>6 the standard of care would necessarily require</p> <p>7 the measurement of the hemoglobin and</p> <p>8 hematocrit which, in fact, in and of itself in</p> <p>9 bleeding can be misleading. But the standard</p> <p>10 of care does require monitoring of vital signs</p> <p>11 and close attention to the patient, which I</p> <p>12 think the record reflects was given.</p> <p>13 Q. But certainly the hemoglobin and</p> <p>14 hematocrit test would have shown if the patient</p> <p>15 was becoming more anemic, right?</p> <p>16 MS. CARULAS: Objection.</p> <p>17 A. Well, certainly would have shown</p> <p>18 if the patient was becoming more and more</p> <p>19 anemic. But, again, I think I agree with Dr.</p> <p>20 Ballard, that there are erroneous values is</p> <p>21 that don't necessarily reflect the physiologies</p> <p>22 intravascularly that's going on because of</p> <p>23 fluid shift in an acute bleed.</p> <p>24 Q. This patient was given two units</p> <p>25 of blood late in the evening, right?</p>

<p style="text-align: right;">65</p> <p>1 A. Yes.</p> <p>2 Q. Late in the evening hours and</p> <p>3 early morning hours, right?</p> <p>4 A. Yes.</p> <p>5 Q. Okay. How did she react to those?</p> <p>6 A. She had a response. The</p> <p>7 hematocrit and hemoglobin went up.</p> <p>8 Q. Well, how do you know the</p> <p>9 hemoglobin and hematocrit went up?</p> <p>10 A. Well, I can refer to the fact that</p> <p>11 on the 6th of March at almost two in the</p> <p>12 morning she had a hematocrit of 27.2.</p> <p>13 Q. Okay. And what was the</p> <p>14 hemoglobin?</p> <p>15 A. 9.1. There's usually a 3 to 1</p> <p>16 relationship.</p> <p>17 Q. Did the standard of care require</p> <p>18 her to have been given more blood than was</p> <p>19 given to her?</p> <p>20 A. No. I don't believe so. I think</p> <p>21 at that point in time, again, if you use the</p> <p>22 hemoglobin and hematocrit values, it would have</p> <p>23 been appropriate response. But, as I said, it</p> <p>24 also needs to be guided by vital signs. And,</p> <p>25 in addition, she was being given a fair amount</p>	<p style="text-align: right;">66</p> <p>1 of fluid resuscitation at that time. So it's</p> <p>2 very likely that her actual hematocrit may have</p> <p>3 been higher.</p> <p>4 Q. Is it -- you're mixing words here.</p> <p>5 As lawyers we pay attention to these things.</p> <p>6 You say it likely may have been higher?</p> <p>7 A. More probable than not it would</p> <p>8 have been higher if, in fact, she wasn't given</p> <p>9 -- actual fact, what her absolute red cell mass</p> <p>10 was, was probably a little higher than was</p> <p>11 reflected by the percentage of red cells as</p> <p>12 determined by the lab tests.</p> <p>13 Q. As of the time of this hemoglobin</p> <p>14 and hematocrit test about 0200 in the morning</p> <p>15 was there likely still a bleed occurring?</p> <p>16 A. Yes. I believe so.</p> <p>17 Q. What was done to control that</p> <p>18 bleed?</p> <p>19 A. Well, subsequently, again, to</p> <p>20 control the bleed I think that the physicians</p> <p>21 were monitoring the clinical signs and vital</p> <p>22 signs in giving fluids. But in terms of</p> <p>23 controlling the bleed I'm not sure what you</p> <p>24 mean. There was nothing done that could have</p> <p>25 been done to actually try and intervene to stop</p>
<p style="text-align: right;">67</p> <p>1 the area of hemorrhage.</p> <p>2 Q. Why?</p> <p>3 A. Because, well, certainly I know</p> <p>4 that mention has been made about surgical</p> <p>5 consults. I think that's totally</p> <p>6 inappropriate. This patient would not be a</p> <p>7 surgical candidate; neither, for that matter,</p> <p>8 would there have been a site identified which</p> <p>9 could have changed things.</p> <p>10 Q. At late in the evening, 10:30 time</p> <p>11 frame, when Dr. Hulyakar orders the Heparin</p> <p>12 discontinued my understanding is he does that</p> <p>13 after he learns of the hemoglobin and</p> <p>14 hematocrit test, correct?