V.C. SMITH, M.D.

TUESDAY, MARCH **28, 2000**

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CONDENSED TRANSCRIPT AND CONCORDANCE
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IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

CHRISTOPHER S. LONG, etc.,)
)
Plainriff,)
)
vs.) Case No. 321518
)
CLEVELAND CLINIC FOUNDATION,)
)
Defendant.)

DEPOSITION OF V.C. SMITH, M.D.
Taken at
The Offices of V.C. Smith, M.D.
3131 LaCanada - Suite 217
Las Vegas, Nevada 89109

On Tuesday, March 28, 2000
At 1:30 p.m.

Reporced by: Wanda L. Barnes
CCR NO. 676, RPR

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APPEARANCES:

For the Plaintiff: JEANNE M. TOSTI, ESQ.
Becker & Mishkind Co., L.P.A.
Skylight Office Tower
1660 West Second Street
suite 660
Cleveland, Ohio 44113

For the Defendant: JOHN V. JACKSON, ESQ.
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Whereupon,
V.C. SMITH, M.D.,
having been first duly sworn to testify to the truth, the whole truth and nothing but the truth, was examined and testified as follows:

EXAMINATION

BY MR. JACKSON:

Q. Good afternoon Dr. Smith.

A. Good afternoon.

Q. My name is John Jackson. I represent the Cleveland Clinic in the lawsuit filed by the Long family, and we're here for purposes of taking your discovery deposition. You understand that, I take it?

A. Yes.

Q. Have you ever been deposed before, Doctor?

A. Yes.

Q. On how many occasions?

A. Uhm, two or three.

Q. Okay. You understand that I'm going to ask you questions to which you have to respond verbally, meaning say yes or no if yes or no is an appropriate response rather than gesture or shake your head.

A. Yes.

Q. That way this young lady can record your

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answers.

A. Yes.

Q. Also, if I ask you a question which you do not understand for any reason, please don't answer the question until you've asked me to clarify it for you. Okay?

A. Yes.

Q. I'm going to assume if you answer a question which I ask, that you've understood the question and that since you're under oath you're giving me an honest and complete answer. Okay?

A. Yes.

Q. I just had the opportunity to review what I understand is your file, and that's all the materials lying in front of you there, correct?

A. Yes.

Q. It's my understanding that materials have been removed from your file before I got here today.

MS. TOSTI: Yes.

BY MR. JACKSON:

Q. What has been removed?

MS. TOSTI: I've indicated to you that I've removed the attorney work product correspondence.

BY MR. JACKSON:

Q. How many letters were removed?

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MS. TOSTI: Do you know, Doctor?
THE WITNESS: I don't know.
BY MR. JACKSON:
Q. Doctor, this is your file, and I'm asking what was removed from your file before I got here.
A. Four or five letters that were sent from the Long family to me.
MS. TOSTI: From –
THE WITNESS: I mean from –
MS. TOSTI: – Becker & Mishkind?
THE WITNESS: – Becker.
BY MR. JACKSON:
Q. Four or five letters?
A. Yes.
Q. What are the dates of the letters?
A. I have no idea.
MR. JACKSON: I'm going to ask you to show him, Jeanne, because I'm going to ask him the dates.
MS. TOSTI: I am withholding them as attorney work product.
MR. JACKSON: Well, I disagree with you, but we'll argue before the judge.
BY MR. JACKSON:
Q. There were at least four or five, Doctor?
A. Yes, sir.

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Q. Can you be any more specific than that?
A. No, sir. I didn't count them.
Q. Now, did any of those letters contain factual summaries of the case?
A. I don't recall that they did.
Q. Did you read the letters before they were removed from your file today?
A. Not today, no, I didn't.
Q. Did you read them before – I didn't mean just today, but in preparing for the deposition did you review the file?
A. Yes.
Q. Did you review those letters?
A. No.
Q. You didn't even look at them?
A. No.
Q. Now, the materials that were first sent to you, Mr. Decker – and I know from having practiced with him in the past – usually sends a – some type of summary and an outline of the facts of the case at least. Was that sent to you in this case?
A. There was a summary of the case, yes.
Q. Okay. Tell me what the summary said to you.
A. It was just a basic summary of the case.
Q. When you say a summary of the case, were

