IN THE COURT OF COMMON PLEAS OF CUYAHOGA COUNTY, OHIO

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Lester Weitzel, executrix of the: Estate of Sharon Weitzel, deceased, and Lester Weitzel,

Doc 4/19

Plaintiffs, :

vs. : Case No. **226946**

Saint Vincent Charity Hospital, : et al.,

Defendants.

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DEPOSITION

of William L. Smead, M.D., a witness called on behalf of the Defendant Prem Varma, M.D., taken before me, Kendra E. Johnston, a Notary Public in and for the State of Ohio, pursuant to notice, at the Ohio State University Hospitals, Doan Hall, **410** West Tenth Avenue, Columbus, Ohio, on Monday, May 10, **1993**, at 5:00 o'clock, P.M.

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APPEARANCES:

Charles I. Kampinski Co., L.P.A.,
By Mr. Charles I, Kampinski,
1530 Standard Building,
Cleveland, Ohio **44113**,

On behalf of the Plaintiffs.

Gallagher, Sharp, Fulton & Norman,
By Mr. Burton J. Fulton and Ms. Lynn L. Moore,
Seventh Floor,
Bulkley Building,
Cleveland, Ohio **44115**,

On behalf of the Defendant Prem Varma, M.D.

Barker & Hostetler,
By Mr. Ronald S. Okada,
3200 National City Center,
Cleveland, Ohio **44114**,

On behalf of the Defendant Cleveland Clinic Foundation.

Jacobson, Maynard, Tuschman & Kalur,
By Mr. Joseph A. Farchione, Jr.,
1001 Lakeside Avenue,
Suite **1600**,
Cleveland, Ohio **44114**,

On behalf of the Defendant Dr. Steele.

William J. Coyne Co., L.P.A.,
By Mr. Martin Franey,
1240 Standard Building,
Cleveland, Ohio **44113**,

On behalf of the Defendants Saint Vincent Charity Hospital, Dr. Jayne, Dr. Mohlay, Dr. Onyekwere and Dr. Mayha.

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APPEARANCES (Continued):

Jacobson, Maynard, Tuschman & Kalur,
By Mr. Robert C. Seibel,
1001 Lakeside Avenue,
Suite 1600,
Cleveland, Ohio 44114,

On behalf of the Defendant Dr. Moasis.

ALSO PRESENT:

Doug Clark, Video Reporter

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Monday Evening Session,

May 10, 1993.

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STIPULATIONS

It is stipulated by and among counsel for the respective parties that the deposition of William L. Smead, M.D., a witness called on behalf of the Defendant Prem Varma, M.D., may be taken at this time and reduced to writing in stenotypy by the Notary, whose notes thereafter may be transcribed out of the presence of the witness; that proof of the official character and qualification of the Notary is waived; and that the examination, reading and signature of the said William L. Smead, M.D., to the transcript of his deposition are waived by counsel and the witness; said deposition to have the same force and effect as though signed by the said William L. Smead, M.D.

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(EXHIBITS MARKED FOR IDENTIFICATION.)

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WILLIAM L. SMEAD, M.D.

being by me first duly sworn, as hereinafter certified, deposes and says as follows:

EXAMINATION

By Mr. Fulton:

Q. Would you please state your name, sir.

A. William Lewis Smead.

Q. Would you tell us your occupation?

A. I'm a teacher of surgery at The Ohio State University.

Q. Do you specialize in any particular part of surgery?

A. General vascular surgery.

Q. And what is general vascular surgery?

A. It's the treatment of diseases of the arteries, veins and the lymphatics, virtually everywhere in the body beyond the heart.

Q. Well, Doctor, I'd like to, for the jury and the court, to have a little bit of your personal background, and would you tell us -- let's start with your birthplace. Where were you born, sir?

A. I was born in Hartsdale, New York.

Q. Let's skip through high school to your college.

Where did you attend college?

A. Went to Amherst College in Amherst, Massachusetts.

Q. And did you graduate there with honors, sir?

A. I graduated cum laude.

Q. And did you then go on to medical school?

A. Yes.

Q. And where was that?

A. Vanderbilt University School of Medicine.

Q. And would you tell the court and jury your rank in class when you graduated from Vanderbilt?

A. I was the Founder's Medalist, which signifies first in the class.

Q. And after that, would you tell us what you did after graduating from Vanderbilt?

A. Well, I did my internship and residency at the Massachusetts General Hospital in Boston, Massachusetts.

Q. And thereafter?

A. Then I came here as an assistant professor in surgery with the Ohio State University in 1978.

Q. And you've been here since 1978?

A. That's correct.

Q. And you are certified, what they call board certified; is that not true?

A. I am.

Q. And tell the court and jury what board certification is, I mean how you -- this comes about.

A. Well, I'm board certified in -- in general surgery.

In order to apply to take the examination given by the American Board of Surgery, one must have completed and be certified by an accredited general surgical training program, which I was. One takes a written examination. If one passes that, you're eligible for an oral examination, and if you pass that, then you are board certified in general surgery.

Several years, perhaps five years after I had been board certified in general surgery, a new subspecialty certification was developed for general vascular surgery, and I was certified as a, quote, grandfather, having completed training in general and vascular surgery and then had performed a requisite number of -- of cases per year in the two years prior to that exam. I think it was 100 cases per year.

I then took a written examination, passed that, and received a certificate for what was called at the time special qualifications in -- in vascular surgery, and have subsequently just this past year been recertified in general vascular surgery.

Q. What faculty appointments have you held or do

you now hold at Ohio State University?

A. Well, I have been an assistant professor of surgery, an associate professor of surgery, and about three years ago was named to the Luther M. Keith professorship in surgery.

Q. And what appointments do you have or -- in other words, are you in a position where you have to do any examination of other people applying for surgical privileges?

A. Well, as the chief of the Division of Vascular Surgery, I participate in the recruitment of all of our interns and residents into the general surgical program and also the recruitment of our resident in vascular surgery who spends two years with us following an accredited general surgical program.

As chief of staff of University Hospitals, I was in a position to -- on the Credentials Committee to review the qualifications for all members of the staff at University Hospitals and to participate in quality assurance activities and on two occasions have examined for the American Board of Surgery.

Q. And the American Board of Surgery is located where?

A. In Philadelphia, Pennsylvania. And it's the general board that accredits all surgeons in the United

States.

Q. And I guess, of course, in the meantime, you are a medical doctor here in the state of Ohio?

A. That's correct.

Q. Any other states that you presently hold licenses in, either in abeyance or --

A. Yeah, I -- I was licensed in Massachusetts prior to my coming here, but I've let that lapse.

Q. Incidentally, I'm going to hand you what has been marked Defendant's Exhibit Varma B, and just tell us what that is.

A. It's a copy of my curriculum vitae.

Q. All right. Now, on the -- in the back of that is listed a number of articles you have written. Without going into all of them, could you tell us approximately how many articles you have written?

A. Oh, approximately 50.

Q. And they deal in what areas?

A. Virtually all of them are in the field of general vascular surgery or a closely related field.

Q. All right. Would you tell the court and jury approximately what percentage of your time is spent in active clinical practice, in doing surgery, in doing teaching and so forth?

A. Well, it's sometimes difficult to make that

distinction because the teaching of surgery requires doing it, and in order to do it, one has to develop a large clinical practice. I also spend some time doing active research in the field of vascular surgery. But I would suspect that 90 percent of my time is spent either in the general practice of vascular surgery or in teaching it or both.

Q. And as part of your duties in teaching and in being engaged in vascular surgery, are you required to read various articles, keep up with the medical literature in your specific area?

A. I -- I read a large volume of literature virtually constantly in the field of vascular surgery and related fields. One also has -- always has to keep up ahead of the residents and surgeons -- and students on the service.

Q. All right. Now, directing ourselves to the case at hand, were you asked to review certain medical records, x-rays, and so forth regarding a Mrs. Weitzel who had been a patient at Saint Vincent Charity Hospital in Cleveland?

A. Yes, I was.

Q. And did you prepare a report with respect to that?

A. I did.

Q. And I'm handing you what has been marked Defendant's Exhibit Varma A, and what is that?

A. This is a copy of my letter addressed to you reviewing my opinions regarding this case.

Q. All right.

MR. SEIBEL: Objection.

Q. Let me ask you this. What -- just tell the court and jury what you received and what you reviewed before you wrote this letter and what, if anything, you've reviewed since then.

A. Well, I had received the hospital records from Saint Vincent Charity Hospital for the admission from February 12th, 1991 to March 15th, 1991. There were three volumes. I also received and reviewed depositions from Doctors Varma, Steele, Kitchen, Chmielewski and Moasis, and I also received some expert opinion letters from Doctors Mazal, Pitluk, Holland, VanAman, Kohn, Watts, Rollins, Rosenberg, Schultz, Buchter, Lach and Markowitz. I also received a copy of the autopsy report and some copies of assorted x-rays.

Q. And since preparing this report, do you recall offhand what you have reviewed?

A. I reviewed a -- about a one or -- a two-page copy of a emergency report I think from the referring hospital in Ashland.

MR. KAMPINSKI: Objection. Move to strike.

Q. All right. Did you also receive a copy of certain Ashland Hospital records, certain portions?

A. I have not reviewed any records from the Ashland Hospital.

Q. All right. Well, I'm handing you here what is entitled the "city of Ashland, Division of Fire, Emergency Medical Service Report." Is this what you're referring to as having reviewed?

A. Yes.

MR. KAMPINSKI: Excuse me, Mr. Fulton. I'm going to object to this document, and if you want, I'll object each and every time.

MR. FULTON: No. You can have a continuing objection.

MR. KAMPINSKI: All right.

MR. FULTON: I'm not going to go into it other than just asking him if he had a chance to review it.

MR. KAMPINSKI: I object.

THE VIDEOGRAPHER: We're off record.

(EXHIBIT MARKED FOR IDENTIFICATION.)

Q. Just for the purpose of the record here, Doctor, I'm handing you what has been marked Varma's Exhibit G. Is this the record you were referring to that you've had occasion to review?

A. That's correct.

Q. Since writing that report?

A. That's correct.

Q. And did you have occasion prior to your discovery deposition being taken to review any particular articles relating to what might be your opinions regarding Mrs. Weitzel's treatment?

A. Yes, I did.

Q. And I'm going to hand you what have been marked Varma's Exhibits C, D, E and F.

MR. KAMPINSKI: I'm going to object to the reference to various articles because they're clearly not admissible and allowed.

Q. Are these the articles you had occasion to --

MR. KAMPINSKI: Do you want me to have a continuing objection to these all?

MR. FULTON: Continuing objection. I'm not going to go into them. I'm just going to ask him if he -- yes, you can have a continuing objection.

MR. KAMPINSKI: Thank you.

Q. Are these the articles that you've had occasion to review in the past and just prior to your testimony being taken?

A. These are.

Q. All right. And had you not received a request

from me to have with you any of the literature that you might have utilized in coming -- arriving at your opinions prior to your deposition being taken for discovery?

A. Yes, you'd asked me to bring them with me.

Q. All right. Now, you have prepared a report in this case, have you not, sir?

A. I have.

Q. And you have reviewed the treatment received by Mrs. Weitzel over a period of time while at Saint Vincent's Charity Hospital and other documents which you have referred to, and I'm going to ask you certain opinions that you might have regarding her care and treatment, and in each case I want you to give your opinion based upon reasonable medical probability and certainty. Could you do that then, sir?

A. I can.

Q. All right. Did you come to certain opinions with respect to Mrs. Weitzel's treatment after you had reviewed these various records?

A. I did.

Q. And did you come to an opinion based again upon reasonable medical certainty and probability regarding her chance of survival?

A. I did come to that opinion.

Q. All right. And would you tell us what that opinion is, sir?

A. Well, I thought that on the basis of her initial event, cardiac arrest, and her subsequent complications, that her chance of leaving the hospital alive was significantly less than 50 percent.

Q. All right. And did you in reviewing the various records set forth what was the history of Mrs. Weitzel following her cardiac arrest while at work and her treatment at the hospital? Did you do that, sir, in your report?

A. Well, I -- I did not attempt in any but the most cursory fashion to review the sequence of events that occurred during her hospitalization.

Q. All right. Well, what was your history of the plaintiff prior to -- both before coming to the Saint Vincent Charity Hospital as well as while receiving treatment? What was your history that you had of her?

A. Well, my review of the records suggested that while at work on February llth, Mrs. Weitzel collapsed, and the squad was called. They arrived on the scene. A cardiopulmonary resuscitation was begun and continued for approximately 35 minutes, until she arrived in the hospital in Ashland, where her resuscitation continued to the point where she stabilized to some extent; that as

further complications, predominantly those of cardiac failure and serious ventricular arrhythmias, she was then transferred to Saint Vincent Charity Hospital for further care.

Q. Did she have various organ systems problems while at Charity?

A. Yes. She had evidence of involvement of most organ systems.

Q. And that would include what, for example?

A. Well, she had evidence of neurologic failure with an altered state of consciousness and multiple abnormal neurologic findings.

She had evidence of pulmonary failure, what's referred to as adult respiratory distress syndrome, or ARDS, relating to her initial cardiac arrest and undoubtedly relating to bilateral pneumonia from a multitude of organisms. These required prolonged ventilation and, in fact, tracheostomy.

She had some evidence of kidney dysfunction with elevation of the blood urea nitrogen and creatinine level.

She had elevated liver function studies and a large liver, which suggested dysfunction of the liver, the major metabolic organ of the body.

Q. All right. Now, Doctor, with respect to the

opinion you have rendered regarding her chance of survivability, tell us what you base that on. Is that based upon your own experience with patients?

A. Yes, in large part.

Q. All right. And was it based upon anything else?

A. Well, it's based upon the medical literature, which has done several things. One is the --

MR. KAMPINSKI: Excuse me, Doctor. I'm going to object at this point and move that his opinion be stricken.

MR. FULTON: Go ahead. Go ahead, Doctor.

A. Obviously, as a physician, one bases many opinions upon the medical literature. That's where we develop the scientific data on which accurate opinions can be based.

Based on the literature, there have been several scoring systems developed to allow physicians to try to predict a patient's survivability based upon certain pieces of clinical data.

Q. And with respect to Mrs. Weitzel, in your opinion, again based upon reasonable medical probability and certainty, regarding her chance of survival were what, sir?

MR. KAMPINSKI: Objection.

A. In my opinion, the -- based upon my own

experience plus the experience related in the literature, that her survivabil ty was less than 50 percent.

Q. And has your own experience included treating patients with the problems such as were demonstrated in Mrs. Weitzel?

A. Yes.

Q. And that's been over a period of what time, sir?

A. Well, my first year in active clinical medicine as an M.D. was 1972, so that would be 21 years.

Q. Now, in the review of the records, you found that there were intraluminal guidewires that were in the body of Mrs. Weitzel, did you not?

A. That's correct.

Q. And from reading the records, what was revealed to you with respect to the method in which these particular wires had been removed or attempted to be removed?

A. Well, there was a single attempt to remove the wires percutaneously with a -- I think a biopsy forcep. One of the wires was successfully removed in that fashion. The second could not be retrieved. And the patient subsequently was taken to the operating room where the surgeon removed the second wire.

Q. All right. Now, before I ask you certain of your opinions, have you had experience with respect to

the removal of such wires from an individual?

A. Yes, I have.

Q. And would you tell the court and jury what your experience has been?

A. Well, over the past five years, I'd say, I've been referred perhaps six to eight patients per year from a variety of sources with intraluminal foreign bodies and have been in a position to make a decision about their extraction.

Q. And what has your experience been as to the means of extracting such wires?

A. I've referred all of these patients to our interventional radiologists, who have been able to successfully remove all of the wires using minimally invasive techniques. There was one exception. There was a wire that -- where a significant portion of the -- the catheter was outside the vascular system between the vessel and the skin, and we under local anesthesia made a small cut down, grabbed the wire and removed it in that fashion. All the remaining wires were removed percutaneously.

Q. And there was no need of any of these removals, even the one you just have mentioned, to utilize general anesthesia?

A. No, I have not had any experience with removing

these under general anesthesia.

Q. Having reviewed the chart and based upon your experience in this area, did you come to an opinion, again based upon reasonable medical probability and certainty, as to whether another means of attempt of removal should have been undertaken in the case of Mrs. Weitzel?

MR. KAMPINSKI: Objection.

MR. FARCHIONE: Objection.