</p> <p>15 A. Correct.</p> <p>16 Q. Okay. Why wasn't a hemoglobin and</p> <p>17 hematocrit test run at 1600 or 1700 in the</p> <p>18 afternoon, do you know?</p> <p>19 A. I don't know.</p> <p>20 Q. Would the standard of care have</p> <p>21 required it at that point with this patient --</p> <p>22 MS. CARULAS: Objection.</p> <p>23 Q. -- immediately when he noticed</p> <p>24 blood beginning to drop run a hemoglobin and</p> <p>25 hematocrit test?</p>	<p style="text-align: right;">68</p> <p>1 MS. PETRELLO: Objection. Asked</p> <p>2 and answered.</p> <p>3 A. Again, I think I answered that.</p> <p>4 Q. I don't think you did. If you did</p> <p>5 humor me and answer it again, please.</p> <p>6 MS. PETRELLO: That's the third</p> <p>7 time you've asked it.</p> <p>8 A. I think what I had said was it</p> <p>9 related to certainly the clinical signs of the</p> <p>10 patient and I already articulated the issues</p> <p>11 relating to the measurement of hematocrits</p> <p>12 during bleeding. So it's the same issue.</p> <p>13 Q. Was the fact that the woman hadn't</p> <p>14 passed urine all day and had to be straight</p> <p>15 cathed and 100 cc's, I think, of concentrated</p> <p>16 dark urine were obtained at about 1700, is that</p> <p>17 related to the blood loss in this case in terms</p> <p>18 of probability?</p> <p>19 A. I think that the blood loss</p> <p>20 probably contributed in terms of probability.</p> <p>21 However, as was pointed out by the nephrology</p> <p>22 consult, there were other factors that were</p> <p>23 playing into that equation.</p> <p>24 Q. By 0300 in the morning I think you</p> <p>25 will agree with me by looking at the chart the</p>

<p style="text-align: right;">69</p> <p>1 woman had not passed any more urine. Assuming</p> <p>2 that to be the case is that fact evidence of</p> <p>3 Mrs. Robinson entering a state of hypovolemic</p> <p>4 shock or in a state of hypovolemic shock?</p> <p>5 A. I think, on the basis of</p> <p>6 retrospective, it probably contributed to it.</p> <p>7 But prospectively better than -- already had</p> <p>8 chronic renal insufficiency. Had already been</p> <p>9 seen by a physician who was a nephrologist who</p> <p>10 was an expert in fluid management and kidney</p> <p>11 function. There were other factors that were</p> <p>12 playing into the equation there. And I think</p> <p>13 they were concerned about her actual kidney</p> <p>14 function period.</p> <p>15 Q. I'm not talking standard of care</p> <p>16 here. I'm not talking whether someone managed</p> <p>17 this right or wrong. What I'm asking is was</p> <p>18 the fact that she was not passing urine at 0300</p> <p>19 in the morning likely a sign or symptom of</p> <p>20 hypovolemic shock?</p> <p>21 A. It likely was.</p> <p>22 Q. Okay. That's certainly something,</p> <p>23 if you're managing this patient, you want to</p> <p>24 know that she's not passing urine as of 0300 in</p> <p>25 the morning; is that correct?</p>	<p style="text-align: right;">70</p> <p>1 A. Yes.</p> <p>2 Q. Was the fact that they were having</p> <p>3 a difficult time getting a peripheral pulse on</p> <p>4 this patient, as of 0300 in the morning and</p> <p>5 throughout the morning hours, was that also a</p> <p>6 sign or symptom of hypovolemic shock in this</p> <p>7 patient?</p> <p>8 A. Yes.</p> <p>9 Q. Again, something as a physician</p> <p>10 you want to know about if you're talking to a</p> <p>11 nurse at 0300 in the morning, right?</p> <p>12 A. Yes.</p> <p>13 Q. You conclude that this patient</p> <p>14 was not salvageable once this bleed began at</p> <p>15 1600 on the 5th. Can you be any more specific</p> <p>16 than you've been in describing the mechanism as</p> <p>17 to why she was not salvageable?</p> <p>18 A. No. I don't think so.</p> <p>19 Q. Just basically based on the -- on</p> <p>20 her history with the difficulties with</p> <p>21 cardiomyopathy. I wrote them all down.</p> <p>22 Hypertension, congestive heart failure, poor</p> <p>23 circulation, past history of stroke, two</p> <p>24 previous pulmonary lung -- pulmonary emboli?</p> <p>25 A. Well, actually it was venous --</p>