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there – were there claims – the claims they were alleging or raising in the case included in that letter?
A. I don't recall there were any claims raised, no.
Q. What do you recall from the letter?
A. It was a summary.
MS. TOSTI: Why don't you ask the doctor if he relied upon it for –
MR. JACKSON: I don't have to ask him that, Jeanne.
MS. TOSTI: – any of his opinions in this case.
MR. JACKSON: That's not what I have to ask him. I want to know what the letter contained.
BY MR. JACKSON:
Q. Tell me what the summary was, Doctor.
A. It was a one- or two-page summary of the course of events of Mr. Long in the hospital at the Cleveland Clinic.
Q. Were there any criticisms of the care rendered in the summary?
A. I don't recall any criticisms.
Q. Tell me what the other letters were. What were those?
A. Setting up times and dates of the

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depositions, receipt that they received my opinion letter. There was – I don't recall.
I'm not trying to withhold it from you: I just don't recall because I didn't – didn't review those to go over my deposition, to get ready for my deposition.
Q. Doctor, are you going to render opinions in this case that the Cleveland Clinic or some of its employees fell below standard of care?
A. Yes.
Q. Define the standard of care for me.
A. Standard of care in my mind is what the majority of doctors would do in a certain situation, doctors, nurses, employees of a hospital, whatever.
Q. Who are you going to say fell below standard of care in the treatment of Mr. Long?
A. People that were involved in his care.
Q. Tell me who they were.
A. Dr. Cosgrove, Dr. Muehlebach, Dr. Hernandez I think is his name, and the nurse taking care of him.
Q. What did Dr. – in what way did Dr. Cosgrove's care of Mr. Long fall below standard of care?
A. Dr. Cosgrove was the primary surgeon in charge of Mr. Long's care and was the admitting doctor,

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and he is in charge of the supervision of all people under him to ensure that Mr. Long's care was appropriate.

Q. In what way did Dr. Cosgrove's care fall below standard of care?

A. I don't think Dr. Cosgrove was –supervised the people under him well enough to ensure that Mr. Long's outcome was good.

Q. What did he do in failing to supervise his people?

A. He didn't instruct Dr. Muehlebach and – or Muehlebach and Dr. Hernandez situations that may lead to Mr. – or lead to a problem in a patient and didn't instruct the nurse that was taking care of Mr. Long that –what problems that might occur or were occurring in this patient.

Q. Anything else that Dr. Cosgrove did or failed to do that you say fell below standard of care?

A. No.

Q. Okay. What did Dr. Muehlebach do that fell below standard of care?

A. I assume in his position as the chief resident or chief surgeon and – or chief resident on this case and evidently from what I can read through the records was responsible for his care in the intensive

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care unit, that Dr. Muehlebach didn't act on abnormal findings and do something to help this patient

Q. Okay. He did not act on abnormal findings and do something to help the patient; is that what you're saying?

A. Yes.

Q. Anything else that Dr. Muehlebach did or did not do that fell below standard of care in your opinion?

A. I don't think that he instructed Dr. Hernandez that Dr. Hernandez may be responsible for this patient when Dr. Muehlebach left the hospital.

Q. He did not instruct Dr. Hernandez that Dr. Hernandez may be responsible when Dr. Muehlebach was not there;. is that what you're saying?

A. Yes.

Q. Anything else that Dr. Muehlebach did or failed to do that you say was below standard of care?

A. No.

Q. What did Dr. Hernandez do that you say – or failed to do that you say was below standard of care?

A. I'm not sure that he knew what his responsibilities were to be taking care of this patient or that he didn't have responsibilities to be taking care of this patient

Q. You're not sure that he knew what his

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responsibilities were? Is that what you said first?

A. Yes.

Q. And what was the second thing? I missed it. I'm sorry.

A. I don't know what I said. I don't know what I said the second time.

MR. JACKSON: Okay. Would you read that back for him.

(Record read.)

BY THE WITNESS:

A. That he did or did not know what his responsibilities were in this patient's care, and I can't tell from the records whether he in fact was responsible for it.

BY MR. JACKSON:

Q. Okay. So I'm trying to understand what you're saying about Dr. Hernandez. You're saying that you're not sure whether he knew what his responsibilities were regarding caring for the patient?