A. I do have an opinion.

Q. All right. Tell us what that opinion is.

MR. SEIBEL: Move to strike.

A. Well, my personal approach or recommendation, had I been consulted at this time, would have made -- been to make another attempt to remove the wire percutaneously. If that expertise or experience was not available in my hospital, I would have considered referring the patient to a hospital where that expertise or experience was available.

MR. FARCHIONE: Move to strike.

Q. And again, and this opinion you've just given here again is based upon reasonable medical certainty and probability, again based upon your experience as a vascular surgeon here at Ohio State?

A. Yeah, based on my experience, I would expect

there would be a very high likelihood of successful retrieval of a wire short of surgery under general anesthesia and would have thought that a second attempt would have been preferable to proceeding to the operating room.

MR. SEIBEL: Objection.

Q. You had a chance, did you not, to review at

Q. And we know that the percutaneous removal of the first wire was on March 13th. Could you tell us with respect to the position of these wires whether, having reviewed those x-rays, there was any signs of any migration of the -- the wires in your opinion?

A. No, I didn't see any evidence of significant migration.

Q. In reviewing the chart of Mrs. Weitzel and the other records you've referred to, did you arrive at an opinion with respect to the operative mortality rate in patients who have had the problems that Mrs. Weitzel had during -- both before and after she was at Saint Vincent Charity Hospital?

A. I do have an opinion.

Q. And is that opinion based upon reasonable medical certainty and probability?

A. It is.

Q. And tell us what that opinion is.

A. Well, I -- as I said before, I think that this patient's in-hospital mortality exceeded 50 percent, so clearly if this patient is then taken to the operating room, the mortality rate must -- must be greater than 50 percent.

In a very general way, there are several classic articles in the literature looking at postoperative mortality following myocardial infarction where the very clear trend is for decreasing mortality the longer one waits between the myocardial infarction and the surgical procedure. In the roughest way, mortality rates, all comers for major surgery at three months following myocardial infarction, is 30 percent at six months, 15 percent, and thereafter perhaps six percent. Those numbers have trended somewhat downward, but in all cases of which I'm aware, the basic premise is that the longer one can wait between myocardial infarction and operation, the safer that operation will be.

MR. KAMPINSKI: I'll object and move to strike the portion of the doctor's testimony as it related to his opinion with respect to his -- her mortality prior to the operation for the same reasons that I objected earlier to that opinion.

Q. Had you -- I'm talking about yourself -- been called in as a vascular surgeon under these circumstances and knowing what you know about Mrs. Weitzel, would you have commenced surgical intervention to retrieve that wire as was done in this particular case?

MR. SEIBEL: Objection. Move to strike.

MR. FARCHIONE: Objection.

MR. FULTON: Go ahead.

A. Given the information that I've been able to review, her entire medical record, my recommendation would have been to make another attempt or even two at percutaneous retrieval.

Q. All right. And again, that opinion is based upon reasonable medical certainty and probability and your experience in this particular area of percutaneous removal of such wires?

MR. SEIBEL: Objection.

A. Yes.

MR. FARCHIONE: Objection. Move to strike.

Q. Now, did you, after reviewing the records you have referred to, arrive at an opinion as to what effect the retention of these guidewires had upon her, Mrs. Weitzel's, chance of survival?

A. I do have an opinion.

Q. All right. And again, is that opinion based

upon reasonable medical certainty and probability?

A. It is.

Q. And tell us what that opinion is, sir.

A. Well, up to the time of her -- her death, neither of the two guidewires had produced a complication which would have shortened her life expectancy.

Q. And your opinion would be what with respect to whether the retention of these wires did change her chances of survival?

A. Well, I think in that sense, they did not affect the chances of her survival. The fact that she had retained guidewires clearly led to a decision to perform an operation, the complications of which resulted in her death.

Q. And you had a chance, I believe, in addition to reviewing all the medical records, I think you did state the autopsy report also, did you not?

A. Yes, I did review that.

Q. Would you tell us in, I guess in simplistic terms, in kind of lay terms, what was the cause of the death of Mrs. Weitzel?

A. Well, the -- the autopsy doesn't provide on the basis of the gross or microscopic evaluation a definitive cause for death.

This patient had bled from the surgical site an

amount of blood equal to about 500 cc's or unit of blood, and I think that was contributory, although that's not a remarkably large amount of postoperative hemorrhage.

On the basis of her history and her clinical course and the autopsy findings, it would be my opinion that she suffered another myocardial infarction or arrhythmia related to her previous infarction which then led to her death.

MR. KAMPINSKI: I'm going to object and move to strike. That's not mentioned in his report. It wasn't set forth in his previous deposition. Apparently that's something new and that we had no knowledge of prior to coming here today.

Q. And this last area. Had Mrs. Weitzel survived this hospitalization, assuming that she had -- you addressed certain areas of that -- do you have an opinion based upon reasonable medical certainty as to what her quality or length of life would be?

MR. KAMPINSKI: Objection.

A. I do have an opinion.

Q. And is it based upon reasonable medical certainty and probability?

A. It is.

Q. And what is that, sir?

A. I think that it's most likely that Mrs. Weitzel

would have a severely compromised quality of life.

Q. And again, that's based upon what, sir? And that's my last question.

A. Based upon my personal experience and based upon data developed in the medical literature.

MR. KAMPINSKI: Objection and move to strike.

Q. And was it also based upon reviewing the various complications and problems that she had while in the hospital?

A. That's correct.

Q. And prior to her admission thereto?

A. That's correct.

MR. FULTON: No further questions. Can we take a --

MR. KAMPINSKI: No. We can keep going. I'm ready.

MR. FULTON: I just wanted -- I wanted to take a second, though.

MR. KAMPINSKI: Why?

MR. FULTON: Because I wanted to get a cup of coffee.

THE VIDEOGRAPHER: Off the record.

(Recess taken.)

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EXAMINATION

By Mr. Kampinski:

Q. Doctor, my name is Charles Kampinski. I represent the plaintiff in this case, the estate of Mrs. Weitzel.

Have you ever been retained by the law firm of Gallagher, Sharp, Fulton & Norman before?

A. I have been reminded just prior to this ceremony that I had been involved in a case on the other side of the issue with -- with that firm in the -- approximately ten years ago. I had been asked that question at the deposition and had no specific recollection, but I have been reminded today that I was retained I think by the plaintiff in a case where Mr. Fulton's firm was representing the defendant.

Q. No. My question was had you ever been retained by Mr. Fulton's firm as an expert before?

A. Not to my knowledge.

Q. Well, the reason I ask that is because I have a report of yours, Doctor. Could you tell the jury what that is?

A. It's a letter, an opinion letter, to an attorney I guess in the same firm regarding a -- another legal case regarding the breakage of a Surgilene suture used during abdominal surgery. I had not recollected this

case.

Q. Well, and here is -- here is your deposition, Doctor, in that same case; correct?

A. It is?

Q. Yes. Taken September 21st, 1990, by me.

A. That's correct.

MR. FULTON: Let me take a look.

Q. Which is the only reason I knew about it, Doctor. In other words, you were retained by their firm to be an expert in another case in Cleveland; correct?

A. That's correct.

Q. All right. Are there any others that -- that you don't recall at the moment?

A. I -- you asked me whether I had recalled them and I answered honestly that I had not recalled it, and clearly I was in error. There are no other cases of which I'm aware.

Q. How about the firm of Jacobson, Maynard, Tuschman & Kalur; have they retained you as an expert on their behalf?

A. They have.

Q. Approximately how many times, sir?

A. Approximately four or five times, I would guess

Q. Doctor, you testified in direct examination as to which materials you had reviewed prior to preparing

your report; right?

A. I did.

Q. And there were a number of depositions. I think you said Dr. Varma, Steele, Kitchen, Chmielewski and Moasis; correct?

A. That's correct.

Q. All right. Did you have any input into which depositions you were sent to review? I mean did you request certain ones, or did you just get a package and say "Would you please review these and give us an opinion"?

A. I got a very large cardboard box delivered to my office that retained those depositions. I requested no specific ones.

Q. All right. After -- after you looked at the medical chart and reviewed those depositions, did you ask for any additional depositions --

A. No.

Q. -- to review?

All right. You were aware, I take it, that there were other physicians who had been deposed in this case, or were you?

A. I was not.

Q. All right. You've rendered opinions about various organs of Mrs. Weitzel, for example, the heart,

the lungs, I think neurologically, and liver and kidneys; correct?

A. That's correct.

Q. Do you know whether or not there was a specialist taking care of her lungs?

A. I don't recollect specifically a pulmonologist. I do -- I am aware that the infectious disease expert, Dr. Chmielewski, was intensively involved in the management of her various pulmonary infections, and doctor -- Doctors Steele and Kitchen as cardiologists clearly have expertise with regard to pulmonary function.

Q. Well, if there had been a pulmonologist involved, would it have been important for you to have looked at his testimony?

A. It might well have been helpful.

Q. Well, I mean, would it be important for your opinion to know what his belief, that is the treating pulmonologist, was with respect to how long, for example, she'd be on a ventilator?

A. It might be helpful information. It's unlikely, given my intensive and long-standing experience with patients with this problem, that it would alter my opinion.

Q. Well, I assume you would defer in terms of the clinical situation of a patient to the treating

physicians, would you not? They were there. They saw her. They were dealing with her.

MR. FULTON: Objection,

A. Only in part.

Q. All right, So whether or not the pulmonologist believed she'd be weaned from the ventilator has no impact on you in terms of your opinion; correct?

A. Oh, it would have some -- some impact.

Q. Well --

A. If -- if he told me that this patient could predictably be weaned on the day or within a week following her death, I would not believe that opinion based upon the information provided in the chart, based upon my extensive experience with patients in similar circumstances. So it would depend a bit on what the opinion was and whether it agreed with my -- my experience.

Q. Uh-huh. Okay. If he was right, though -- let's assume that was his opinion, and if he was right, would that impact your opinion?

A. Well, if he were correct, surely.

Q. How would it impact your opinion?

A. Perhaps I could ask you what opinion --

Q. Well, let's say this --

A. -- you're asking me about.

Q. Sure. Sure. Let's assume -- I'll ask you to assume that his opinion was that she would have been weaned off the ventilator within two weeks of her -- of the time that she did, in fact, die. How would that alter your opinion, sir?

MR. FULTON: Objection.

A. Well, that would be a surprising opinion, but clearly, as solutions were found to her various organ systems failure, that would perhaps improve her chances of surviving the hospitalization.

Q. Well --

A. And would improve the -- the quality of her subsequent life.

Q. And when you say improve, to what degree? I mean, I assume -- and correct me if I'm wrong -- that that's one of the major factors that goes into your opinion regarding her survivability.

A. One of many major factors that goes into making that opinion.

Q. Yeah. And that's -- that's a major one, isn't it, Doctor?

A. Yes, it's a major organ system.

Q. **All** right. **So** how -- how would that then impact in term -- or can you quantify it?

A. I couldn't quantify it specifically.

Q. Okay. That's one of the four organ systems that I believe you commented on; correct?

A. That would certainly be one of the major organ systems that would have led to my opinion that she had a high mortality risk.

Q. Yeah. In your report, sir, you stated the following thing: "She developed septic complications early in her hospitalization and required prolonged antibiotic therapy until her death." Did I read that correctly?

A. That is correct.

Q. All right. And that was -- you wrote that after careful review of the chart; correct?

A. That's correct.

Q. Would you please tell the jury whether or not she was on antibiotic therapy at the time that she underwent surgery on the 13th?

A. There was a brief period of time immediately prior to that operation where she -- where I think all but one of her antibiotics were discontinued. I would be very surprised if the surgery was undertaken without reinstituting the antibiotics prior to that -- that time.

Q. Well, one of the depositions that you were provided was Dr. Chmielewski's; right?

A. That's correct.

Q. And you recall his testimony, don't you, Doctor, indicating that antibiotics had, in fact, been stopped, I believe, on the 9th of March?

MR. FULTON: I have an objection unless you specifically refer to something.

Q. Well, do you recall that, sir?

A. Yeah. I think I just told you that they had been discontinued for a period of time immediately prior to her operation.

Q. Well, that's four days. I mean, you don't discontinue antibiotics on someone who's septic, do you?

A. Yes. Well, not who's septic, but one of the strategies in a patient with multiple infections requiring multiple antibiotics -- and at one point I think she was on as many as six different antibiotics -- that if one is not getting a clinical response in terms of lowering white blood count, defervescence of her fever or clinical improvement, is to discontinue the antibiotics entirely, culture the patient intensively for several days in an effort to identify the specific organism contributing to the persistent septic course.

It's also not uncommon that patients who have persistent fever on antibiotics do so because of drug fever, and one of the ways to sort that issue out is to discontinue the -- the drugs and see what happens to the

fever course.

Q. Doctor, was that the reason Dr. Chmielewski discontinued them or was it because there was no blood infection, she wasn't febrile, and the cultures looked clear up until that point, and isn't it a fact, sir, that it was his opinion that the reason for her elevated white blood count was the steroids that she was on?

MR. FULTON: Objection.

A. I don't recollect his -- his deposition in perhaps that great detail.

This patient did have multiple positive cultures from catheter tips, sputum, urine, et cetera, throughout her hospitalization, at least as recorded in the -- the laboratory section of her chart.

Q. Uh-huh. So it's your testimony that he didn't discontinue the antibiotics because her cultures had been clean since February 28th? Is that your testimony, Doctor?

A. No. I think -- I think the -- the decision to stop her antibiotics was a -- was a logical one based -- at that time based upon the information available.

Q. Well --

A. You're suggesting -- you're suggesting to me that this patient, who's been in the hospital since 2-11-91 until four days prior to her operation, on

antibiotics that entire period of time, that my statement that she was persistently septic for that period of time is incorrect, and I would be willing to stand corrected that all but four of the days from her cardiac arrest were on antibiotics and that those four days were off antibiotics.

Q. Are there any other statements in your report that you wish to correct before I continue?

MR. FULTON: Objection.

Q. Or do you believe --

MR. FULTON: It's not a correction.

Q. Do you believe that the rest of them are accurate?

A. I think it's a generally accurate letter based upon my review of the information available to me.

Q. Okay. Well, that's -- that may be all well and good. We've already established some of the information wasn't provided. For example, Dr. Sopko's deposition, who was the pulmonologist, that you didn't have an opportunity to review, did you?

A. I did not.

Q. Do you know why you weren't sent that deposition, Doctor?

A. No, I do not.

Q. Were you sent the depositions of any of the

experts in this case?

MR. FULTON: What do you mean experts?

MR. KAMPINSKI: Any of the experts.

A. No.

Q. Okay. You haven't had an opportunity to have read Dr. Markowitz's deposition testimony?

A. No, I have not.

Q. Have you been told what he testified to?

A. Not really.

Q. You would disagree with him in -- or would you disagree with him in terms of his testimony that at the time that the decision was made to do surgery on Mrs. Weitzel, that she was getting better?

MR. FULTON: Objection. I don't think that's quite what he said.

Q. Do you disagree with that opinion?

A. No. I think if -- if his testimony is that she was getting better at the time of her operation as compared to her previous course, I think that's -- that would be an accurate statement. She started out her clinical syndrome, of course, dead with asystole and then ventricular fibrillation, so that it clearly -- you know, at the time of her operation, she was considerably better than she was at the onset of her illness.

Q. With respect to her neurological status, Doctor,

was that one of the things that went into your opinion with respect to her probable survivability?

A. That's correct, it is.

Q. And what was her neurological status prior to the operation?

A. Well, it was somewhat difficult to be certain of her precise neurologic status immediately prior to her operation at least on the basis of information recorded in the chart, which was the only information, of course, available to me.

There were scattered comments in the record I think as late as the 11th of March that suggested that she was obtunded, lethargic, which are statements suggesting profound neurologic dysfunction.

She was admittedly being given drugs like pancuronium to -- to paralyze her to allow her to be ventilated, which would influence a neurologic exam, and on a drug called Versed, which would likewise significantly affect a physician's ability to accurately comment on her neurologic status.

Q. Then why in the world would you mention that in terms of analysis of her neurological status to the jury if in fact she was under neuromuscular blocks as well as Versed, which would make it impossible at that time, at that time, the time you're citing to the jury, to assess

her neurological status?

MR. FULTON: Objection, because he didn't say it was impossible.