<p style="text-align: right;">71</p> <p>1 deep venous thrombosis.</p> <p>2 Q. I'm sorry, deep venous</p> <p>3 thrombosis, and hepatitis C. Just by the mere</p> <p>4 fact that these -- this collection of problems</p> <p>5 you just don't believe she was likely going to</p> <p>6 survive once this bleed started at 4:00 in the</p> <p>7 afternoon?</p> <p>8 A. That is correct. I should also</p> <p>9 mention I didn't specifically mention her</p> <p>10 incompetence of her valves; her cardiac valves</p> <p>11 were not functioning well either. Both the</p> <p>12 tricuspid and the mitral valves. She really</p> <p>13 had marginal reserve at best. And it was no</p> <p>14 chance of salvaging her, I don't think.</p> <p>15 Q. No chance at all? Zero chance?</p> <p>16 A. Well, very limited. That's all I</p> <p>17 could say. I mean --</p> <p>18 Q. I mean, was there a 30 or 40</p> <p>19 percent chance of salvaging her?</p> <p>20 MS. CARULAS: Objection.</p> <p>21 A. No. I think that, again, now I</p> <p>22 have the benefit of the retrospectoscope</p> <p>23 analyzing her circumstances and I don't believe</p> <p>24 that she was salvageable at all.</p> <p>25 Q. If you were managing this patient</p>	<p style="text-align: right;">72</p> <p>1 would you have even bothered to give her blood</p> <p>2 product?</p> <p>3 A. No. Of course prospectively I</p> <p>4 would be assuming that everything I could do to</p> <p>5 salvage her would be done. I think -- but</p> <p>6 certainly her prognosis was very poor and I'm</p> <p>7 sure the physicians realized that and indeed I</p> <p>8 believe it was communicated to her son that she</p> <p>9 had a very grave prognosis even at that time.</p> <p>10 Q. Doctor, hypothetically, Dr.</p> <p>11 Hulyakar sees the CT scan results on the 4th,</p> <p>12 he knows hemoglobin and hematocrit tests at</p> <p>13 0400 in the morning on the 4th, why wouldn't he</p> <p>14 -- strike that.</p> <p>15 Would it have been reasonable for</p> <p>16 him to have discontinued the Heparin and</p> <p>17 monitored her hemoglobin and hematocrit for 24</p> <p>18 hours to ensure that there was no continued</p> <p>19 bleeding?</p> <p>20 MS. CARULAS: Note my objection.</p> <p>21 Go ahead.</p> <p>22 A. Would it be reasonable?</p> <p>23 Q. Yes.</p> <p>24 A. It would be reasonable.</p> <p>25 Q. Okay.</p>

<p style="text-align: right;">73</p> <p>1 A. However, again, one has to</p> <p>2 carefully weigh the risk of discontinuing it</p> <p>3 versus the risks of continuing it. And this is</p> <p>4 a judgment call that would be made by</p> <p>5 physicians at the time who have knowledge of</p> <p>6 the patient.</p> <p>7 Q. Were there other options available</p> <p>8 to him aside from Heparin which would have</p> <p>9 guarded against DVT and the arrhythmia problems</p> <p>10 and reduced the risk of the bleed?</p> <p>11 A. I don't believe there were other</p> <p>12 options. And I think I know what you're</p> <p>13 referring to as, I think, your expert referred</p> <p>14 to the Greenfield filter.</p> <p>15 Q. Yes.</p> <p>16 A. This woman was not a candidate for</p> <p>17 a Greenfield filter.</p> <p>18 Q. Tell my why.</p> <p>19 A. Greenfield filters certainly can</p> <p>20 impede, mechanically, the possibility of a</p> <p>21 thrombosis in the lower extremities. But</p> <p>22 certainly one would not prevent any clots from</p> <p>23 occurring in an individual who has paroxysmal</p> <p>24 atrial fibrillation who had previously had a</p> <p>25 stroke. We know that for a fact, as well. But</p>	<p style="text-align: right;">74</p> <p>1 there would be a great likelihood of clots</p> <p>2 developing in the heart and spreading out.