A. That's right.

Q. All right. And that in your mind is below standard of care?

A. Well, the – the below standard of care was that no one seemed to know who was responsible for the patient's care between Muehlebach and Hernandez.

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Q. Okay. I'm trying to understand specifically with Dr. Hernandez what you say he did or did not do.

A. Just what I said.

Q. So Dr. Hernandez' failure to meet standard of care in your opinion was that he was not sure – strike that, that you're not sure that he knew what his responsibilities were regarding the patient?

A. Right.

Q. Anything else that Dr. Hernandez did or failed to do that you say did not meet standard of care?

A. No.

Q. How about the nurse? You mentioned that there was a nurse who you feel fell below standard of care. Who was that?

A. Well, the last hour or so of his care before he went back to surgery there was no indication of what his cardiac – cardiac output was.

It is in the records that she made Dr. Muehlebach aware of different problems that were going on, but evidently she didn't make him aware enough that would make him come back to the bedside and take a look at this gentleman.

Q. Anything else?

A. No.

Q. So as far as the nurse – which nurse are you

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talking about, Doctor? What's her name?
A. I can't recall her name.
If you give me a minute, I'll find it
Young.
Q. Nurse Young.
Your criticism of the way in which you believe Nurse Young fell below standard of care was in the last hour before Mr. Long went back to surgery, there was no indication in the record of his cardiac output?
A. There was poor documentation of his cardiac output
Q. Anything else about the documentation or just the cardiac output?
A. Just the cardiac output.
Q. Okay. And, secondly, you say that you believe she fell below standard of care because she made Dr. Muehlebach aware of problems, but not aware enough?
A. That's right
Q. Are there any other of the employees of the Cleveland Clinic that you believe fell below standard of care in their care and treatment of Mr. Young?
A. No.
Q. Or Long. Excuseme.
No, you've covered them all?

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A. Yes.
Q. Let me go back now to your criticisms of Dr. Cosgrove, if I may.
You said, first of all, that he did not instruct Dr. Muehlebach and Dr. Hernandez regarding what problems they could expect or might expect regarding Mr. Long; is that correct? Was that the criticism?
A. I see no docurnentation of instruction in the chart that I reviewed.
Q. So is it a documentation issue that you take with Dr. Cosgrove? Is that what you're saying?
A. I assume that Dr. Cosgrove did not convey to Dr. Muehlebach the important hemodynamic changes that were going on in this patient that – and he's ultimately responsible for this patient's care.
Q. So you believe that Dr. Cosgrove had an obligation under standard of care to communicate hemodynamic changes to Dr. Muehlebach; is that what you're telling me?
A. To pay attention to hemodynamic changes, yes.
Q. Okay. But I'm trying to understand what you're saying Dr. Cosgrove himself did. You said he didn't instruct Dr. Hernandez and Dr. Muehlebach. What do you say he failed to instruct them about?
MS. TOSTI: He just answered that. He said

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that –
MR. JACKSON: I understand.
MS. TOSTI: – in regard to –
MR. JACKSON: Please, Jeanne. You don't need to –
MS. TOSTI: – hemodynamic changes –well, he's answered the question.
MR. JACKSON: No.
MS. TOSTI: You're asking it again.
MR. JACKSON: No, I'm not.
BY MR. JACKSON:
Q. What was it that you say Dr. Cosgrove failed to instruct Dr. Muehlebach and Dr. Hernandez?
A. That this patient's hemodynamics were abnormal and that something should be done about them.
Q. What should Dr. Cosgrove have told Dr. Muehlebach and Dr. Hernandez in your opinion to meet standard of care?
A. That this patient is not behaving well – starting to not behave well when Dr. Cosgrove was at his bedside and he needs to be watched closely.
Q. What time was that?
A. Dr. Cosgrove was at his bedside at 1730 – 1830. I'm sorry. 1830.
Q. In what way do you say that the patient was