A. Well, the -- there are two comments I would make to that. One was that all of these drugs were discontinued, at least as I can tell from reviewing the record, on the 11th of March, and she was allowed to -- those drugs were allowed to be metabolized, and that would allow her reexamination.

Pancuronium is a drug which has a half-life of about two hours, and would, therefore, be expected to be -- its effects would be expected to be gone substantially within 24 hours. It's predominantly excreted by the liver 80 percent and 20 percent by the kidneys, so that there was an opportunity to review her neurologic status and following its discontinuation and prior to the operation on the 14th.

The other issue which I think is important to mention is that the basis of this opinion and prediction of poor outcome, mortality, is based upon her neurologic status as it is recorded and reported in the chart at the onset of her hospitalization. The literature to which I referred earlier provides a system by which one can predict survivability based upon information at the time of admission to the hospital.

MR. KAMPINSKI: Objection. Move to strike, Doctor.

MR. FULTON: Well, I move it to stay.

MR. KAMPINSKI: Why? Because of his cute attempt to interject the literature; is that right, Mr. Fulton?

MR. FULTON: No. Because you don't like the answer.

MR. KAMPINSKI: No. Because it wasn't responsive to the question that I asked.

MR. FULTON: I thought it was responsive.

Q. With respect to the drugs being stopped, Doctor, how did your careful review of the record reflect how long the drugs and which drugs are you referring to were stopped?

A. Pancuronium and Versed.

Q. When were they stopped and for how long?

A. Well, on the 11th of March, my review of the physician's orders, there was a note to DC those drugs, and I don't see any second order to resume them.

Q. Well, who is it that discontinued them and who assessed her neurological status?

A. I don't recollect.

Q. Wouldn't that be important in terms of trying to analyze what her neurological status was, to see what the

physician who actually assessed it had to say about it?

A. I said that that would be valuable information. I can review the record.

Q. Would you?

A. The exact doctor who discontinued them of course would be largely irrelevant as long as that was -- that was done.

Q. I think that would be a note on March 12th, Doctor.

MR. FULTON: What would be?

MR. KAMPINSKI: The person who analyzed her neurological status.

MR. FULTON: Are you talking about March 12th or are you talking about her admission?

A. Yeah, on 2-11-91, a note by someone with an illegible signature with an M.D. after it writes "Neuromuscular blockade and sedation will be discontinued."

Patient was also given Robinul and neostigmine, which are agents given in attempt to actually pharmacologically reverse the paralyzation, at which point she had positive doll's eye.

Q. Would you refer to what you're reading, Doctor?

A. I'm reading a note on March 12th, 1991, at 9:30.

Q. And whose note is that, sir?

A. I think a Dr. R. Fritz, countersigned by Dr. Rollins.

Q. And who's Dr. Rollins?

A. Dr. Rollins was a physician consulted in this case, internist.

Q. Was he a cardiologist?

A. Yes.

Q. Were you given his deposition to read, sir?

A. If I didn't have it on this list as depositions I reviewed, then I didn't see it. No, I did not.

Q. Do you know why?

A. No.

Q. Okay. You were about to read that particular note.

A. Yeah. He said the patient demonstrated positive --

Q. Well, before he says that, how long was the medication removed for?

A. Well, that --

Q. Why don't you read the note.

A. Several hours, somewhere between **3-11-91**, where it said neuromuscular blockade and sedation will be discontinued --

Q. Would you read --

A. -- which is not dated with a time, until **3-12-91**

at 9:30 a.m., that interval, and I can't determine --

Q. Would you read the note the way it's written, sir?

A. I'd be glad to.

Q. Thank you.

A. "Patient given 0.4 milligrams Robinul and four milligrams neostigmine over five-minute period."

Q. And what was that given for? Why were those drugs given?

A. They were given to reverse the paralyzing agent pancuronium.

Q. So that was given over a five-minute period?

A. That's correct.

Q. Okay. Go ahead.

A. "Patient represented positive doll's eye and blink reflex and moved left arm apparently on command. Discussed with medical residents and will restart Versed drip for sedation until Norcuron is worn off."

Q. Is that a good sign, the positive doll's eye, blink reflex and moving left arm apparently on command?

A. Moving the left arm is a generally good sign. One would ask what was -- why was the right arm not moving.

Blink reflex is certainly a positive finding as compared to the alternative finding of no blink reflex,

and there's no information as to whether that reflex is extinguished over time or not, which would be a helpful observation.

Doll's eye movements are a severe sign of midbrain damage and would be a grave prognostic indicator.

Q. Doctor, I'm going to refer you to page 110 and 111 of Dr. Rollins' deposition, which you weren't given. The following question, the following answer were -- were given by Dr. Rollins, who had an opportunity to see Mrs. Weitzel. Question: "What does it mean when a patient has positive doll's eyes and blink reflexes and moves tje left arm apparently on command?" Answer: "Those are good things. That shows neurological function is intact."

Do you agree or disagree with that, sir?

MR. FRANEY: Objection.

A. I agree with part of that statement and disagree with another part.

Q. Are you a neurologist?

A. No.

Q. Are you a cardiologist?

A. No.

Q. Did you see Mrs. Weitzel?

A. No.

Q. What -- what was her neurological status prior to the time that she was given the medication that you've been referring to, that is the neuromuscular blockade as well as the Versed, after her initial admission to the hospital starting, let's say, on the 13th? What was her neurological status like from the 13th until the 20 -- 22nd of February?

A. Well, I -- I -- there are some comments as to -- to her neurologic status. There are many days that go by with no clear comment about her neurologic status. There were comments that suggested on one occasion that she was obtunded.

Q. From the 13th to the 22nd, Doctor?

A. 13th of February?

Q. Yes, sir.

A. Yes.

I can pull them out of here if you -- if you'd like. It would take me some time.

Q. Sure.

If you want, I can refer you to specific references, Doctor, if that would help you.

A. I guess that would be helpful.

Q. All right. Why don't we look at Dr. Chmielewski's prog -- or consult report. Do you have that?

MR. FULTON: Why don't you refer to him where the page is.

MR. KAMPINSKI: Beg your pardon?

MR. FULTON: Why don't you help him --

MR. KAMPINSKI: He -- he --

MR. FULTON: -- with the page?

MR. KAMPINSKI: No. You know what?

MR. FULTON: What?

MR. KAMPINSKI: He did a careful review of this record.

MR. FULTON: So did you.

MR. KAMPINSKI: You know where the stuff is?

MR. FULTON: Just give him the page. How many pages do you have here?

MR. KAMPINSKI: They're not -- they're not numbered. What do you mean give him the page? It's --

MR. FULTON: There are thousands of pages here. You know that.

MR. KAMPINSKI: You want to make yourself the issue, make it another case. All right?

MR. FULTON: All right. Well, just --

Q. Do you have that, Doctor?

MR. FULTON: -- be kind now, Charles. No use getting excited here.

A. Are you referring to the --

MR. FULTON: I don't want you to have to go under a stroke evaluation.

Q. Do you have it, sir?

A. Are you referring to the consult note of 2-20-91?

Q. I believe that's correct. On page 2 of that, it's got by 2:15, "The patient showed some signs of clinical improvement, was awake and followed commands." See that?

A. I did see that.

Q. By 2:20, the note at the bottom under his physical exam, "She was alert and cooperative with examination, appeared to be in no acute distress." See that?

MR. FULTON: Well, let's -- let's find a page. What page are we on now?

MR. KAMPINSKI: Page 2.

MR. FULTON: You're reading from something.

MR. KAMPINSKI: Page 2. We're on the same page at the bottom.

MR. FULTON: All right. Just so you --

Q. All right? You see that, sir?

A. Yes, I do.

Q. All right. Page 3, the next page --

MR. FULTON: Well, we want to be fair here so he

sees exactly what page that you're referring to.

Q. Next page, sir, second full paragraph, neurologically the patient appeared intact, moving all four limbs, and she had no gross ataxia. You see that?

A. I do.

Q. What is ataxia?

A. Incoordination.

Q. So she didn't have that?

A. Didn't according to Dr. Chmielewski's note.

Q. All right. If you look at the progress note of a Dr. Onyekwree of February 19th, 1991, a procedure note; see that?

A. I'll have to find it.

Q. All right. It's at 5:05 p.m.

A. Yes.

Q. All right. At the bottom of that in parentheses, "Indications and need discussed with patient and she agreed prior to proceeding." You see that, Doctor?

A. I see that.

Q. And is that someone who's neurologically impaired agreeing to proceeding with a procedure?

A. Well, it -- it -- it would -- it would be a surprising comment given a patient --

Q. Well, did you see --

A. -- you know, on a ventilator.

MR. FULTON: Let him finish his answer.

A. Yeah, I -- I've just agreed that I'm reading this along with you and I do see the note.

Q. Did you see that when you reviewed the chart initially?

A. No.

Q. All right. Why don't we go to -- and, by the way, nurses' notes would be a very good place to look for neurological status, wouldn't you agree, Doctor, because they see the patient every day?

A. I would suspect the physician would see the patient every day also, and the nurses' notes are -- are often a good source for making this assessment, sometimes yes and sometimes no, depending on the expertise of the individual nurse.

Q. Okay. If you want, I can show you copies of these as opposed to having you leaf through the nurses' notes, if that would be easier for you, Doctor.

MR. FULTON: Are you going to mark that as an exhibit, if you haven't? You want to mark it as an exhibit?

MR. KAMPINSKI: The whole record's going to be an exhibit.

MR. FULTON: I want that marked as an exhibit.

MR. KAMPINSKI: Mr. Fulton, I don't care what you want.

MR. FULTON: Well, I -- I care what I want. I want it marked as an exhibit, and I think we should.

MR. KAMPINSKI: Why don't you -- why don't you leaf -- you know, I tried to make it easy for him. You don't want that.

Why don't you turn to the nurses' notes then.

MR. FULTON: All right. Refer him to each one and get to the page. We can do it page by page, the right way. You know how to do it, Charles.

MR. KAMPINSKI: Is that an objection, Mr. Fulton, or do you -- do you just want to interject for the sake of interjecting? Is that the game you want to play here, sir?

MR. FULTON: That's what you're doing.

THE WITNESS: What date? I'm in the general section here.

Q. It's supplemental nurses' records. I believe this is on the 20th.

I'll hand you this so you can find the corresponding page in the original.

A. The 20th of February?

Q. I believe that's correct. Take your time.

It might even be before that, Doctor. I don't

want to --

A. I'm on 2-20, but I don't see anything that corresponds to this page. I've got 2-21, 2-19, 2-18. You're sure this is the 20th?

Q. I said that I wasn't.

MR. KAMPINSKI: Go off the record.

(Off the record.)

MR. FULTON: Put this on the record. We're off here. I got two minutes after 6:00, and I want to put on when we go back on.

6:03. Put that down, Miss Reporter.

I want to have this on the record. This is my deposition. Get it rolling.

MR. KAMPINSKI: No, it's not your --

MR. FULTON: It is my deposition. You put that on. I hired him. He's going to have it on.

THE VIDEOGRAPHER: We're on the record.

MR. FULTON: You can look at me all you want, Mr. Kampinski. This is my deposition. That's going to roll, just like in court.

THE WITNESS: I see among the nurses' notes here between 2-19-91 and 2-21-91 only I guess two pages of nurses' notes, none of which correspond to the -- to the one that you've asked me to compare it with.

MR. KAMPINSKI: Okay. Keep looking then.

THE WITNESS: Do you want me to go through every one of these nurses' notes until I --

MR. KAMPINSKI: Every single one of them.

THE WITNESS: See, you've had a longer time than I have to review this chart. Perhaps you could direct me --

Q. Did you review the nurses' notes before you prepared your report?

A. I have.

Q. Okay. Then why don't you see if you can't find it.

MR. KAMPINSKI: Tell you what. While the doctor's looking, why don't you mark this.

MR. FULTON: That's what I asked you to do before.

MR. KAMPINSKI: You know, if you got an objection, make it. Don't interrupt me again, Mr. Fulton.

MR. FULTON: I'll interrupt anytime I want.

MR. KAMPINSKI: No, don't interrupt me again, sir.

MR. FULTON: Don't be pointing your finger at me.

MR. KAMPINSKI: Now, don't you tell me what to do.

MR. FULTON: I'll tell you anything I want to say. Just remember that.

MR. KAMPINSKI: If you've got an objection, make it. You've interrupted the deposition more than enough, sir.

MR. FULTON: Charles, you're shouting and yelling.

MR. KAMPINSKI: Yeah. My name is Mr. Kampinski, Mr. Fulton, and I'd appreciate you referring to me as such and I'll refer to you as Mr. Fulton.

MR. FULTON: That's very good with me.

MR. KAMPINSKI: Now, why don't you mark that, please.

MR. FULTON: How about Mr. Charles? Can I refer to you that way?

MR. KAMPINSKI: You going to let her mark it?

MR. FULTON: I hope so. I don't know why you're shouting, though.

MR. KAMPINSKI: Please, 1 -- 1C.

MR. FULTON: You know, Mr. Kampinski, I want to make one thing very clear here. You may intimidate some people, but you're not going to intimidate me.

MR. KAMPINSKI: Are you going to let her mark

it?

MR. FULTON: I'll let her do anything she wants.

MR. KAMPINSKI: Are you going to let her mark it now?

MR. FULTON: I'm just not going to let you intimidate me.

MR. KAMPINSKI: Are you going to let her mark it?

Would you mark it now, please, for the fourth time?

MR. FULTON: Don't try to intimidate the reporter.

(EXHIBIT MARKED FOR IDENTIFICATION.)

Q. Doctor, I'll hand you what's been marked 1-C.

MR. FULTON: Just hand it to him. Don't throw it at him. Be a professional.

MR. KAMPINSKI: Unbelieveable. You're something, aren't you?

Anything else you want to say, Mr. Fulton? Any other way you want to try to disrupt this deposition?

MR. FULTON: I'd just like you to act professional; that's all.

MR. KAMPINSKI: Anything else you want to do to try to disrupt us? I mean you're doing fine. Keep it going.

Q. Doctor, would you look at Exhibit 1-C, please?

Would you tell the jury what the highlighted nurses' notes say with respect to Mrs. Weitzel's neurological status?

A. "Initial assessment unchanged. Patient awake, cooperative, follows commands well. Patient denies any pain. Patient -- I can't read that word -- again regarding biting on endotracheal tube." Can't read the next word. "1:00 awake and cooperative. Later patient awake and cooperative. Later at 2:20 patient attempting to mouth words. Patient tried to write but unable to hold pen in right hand, which remains edematous. Sleepy."

Q. So she was awake, trying to mouth words and write -- write words; is that what she was trying to do, Doctor? Is that correct?

A. That's what the nurse observed.

Q. Is that good neurological status, sir?

A. That's considerably improved over her admission neurologic exam, yes.

Q. Uh-huh. And --

MR. FRANEY: Move to strike this line of questioning on the grounds we haven't found this reference in the chart after ten minutes of looking for it.

Q. Is there -- is that an indication of a neurological status consistent with your opinion on survival?

A. I think it -- it may be helpful to -- to review the basis of making decisions regarding prognosis based upon the Apache II score, which -- which is significantly different than what you're asking me now.

Q. Doctor, can you answer my question as opposed to trying to refer to the literature which I've objected to on numerous occasions, and, you know, that's not responsive to my question.

A. How would you have an expert or any physician respond to you regarding his opinion without being able to draw upon the medical literature, which is a significant part of the total experience on which any physician bases an opinion?

Q. Well, one of the ways would be I guess to review the record of the individual patient, sir, and in this case, that is part of the record that I just handed you, reflecting what her neurological status is, in addition to which Dr. Rollins' deposition, who is one of the individuals who treated her that you weren't provided with. I mean that would be a way that I'd like to talk about Mrs. Weitzel as opposed to maybe other people.

MR. FULTON: Is that a question? Objection.

MR. KAMPINSKI: Well, I'm trying to respond to the doctor's question.

A. But if one is going to base an opinion upon the mortality prognosis, one has to base that upon previous experience and not upon the individual experience of one patient.

Q. Are you --

A. In other words, any decision based upon my opinion about a patient's mortality rate cannot, of course, be dependent upon my experience with one individual patient. It must be based upon my experience with a wide number of previous patients or presumably also the medical literature where patients in similar circumstances have been -- been treated and their risk of mortality been observed.