</p> <p>3 Greenfield filter has no role in that.</p> <p>4 Q. You state in your report on the --</p> <p>5 gosh, I think it's the third full paragraph in</p> <p>6 reference to the primary indication for</p> <p>7 anti-coagulation, state that, and I'll quote,</p> <p>8 this is based on the statistically greater</p> <p>9 probability of the patient with her risk</p> <p>10 factors having a life threatening</p> <p>11 thromboembolic event than one of a hemorrhagic</p> <p>12 nature, closed quote. Do you see that?</p> <p>13 A. Yes.</p> <p>14 Q. Okay. On what are you relying for</p> <p>15 that statement, Doctor, when you talk about a</p> <p>16 technically greater probability?</p> <p>17 A. I'm relying on my background,</p> <p>18 education and experience and my knowledge of</p> <p>19 the patient's records.</p> <p>20 Q. As part of your background,</p> <p>21 education and training are you relying on any</p> <p>22 kind of studies?</p> <p>23 A. Well, I don't think there have</p> <p>24 been any studies specifically getting an</p> <p>25 aggregate of patients with exactly the same</p>
<p style="text-align: right;">75</p> <p>1 issues that she has and being able to give us</p> <p>2 some statistics on this. But --</p> <p>3 Q. So I guess where I'm coming from</p> <p>4 is what's your basis for a statistically</p> <p>5 greater probability? I mean, that -- I guess</p> <p>6 that means to me that there's a study you're</p> <p>7 relying on. Does that mean the same to you?</p> <p>8 A. No, not at all. What I'm saying</p> <p>9 is that it's more probable than not</p> <p>10 statistically, in fact, substantially more</p> <p>11 probable than not statistically that she would</p> <p>12 have a thrombo embolic event versus a</p> <p>13 hemorrhagic event that would be life</p> <p>14 threatening. Hemorrhagic events, more often</p> <p>15 than not, are controllable and manageable.</p> <p>16 Thrombotic events cause death of tissue.</p> <p>17 That's very likely irreversible.</p> <p>18 Q. So this statistically greater</p> <p>19 probability is just something that you are</p> <p>20 relying on, I mean, you're coming to that</p> <p>21 conclusion based on your experience; is that</p> <p>22 right?</p> <p>23 A. Well, it's based on my experience</p> <p>24 and this particular patient. I'm referring to</p> <p>25 what is her statistical probability, not the</p>	<p style="text-align: right;">76</p> <p>1 literature in the world's published material</p> <p>2 because she is a very unique patient.</p> <p>3 Q. Break it down statistically for</p> <p>4 me. How would you describe that?</p> <p>5 A. Well, again, you might use more</p> <p>6 probable than not. That, statistically, would</p> <p>7 be greater than 50 percent. And I am using</p> <p>8 that same analogy to base my statement.</p> <p>9 Q. What's your basis for the</p> <p>10 statement that this was a difficult yet</p> <p>11 carefully weighted decision? How do you know</p> <p>12 it was a carefully weighted decision?</p> <p>13 A. Well, I have no doubt that, in</p> <p>14 fact, there was many doctors that were involved</p> <p>15 in it. None of them expressed any concern</p> <p>16 about the continuation of the anti-coagulants.</p> <p>17 They clearly realized the difficulty and the</p> <p>18 difficult situation they were faced with. And</p> <p>19 also base it on my review of Dr. Hulyakar's</p> <p>20 deposition.</p> <p>21 Q. How do you know that Dr. Chrismer</p> <p>22 carefully weighted this decision?</p> <p>23 A. Well, I think you'd have to ask</p> <p>24 Dr. Chrismer but I would imagine, again, this</p> <p>25 is my assessment based on my review of the</p>