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not behaving well at 1830 that should have prompted Dr. Cosgrove to instruct Drs. Muehlebach and Hernandez?
A. This is a patient that had bled in the operating room; he's had moderate amount of chest tube drainage after surgery; his hemodynamics had changed from the time that he had come out of surgery to this time at 1830; and that it bared watching very closely.
Q. How had the patient's hemodynamics changed in your opinion that should have prompted Dr. Cosgrove to instruct Drs. Muehlebach and Hernandez?
A. His cardiac output had gone down; his blood pressure had gone down.
Q. Anything else?
A. His chest tube drainage had picked up over the first hour he was there.
Q. Is that unusual?
A. Uhm, not unusual, no.
Q. It's not unusual?
A. Notunusual.
Q. Okay. When you say he bled in the OR, are you saying –would you consider this patient a bleeder, quote, end quote?
A. I don't know what you mean by bleeder.
Q. Okay. Well, when you say he bled in the OR, what does that mean?

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A. He had a bleeding problem that required them putting him back on bypass to fix the bleeding problem.
Q. What was the bleeding problem?
A. Suture line bleeding.
Q. That's not an uncommon thing, is it, in cardiac surgery, is it?
A. No.
Q. So that in of itself is of no significance or consequence as it relates to the patient's hemodynamics, is it?
A. That particular incident?
Q. Yes.
A. No. It does raise a red flag that if someone has had a bleeding problem from a suture line in surgery, then he may very well have another problem after surgery.
Q. Well, the bleeding problem from the suture line was what? That there was a loose suture, correct?
A. I don't know if it's a loose suture or just an area they didn't quite get together, but -
Q. Okay. It didn't have anything to do with the patient's blood or hemodynamics. It was because there was -the stitch was not the way it should have been, and when they restitched it, everything was fine?
A. It had nothing do with the patient's blood,

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no.
Q. Okay. Now, are you saying - and you just said that that incident of itself is of no significance to the hemodynamics of the patient, correct?
A. It has nothing to do with - someone putting in an extra stitch has nothing do with the hemodynamics, no.
Q. And that was addressed operatively or in the operation and it was repaired appropriately; wasn't it?
A. That's true.
Q. And in terms of his hemodynamics, you just told me that the only two things were the cardiac output and the blood pressure had decreased?
A. That's right.
Q. So do I understand you to be telling me, Doctor, that Dr. Cosgrove in his care of Mr. Long fell below standard of care because he didn't tell Dr. Muehlebach and Dr. Hernandez that Mr. Long's cardiac output had dropped some and that his blood pressure had dropped some? Is that what you're telling me?
A. And that he bared watching, yes.
Q. And that he bared watching.
So he should have said -- well, tell me what was the decrease in the cardiac output that you say should have alerted someone to a problem.

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A. His index went from 3.3 to 2.0.
Q. What did dues that mean to you?
A. It means his cardiac index went from 3.3 to 2.0.
Q. What causes that?
A. There's a whole host of things that can cause that.
Q. What?
A. Hypovolemia, poor myocardial function, a problem with the valve that they've implanted, tamponade, respiratory problems, ventilator problems, pneumothorax.
Those are the ones I can think of off the top of my head.
Q. The blood pressure decrease, what was that?
A. It went from a hundred and ten to 75 systolic.
Q. This was before 1830 when Dr. Cosgrove was there; is that what you're talking about?
A. Like I said, 1830, when he was there, it was 90. So from a hundred ten to 90.
Q. And the cardiac output dropped from 3.3 to 2.0 before 1830?
A. 1830 was 2.4, not 2.0.
Q. Okay.

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A. 20 minutes later.
Q. So Dr. Cosgrove was at the bedside when the cardiac output had dropped 3.3 to 2.4, blood pressure 110 to 90?
A. Yes.
Q. So those are the parameters I guess that you're talking that he should have told his - Drs. -
A. Yes.
Q. - Hernandez and Muehlebach, correct?
A. Yes.
Q. What should he have told them to do that you say he didn't?
A. To pay special attention to this gentleman.
Q. In what regard, Doctor?
A. To watching his hemodynamics.
Q. What specifically should he have told them to watch?
A. Blood pressure, heart rate, how the patient looks, chest tube output, what repeat studies might show.
Q. Is it your belief that Dr. Muehlebach and Dr. Hernandez would not have been aware of these things, that they should watch these things, or that they would not have the experience or knowledge to deal with this situation short of being told specifically by