Q. Well, are you an intensivist?

A. I am -- I am not an intensivist. On the other hand, I at any one moment --

Q. So that you've answered that question then; correct?

MR. FULTON: Let him finish -- let him finish his answer.

Q. You're not an intensivist?

If you don't understand my question, tell me. I'd appreciate --

MR. FULTON: You're permitted to finish the question.

MR. KAMPINSKI: I'd appreciate responses to my questions, however.

MR. FULTON: I'd appreciate you letting him answer the question.

Q. Is that -- is that a no, you're not?

A. I don't understand your question.

Q. What's an intensivist?

A. Well, currently -- and this is quite different from the situation at the time of my training -- there is a group of patients (sic) with special qualifications who are -- undergo additional training in intensive care medicine.

A vascular surgeon at any moment has a large number of patients in an intensive care unit over which he has primary responsibility.

If you're asking me whether I have significant experience, training and expertise in the management of patients with critical illness, then the answer to that question is yes. If you're asking me whether I have a certificate of special qualification in intensive care medicine, the answer to that question is no.

Q. Was a vascular surgeon or a surgeon called in to treat Mrs. Weitzel when she came into the hospital?

A. I think Dr. Moasis.

Q. That was on March the 14th for the removal of the wire. Was one called in at any time before that?

A. Not to my knowledge.

Q. Would you have been called in at any time before that to treat Mrs. Weitzel?

A. Not in all likelihood, no.

Q. In other words, the only reason you might have been called in was for the same reason Dr. Moasis was, and that is for the potential removal of the guidewire; correct?

A. That, or as a vascular surgeon, not infrequently called in for the placement of intravascular catheters, and I have exper -- extensive continuing experience in the management of patients with ARDS, congestive heart failure, hepatic failure, neurologic failure, pulmonary failure and the like.

Q. You don't call in consultants to deal with those issues, sir?

A. On some occasions, I do.

Q. In other words, you would treat her pulmonary condition without a pulmonologist?

A. I -- in this hospital, I would treat this patient in our intensive care unit, which in essence mandates the involvement of an intensivist and would

probably not involve a pulmonologist in the care of this patient. I would certainly have been in consultation with a cardiologist, hepatologist, a neurologist.

Q. Infectious disease?

A. And perhaps an infectious disease physician, yes.

Q. All right. At least in terms of the records we've looked at, Doctor, her neurological status was improving, was it not, sir?

A. That's correct.

Q. And what I read to you from Dr. Rollins' testimony was that -- which you didn't have an opportunity to see or read -- was that neurologically she was fine?

A. Well, I think that opinion that she was fine or that these were good signs does not jive with my understanding of positive doll's eyes, which to my understanding of neurology indicates a significant brain stem deficit.

Q. I'm sorry. Maybe I missed it. Did you say that you were or were not a neurologist?

A. I am not a neurologist --

Q. Thank you.

A. -- but I treat patients with stroke, perform perhaps 100 operations per year on these patients, and

have an extensive ongoing and continuing interest in neurologic diseases, diagnosis and management.

Q. How about cardiologist? Do you treat heart patients too?

A. Sixty percent of my patients have significant coronary artery disease and cardiovascular complications.

Q. So do you treat them for their heart disease?

A. As part of their surgical therapy, yes.

Q. Was her heart stable?

A. No.

Q. Did they stop serial EKG's?

A. Yes.

Q. Did you read Dr. Steele's testimony where he said her heart was, in fact, stable?

A. Well, stable is a --

Q. Did you read it or didn't you? That was the question.

MR. FULTON: Well, let him answer.

MR. KAMPINSKI: Right, I'd like an answer to my question for a change.

Q. Did you or did you not read that testimony where he said her heart condition was stable?

A. I don't recollect that specifically.

Q. Do you disagree with that if that's what he said? Do you or don't you, yes or no?

MR. FULTON: Maybe it's between.

A. Yes, with --

Q. Can you answer that?

A. Yes, with -- yes, with qualification. The ultimate state of clinical stability is death, so that a -- this patient was stable from a cardiovascular standpoint clinically even when things were early on in critical condition. She -- I do agree that her cardiovascular condition was stable, but if you mean by stable that it was good, then I would disagree.

Q. The other -- the other systems that you said -- did you say they were in failure or that they were affected? I wasn't quite sure on your direct testimony of the liver and the kidneys, did you say they were in failure, Doctor?

A. There were abnormal functions which would not represent liver or renal failure. They were clearly abnormal function. Her BUN and creat -- the creatinine level of two and a half would suggest that she had perhaps 25 percent of normal kidney function remaining, and her abnormal liver function studies would not allow one to make a clear assessment as to how much of her hepatic function remained because you need to have 85 percent of your normal liver function inoperative before one sees dramatic changes in liver function studies. So,

yes, there was clear evidence of dysfunction of both the kidneys and liver, but I wouldn't go so far as to call that renal failure or hepatic failure.

Q. All right. So those organ systems were not in failure then?

A. That's correct.

Q. So in terms of analyzing what organ systems were in failure for your analysis, you wouldn't include those? I mean you just mentioned them in passing; is that what you did?

A. Well, you know, my opinion that this lady had a mortality statistic of greater than 50 percent is based upon not any one organ system taken in total and --

Q. I'm trying to deal with all of them.

A. Right. And in order to render that opinion, clearly abnormal kidney function, even though it may not represent failure requiring dialysis, would influence in a negative way her mortality prognosis. The same would go for her hepatic function. So, yes, the abnormal liver function studies and renal function studies did help make a decision that she had a high mortality risk, but, no, each individual system was not in failure.

Q. Do you treat test results or -- I mean how would one actually determine whether or not there was a problem with the liver or the kidneys? Would the best way be,

for example, to biopsy it?

A. That would be information that would be he pful, but in many ways no more helpful than -- than the abnormal blood chemistry results.

Q. Well, how about to look at it, examine it and actually look at the structures; would that be helpful?

A. Helpful. Again, both the biopsy and the observation at autopsy would tell you information regarding anatomy but are often very unhelpful to answer questions about function. The liver function studies or chemistries are more valuable in terms of telling you whether this liver cell which may look normal is either functioning normally or abnormally.

Q. What was the findings at autopsy, Doctor, with respect to her liver or kidneys?

A. They did not find striking abnormalities in either system.

Q. As a matter of fact, I think the liver was totally normal, wasn't it?

A. Yes, to my recollection. I could review the autopsy report. I don't have it in front of me.

Q. And that was true of the kidney as well; correct?

A. No striking abnormalities.

Q. Yeah. And, you know, the reason I'm asking you

this, I mean you alluded to it partially in direct testimony, but you were asked that in deposition, and that is what organ systems it was that failed that cause you to have your opinion, and that was abnormal kidney, liver, pulmonary and neurologic. Those are the four you mentioned. We've now gone through those, and in terms of the autopsy, the kidney and the liver were normal; right? Dr. Sopko testified --

MR. FULTON: Objection.

MR. KAMPINSKI: Excuse me. Let me finish my question.

Q. Dr. Sopko testified that the pulmonary -- she was going to be weaned off the ventilator, and everything we've looked at in terms of the neurological status when she wasn't on neuromuscular blockade as well as the testimony of Dr. Rollins seems to indicate that she was okay neurologically.

Now, do you just make up the facts to fit your hypothesis, Doctor, or do you base them on what's in the record, sir?

MR. FULTON: Well, I have an objection to that. It's not a question. It's a statement. If you can answer --

Q. Can you answer that?

MR. FULTON: If you can answer it, it's a

statement as far as I --

Q. Did I misstate any of the things that I -- that I said there, sir?

A. Well, if I understand your statement, you would be accusing me of perjury, and I obviously don't -- would not agree with making up any of these -- these opinions.

I think there is ample evidence in the chart to support my comments in my opinion letter that this patient had evidence of abnormal kidney function, liver function, neurologic function, pulmonary function and heart function.

Q. All right.

A. Whether they -- the definition of failure is extremely broad, and there is no, to my opinion and to my knowledge, no generally recognized standard to define failure versus non-failure. There is clear evidence that she had dysfunction in all of those systems, and the absence of findings at autopsy on gross or microscopic examination would not influence that opinion.

MR. KAMPINSHI: Doctor, I'm going to -- at this point let the record reflect that I'm going to ask questions of this physician based upon the attempted testimony by him on four or five occasions in this case to bring in the literature. As we're now in Columbus and I don't know how the Court is going to rule on that, I'm

going to ask those questions. I would withdraw them if the Court rules that that testimony is not admissible.

Q. You had tried to refer a number of times -- and just so the record's clear, we're here on -- on the, I believe the 10th of May, which is more than a week before trial, Doctor. Is there a reason that you can't come to the trial live? Were you asked to come?

The Apache II that you referred to, is that the latest in the series of Apaches or is there a newer one? Is there Apache III now?

A. Yeah, I think there is an Apache 111.

Q. All right. But you were referring to the Apache II?

A. That's correct.

Q. Is that now outdated because of more recent findings?

A. No. It's just the one with which I have the most familiarity.

The Apache 11, Apache 111, Apache I, for that matter, all are substantially the same, are attempts to predict exactly the same information.

Q. Do you use that for --

A. The, quote, improvements in the Apache from

Apache I to Apache II to Apache III have been entirely to simplify them so that fewer pieces of information need to be considered before rendering a mortality prognosis, so -- and I'm not aware of any information that one score as compared to its predecessor is more accurate. It's just more simple and, therefore, more easily applied.

All of these scores are intended to predict mortality based upon information obtained on admission or shortly thereafter admission and are not intended to be continually upgraded throughout the hospitalization.

Q. Is that -- is that a yes, that it is different, or it isn't different?

A. It's different only in the number of variables that are required to arrive at a prognostic figure. I don't use the Apache III score, so I didn't quote it.

Q. Do you use this for patient care?

A. No.

Q. And when I say patient care, I mean how you would care for a patient when she comes into the hospital; correct?

A. Well, not -- I would answer that question no, I don't think we do use it to -- in a specific way to manage any one particular patient.

Q. So if somebody needs care and attention, they get it regardless of any score on various tests; correct?

A. At least at this point in time. Obviously these scores have been suggested as a way of identifying those patients who have such a miserable chance of survival that one might save valuable national and local health care resources. But I don't know of anyone who uses this to take care of any one individual patient.

A. That would be my prediction. There is, however, not enough information in the chart to be able to recalculate the Apache score. It's made very clear in all of the articles that one should resist the temptation to invent numbers to fill in the blanks if they're not available.

Q. Well, 20 to **26**, according to at least the article that you I guess provided -- this is the article

by Knaus and Draper. Do you have that one there? There's a chart on page 823. You see that, "Apache II and Hospital Death"?

A. Yes.

Q. Okay. And that would be the relationship between the Apache II scores and hospital mortality, that graph?

A. That's correct.

Q. Well, if you take the score of 20 to 24 and you follow that bar graph along, could you please tell the jury what the death rate is?

A. It's about 15 percent.

Q. So that if the score then was between 20 and 24 and you had it between 20 and 26, the probability is that she would, in fact, live?

A. Well --

Q. Am I correct?

A. No.

Q. Oh.

A. If you look at the following page, page 824, and look under patients with congestive heart failure, looking at the most specific category, because there is clearly a difference in mortality risks whether you arrive at your Apache II score with congestive heart failure or trauma or a gastrointestinal bleeding and the

like, so if you take out those patients with congestive -- and isolate those patients with congestive heart failure with a score of 20 to 29 and read that bar graph across, that's the 50th percentile.

Q. No. It's less than 50, Doctor, if I read that correctly.

A. Well, in the body of the paper --

Q. Doctor, why don't you show that to the jury. Hold that up and show it, show the bar graph, and let's see if it's less than 50 or more than 50, the one that you're pointing out.

A. This is the bar graph.

Q. Is that --

A. It's 50.

Q. So is it less than 50, sir?

A. Well, it's -- it doesn't have a line drawn across it.

Q. Why don't you draw a line. Is it less than 50?

A. In the body of the paper --

Q. Doctor, is it less than 50? Can you answer that question?

A. No, it is not.

Q. Why don't you draw a line across it.

MR. FULTON: Don't -- just hand it. Be professional, please.

A. I think you're asking me to do -- do something

Q. Why don't you draw a line across it, Doctor. The jury can decide whether it's relevant or irrelevant. You can use a paper to make sure it's linear, and let's see if it's less than 50 or more than 50.

A. The article specific --

Q. Doctor, my question is very simple, sir. Is it less than 50 or more than 50?

MR. FULTON: Let him answer it.

MR. KAMPINSKI: He's answered it, and now let's see if he's accurate.

MR. FULTON: No, no, he is gonna answer. He said in the basis of the whole article, it says it's over 50.

A. If one draws this straight across, it is about 58 percent death rate.

Q. Can I see what you did?

A. Which is consistent with the information in the body of the article.

Q. Where did you draw it? You didn't draw it at all.

A. See that mark? I'll draw the line if you'd like.

Q. Doctor, you drew it on the one called septic

shock. You were referring to congestive heart failure. Why would you do that?

A. I made a mistake.

Q. Oh. Well, why don't you do it correctly then.

MR. FULTON: Well, move to strike.

A. You're asking me to perform a task which is --

Q. I'm asking you to do what you said to the jury reflects that it was over 50 percent when the fact of the matter is that it's not, sir.

MR. FULTON: Well, you're -- that's completely --

Q. Now, would you draw it now?

MR. FULTON: -- a misstatement because within the body of the article -- we'll have to bring it out on direct.

Q. Would you draw it now, sir?

Is it less or more than 50 percent now, Doctor?

A. It's about 48 percent.

Q. So that's less than 50; right?

A. That's correct.

Q. So that she probably would have lived even with your definition under this article?

MR. FULTON: Don't --

A. That's incorrect.

MR. FULTON: Doctor, you don't have to --

Q. According to this graph --

MR. FULTON: Wait. Doctor, you don t have to answer him if he's going to shout.

Q. According to this --

MR. FULTON: Lawyers don't have to shout at a witness; I can tell you that.

Q. According to this graph that you pointed out, it's less than 50 percent; right?

A. According to the graph.

Q. Yeah. Did she have congestive heart failure?

A. She did at the time of her admission, yes.

Q. Did she have it thereafter?

A. At intervals throughout the first week of her hospitalization, yes.

Q. How about thereafter?

A. I saw no evidence in the chart that she did.

Q. And if you go back to the previous chart that I was referring to, that is Apache II and Hospital Death, I think you said that was what, 15 percent, 15 to 20 I think you testified to?

A. That's the chart of all causes of --

Q. Yes, sir.

A. Yes.

Q. Okay. All right. Okay. Now, I've concluded my questioning with respect to the doctor's opinions

regarding Apache, depending upon the court's decision.

Doctor, were you -- one of the reports that you reviewed was Dr. Holland's; correct?

A. That's correct.

Q. You're aware of the fact, I take it, that Dr. Holland was retained by Dr. Varma to act as an expert on his behalf? You're aware of that?

A. May I review that letter?

MR. FULTON: You mean --

THE WITNESS: Dr. Holland's letter.

MR. FULTON: Well, just wait a minute.

MR. KAMPINSKI: Do you want to stay on the record, Mr. Fulton?

MR. FULTON: Yeah, I want to stay on the record all the time.

MR. KAMPINSKI: You sure?

MR. FULTON: I want them to hear exactly what you're saying.

MR. KAMPINSKI: Okay. You too, huh?

MR. FULTON: Holland's report. I don't know. Where is it?

Do you have Holland's report? Can you get it?

Q. Well, don't you -- don't you have what you reviewed, sir?

A. I didn't bring -- didn't bring that piece of

information with me today.

Q. Where is it?

A. I suppose that it is probably in my office.

Q. I mean you didn't bring any information. What's in front of you was the original chart that was brought by the hospital attorney; right?

A. That's correct.

Q. I mean you didn't bring anything that you were sent, right, here to this deposition?

A. I wasn't aware that I was asked to bring anything to this deposition.

Q. Okay. All right. My only question is, Dr. Holland, were you aware of the fact he was retained by Dr. Varma to act as an expert?

A. I would prefer to look at that letter before answering that question.

MR. FULTON: You want him to go back? I don't have that. Want to go back and --

MR. KAMPINSKI: I'll be happy to show it to you.

MR. FULTON: Well, show it to him.

MR. KAMPINSKI: It's got my markings. I mean, is that okay?