<p style="text-align: right;">77</p> <p>1 medical record and the number of physicians 2 involved and the deposition. 3 Q. With regard to Dr. Chrismer you're 4 assuming it is a carefully weighted decision 5 correct? 6 A. Yes. 7 Q. Okay. With regard to Dr. Hulyakar 8 are you assuming it was a carefully weighted 9 decision? 10 A. I am absolutely. 11 Q. You're assuming? 12 A. Yes. 13 Q. Okay. By the way, given the fact 14 that she was on Heparin, and we note that her 15 blood pressure began to fall at 4:00 in the 16 afternoon, wouldn't it have been appropriate 17 that her Heparin had been discontinued at 4:00 18 in the afternoon? 19 A. It would be appropriate to 20 consider the timing when Heparin should be 21 stopped, yes. 22 Q. Okay. Heparin should have been 23 stopped more quickly than it was in this case, 24 correct -- 25 MS. CARULAS: Objection.</p>	<p style="text-align: right;">78</p> <p>1 Q. -- or stopped sooner than it was 2 in this case, correct? 3 A. No. I think that, again, faced 4 with all the events that were happening 5 prospectively I think the decisions that were 6 taken were reasonable decisions. Certainly I 7 have the blend of hindsight looking at all the 8 records after her death. And I might say that 9 it could have been stopped earlier, yes. 10 Q. Now protamine reversing the 11 Heparin in the report, you say it's not 12 uncommonly associated with severe reactions? 13 A. That's correct. 14 Q. Yet that can be life threatening, 15 right? 16 A. Yes. 17 Q. What are those, please? 18 A. Anaphylactic reactions, severe 19 allergic reactions to the protamine, and 20 protamine in and of itself is also an 21 anti-coagulant. It can also anti-coagulate. 22 Q. Were there any other options 23 available to her physicians to reverse the 24 effecting of the Heparin? 25 A. No. This is the standard</p>
<p style="text-align: right;">79</p> <p>1 medication that, in fact, is used to reverse 2 Heparin. It works in an antagonistic way to 3 Heparin but, of course, as I pointed out it can 4 also be an anti-coagulant. 5 Q. Does it also act as an 6 anti-coagulant? 7 A. If enough of it is given, yes. 8 Q. How much needs to be given to act 9 as an anti-coagulant? 10 A. That's very variable. It depends 11 upon patient's idiosyncrasy. 12 Q. Okay. 13 A. But it can certainly do that. 14 Q. Okay. What should have been given 15 to this patient such that it would not have 16 acted as an anti-coagulant? What amount? 17 A. I don't know. 18 Q. Why don't you know? 19 A. Well, I think there were a number 20 of dynamic things that were happening in this 21 patient at the time. In general, what one does 22 is one sort of does an empiric cardiovascular 23 bypass surgery which is where protamine is 24 usually used. This is an acute amount of 25 Heparin that is given. The measurement of</p>	<p style="text-align: right;">80</p> <p>1 activated clotting time is done at the time and 2 an empiric amount of protamine is given to 3 reverse it. 4 Q. Did Dr. Hulyakar consider 5 reversing this with protamine? 6 A. I don't know what he considered. 7 I would imagine that would have been a thought 8 that would have gone through his mind. 9 Q. Okay. Was there an amount that 10 could have been given to her that would have 11 fallen short of acting as an anti-coagulant? 12 A. Again, as I've answered the 13 question, it is very idiosyncratic and depends 14 upon the kinetics of Heparin. But an amount 15 can be given to reverse Heparin. 16 Q. What do you mean by kinetics of 17 Heparin? I don't understand that. 18 A. The amount of Heparin is excreted 19 by the liver and the kidney. And it is not 20 easy to get a Heparin level in a community 21 hospital. There are some research centers 22 where you can get an actual Heparin level. 23 Most often it is done by surgical testing. 24 But in a person who has kidney and 25 liver disease there may be more Heparin on</p>