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Dr. Cosgrove?
A. I'm sorry. You'll have to ask that again.
Q. Sure.
A. There were several questions.
Q. What is your understanding -- well, there was one question. I'm trying to understand these things you talked about would be -- would be things that in your opinion a cardiac surgeon would know to look for and be concerned about in a patient -
A. Yes.
Q. -- correct?
A. True.
Q. Is it your belief that Dr. Muehlebach did not have sufficient knowledge or experience or training to know these things without being told that by Dr. Cosgrove?
A. He was in training at the Cleveland Clinic under Dr. Cosgrove's tutelage, so I don't know what his prior training had been.
Q. What was his background, as far as you know? I mean you read his deposition.
A. He came from another heart institute - another heart program to have a year of special training with Dr. Cosgrove.
Q. Okay. And is it your belief that

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Dr. Muehlebach was at a level of training or knowledge and experience that he would not have known to watch these parameters without being told that by Dr. Cosgrove?
A. He should have been at that level, yes.
Q. Okay. How about Dr. Hernandez?
A. I don't know what Dr. Hernandez' background was.
Q. Do you have any reason to believe, Doctor, that Dr. Muehlebach didn't understand that these different parameters would be things that you would watch in a patient like Mr. Long?
A. No.
Q. Okay. So there really isn't any need for Dr. Cosgrove to have an obligation in that setting to tell Dr. Muehlebach what would be rather basic things for a person of his experience level to know; wouldn't you agree with that?
A. No.
Q. You don't agree with that?
A. No.
Q. Okay. So you hold Dr. Cosgrove to a position of having to say to Dr. Muehlebach and Dr. Hernandez: I want you to watch blood pressure, heart rate, how he looks, all of the things you outlined here -

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A. Yes.
Q. -- correct?
And if he failed to specifically instruct them in that regard, in your opinion he fell below standard of care?
A. . Yes.
Q. Is that true regardless of the knowledge, level of training and experience of Dr. Muehlebach?
A. Yes.
Q. Is that true regardless of the knowledge, level of experience and training of Dr. Hernandez?
A. Yes.
Q. Is that true regardless of Dr. Cosgrove's awareness of the level of Dr. Muehlebach's knowledge, experience and training?
A. Yes.
Q. Okay. So even if he knew that this was a well-trained competent cardiac surgeon, you feel the standard of care required him to state these things to Dr. Muehlebach?
A. Yes,
Q. Doctor, where would you -- where would you get that kind *of* an idea? I mean where would that be in terms of any literature or anywhere -
A. That's my --

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Q. -- that would suggest that that's the standard *of* care in cardiac surgery?
A. That's my practice and experience. That's the way my practice and experience says, says so.
Q. All right. So you're basing this on your personal practice and experience?
A. I'm basing it on the practice - yes, on my personal experience and practice.
Q. Is there anyplace other than that, like any literature, textbooks, anything like that that would support that kind of a position?
A. Not that I'm aware of.
Q. The second criticism you had of Dr. Cosgrove, if I'm correct, was that he failed or did not instruct the nurse regarding Mr. Long. In other words, you said the second thing in which -- the manner in which you feel Dr. Cosgrove fell below standard of care, No. 1, he didn't instruct the doctors, No. 2, he didn't instruct the nurse. Am I correct?
A. Yes.
Q. In what way do you say Dr. Cosgrove fell below standard *of* care with regard to the nurse?
A. Much that he didn't say this guy's had a problem in the surgery, his heart's not good, his hemodynamics have changed. I want *to* be called in

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there's a problem.
Q. So he should have said the things that you just outlined for me?
A. Yes, sir.
Q. And if he didn't specifically state all of those things, then in your opinion he fell below standard of care?
A. Yes.
Q. Would that be true regardless of his – regardless of the nurse's knowledge, experience, training?
A. That would be true, yes.
Q. Would that be true regardless of Dr. Cosgrove's awareness of her knowledge, experience, training?
A. You're asking me about Dr. Cosgrove's experience and training?
Q. No. His knowledge of her, of –
A. Yes.
Q. So he would have to say that to her regardless of what he knew about her or her background or her qualifications to be in the position she was in?
A. Yes.
Q. And, again, I assume that this standard of care that you're stating is based upon your personal