MR. FULTON: Well, if that's all you can do. You have nothing without markings on it? Well, if it's all you have, it's all you have.

Q. All right, Doctor. Do you recall it now?

MR. FULTON: Well, let him take a look at it.

MR. KAMPINSKI: I just want to -- it was a simple question. I didn't ask him for the content of it. I just wanted to know whether he was aware of the fact that Dr. Holland was retained by Dr. Varma. Simple question.

MR. FULTON: I don't know if that letter tells it.

A. No, I -- no, I wasn't aware. This letter was written to a Mr. Fred N. Carmen of Chattman, Sutula, Friedlander & Paul, and I'm certainly not aware of who that individual is representing in this case.

Q. All right. I will tell you that he represents Dr. Varma in -- in addition to Mr. Fulton and in addition to Mr. Coyne, who represents the hospital who's responsible for him, and/or Mr. Okada's firm, who represents the Cleveland Clinic, who he was employed by.

MR. FRANEY: Objection.

MR. OKADA: Objection.

Q. But this man, Mr. Carmen, has specifically entered an appearance on behalf of Dr. Varma as well. So you're aware now that --

A. Right, I am now.

Q. -- he was retained by him?

A. Yes, sir.

Q. All right. And you weren't given an opportunity to read his testimony; is that correct? That's not one of the depositions that you were provided with?

A. Dr. Holland's? No. I've only read this letter.

Q. All right. He's a cardiologist. Do you believe that he would be in any better position to give an opinion about the appropriateness of removing the wire, the second wire, by surgery or would you be in as good a position as him to do so?

A. I think I would be in as good a position as he is to make that opinion,

Q. All right. I want to make sure I understand your testimony.

Now, Dr. Holland has testified that Dr. Steele fell below the appropriate standard of care required of him at the time that he made the decision to remove the wire. Do you agree or disagree with that opinion?

A. Do you mean by that question remove the wire percutaneously or by surgery?

Q. By surgery.

A. I would -- I think I've testified that I would clearly make a different decision than -- than Dr. Steele and would personally have recommended another course.

MR. FARCHIONE: Move of strike.

Q. Yeah, I just -- I just don't want the jury to be at all confused because I'm sure that wouldn't be Mr. Fulton's intent to submit two experts with differing opinions.

My question was really a very specific one, and that is, do you agree or disagree with him that Dr. Steele fell below the appropriate standard of care required of him? Do you agree or disagree, Doctor?

MR. FARCHIONE: Objection.

A. I disagree with that opinion.

Q. So in other words -- well, all right. Maybe you can help me in maybe explaining how the jury is supposed to figure out which expert of Dr. Varma to believe.

If Dr. Holland's opinion is that he did fall below the standard of care and yours is that he didn't, who is the jury supposed to believe and why are they supposed to believe them?

MR. FULTON: Don't answer that question in that form. That isn't a question. It's a statement. If you want to ask him any question about if he agrees or disagrees, that's fine.

MR. KAMPINSKI: Are you instructing the witness not to answer, Mr. Fulton?

MR. FULTON: I am that -- I am on that question, yes.

MR. KAMPINSKI: Okay.

MR. FULTON: I ask you to make a -- it was about four questions.

MR. KAMPINSKI: Well --

MR. FULTON: Ask him anything you want about his opinion agreeing or disagreeing with it. I have no problem with that.

MR. KAMPINSKI: Good. Thank you, Judge Fulton.

MR. FULTON: You're welcome, Mr. Kampinski.

MR. KAMPINSKI: That's one of the reasons we have a judge, so that he can decide what the witness is supposed to answer or not answer. You know, like you said before, just like we're in court, Mr. Fulton. You're not in a position or you shouldn't be in a position to instruct him to answer or not to answer. That's the judge's decision. So why don't you let him answer the question. Then if the judge decides it's not appropriate, he'll strike it.

MR. FULTON: That's an interesting approach.

MR. KAMPINSKI: You're instructing him not to answer? That's fine.

MR. FULTON: Let's get the question.

MR. KAMPINSKI: Are you going to let him answer or not?

MR. FULTON: I can't understand the question.

MR. KAMPINSKI: I don't care if you can understand it.

Q. Can you understand the question, sir?

MR. FULTON: Want the question reread?

THE WITNESS: I'd like it reread before answering.

(Question read.)

A. I really can't answer that question. I think it's my obligation as an expert witness to give you my opinion, and it's up to the jury to -- to decide which of those opinions seems most reasonable to them.

Q. Okay. Well, if his opinion, once again, Dr. Holland, who was retained by Dr. Varma, was that Dr. Moasis fell below the standard of care required of him in the surgical -- the decision to surgically remove the wire on March 14th, do you agree or disagree with that opinion?

A. I disagree.

Q. Okay.

A. If -- I want to make sure because we have some double negatives perhaps.

I do not feel that Dr. Steele nor Dr. Moasis fell below the standard of care in coming to a decision to surgically remove the second wire.

Q. Sure. Okay. That's -- that was my question.

And you're at odds then with the other expert that's hired by Dr. Varma to g ve expert opin on?

A. In that respect.

Q. Yeah. And do you agree or disagree with Dr. Holland's opinion that the conduct of Dr. Steele and Moasis which he believes was below the standard of care in surgically removing those wires contributed to cause Mrs. Weitzel's death?

MR. FULTON: Well, I object to -- I have an objection to the form of the question because you have -- you're inserting something in there. Well, go ahead if you can answer it.

A. Well, you know, clearly there was a temporal relationship between the operation to remove the wire and Mrs. Weitzel's death, and I think it's probable that the operation hastened her demise. My -- my opinion is that she was more likely than not not going to survive her hospitalization, then the ultimate conclusion would be the same whether she had the operation or not.

Q. Okay. His opinion, by the way, with respect to survivability is -- is to the contrary of yours. You disagree with him on that as well; correct?

MR. FULTON: Objection.

Q. Is that correct, sir?

A. I'd like to reread the letter again to see if

that's what my interpretation of his opinion would be.

Q. Well, he changed his opinion in his deposition from his letter. Were you aware of that?

A. I didn't --

Q. Well, you couldn't have been because you didn't see his deposition.

A. -- didn't see his deposition, so I can't comment on that.

Q. Sure.

A. Just make a statement that the patient had a grave clinical status as she entered the operating room, and that she had multiple other serious and life-threatening medical problems at the time she was brought to the operating room. So I would have to interpret his letter as suggesting that he felt that, you know, during her clinical course in the hospital from admission to operation, that she had serious, grave medical problems.

Q. Doctor, the following testimony is what was given by Dr. Holland.

MR. FULTON: Read it to him because he hasn't seen it.

Q. Question, page 58. This is of Dr. Holland's deposition, referring to Dr. Steele. "Do you believe he fell below the standard of care in making that decision

then?" Answer: "I believe so." Question: "Did that failure contribute to cause Mrs. Weitzel's death?" Answer: "I believe so." Question: "Did Dr. Moasis's input and collaborative effort I guess with Dr. Steele in deciding to do the surgery fall below the standard of care in Mrs. Weitzel's case?" Answer: "I believe so. would qualify that with I am not a vascular surgeon, but I think between the two of them, I think the fact that

"

Do you agree or disagree with that testimony?

MR. SEIBEL: Objection.

A. I disagree.

MR. FARCHIONE: Objection.

Q. Beg your pardon?

A. I disagree.

Q. And this, once again, is testimony of Dr. Holland's, who was also retained by Dr. Varma. If I could have that back, sir.

Do you have an opinion to a reasonable degree of medical certainty as to whether or not the nurses and residents postsurgically fell below the standard of care required of them in dealing with Mrs. Weitzel on March the 14th?

MR. FRANEY: Objection.

MR. OKADA: Objection.

A. No, I have no opinion.

Q. You have no opinion? Well, I mean, did you review that, that part of the medical record?

A. I did.

Q. Was she undergoing any problems postsurgically?

A. Yes. She died postoperatively.

Q. How about before she died, did she have any evidence of experiencing any problems, Doctor?

A. Well, the -- the record is remarkably weak in reflecting her clinical status from the time of the operation until the time of her death. In the progress notes, I think I'm only able to find a death note following the -- the operative note.

Q. Well, so we're clear, you mean there's no physicians' notes after the surgery telling you what her status is?

A. My reading of the record is that there was an operative note of **3-14-91**, and the next note on **3-15-91** at **2:30** a.m. is the arrest note and death note.

Q. So from **4:30** until -- **4:30** p.m. until **1:30** a.m. there's no physician writing a note in the record as to what her status is?

A. Until **2:30** a.m., that's correct.

Q. Well, how about the nurses' notes, does that help you?

A. The nurses' notes did provide some information, that she was getting in trouble with tachycardia and lowering blood pressure. It's not as well documented as I would like in order to make a definite opinion, which is what you requested, as to whether the quality of care was satisfactory or not.

Q. Well, have you looked at the critical care flow sheet in the -- in the nurses' notes?

A. I have looked at it. I would be happy to review it again with you.

Q. Can you find it there?

A. I couldn't tell you. I was certainly not able to find the first note.

Q. This is March 14th, Doctor. This is what it looks like.

MR. FULTON: Is there a question pending? Could we have it read back?

THE WITNESS: Can I --

Q. You got it?

A. Well, I have one that's dated 3-14. I'm not sure it's the one you're going to be talking about.

Yes.

Q. Her blood pressure at 4:00 was 130 over 80?

A. That's correct.

Q. Next recorded one is at twelve hundred. What time is that? 8:00 o'clock?

A. That would be 8:00 o'clock.

Q. Is there a drop in the blood pressure?

A. Yes, there is.

Q. And should a physician have been notified at that time?

A. Not on the basis of the blood pressure alone.

Q. How about --

A. The blood pressure to which it had dropped is a normal value.

Q. How about the heart rate and the respiration in conjunction with the drop?

A. Yeah, the heart rate went from 127 at 4:00 p.m. to 141 at 10:00 p.m., and the respiratory rate --

Q. No, that's at -- that's at 8:00 p.m.; right?

A. Yes, you are correct. 127 at 4:00 p.m, 141 at 8:00 p.m. Heart rate went from 18 to 33.

Q. Uh-huh. Should a physician have been notified and come to see her?

A. Yes.

Q. And there's no record of that occurring, is there?

A. I didn't see one.

Q. Well, if that's the case then, would that be a deviation from the appropriate standard of care, Doctor?

MR. FRANEY: Objection.

A. If that's indeed the case. It's -- obviously as a physician for 21 years in a hospital, it's very clear to me that things happen that are not documented, but on the basis of what can be clearly documented in the chart, yes, that would -- that would fall below the standard of care.

Q. So there is enough information then with respect to the failure of anyone to attend to her condition, isn't there?

MR. FRANEY: Objection.

A. No. Only -- only if indeed no one was called or if someone was -- you know, it depends on whether someone --

Q. Well, the only way to tell is from the record; isn't that right?

A. That's correct.

Q. And the record doesn't reflect it?

A. That is -- yes, but that doesn't mean it didn't happen. But on the basis of the information available, that would be a correct statement.

Q. All right. And that's what you base expert opinions on, from the information available, I thought

you told us earlier, right?

A. That's correct.

Q. All right. And then at 2200, which would be 10:00, there's no blood pressure listed at all, is there?

A. That's correct.

Q. Shouldn't --

MR. FULTON: May I now ask a question, Mr. Kampinski? Are you now waiving any opinions that go outside of what the written report is?

Q. Shouldn't there have been, Doctor?

MR. FULTON: I just want to know if you're waiving that because --

Q. Doctor, shouldn't there have been?

MR. FULTON: Should have been what?

A. A blood pressure recorded, is that --

Q. Right.

A. -- your question?

Yes, normally a blood pressure would be recorded there.

Q. And it's not there, is it?

A. That's correct.

Q. So can we tell what it was?

A. No.

Q. I assume -- well, I mean this is a picture that's consistent with -- with someone bleeding; correct?

That is a drop in blood pressure can cause or can be evidence of -- of a bleed; is that correct?

A. That's correct. These are nonspecific enough pieces of information that there are a multitude of potential causes for -- for these vital sign changes, but I would agree if you're suggesting that these changes would warrant a call to a physician and a physician personally coming to the bedside to assess them and to initiating therapy, then I would agree that that -- it would be the standard of care.

Q. And the nurses' notes indicate that she was diaphoretic at 10:00. That's also an indication of a worsening condition; isn't that true?

A. It may be.

Q. Yeah.

A. It's -- it's a very nonspecific finding.

Q. Well, what --

A. But, yes, along with the blood pressure changes and tachycardia and respiratory rate increase, yes, that would be another piece of information that would tell you this patient is getting in trouble.

Q. Yeah. And there's nothing in the record to reflect that anyone did anything about it, is there?

A. No, there is not.

Q. And somebody should have, shouldn't they?

A. Yes.

Q. And isn't that then a deviation from the standard of care required of the nurses and the residents?

MR. FRANEY: Objection.

MR. OKADA: Objection.

MR. FULTON: Objection. He's answered it already.

MR. KAMPINSKI: I don't know that he has. Go ahead.

occur, then it would fall below the standard of care.

I think it was incumbent upon a nurse obtaining these vital signs to contact the physician regarding the issue. It would be the responsibility of the physician receiving the information to come to the bedside to evaluate the patient and to assess it, make a diagnosis, and to initiate appropriate therapy.

Q. All right. So in that regard, you agree with Dr. Holland when he testified that the nurses and residents postsurgically did fall below the standard of care and contributed to cause her death?

MR. OKADA: Objection.

MR. FULTON: Objection. He said he did not agree with him. He said he had no opinion.

Q. You still have no opinion?

A. Well, it's -- I -- my -- my opinion is just based upon a relatively small amount of information on which to base an opinion.

Q. And that opinion is that it was below the standard of care?

A. If -- if the opinion -- if -- if this was indeed all that was done on this patient postoperatively in terms of monitoring the patient and initiating medical therapy, then that would indeed fall below the standard of care, yes.

MR. FRANEY: Move to strike.

Q. Was this surg -- the surgery of the 14th elective, Doctor?

A. Oh, that's not a very useful -- useful term. It really wasn't elective in the sense of, you know, a face lift or a rhinoplasty, a nose job, but it was -- it clearly was not an operation that was required on the 14th versus the 15th versus Ap -- you know, April. It was --

Q. And --

A. It's an operation -- at some point these wires would need to be removed. It was not urgent that they be removed on this date.

Q. Had there been an assessment and the bleed

discovered after the surgery, would it have followed that she would have needed another surgery to repair that or might that bleed have stopped by itself with other supportive care?

A. It's possible that either of those scenarios could have been played out. One would have initiated -- first of all, one needs to assess the reason for these vital signs deteriorating. The most probable was hemorrhage from the surgical site, and indeed some evidence of hemorrhage was noted at the autopsy, not a particularly large amount of blood in the big picture of postoperative hemorrhage, but a significant amount, particularly in someone who is critically ill from cardiac, pulmonary, renal and hepatic and neurologic bases.

Other possibilities would include pulmonary embolism, recurrent congestive heart failure.

Those would have been my first thoughts on being called to see this patient with these vital signs following this operation.

Q. Doctor, you testified that you've never had to remove a guidewire surgically; correct?

A. Other than the one instance that we were able to do it under local.

Q. Was that a guidewire or a catheter?

A. It was a catheter.

Q. And it s different, isn t it?

A. No. If the guidewire had extruded from the vessel in the fashion that the catheter had, then we would have been in exactly the same situation.

Q. A catheter is different than a guidewire? That was my question.

A. Oh, of course.

Q. And you've never removed a guidewire, have you, surgically?

A. No.

Q. As a matter of fact, the foreign objects that you referred to as your having been consulted about, every one of those you referred to an invasive radiologist; correct?

A. That's correct.

Q. And that's Dr. VanAman?

A. Dr. VanAman or Dr. Stockham.

Q. Uh-huh. And they've been able to remove every single one percutaneously?

A. That's correct.

Q. So you've never had a situation like Mrs. Weitzel, have you, where there's been a surgical removal post MI?

A. No.

Q. Have you ever seen two guidewires, whole guidewires, left in a patient?

A. No.

Q. You ever even heard of that?

A. Oh, I've heard of it. There -- there are --

Q. Two -- two guidewires left?

A. Not two. I've heard of one guidewire left in a patient, but I've not heard of two, no.

Q. Is that something that somebody can do and not be aware of, that is leave two guidewires, two 18-inch guidewires, in a patient's arterial system?