<p style="text-align: right;">81</p> <p>1 board than is simply estimated on the basis of</p> <p>2 either the surrogate tests or the amount of</p> <p>3 Heparin that was given as a total amount and</p> <p>4 the half life of Heparin, which is about an</p> <p>5 hour and a half.</p> <p>6 Q. What does that mean?</p> <p>7 A. What it means is that there are</p> <p>8 many factors that go into that equation. And</p> <p>9 the factors are the amount of Heparin that is</p> <p>10 given, the test that is used which is a</p> <p>11 surrogate for Heparin and the metabolism of</p> <p>12 Heparin and the uniqueness of the patient's</p> <p>13 clinical condition.</p> <p>14 Q. Do you have any indication that</p> <p>15 Dr. Hulyakar entertained any of this?</p> <p>16 A. I don't know. I would imagine</p> <p>17 that in a patient who's bleeding, was on</p> <p>18 Heparin, when one considers continuing</p> <p>19 anti-coagulation these factors go into the</p> <p>20 assessment.</p> <p>21 Q. Certainly, Doctor, you would have</p> <p>22 expected that, to meet the standard of care,</p> <p>23 Dr. Hulyakar, at some time during the course of</p> <p>24 the evening, had to have considered utilizing</p> <p>25 protamine in an amount that would have been</p>	<p style="text-align: right;">82</p> <p>1 such that it would not have acted as an</p> <p>2 anti-coagulant in this patient, correct?</p> <p>3 A. No. I wouldn't. As I pointed out</p> <p>4 I'm not sure that I would have used protamine,</p> <p>5 or I would have recommended protamine in this</p> <p>6 patient. Prospectively, considering all the</p> <p>7 events that were happening.</p> <p>8 Q. What adverse reactions would you</p> <p>9 have expected from this patient? You say in</p> <p>10 terms of probability whether she would have had</p> <p>11 any adverse reactions to the administration of</p> <p>12 protamine?</p> <p>13 A. Well, I think as a premise, first</p> <p>14 off, I would not have recommended protamine.</p> <p>15 Q. Because it can act as</p> <p>16 anti-coagulant?</p> <p>17 A. No. Because I at least would have</p> <p>18 been following the patient, following vital</p> <p>19 signs and following fluid and blood</p> <p>20 replacement. And I believe that, in fact, her</p> <p>21 risk of thrombo embolic events were quite</p> <p>22 substantial.</p> <p>23 I do not believe that, in fact,</p> <p>24 giving protamine to this patient would have</p> <p>25 made any difference or would have changed the</p>
<p style="text-align: right;">83</p> <p>1 circumstances. I would not have recommended</p> <p>2 protamine.</p> <p>3 Q. And just so I understand, you talk</p> <p>4 in terms of acting as an anti-coagulant and you</p> <p>5 also talk in terms of other adverse reactions.</p> <p>6 You mentioned severe allergic reactions. Were</p> <p>7 there any other severe reactions that one could</p> <p>8 expect from the protamine?</p> <p>9 A. No. Certainly the literature is</p> <p>10 replete with protamine adverse events including</p> <p>11 people dying from the administration of</p> <p>12 protamine. The cardiovascular literature has</p> <p>13 many articles about this. In fact --</p> <p>14 Q. What severe reactions would you</p> <p>15 have been concerned about in this patient, just</p> <p>16 so I understand your testimony?</p> <p>17 A. Well, I was talking about,</p> <p>18 generically, about protamine. As I pointed out</p> <p>19 it is associated with and can be associated</p> <p>20 with anaphylactic reactions which further drop</p> <p>21 blood pressure.</p> <p>22 Q. Okay. What else?</p> <p>23 A. Well, I think I've already</p> <p>24 mentioned its potential if excess is given for</p> <p>25 anti-coagulation.</p>	<p style="text-align: right;">84</p> <p>1 Q. Anything else?</p> <p>2 A. No. Those are the main ones.</p> <p>3 Q. Any minor ones?</p> <p>4 A. Well, I think in any person</p> <p>5 getting any medication there are always</p> <p>6 idiosyncratic reactions but I think we've</p> <p>7 spoken about the reactions.</p> <p>8 Q. Doctor, if Mrs. Robinson had not</p> <p>9 been on Heparin following the procedure on the</p> <p>10 27th could we agree it's more likely than not</p> <p>11 that she would not have experienced this bleed</p> <p>12 that would have or that had led to her death?</p> <p>13 MS. CARULAS: Note my objection.</p> <p>14 Go ahead.</p> <p>15 A. No. We can't agree with that.</p> <p>16 Q. Okay. Why not?</p> <p>17 A. Because needle punctures into</p> <p>18 vessels would certainly have or can cause</p> <p>19 bleeding into the tissues. And I think I've</p> <p>20 already articulated that I'm not sure what the</p> <p>21 cause of the retroperitoneal bleed was. And it</p> <p>22 may have indeed been related to the vessel</p> <p>23 punctures. I cannot say whether it was that</p> <p>24 versus the Heparin. So I can't agree with</p> <p>25 that.</p>