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experience. I wouldn't be able to go to a textbook or something –
A. No, no textbook.
Q. So it's personal experience that you have. This is your opinion of standard of care?
A. Yes.
THE WITNESS: Can we stop for just one second?
(Pause in the proceeding.)
BY MR. JACKSON:
Q. Have we covered all of your criticisms of Dr. Cosgrove or the manners in which you believe he fell below standard of care in the treatment – his care and treatment of Mr. Long?
A. Yes.
Q. Okay. Now – well, let me ask you this first. In what way did Dr. Cosgrove's not saying to Dr. Muehlebach and Hernandez the things you say he should have said to them caused any harm or injury *to* Mr. Long?
A. I think if he had impressed upon them to pay more careful attention to this gentleman #an they would the routine patient, he wouldn't have had the problems in the end that he did have.
Q. So you're saying if Dr. Cosgrove had said the

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things to Dr. Muehlebach and Dr. Hernandez that you feel he should have said, that Mr. Long would not have had what problems?
A. Brain death.
Q. So if I understand you, Doctor, you're saying that Dr. Cosgrove's failure to say the things you told us to Drs. Muehlebach and Hernandez was a proximate cause of Mr. Long's brain death in your opinion?
A. Yes.
Q. Is that to a reasonable degree of medical certainty or probability?
A. Yes.
Q. What does that term mean to you?
A. That the preponderance of information being more than 51 percent, 51 percent or more, that something would have happened did happen.
Q. Now, as it relates to Dr. Cosgrove's instructions *to* the nurse, are you saying or do you have an opinion that the fact that he didn't say to the nurse what you tell us he should have said by standard of care, that caused some injury or harm to Mr. Long?
A. Yes.
Q. And what did Dr. Cosgrove's failure to say the specific things you say he should have said *to* the nurse cause, what harm did it cause to Mr. Long?

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A. His ultimate brain death.
Q. Let's talk about Dr. Muehlebach then. Your comment was he didn't act on abnormal findings and do something to help the patient.
Tell me what you say Dr. Muehiebach – what abnormal findings, first of all, should he have acted upon, when should he have done that, and what should he have done in your opinion.
Now, if you want me to break that down more –
A. I think you should.
Q. Okay. First of all, what abnormal findings did Dr. Muehlebach fail to act upon?
A. Decreasing hemodynamic performance with increasing inotropic support in a patient that probably would have not needed – would have not needed inotropic support after an aortic valve replacement, who didn't come out of the operating room on inotropic support
Q. I'm going to ask you to be more specific, Doctor. You said decreased hemodynamics and increased inotropic support. Correct?
A. That's what I said.
Q. What were the specific decreasing hemodynamics that Dr. Muehiebach should have acted upon? What were the abnormal findings that you say he didn't

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act upon?
A. His blood pressure was falling.
Q. I'm going to ask you to be specific in terms of times.
A. From 1850 until the time he was taken back to surgery he never had what I would consider a normal blood pressure.
Q. Okay. And you're saying that should have prompted Dr. Muehlebach to do something that he didn't do?
A. Yes.
Q. What should he have done regarding the blood pressure and when?
A. I think he should have done an echo or a transesophageal echo anywhere from 1910 to 21 - 2210.
Q. So he should have between those - between those, what, three hours -
A. Three hours.
Q. - you're saying standard of care required that he do a TEE or an echo?
A. Yes.
Q. And failure to do that was in your opinion below standard of care?
A. Yes.
Q. Okay. Why should have he have done a TEE or

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echo? Because of the blood pressure?
A. Well, blood pressure was the only one you asked me about before.
Q. I understood. But I'm asking you now is there more that he should have -
A. Yes.
Q. What was it?
A. His cardiac output was falling: he was on increasing doses of inotropic support; he had had at least one dump out of his chest tubes.
Q. Are all of these things things that are unusual in a patient like Mr. Long?
A. Yes, I would say they were unusual, yes,
Q. So decreasing cardiac output would be unusual?
A. Yes.
Q. The inotropic support would be unusual?
A. Yes.
Q. And the chest tube drainage would be unusual?
A. Yes, the chest tube drainage dump some two hours after he came from the operating room.
Q. What time was that dump that you're referring to?
A. Two hours after he came from the operating room.