A. I can't answer that question. I guess it would depend on who that person would be.

Q. Well, a physician.

A. And it's hard for me to imagine that I could leave two guidewires under these circumstances.

Q. A physician.

A. Well, I suspect it would depend to some extent on the experience and training of the individual placing the guidewires, but it would be difficult to imagine leaving one or two guidewires in a patient and not recognize it.

Q. Sure, because that's something that you're supposed to pull out and throw away?

A. That's correct.

Q. So if you didn't pull it out and didn't throw it away, you'd know it would be in the patient, wouldn't you?

A. I would think so.

Q. Yeah. And especially two of them, that would indicate two attempts to put a catheter in; right?

A. Well, I'm not sure I understand the thrust of that question. I guess if one could do it once, they could do it twice. But I think the general thrust of your questions would -- is -- is is this something that would be -- would it be easy to leave a guidewire within a patient, and my answer to that question would be no, certainly without recognizing it.

Q. Right. And how would you characterize a physician leaving two guidewires in a patient and not apprising anybody of it, not reflecting that it had occurred in the record?

MR. FULTON: Objection. That isn't a fair statement. It is in the record.

MR. KAMPINSKI: Well, from February 26 until it was recognized by somebody else, it isn't in the record.

A. Well, I think a physician who -- who knowingly leaves behind two guidewires in a patient, not telling another physician or a superior in a training circumstance, that that would certainly fall below the

standard of care.

Q. And that's it, huh, just fall below the standard of care?

A. Well, I'm not sure what you're -- what you're asking me to say.

Q. Well, that's how you would characterize that conduct, as falling below the standard of care?

A. It certainly does that.

Q. Does it go beyond falling below the standard of care --

MR. FULTON: Objection.

Q. -- Doctor?

MR. FULTON: Objection.

A. I really can't answer that, sir.

Q. Well, does it reflect a reckless disregard for the rights and safety of -- of that patient?

MR. FULTON: Objection.

MR. FRANEY: Objection.

A. That's not a medical term on which I could provide an expert statement.

Q. Well, is it disgusting, repulsive, abhorrent?

MR. FULTON: Objection.

Q. Unethical, immoral? I mean do those adequately describe that conduct?

MR. FULTON: Objection.

MR. FRANEY: Objection.

MR. OKADA: Objection.

A. I don't think I could agree to any of those comments.

Q. You don't agree with those?

A. No.

MR. KAMPINSKI: That's all I have.

MR. FULTON: Can we take a short break?

MR. KAMPINSKI: You need more coffee?

MR. FULTON: Yeah. I want to give you some to make you more pleasant.

MR. KAMPINSKI: No. Let's stay on -- let's stay on the record.

MR. FULTON: Oh, we'll stay on the record any time with you, Kampinski.

MR. KAMPINSKI: We'll stay on the record totally.

MR. FULTON: Good. On the record all the time.

MR. KAMPINSKI: That's right.

MR. FULTON: Just remember, I'm a lot older, but if you ever step across that line, you better be ready to kill me, buddy.

MR. KAMPINSKI: Well, that -- that makes -- that makes two of us.

MR. FULTON: All right. Then we know each

other.

MR. KAMPINSKI: That -- that makes two of us.

MR. FULTON: Good.

MR. KAMPINSKI: We do know each other.

MR. FULTON: You're damn right we do.

MR. KAMPINSKI: Anyone else going?

MR. SEIBEL: Yeah. I need a mike. I'm going to go.

MR. FULTON: You need this?

MR. KAMPINSKI: Can you pick up objections?

MR. FULTON: You want this one?

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EXAMINATION

By Mr. Seibel:

Q. Dr. Smead, my name is -- we were introduced before your deposition, but for the record, my name is Bob Seibel, and I represent Dr. Moasis in this case.

Would you tell the jury when Dr. Moasis became involved in the care of Mrs. Weitzel?

A. Well, there was a consult note in the record that would document that date quite clearly, be 3-13-91.

Q. Right. It wasn't until March 13th of 1991 that Dr. Moasis was in any way involved with the care and treatment of Mrs. Weitzel; correct?

A. That's correct, to my knowledge.

Q. And the remaining guidewire that was present in Mrs. Weitzel at that time posed significant risks to Mrs. Weitzel, did it not?

A. Potential risk, yes.

Q. And those risks included perforation of the artery in which the wire lied?

A. That's correct.

Q. And would you tell the jury and maybe describe on yourself where the iliac artery, the aorta, and the carotid artery are?

A. Well, the carotid artery, the main arteries to the brain that come off the transverse arch of the aorta in that direction. One of the wire's tips was up the left common carotid artery.

The aorta is the entire great vessel from the heart across the transverse arch, descending aorta, abdominal aorta, to about the level of the bellybutton, where it divides into the two common iliac arteries, which go a short distance, where they divide into the internal and external iliac arteries. And a catheter was -- these guidewires were in the left common iliac artery, abdominal aorta, descending thoracic aorta and left carotid aorta.

Q. And one of the risks to Mrs. Weitzel of the remaining wire was perforation of any of those portions

of those arteries; correct?

A. That's correct, although the perforation would be most likely at the tip of the guidewire, which would be either in the carotid artery or the iliac article.

Q. And if it was in the carotid artery, that's the major blood vessel that services -- that provides blood to the brain?

A. That's correct.

Q. And another risk that was posed by this wire was having a blood clot travel from any portion of this arterial system?

A. Well, any intraluminal foreign body -- guidewire would be a good example -- can incite clotting of blood around the catheter, which could lead to just complete blockage or occlusion of the blood vessel or embolization of that clot, that is breaking loose and traveling in the arterial circuit to plug up a vessel below that -- that point.

Q. And this wire also posed a potential of embolizing or causing a piece of atherosclerotic plaque to embolize as well?

A. That's correct.

Q. And another risk to Mrs. Weitzel of the presence of this wire was that it might be the site of an infection?

A. Yeah, any -- any intraluminal foreign body or, in fact, any foreign body within the body can become a nidus for infection.

Q. And all of those risks from the guidewire were life threatening; correct?

A. Potentially life threatening, yes.

Q. And you would agree that the wire had to be removed at some point --

A. Yes.

Q. -- because of those risks?

A. That's correct.

Q. And there's no way that you as a physician could predict when any of those risks would occur in Mrs. Weitzel?

A. That's correct.

THE VIDEOGRAPHER: Excuse me, counsel. I have to go off the tape to change my videotape.

We're off record.

(Recess taken.)

THE VIDEOGRAPHER: We're on record.

Q. Doctor, picking up where we left off, the wire had to be removed because of the risks it posed to Mrs. Weitzel's life; correct?

A. That's correct.

Q. And, in fact, if the wire was left in, it is

very likely that one of those life-threatening complications would occur?

A. More likely than not, yes.

Q. And a careful and conscientious physician would not have sent Mrs. Weitzel home with one of those wires in her; correct?

A. Most probably not.

Q. Isn't it true that Dr. Moasis chose the only plausible surgical procedure, to retrieve this wire?

A. Well, I think there were some -- some other plausible procedures to remove the wire, but this was I think the most logical approach.

Q. And bleeding, postoperative bleeding, is a known complication of virtually any vascular surgery?

A. That's correct.

Q. And the fact that Mrs. Weitzel began to bleed sometime after her surgery on March 14th is not evidence that Dr. Moasis improperly performed the surgery.

A. That's a true statement.

Q. And from the hospital records and reading Dr. Moasis's testimony, there is no evidence that Dr. Moasis was negligent in his postoperative involvement with Mrs. Weitzel?

A. No, there's no written evidence that he was negligent postoperatively.

Q. Now, the decision to do surgery, that involves balancing the risks versus the benefits?

A. That's correct.

Q. And in any given case where the benefits outweigh the risks, the decision to proceed with surgery is appropriate and reasonable?

A. Yeah, as a general statement, that's true.

Q. And at least here, the benefits of the March 14th surgery to remove the remaining wire were avoiding the life-threatening problems that were likely to occur at any time?

A. That's correct.

Q. And the people involved in assessing the risk of the surgery would be at least the cardiologist; correct?

A. Yes.

Q. The anesthesiologist?

A. Yes.

Q. And the surgeon?

A. Yes.

Q. And the real worry in a patient like Mrs. Weitzel, who's had a recent MI, is surviving anesthesia; correct?

A. Anesthesia and the hemodynamic consequences of your operation.

Q. As far as you were able to glean from the

records, Mrs. Weitzel had no anesthetic-related complications from her March 14th surgery; correct?

A. Well, it's difficult to -- to very accurately break out anesthetic versus surgical complications, you know, to break it out specifically, but there are no specific complications related to the course of the anesthesia that I can sort out.

Q. And you're not telling this jury that the decision to go forward with surgery on March 14th was a breach of reasonable medical care, are you?

A. No.

Q. And, in fact, in your practice as a vascular surgeon here at Ohio State, you depend on cardiologists referring patients to you for surgery to have assessed the medical risks of any particular surgery?

A. Yes.

Q. And I want to ask you a couple more questions about the postoperative period.

If you assume things happen the way the medical records suggest they did, then the coronary care unit nurses and the hospital resident negligently cared for Mrs. Weitzel after her surgery; correct?

MR. FRANEY: Objection.

MR. OKADA: Objection.

A. Yes, I would agree with that.

Q. And that's because the records indicate that around four hours after surgery, Mrs. Weitzel's condition began to deteriorate?

A. Yes, that's true.

Q. Her blood pressure began to fall?

A. Yes, although it didn't -- it was -- fall in the sense it was lower than the initial measurement, but it's still not fallen to a -- an abnormal level.

Q. Her heart rate went up?

A. Yes, it did.

Q. She became diaphoretic or sweaty?

A. That's correct.

Q. And her respiration rate increased?

A. That's correct. That's perhaps the most worrisome observation.

Q. During that particular period, beginning four hours after surgery, she would have survived that particular episode if she had received appropriate therapy; correct?

MR. FRANEY: Objection.

A. I think that's -- I can't say that, that statement specifically.

Q. Well, do you recollect me asking you that question at your deposition last week Doctor, page 68?

A. Well, if you're asking me would she have

survived the evening, I think the answer to that question would be clearly correct. If you're asking me if she would survive, you know, her hospitalization, then I would disagree with -- with that.

Q. Sure.

A. And all of the postoperative mortality following myocardial infarction does not occur during the first postoperative day or even the first postoperative few days.

Q. I understand what you said before, and my question was simply if she had received appropriate therapy sometime after she became -- she began -- strike that.

If she received appropriate therapy sometime after she became hemodynamically unstable, around four hours after surgery, she would have at least survived that particular bleeding episode; correct?

MR. FRANEY: Objection.

A. I would like -- I'd rather answer that question that it would have, you know, significantly improved her chances of -- of surviving that particular bleeding episode. You know, I'm not absolutely positive that the hemorrhage is completely responsible for -- for her clinical deterioration, although I'm sure it was a major contributing factor.

Q. Do you have your deposition in front of you, Doctor?

A. No.

MR. FULTON: No, but I have it here. What page do you want?

MR. SEIBEL: Page 68.

THE WITNESS: I do.

Q. All right. I asked you a question at line 10, and you gave me an answer at line 12, but actually it began with your answer to a previous question where you said "Had she been resuscitated appropriately, had she been resuscitated following the postoperative hemorrhage, I think her mortality risk would have been the same as it had been since the day before her -- the wire was put in." Then I asked you, "Would she at least have survived this postoperative bleeding episode?" Your answer, "Most probably."

A. I think we may be -- I would agree with that statement, and I think we may be, you know, quibbling with regard to detail or -- or semantics. But clearly had she been appropriately resuscitated that evening, her chances of surviving that bleeding episode would have been significantly improved and she would most probably have survived it.

Q. She had about an even chance that she would not

have needed more surgery that night; correct?

A. Yes, I think it s -- about half of these will stop on their own. About half of them require exploration for surgical control of bleeding.

Q. And to give her the chance of even avoiding more surgery and of surviving that particular episode, all she would have needed were IV fluids and maybe a blood transfusion?

A. Yes. Perhaps clotting factors if those were abnormal.

Q. And it's just as common for bleeding to stop on its own versus the need to reexplore with surgery?

A. Yes, at least as common, perhaps more common.

Q. Now, we can agree, can't we, Doctor, that Mrs. Weitzel underwent surgery on March 14th, 1991 because of a wire that was never meant to remain in her and had to come out?

A. I can certainly agree with that statement.

Q. And there's an agreement among vascular surgeons that intraluminal foreign bodies are bad?

MR. FULTON: Objection to the form of that question.

A. Yeah, I think intraluminal foreign bodies of this nature are bad.

Q. And they have to be removed?

A. In my opinion, yes.

Q. And it's simply a matter of judgment when they should be removed; correct?

A. That's correct.

MR. SEIBEL: I have nothing further.

MR. FRANEY: Want to go?

MR. FARCHIONE: Sure.

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EXAMINATION

By Mr. Farchione:

Q. Doctor, my name is Joe Farchione. I'm here on behalf of Dr. Steele.

Would you define what you -- you mean by the term "standard of care"?

A. I suspect that's at least as much a legal term as it is a medical term. My understanding --

Q. I'm interested --

A. My understanding of it --

Q. I'm interested in the medical.

A. My understanding of it as a physician is that the standard of care would represent that behavior on the part of a physician, a reasonable and prudent physician, in caring for an individual patient.

Q. Would you agree with me that two physicians can look at the same fact scenario and make two different

judgments as to the course of treatment for that particular patient?

A. That's most certainly true.

Q. And just because two physicians reach two different courses of action doesn't mean that one of them was below the standard of care; correct?

A. Not necessarily, no.

Q. Now, after removing the first wire in this case, the physicians were faced with a choice, were they not? They could either make another attempt at a percutaneous removal or they could perform surgery?

A. Or they could do nothing at all I guess would be the other part of the choice, but yes.

Q. Well, it wouldn't be wise to do nothing at all, to leave that in there permanently, would it?

A. Not permanently. But another decision would have been to leave it in there for several days, weeks, even a month, and remove it at a more remote interval from the myocardial infarction.

Q. Well, the timing issue that you just mentioned, that's a matter of judgment which is made by the physicians caring for a patient; correct?

A. That's correct.

Q. And as far as the choice between surgical removal or another attempt at a percutaneous removal,

that's also a judgment made by the physicians caring for that patient at that time?

A. That's correct.

Q. As it relates to -- to Dr. Steele and his hands-on care and treatment, you do not have an opinion that he deviated from accepted standards of care, do you?

A. I do not.

MR. FARCHIONE: That's all I have.

MR. FRANEY: Hand it over here now.

MR. FULTON: Take it around my back. Don't step on it.

MR. KAMPINSKI: I'm going to object to Mr. Franey asking questions on behalf of Saint Vincent Charity Hospital --

THE WITNESS: Is there any more there? Is there any more there?

MR. FULTON: Get the -- get the doctor --

MR. FARCHIONE: I'm kind of tethered into the -- into the system here by my microphone.

MR. FULTON: Get his first. There isn't much left.

MR. KAMPINSKI: -- in light of the fact that Saint Vincent Charity Hospital is responsible for the conduct of Dr. Varma and should not be allowed to ask questions in addition to Mr. Fulton of this witness.

Either one should ask questions or the other, not both.

MR. FRANEY: Well, the record will reflect that Mr. Fulton is here on behalf of Dr. Varma and I am here on behalf and Mr. Coyne has throughout the course of this litigation represented only Saint Vincent Charity Hospital and various other physicians and nurses, and at no time have we ever represented Dr. Varma. With that objection, I'm going to proceed with my cross examination.

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EXAMINATION

By Mr. Franey:

Q. Doctor, Mrs. Weitzel had an unattended heart attack, is that correct, at work, from your review of the records?

A. That's correct.

Q. Okay. And she had a rather severe heart attack; wouldn't that be correct?

MR. KAMPINSKI: Objection. Asked and answered. Repetitive. This was already gone over by Mr. Fulton, which merely points out why this is totally inappropriate.

Q. Go ahead, Doctor.

A. Yes, it was a severe heart attack.

Q. Okay. Doctor, what does it mean for a person to

go pulseless for a period of time?

A. Well, it means that the cardiac o tput is insufficiently large to produce a palpable pulse. The implication of that is that the profusion of the major organs, the heart, brain, kidneys, is insufficient to maintain viability for a long period of time.