<p style="text-align: right;">85</p> <p>1 Q. You're telling me that if she had 2 not been on Heparin during this hospitalization 3 that it's more likely than not that the 4 puncture in the femoral vein area would have 5 bled to this extent anyways? Is that what 6 you're saying? 7 A. No, that's not what I'm saying. 8 Q. Okay. 9 A. I think originally you asked me a 10 question as to what was the cause of the 11 retroperitoneal bleed. And I answered that I 12 don't know exactly what the cause. But there 13 are several possibilities. One of the 14 possibilities was spontaneous bleed from the 15 anti-coagulation. 16 Q. Okay. 17 A. Then another was that it was a 18 bleed from the puncture site which either 19 stopped or possibly re-bled. But I really 20 don't know which was the reason for the bleed. 21 And I think in this hypothetical I 22 cannot discriminate in terms of what the cause 23 was so I certainly cannot say that she wouldn't 24 have bled had she not been on Heparin. 25 Q. Okay. I understand. Hold on a</p>	<p style="text-align: right;">86</p> <p>1 minute. Let me review my notes, Doctor. I may 2 almost be done with you. 3 Does anybody else have any 4 questions of the doctor while I'm reviewing 5 this? 6 MS. PETRELLO: No. 7 MR. HUDAK: No. 8 Q. Okay. I'm going to put the phone 9 down for just a moment. Doctor, are you still 10 there? 11 A. Yes. 12 Q. Let me just ask you, again, 13 hypothetically, you learned what Dr. Hulyakar 14 learned with regard to this patient as of 10:30 15 or so that evening on the 5th. It's your 16 patient, okay -- and Ann, I understand your 17 objection -- what would you have done in this 18 scenario? 19 MS. CARULAS: Note my objection. 20 A. I certainly would have stopped the 21 Heparin as was done subsequently. And I would 22 have continued to do what the physicians did at 23 that time. As I've already answered it would 24 be my practice to get a hemoglobin/hematocrit. 25 But otherwise I would have done pretty much</p>
<p style="text-align: right;">87</p> <p>1 what they did. 2 Q. Hold on a minute. And, Doctor, 3 just -- I think I know what you're going to say 4 and where you're going but I have to ask you 5 your opinion with regard to her life span. Two 6 more years. Why do you say that? 7 A. Well, I think that was being 8 generous. I think what I said was -- 9 Q. I think you said at most two more 10 years? 11 A. At most. Yeah. I think that's 12 based on my knowledge of pathology and the 13 diseases that she has, or had. 14 Q. Was she hemodynamically stable 15 from 1:20 in the morning until six a.m. in the 16 morning? 17 A. On the 6th? 18 Q. On the 6th, yes. 19 A. No, I think she was 20 hemodynamically fragile. 21 Q. From when to when? 22 A. Well, I think it's apparent 23 obviously when her blood pressures were low. 24 Q. When were her blood pressures low? 25 And I'm talking about after she presents to the</p>	<p style="text-align: right;">88</p> <p>1 CCU at 1:30 in the morning? 2 A. I'm just going to refer to the 3 vital sign monitoring. 4 Q. Yeah. Please go ahead. 5 A. Okay. There's a flow sheet termed 6 critical care flow sheet which I'm looking at 7 now. 8 Q. Okay. 9 A. And this is obviously what you're 10 referring to 1:30 in the morning. Up until 11 nearly 10 in the morning, I guess it was nine, 12 9:05, there are values for blood pressure. And 13 it's apparent that at least with some of the 14 resuscitative measures when she first presented 15 and was admitted to the ICU that her pressures 16 went up, that the pressure's up to about 17 actually 3:20, it dropped again below -- but in 18 actual fact at 4:30 there is a systolic reading 19 that looks like 130. But I'm not sure what 20 this diastolic is. It says 26. I can't 21 believe that. 22 Q. Why? 23 A. Because I think in general when 24 you have a diastolic of 26 you don't register a 25 diastolic. You might get a palpable systolic.</p>