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Q. Okay. What time are you referring to specifically, Doctor?
A. 1930.
Q. So the dump at 1930 was an unusual chest tube output?
A. Yes.
Q. What do you say a TEE or echo between 1910 and 2210 would have shown?
A. That he had blood around his heart or there was something wrong with his valve or that his myocardial performance was not good. These are all things that it could have shown.
Q. Well, having the benefit of looking at this in retrospect, what do you say would have shown?
A. That he was tamponade.
Q. And what do you base that upon?
A. The fact that his cardiac output was going down; his blood pressure was going down; he was on increasing amounts of inotropic support; and he had had bleeding out of his chest tubes.
Q. Okay. So from those findings you conclude that he had tamponade?
A. That was my opinion.
Q. Was there any other potential reason or could that be caused by anything else, those things you just

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described?
A. Other things can cause those things, yes.
Q. Okay. You exclude those or rule those out in Mr. Long's case?
A. Yes.
Q. What are the other things that could cause that constellation of -
A. Hypovolemia, poor myocardial performance, pneumothorax.
Those are the things I can think of off the top of my head.
Q. In response to the - what we - we talked about the blood pressure. You said he should have done a TEE or echo. What were the other hemodynamic changes that you believe Dr. Muehlebach did not appreciate that he should have acted on?
A. That his cardiac output was going down.
Q. What should have done in regard to cardiac output?
A. The TEE would have been the study of choice for all of these things. And it's not that you can point your finger at one particular blood pressure or one particular cardiac output. It's the slow progressive downhill course that he was having.
Q. If I asked you the question about this - the

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increasing inotropic support, would you give me the same answer as what should have been done in regard to that or - does that make sense, what I just asked you?
A. No.
Q. All right. What abnormal findings you said Dr. Muehlebach failed to respond to was this increasing inotropic support, that there was some decreasing hemodynamics and increasing inotropic support -
A. Yes.
Q. -correct?
What should he have done as it relates to the increasing inotropic support, same thing, TEE?
A. TEE or come take a look at the patient.
Q. When should he have, as you say, come take a look at the patient? When should he have done that?
A. Anywhere In that period of time, from - I think we said 1910 until 2110.
Q. I think you said, I believe, 2210.
A. 2210.
Q. Okay. Did he see the patient in that period of time?
A. Not that I'm aware of.
Q. Okay. Is it your understanding that he was -that Dr. Muehlebach was unaware of these situations with the patient or he just didn't react to it? What

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are you saying?
A. Im not sure if he was unaware of it until 2150 when the nurse reports that she called him to tell him that she'd - he'd increased the Levophed up. That's the only time I'm aware that he knew of the problem.
Q. Okay. So prior to 2150 are you saying that he may not even have known about these things?
A. I don't know.
Q. You don't know?
A. No.
Q. Well, if he was not aware of these things, Doctor, are you still critical of him for not responding?
A. He is the one that ordered the Levophed to be started in the first place.
Q. Okay.
A. If I start an inotropic agent, then 111 check on the patient again to make sure what I've asked them to do is indeed working.
Q. When was that started?
A. I don't know what time. 111 have to look. 1930.
Q. When should he have called?
A. Somewhere between 1930 and -you know, give

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it a half an hour and call and see if it's working, if the nurse hasn't bothered to call you.
Q. Is there anything else that you say Dr. Muehlebach should have done for the patient other than what we have we just discussed already, the TEE?
A. He could have ordered a chest x-ray which would have been the other thing I would have gotten.
When I say TEE, I mean a surface echo would be the equivalent of a TEE.
Q. You're saying either or?
A. Eitheror.
Q. So standard of care required either a TEE or a surface echo -
A. Right.
Q. - during that period of time?
A. Right. If they were looking to make sure the valve was functioning well, then the TEE certainly would have been the standard of care.
Q. Well, which do you say they should have done, Doctor? I mean is it one or the other or -
A. If they were worried about the valve, which I would have been worried about the valve, I would have done a TEE.
Q. Did - you've read their depositions and testimony and you've reviewed - was there any