Q. What does it mean for a person to go without blood pressure for a period of minutes?

A. It means that one has got insufficient cardiac output to allow the measurement of a recordable blood pressure.

Q. Okay. And what is CPR?

A. Cardiopulmonary resuscitation, which is a standard -- now standard protocol consisting of maintaining an airway, maintaining breathing and cardiac activity by virtue of airway and external cardiac massage.

Q. And what is anoxic encephalopathy?

A. It means -- the encephalopathy means pathologic condition involving the cerebrum, the brain, relating to a period of low or absent oxygen.

Q. Okay. Can that be a consequence of a prolonged period of being pulseless and having no blood pressure?

A. That's the most common cause of anoxic encephalopathy.

Q. Okay. And wasn't Mrs. Weitzel suffering from anoxic encephalopathy at or about her time of admission to Ashland Hospital or Saint Vincent Charity Hospital later on?

MR. KAMPINSKI: Objection.

A. In my opinion, yes.

Q. Okay. And what is the -- what are the chances of survival of a person suffering an unattended myocardial infarction that results in anoxic encephalopathy?

MR. KAMPINSKI: Objection.

Q. Do you have an opinion to a reasonable medical probability?

A. I do.

Q. What is your opinion?

MR. KAMPINSKI: Objection.

A. My opinion is that the majority of those patients do not survive.

Q. And what is your opinion with regard to those that survive in terms of their quality of life? Do you have an opinion to a reasonable medical certainty?

MR. KAMPINSKI: Objection. Asked and answered. Same reasons.

A. The large percentage of the --

MR. KAMPINSKI: Can I finish my objection,

Doctor?

THE WITNESS: Oh, excuse me.

MR. KAMPINSKI: Same reason I've objected previously, I'm objecting to it again. I'm sorry.

A. The very large percentage of those patients who survive are left with severe neurologic impairment.

Q. Doctor, you reviewed the autopsy in this case?

A. I have.

Q. Okay. In the autopsy, if you -- do you have it there in front of you?

A. No, I do not.

Q. Do you have another copy of the autopsy? Referring to --

MR. FULTON: What page?

Q. Referring to page 1 of the gross anatomical description, it lists a heart weight of 396 grams. Is this -- and on page 2, in the cardiovascular section of that same autopsy, indicates that the heart is enlarged and this is due predominantly to the enlargement of the left ventricle. My question to you, Doctor, is is that heart weight an abnormal finding?

A. It is an abnormal finding.

Q. What does it suggest?

A. Well, it --

MR. KAMPINSKI: Objection.

Q. Based upon your training as a physician and your experience, to a reasonable medical probability.

MR. KAMPINSKI: Objection.

A. In this case it suggests enlargement of the heart relating to increased muscle mass in the left ventricle, the major pumping chamber of the heart.

Q. And what is severe stenosing calcific arteriosclerosis?

A. Severe is self-explanatory. Stenosing means that this process causes a narrowing of the blood vessel. Calcific reflects the fact that this disease of atherosclerosis or commonly known as hardening of the arteries contains calcium, quite a common finding. So this observation is that this patient has coronary artery disease, that these plaques have developed that have caused a severe narrowing of the blood vessel, and that the plaques contained calcium.

Q. And what is near if not complete occlusion of the anterior descending branch of the left coronary artery mean to you based upon your training as a physician?

A. It means that there was such a severe narrowing or even occlusion of the left anterior descending coronary artery, which is the main artery supplying the anterior or front wall of the heart, which is, in fact,

that portion of the heart which was presumed to be the -- the site of the heart attack based on the electrocardiograms.

Q. Okay. So a near if not complete occlusion of that descending artery can result in a person having a heart attack?

A. It's the most common cause of heart attack.

Q. Okay. Referring to the -- further on down in that same paragraph, "The affected area measures up to two inches vertically and up to one inch horizontally," and are we talking about, I take it, the area of damage to the heart itself? Is that correct?

A. They're describing the area of the heart which grossly appears to be the site of the infarction, which means death of tissue.

Q. Would you -- would you describe that as a significant finding --

MR. KAMPINSKI: Objection.

Q. -- based upon your training as a cardiovascular surgeon?

A. Yes, that's a significant finding.

Q. Okay. Does that -- is that based upon your training and experience, evidence of substantial heart damage?

MR. KAMPINSKI: Objection.

A. That would be substantial, yes.

Q. In the respiratory section it says, "The lungs are similar. Both are of greatly increased weight and decreased crepitance." What does that mean, Doctor?

A. Well, it means that the lungs weigh a lot more than they should be. The most common cause by far of that is increased lung water, which can be related to either infection or -- or what's called pulmonary edema, and decreased crepitance reflects the decreased amount of air within the lung tissue.

Q. Okay. And a person that -- you've testified that Mrs. Weitzel underwent or suffered from adult respiratory distress syndrome. Are those findings on autopsy consistent with a person suffering from adult respiratory distress syndrome?

A. They would be classic findings.

Q. Are they also consistent with a person that has had bilateral pneumonia?

A. Yes.

Q. We know that Mrs. Weitzel's cardiovascular problems were not caused by any negligence of any physician; isn't that correct?

MR. KAMPINSKI: Object.

Q. Or any treatment personnel?

MR. KAMPINSKI: Objection.

A. That would be my opinion.

Q. Based upon your review of the records; correct?

A. That's correct.

Q. We know that Mrs. Weitzel's adult respiratory distress syndrome was not caused by the negligence of any physician; isn't that base --

MR. KAMPINSKI: You know, I mean, this has been going on now for 15 minutes. The leading questions that you're asking is further evidence of why it is you shouldn't be asking questions. The hospital is responsible for the conduct of Dr. Varma. To allow you to ask leading questions of this witness is absurd, and I object.

MR. FRANEY: Mr. Kampinski, you've had your objection --

MR. KAMPINSKI: Yeah.

MR. FRANEY: -- and your speech.

Q. Now, you -- with regard to the adult respiratory distress syndrome that Mrs. Weitzel sustained while a patient at Saint Vincent Charity Hospital, is it -- it is your opinion that that is not due to the negligence of any physicians or nursing personnel; isn't that correct?

MR. KAMPINSKI: Objection.

A. I find no evidence of negligence by those parties during this patient's hospitalization.

MR. FRANEY: Mr. Kampinski, I'll give you a continuing objection to all my questions. How does that sound?

MR. KAMPINSKI: To all your questions?

MR. FRANEY: Any questions -- you tell me when you want to stop your continuing objection, so we don't have --

MR. KAMPINSKI: Well, it's not continuing -- If you want to stop your leading questions, maybe I'll stop objecting to each leading question. This man is an employee of the hospital. You can't ask leading questions of him. That's all you've been doing. And I object and I'll continue to object.

MR. FRANEY: Okay. And I'm giving you a continuing objection.

MR. KAMPINSKI: Well, thank you. I'll still continue to object.

MR. FRANEY: Fine.

Q. We know that the anoxic encephalopathy was not caused by the negligence of any physician; isn't that correct?

MR. KAMPINSKI: Objection.

A. I find no evidence of -- that that would be related to negligent care.

Q. Okay. And you find that during -- during her

stay, Mrs. Weitzel developed liver and kidney complications; isn't that correct?

A. That's my finding.

Q. Okay. And that she evidenced signs of neurological problems; isn't that correct?

MR. KAMPINSKI: Objection.

A. That's my opinion.

Q. During the course of her time there, she also developed sepsis; isn't that correct?

MR. KAMPINSKI: Objection.

A. That's my opinion.

Q. Okay. She has -- there is no evidence or you do not have any opinion to suggest that any of those problems, the liver and kidney problems or the neurological problems or the infectious sepsis problem, were caused by any negligence of any physicians or nurses; isn't that correct?

MR. KAMPINSKI: Objection.

A. That would be my opinion.

Q. What function does a pacemaker serve in a patient such as Mrs. Weitzel?

A. Well, there might be several. Many patients following myocardial infarction develop what's called heart block where the electrical conducting system of the heart is involved, and pacing is required just to

maintain normal cardiac activity, pulse rate. In some patients, rapid pacing of the ventricle usually, but occasionally the atrium may be helpful in overriding a focus of ventricular irritability. What that means in lay terms is if you have a heart attack and you have a part of the heart muscle which is -- is irritable and is the source of ventricular fibrillation or ventricular tachycardia, which are two significantly lethal rhythms, one can occasionally -- and in this case it would appear that it was successful -- one can occasionally override this focus of ventricular irritability and prevent its, you know, its continuation, and in fact can be lifesaving.

Q. In this case, it can be used to stabilize the patient?

A. That's correct.

Q. Doctor, based upon your review of the records that are there in front of you, did you find any evidence that Mrs. Weitzel had developed any of the complications from the guidewires being left in her that you spoke about during Mr. Seibel's cross examination of you, that is infection, thrombosis --

MR. SEIBEL: Perforation.

Q. -- perforation of the line -- of the artery?

A. No.

Q. What does the term "emergent surgery" mean?

A. That's surgery that's indicated right now, as quickly as it can be arranged.

Q. Do you have an opinion to a reasonable medical probability whether the surgery performed on Mrs. Weitzel on or about March 14th was emergent in nature?

A. I do have an opinion.

Q. What is your opinion?

A. That it was not emergent.

MR. FRANEY: I have no further questions.

MR. OKADA: I have no questions. I have no questions on behalf of the Cleveland Clinic Foundation.

MR. FULTON: Mr. Kampinski, I just have about three questions. Want me to go first or you go?

MR. KAMPINSKI: I think if we were going in turn, it would be your turn. I object to your asking questions in addition to the questions that were just asked by Mr. Franey for the same reason that I objected to his asking questions that you've already asked.

MR. FULTON: Well, this will be very short.

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FURTHER EXAMINATION

By Mr. Fulton:

Q. These questions are in reference to questions asked of you by Mr. Seibel. You did come to certain

opinions based upon reasonable medical certainty, probability, regarding whether or not a second attempt should have been made percutaneously, did you not?

MR. SEIBEL: Objection.

MR. FARCHIONE: Objection.

A. I did.

Q. And what is that?

MR. SEIBEL: Objection. Move to strike.

A. I --

MR. FARCHIONE: Same objection.

A. It was my opinion that a second attempt should be attempted.

Q. And do you have an opinion, again based upon reasonable medical certainty and probability, whether an interventionalist with greater experience should have been contacted regarding the possibility of a second percutaneous removal?

MR. SEIBEL: Objection.

MR. FARCHIONE: Objection.

Q. Go ahead.

A. I guess I have an opinion.

Q. Would you state it, sir?

A. Well, I think my opinion would be that the two specialties which -- who would be specialists who would be most capable of performing percutaneous extraction of

guidewires or catheters would be either an interventional radiologist or cardiologist and that it would depend almost entirely upon the local experience and individual expertise of the individual rather than the specialty they represent.

Q. All right. And you were asked a question both by Mr. Kampinski and Mr. Seibel dealing I believe with the surgery and also dovetailed into standard of care.

Forgetting any standard of care, do you have an opinion based upon reasonable medical certainty and probability as to whether the surgery contributed to her death? Do you have an opinion?

A. I do have an opinion.

Q. What is that, sir?

A. Well, I think that certainly the timing of her death was advanced by the operation.

Q. And do you have an opinion, sir, with reasonable medical probability and certainty as to whether or not the delay in recognizing or reporting the presence of these guidewires had any effect upon her survival?

A. I do have an opinion.

Q. What is that?

A. It had no effect on her survival, her survivability.

Q. This last question dealing with Mr. Kampinski.

He asked you several questions and had you draw a line with respect to Apache 11, Defendant's Varma Exhibit E. Was there something within the contents of the article you wanted to explain relative to mortality rate?

MR. KAMPINSKI: I'm going to object for the previous reasons that I've objected to the discussion regarding some study or document.

Q. That may be an inarticulate question, but do you understand what I'm asking you? Was there something you wanted to refer to in the base of the article?

MR. KAMPINSKI: And if you don't mind, I will take a continuing objection as I did earlier.

MR. FULTON: That's the last question.

A. Yes. These charts that are drawn in this article are -- I would -- I would feel confident are not intended to be accurate within fractions of a millimeter as to whether this is 48 percent or 52 percent mortality rate.

In the body of the article, the Apache II score between 20 and 29 represents a 50 percent mortality rate, so it sits right on the -- on the fence, so to speak, and, you know, I think that's -- that's what I was -- I was going to refer to.

If one looks at all of the patients studied in this paper with post cardiac arrest as the diagnosis,

there were 155 patients, 103 deaths. 66 percent of these patients d ed. Now, they clearly represented patients with Apache II scores that ranged from the very low to the very high, but clearly a very significant majority of patients post cardiac arrest in this paper, some 155 patients died during their hospitalization.

MR. KAMPINSKI: Just what are you referring to, so we --

THE WITNESS: I'm referring to the article, "Apache 11: A severity of disease classification system" by Knaus, Draper, et al.

MR. KAMPINSKI: No. What part in terms of the citation you'd just given?

THE WITNESS: Page 826, figure 6, or perhaps table six. Table six. If one looks at nonoperative patients, the second category is cardiovascular failure or insufficiency from -- the third from the bottom in that subsection is post cardiac arrest. Number of patients studied was 155, number of deaths 103, for a 66 percent mortality rate.

MR. FULTON: I have no further questions.

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FURTHER EXAMINATION

By Mr. Kampinski:

Q. Once again, this question, Doctor, is premised

upon what the court does with respect to allowing or disallowing discussion regarding this article.

You're the one that pointed out on direct examination this figure four as most reflective of where she would fall in terms of death rate, and that is the congestive heart failure, which you then conceded didn't even exist later on in her hospitalization; correct?

A. Yes.

Q. Okay. And that does fall below 50 percent, which would mean, at least according to that part of the article, that she probably would have lived if that is the accurate table; correct? Am I correct or incorrect?

A. Well, I -- I continue, I guess, to -- to find that exact bar being drawn across as a straight line being 48 percent in a bar graph with no cross -- crosshatches in the vertical or horizontal axis is not meant to be precise.

Q. Doctor, this --

A. Again --

Q. -- is a simple question.

A. And I'm trying to give you a simple answer.

Q. Well, am I correct that if, in fact, that is the accurate graph, which is the graph that you pointed out, it's less than 50 percent? Simple question, and I'd like a simple answer from you if I could have one.

A. My answer is that it's about 50 percent.

Q. It's less than 50 though, isn't it?

A. My answer is it's about 50 percent.

Q. Is the graph less or more than 50, sir?

A. It's about 50 percent. It's not intended to be more precise or accurate than my statement allows.

Q. If you look at page 825, and under the discussion part, the bottom paragraph, it says "It should be emphasized" -- this is by the author of this article apparently -- "that first day Apache II scores do not perfectly predict death rates for individual patients." You'd agree with that, wouldn't you?

A. Yes.

Q. Okay. And that these prognostic estimates are still only estimates? I think he goes on to say that.

A. Yes, I would agree with that.

Q. All right. And, Doctor, anoxic encephalopathy which you were asked to define, that refers to an event occurring, that is lack of blood supply to the brain for some period of time. It could be momentarily; it could be longer. Correct?

A. That's correct.

Q. All right. And it doesn't tell you -- I mean just the term itself doesn't tell you anything about whether or not somebody has sustained permanent damage,

partial damage or no damage; correct?

A. That's correct.

Q. Okay. So you would have to look at how that person later responds -- would that be a fair statement -- to determine if they've suffered any damage neurologically?

A. That's correct.

Q. Okay. And one of the things that you did, I think you testified earlier, was you looked at the very first day to see how she responded?

A. Well, the -- the first day or two days because remember her -- her first day in Saint Vincent's Hospital was the first -- the end of the first day following her arrest.

Q. Okay.

A. And the first day at Saint Vincent's Hospital was the second day following arrest.

Q. Yeah. And I think you testified you didn't even have the Ashland records, so obviously you didn't look at those.

A. That's correct.

Q. So the values you looked at and the evidence you looked at in this case to reach your opinion was based upon the first day at Saint Vincent's?

A. That's correct.

Q. All right. And I'm going to apologize to you and I'm going apologize to the jury, Doctor, because what I have previously marked as -- and, by the way, it would make a difference to you if neurologically she was not in bad shape the first day, right, in terms of the prognosis?