<p style="text-align: right;">89</p> <p>1 Q. Okay.</p> <p>2 A. Especially with a systolic of 130.</p> <p>3 But, overall, the point being that there were</p> <p>4 attempts at resuscitation during this period</p> <p>5 and her blood pressures were not able to be</p> <p>6 sustained in any reasonable value. So that's</p> <p>7 the reason that I'm saying she was</p> <p>8 hemodynamically fragile and I guess you could</p> <p>9 say unstable certainly from beyond 3:20 in the</p> <p>10 morning.</p> <p>11 Q. At 3:20 in the morning would the</p> <p>12 administration of additional blood products</p> <p>13 have at least served to make her more stable</p> <p>14 than she was in terms of probability?</p> <p>15 MS. CARULAS: Objection. This has</p> <p>16 been gone over extensively but go ahead one</p> <p>17 more time. And then you'll let me get my</p> <p>18 plane, right?</p> <p>19 Q. Yeah.</p> <p>20 A. I actually don't believe so.</p> <p>21 Because I think at this point in time she is</p> <p>22 shocked, her reserve probably is really quite</p> <p>23 depleted and even the administration of</p> <p>24 additional blood products probably would not --</p> <p>25 more probable than not, I should say, have made</p>	<p style="text-align: right;">90</p> <p>1 any difference.</p> <p>2 Q. Would they possibly have made any</p> <p>3 difference?</p> <p>4 A. I don't know.</p> <p>5 Q. All right. Doctor, that's all I</p> <p>6 have.</p> <p>7 A. Thank you.</p> <p>8 Q. Thank you, Doctor. Thank you for</p> <p>9 the time.</p> <p>10 MS. PETRELLO: I have no</p> <p>11 questions.</p> <p>12 MR. HUDAK: Nor do I.</p> <p>13 MS. CARULAS: You have the right</p> <p>14 to read over the transcript to make sure it's</p> <p>15 been taken down accurate on your behalf. It's</p> <p>16 your option.</p> <p>17 THE WITNESS: I'll waive it.</p> <p>18</p> <p>19 (Signature waived)</p> <p>20 RONALD SACHER, M.D.</p> <p>21 ---</p> <p>22 (DEPOSITION CONCLUDED AT 2:15 P.M.)</p> <p>23 ---</p> <p>24</p> <p>25</p>
<p style="text-align: right;">91</p> <p>1 CERTIFICATE</p> <p>2 STATE OF OHIO</p> <p>3 : SS</p> <p>4 COUNTY OF HAMILTON</p> <p>5 I, Valerie Jones Conn, the undersigned,</p> <p>6 a duly qualified notary public within and for</p> <p>7 the State of Ohio, do hereby certify that</p> <p>8 RONALD SACHER, M.D. was by me first duly sworn</p> <p>9 to depose the truth and nothing but the truth;</p> <p>10 foregoing is the deposition given at said time</p> <p>11 and place by said witness; deposition was taken</p> <p>12 pursuant to stipulations hereinbefore set</p> <p>13 forth; deposition was taken by me in stenotypy</p> <p>14 and transcribed by me by means of computer;</p> <p>15 deposition was submitted to the witness for</p> <p>16 examination and signature; I am neither a</p> <p>17 relative or any of the parties or any of their</p> <p>18 counsel; I am not, nor is the court reporting</p> <p>19 firm with which I am affiliated, under a</p> <p>20 contract as defined in Civil Rule 28(D) and</p> <p>21 have no financial interest in the result of</p> <p>22 this action.</p> <p>23 IN WITNESS WHEREOF, I have hereunto set</p> <p>24 my hand and official seal of office at</p> <p>25 Cincinnati, Ohio, this ____ day of _____,</p> <p>2001.</p> <p>26 _____</p> <p>27 My commission expires Valerie Jones Conn, RPR</p> <p>28 September 4, 2002 Notary Public - State of Ohio</p>	

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