A. Yes.

Q. Okay. And I'm going to apologize to both you and the jury because the sheet that I had marked that you couldn't find that I was suggesting somehow was on the 20th, as a matter of fact, I think you'll find on the 12th, the very first day.

A. 12th?

Q. Yes, sir.

A. The 12th of February?

Q. Yes, sir.

A. Okay. I was -- do you want me to look that up now?

Q. Yeah, please.

A. Can I look at that sheet again to compare it?

Q. Yes, sir. Well, what I've got is I have a photograph copy of the chart, and looking at it chronologically, that same sheet is the --

A. Yes, I have --

Q. -- first, second, third, fourth -- fifth sheet

in the record?

A. I have -- I nave found that now.

Q. All right. And it does indicate that on the very first day, she was attempting to mouth words; she was trying to write, but she couldn't hold the pen in her right hand because her right hand was swollen. She was awake and cooperative. And this is by numerous nurses a reflecting this. She's awake, cooperative, following commands well, denying any pain, requesting -- or she nods understanding. Is that correct, Doctor, throughout that -- that nurses' note chart?

A. That's substantially correct, yes.

Q. That would indicate, would it not, that she was not comatose; correct?

A. Yes.

Q. And that she was, in fact, understanding and responding and was cooperative and she was attempting to communicate; am I correct about that, sir?

A. Those particular references in the nurses- note would -- would suggest that, yes.

MR. KAMPINSKI: That's all I have.

Q. By the way, that corresponds with Exhibit 1-C that I had marked earlier; correct?

A. Yes.

MR. KAMPINSKI: All right. I apologize.

MR. SEIBEL: I'm not sure we picked it up.

Q. That corresponds with Exh bit 1-C, correct, Doctor?

A. Whatever exhibit.

MR. FULTON: We'll agree that's a fact.

A. Yes.

MR. KAMPINSKI: All right.

MR. FULTON: You going to leave that with the reporter?

MR. KAMPINSKI: Well, not anymore, now that we know that it's in the chart.

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FURTHER EXAMINATION

By Mr. Seibel:

Q. Doctor, very briefly. We've been here a long time and you've been patient, but one -- one point in follow-up.

When you talk about the likelihood that the remaining wire would cause one of the recognized complications that we discussed, there is, in fact, literature that studies the complication rates from retained intraluminal foreign bodies; correct?

A. There is.

MR. KAMPINSKI: Objection.

Q. And at least one of the articles that you, in

fact, cited me to after last week's deposition indicates a complication rate of about 71 percent?

MR. KAMPINSKI: I'm going to object to the literature.

Q. Would you like to take a look at it just briefly?

A. No, that's -- that's --

MR. KAMPINSKI: Can I have a continuing objection, Mr. Seibel?

MR. SEIBEL: Sure.

A. That's correct.

MR. SEIBEL: That's all I have.

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FURTHER EXAMINATION

By Mr. Farchione:

Q. Doctor, your opinion that, instead of surgery, a second percutaneous attempt should have been made is a personal opinion, is it not, Doctor?

A. That's correct.

Q. All right. You're not in any way suggesting that it was a deviation from accepted standards of care for the physicians to go ahead and do the surgery, are you?

A. No. I think it's an example of the sort of difference of opinion of physicians about the management

of a particular medical problem.

Q. And, Doctor, when you review a case, would you agree with me that it would be fair to look at the care and treatment in light of the standard of care as opposed to personal opinions?

A. I'm not sure I understand that question.

Q. Well, when you review a case, Doctor, do you review it in terms of what the standard of care would require of that physician?

A. Well, I first of all read through the case and then try to determine, you know, what I would feel would be the most appropriate care issues, and at those junctures where they're different, then would try to assess whether that care fell below a standard of care. This is a -- is a particular issue where I'm not aware of any very clear standards of care, and so it really gets down to a difference of opinion as to the risk-benefit ratio of surgery versus percutaneous removal versus a continued course of observation. Although I may come up with a different opinion as to how I would have approached the problem, it's my opinion that the course taken in this case did not fall below the standard of care.

MR. FARCHIONE: Thank you, Doctor. Nothing further.

MR. FRANEY: All right. Doctor, one -- a couple of quick follow-up questions.

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FURTHER EXAMINATION

By Mr. Franey:

Q. In response to Mr. Kampinski's objection, you were --

MR. KAMPINSKI: Let me just object again, Mr. Franey, for the same reason I've been objecting.

Q. You were not -- you were not retained by either Mr. Coyne or by myself on behalf of Saint Vincent Charity Hospital in this litigation, were you?

A. No, I don't think so.

Q. Okay. You were retained by Mr. Fulton on behalf of -- of the doctor, of his client; correct?

A. That's my understanding.

Q. Now, Doctor, what is the basis for your opinion that Mrs. Weitzel sustained brain or neurological complications or dysfunction?

MR. KAMPINSKI: Objection.

A. Well, following arrest, she was described as being unresponsive. She was respon -- said to have exhibited the physical finding of clonus.

Q. What is that, Doctor?

A. It's a clonic-tonic shaking movement usually in

an extremity in response to flexion-extension of the extremity.

Q. Okay. What's --

A. And it's usually a sign of severe neurologic dysfunction.

Q. Where in the chart are you locating that? To speed things along --

A. I think it's the --

Q. -- I see a note at **2-12-91**, history and physical of the doctor's clinical note, positive clonus?

A. Yeah. That's the initial neurologic examination, which was not particularly complete.

Q. Okay.

A. Also there are notes in the chart suggesting a significant enough decrease in mental status to rec -- that there are a few notes in here suggesting the need to do a CAT scan to rule out intracerebral hemorrhage.

Doll's eye activity, which was referred to earlier, is a sign of significant midbrain damage in which the eyes keep to the center when the head is turned to one side or the other, very much like a doll would, to -- to motion. That's usually a negative significant neurologic sign suggesting a poor prognosis.

During the first day of following her arrest, she was described as being decorticate, which is an

exaggerated extensor response usually to stimulus, usually a sign of midbrain involvement.

On 2-12-91, neuro exam, patients eyes wander. I'm not sure exactly what that means. I suspect that does not reflect purposeful eye movement. "Patient doesn't follow commands." This is again by a physician. Blinks to clap. Does have a positive corneal reflex such as a blink to stimulation of the eyeball, and does respond with coughing to -- to suctioning.

On 2-12-91 later, the note "Positive clonus," which is usually a significant neurologic finding. On the same date earlier, she is described as having a left eye droop. That usually reflects upper motor neuron dysfunction, brain injury. The physician analyzing the patient thought it was most likely an anoxic event, thought that a CAT scan was indicated to rule out an infarct, which would be a stroke, related to that anoxic event.

There are other notes, you know, over the next several days which again reflect some evidence of neurologic dysfunction.

MR. KAMPINSKI: Objection. Move to strike unless he's going to point to some specific.

THE WITNESS: Do you have my copy of the -- of the hospital chart? I have some of those checked off and

noted. I could find them more quickly. I think that's it. I think that's it. If you'll hand me that.

What's in many ways most striking is the relative absence of notes regarding neurologic condition, and the reason for that I -- I don't know.

On 3-11-91 there's a note that -- that she responds minimally to noxious stimuli.

Q. What would that indicate to you, Doctor?

A. Significant alteration of neurologic status, certainly not a normal -- normal patient.

Later in the day there's another comment of obtunded, minimally responsive.

And the following day, neurologic exam really as above, requiring prolonged recovery time from sedation, neuromuscular blockade. Neuromuscular blockade really should be gone by 24 hours even with mild hepatic or renal dysfunction.

Q. And what would that indicate to you, Doctor?

A. Well, I'm -- I'm just suggesting that her neurologic status, you know, following her cardiac arrest now a month later was still not normal.

MR. FRANEY: Thank you, Doctor. No further questions.

MR. FULTON: No questions.

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FURTHER EXAMINATION

By Mr. Kampinski:

Q. Just a couple things, Doctor. Did I hear you suggest to the jury in reading a note on February 12th that they were going to do a CT because of her mental status? Is that what the note says? Would you refer to that note that you read on February 12th? I don't believe that's what it said, sir.

MR. FARCHIONE: Just put an objection down. I think this witness was Mr. Fulton's, and he's done asking questions, so this deposition should be done at this point.

MR. KAMPINSKI: Well, that may depend on how the judge rules on my objection to Mr. Franey asking questions, I suppose.

MR. FARCHIONE: May well.

MR. KAMPINSKI: That's right.

Q. You see that note that you read before, February 12th, sir?

A. Yes.

Q. It says, and I'm quoting, "If acute decreased mental status or focal deficit, need CT to rule out bleed." That's what it says; correct?

A. Yes.

Q. Was a CT done?

A. I didn't see that CT report.

Q. So there wasn't a decreased mental status or focal deficit then?

A. Well, I think there's ample evidence at least from the physician's note that there was a decreased mental status and the -- immediately, in the immediate preceding page to that note, that says "Check mental status, most likely anoxic event." I suspect that they weren't making the question -- the presumption that it was most likely an anoxic event based on any other basis other than the fact that she must have some neurologic disability.

Q. Doctor --

A. Star, "May need CAT scan to rule out infarct." Turn page. "If acute decreased mental status or focal deficit, need CT to rule out bleed."

Q. And they didn't do it, did they? So her mental status didn't decrease, did it, as opposed to your suspicions; correct, doctor? Am I correct about that?

A. Well, I'd have -- I didn't look at the specific radiology report to see if a CT had been done. My recollection, having reviewed this, you know, a week ago, was that the CT was normal and had excluded an infarct or -- or bleeding.

Q. Doctor, when Mr. Franey just asked you whether

or not you'd been retained by the hospital, your hospital has residents that you train; is that correct?

A. That's correct.

Q. Are they employees of the hospital?

A. No.

Q. Isn't the hospital responsible for them?

A. They're actually --

MR. FRANEY: Objection.

A. -- employees of the College of Medicine in this particular circumstance.

Q. Have you read the depositions with respect to what Dr. Varma's status was at Saint Vincent?

MR. FULTON: I have an objection here.

MR. FRANEY: Objection.

MR. FULTON: Just let me tell you why. Because I think you get into a legal proposition. But go ahead and ask it.

A. My understanding from the depositions, without being able to quote chapter and verse, is that Dr. Varma was a resident of the Cleveland Clinic Foundation and that the Cleveland Clinic Foundation had a relationship with Saint Charity Vincent Hospital to -- for resident training. We have that for several of the hospitals here in Columbus. In fact, Cleveland Clinic sends surgical residents down to Grant Hospital here in Columbus for --

for care. That's a common event. And that Dr. Varma was then funct oning as a medical resident at Saint Vincent Hospital, Charity Hospital.

Q. So, in other words, they would be responsible for his conduct while he was at Saint Vincent?

MR. FRANEY: Objection.

MR. FULTON: Objection.

MR. OKADA: Objection.

A. I think that would be a legal determination rather than a medical one.

Q. Well, how about Dr. Steele, would he responsible for the conduct of Dr. Varma while he was a resident of his?

MR. FARCHIONE: Objection. Beyond the scope.

A. Again, I think that's a legal --

Q. Well, are you responsible for your residents, Doctor, while they're working for you?

MR. FRANEY: Objection.

A. I have always presumed that I've been responsible for some of what they do and not responsible for other things that they might do without my direction.

Q. Well, are they responsible if it adversely affects on the patients that you're taking care of and that you allow them to take care of under your service?

MR. OKADA: Objection.

A. I think it would depend a bit on what actions the residents have taken towards my patients.

Q. How about putting a guidewire in and leaving it in?

MR. OKADA: Continuing objection.

A. Then I personally -- I personally would not feel responsible for that activity.

Q. Would the employer of that resident be responsible?

MR. FRANEY: Objection.

MR. OKADA: Objection.

MR. FULTON: Objection. That's a legal --

A. That's a legal opinion.

Q. Well, Mr. Franey opened this door in terms of trying to suggest somehow that the interests of Dr. Varma and Charity aren't the same. To the extent that Charity is responsible, Saint Vincent is responsible for Dr. Varma, then they are the same, aren't they?

MR. FRANEY: Objection.

MR. FULTON: Objection.

A. Again, I think that's a -- that's an issue that you lawyers are going to need to sort out among yourselves. It's not a medical issue.

Q. Well, let me try to sort out this last issue, Doctor. What do you have in front of you that's -- that

your elbow is on?

A. Oh, this is a xeroxed copy of the medical record that I was provided along with the other information.

Q. Well, you know --

A. As I've answered these questions, I've then come to the identical page in the actual medical record --

Q. Doctor, I had a simple question.

A. -- to verify its accuracy.

Q. I had a simple question which I've tried to ask you all evening. That was, what is it that is in front of you? Would you answer that for me?

A. Well, I have --

Q. No, no. The thing that's right in front of you.

MR. FULTON: What are you talking about?

Q. That right there.

A. This is a xerox copy of the medical record of Sharon Weitzel for the admission.

Q. That you just said was provided to you; correct?

A. That's correct.

Q. When I asked you earlier where the chart was that you were provided with, you said it was back in your office.

A. You asked me where the --

MR. FRANEY: Objection.

A. -- letter of expert opinion from Mr. Holland

was, and that is, in fact, probably back in my office.

Q. I asked you where the information was that yo were provided with. You said you didn't bring any of it here to the deposition, that it was all back in your office. That's what you testified to.

A. I think that was --

MR. FRANEY: Objection.

A. That was over on the desk over there.

Q. Can I see that, please?

A. Sure.

(EXHIBIT MARKED FOR IDENTIFICATION.)

Q. Doctor, I'm going to hand you what I've now marked as Plaintiff's Exhibit 2, and that's the record that you reviewed to give an expert opinion in this case?

A. It is.

Q. Would you please show the jury where the nurses' notes are in that record?

A. I didn't -- they're not in this portion of the record that is here today. They're back in my office, the nurses' notes. This is the progress notes, consultations, operative and path reports and physicians' orders.

MR. KAMPINSKI: That's all I have.

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FURTHER EXAMINATION

By Ir. Fulton:

Q. Well, it also contains here, does it not, the City of Ashland, Division of Fire, Emergency Medical Service Report, does it not?

A. It does.

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FURTHER EXAMINATION

By Mr. Kampinski:

Q. Which you've already testified you didn't even have before writing your report?

A. That's correct.

MR. FULTON: Would you mark this as Plaintiff's Exhibit 2-A.

MR. KAMPINSKI: Mark it as a defense exhibit.

MR. FULTON: All right. Defendant's Exhibit 2-A. We can do that.

MR. SEIBEL: No further questions.

MR. FARCHIONE: I'm done.

MR. FRANEY: No further questions.

MR. OKADA: No further questions.

MR. FULTON: I have no further questions.

THE VIDEOGRAPHER: Doctor, it's your right to view these videotapes for their accuracy or you can waive that right.

THE WITNESS: Please don't make me do that.

THE VIDEOGRAPHER: Will counsel waive all the filing requirements on these videotapes?

MR. FRANEY: As long as you'll hold onto the videotapes.

MR. KAMPINSKI: Who's going to provide a copy to the judge to rule on the objections? You are?

MR. SEIBEL: Well, the transcript's going to be filed; right?

MR. FRANEY: Thought we were going to waive that last week, filing of all the deposition transcripts.

MR. SEIBEL: Certainly the timeliness, but they should be on file.

MR. KAMPINSKI: What are you going to do with all these exhibits?

MR. FULTON: I'm go to give them to the court reporter, I presume.

MR. KAMPINSKI: I take it they'll be attached to the deposition.

(EXHIBIT MARKED FOR IDENTIFICATION.)

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CERTIFICATE

State of Ohio
SS:
County of Franklin

I, Kendra E. Johnston, Notary Public in and for the State of Ohio, duly commissioned and qualified, certify that the within named William L. Smead, M.D., was by me duly sworn to testify to the whole truth in the cause aforesaid; that the testimony was taken down by me in stenotypy in the presence of said witness, afterwards transcribed upon a computer; that the foregoing is a true and correct transcript of the testimony given by said

caption specified and completed without adjournment.

I certify that I am not a relative, employee, or attorney of any of the parties hereto, or of any attorney or counsel employed by the parties, or financially interested in the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Columbus, Ohio, on this _____ day of May, **1993.**

_____
Kendra E. Johnston,
Notary Public in and for
the State of Ohio and
Registered Professional Reporter.

My commission expires July **13, 1997.**