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indication that there was a problem with the valve?
A. No, there wasn't. But without a test at that time I don't know how you would know.
Q. Was there any indication that they were concerned about the valve?
A. No.
Q. But you're saying they should have been concerned about the valve? Is that what you're saying?
A. If I put a homograph in someone and they're not behaving the way I think they should be doing, I would be concerned about the valve.
Q. They should have done either a TEE or an echo?
A. Yes.
Q. Okay. In response to these abnormal findings and the decrease in the - excuse me, the increase in the inotropic support?
A. Yes.
Q. Well, why did they give inotropic support?
A. Because his cardiac output was falling and his blood pressure was falling.
Q. Did the - did those things respond to the inotropic support?
A. No.
Q. If I understand you correctly then with

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Dr. Muehlebach, if he had acted sometime between 1910 and 2210 in your opinion by doing a TEE or an echo, he would have met standard of care as it relates to Mr. Long?

A. Yes.

MS. TOSTI: The doctor also mentioned the chest x-ray in there, too.

BY MR. JACKSON:

Q. Well, if he had done a TEE or echo -- are you saying he had to do a TEE or an echo and a chest x-ray?

A. That's what I said, yes. Or that's what I meant, yes.

Q. Okay. So he had to do both; is that what you're saying?

A. Right Obviously if one had been abnormal, the other one would not have been necessary.

Q. Well, that's what I'm trying to understand. You say - you told me before, before Ms. Tosti interjected, that he could have done a chest x-ray - TEE, echo or he could have done a chest x-ray.

Now I'm understanding you to tell me you're saying he should have done TEE, echo and a chest x-ray. There is a difference there, is there not?

A. There is.

Q. Okay. Which is it?

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A. That they should have done a TEE. If that had been normal, then I would have done a chest x-ray.

Q. Well, if they had done a chest x-ray rather than a TEE or an echo, in your opinion does that meet standard of care?

A. If the chest x-ray had shown a chestful of blood, then that would have meant what the problem was.

Q. My question is if they had done a chest x-ray rather than done a echo, would that have met standard of care -

A. If they had done a chest x-ray and it was perfectly normal, then yes, it should have been a TEE or an echo. An abnormal chest x-ray would have pointed them in one direction. Okay. If it was normal, then they have to look in a different direction.

Q. Again, I'm trying to understand the logic here, Doctor, because I want to know are you saying that the chest x-ray - I mean should have been done in lieu of a TEE or echo?

A. I didn't say that

Q. Well, that's what I'm trying to understand, because you're giving me the results of the tests, and I'm trying to understand what you say they should have done regardless - I mean you do the tests and find out the results and act on that.

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But if they had done a chest x-ray on Mr. Long, what do you say would have been found in the chest x-ray? Maybe that's the way to approach it.

A. I don't know what would have been found.

Q. Okay. So you don't know what a chest x-ray would have shown, but based upon the chest x-ray, you're saying they would have either seen blood and known what to do or, if it was normal, they should have done something else?

A. Yes.

Q. Is that what you're saying?

A. Yes.

Q. So the chest x-ray alone may have been enough in this case to meet standard of care; is that correct?

A. If he had had a chestful of blood or a pneumothorax and they would have treated that particular problem, then yes, it would; and he got better, then you wouldn't have needed a TEE.

Q. Okay. But in this case, Doctor, was a chest x-ray required by standard of care in Mr. Long?

MS. TOSTI: He said three times that the echo -

MR. JACKSON: That's what I'm trying to understand?

MS. TOSTI: If the TEE was normal, then he

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would do the chest.

MR. JACKSON: Please don't do that.

MS. TOSTI: And he did the chest and it was normal -

MR. JACKSON: You don't need to -

MR. TOSTI: - he would go on to do the TEE. He said it three times now, John,

MR. JACKSON: He has not.

MS. TOSTI: I'm going to enter an objection because you asked -

MR. JACKSON: You added -

MS. TOSTI: - the question three times.

MR. JACKSON: Every time you add something -

MS. TOSTI: Let me get my objection on the record.

MR. JACKSON: Then just say objection.

MS. TOSTI: I'm objecting because this has been asked three times now.

BY MR. JACKSON:

Q. Doctor, I'm confused here because you're saying different things to me, at least what I'm hearing.

A. I'm trying not to say different things to you. I'm trying to say one thing repeatedly.

Q. I understand. The TEE or echo was required

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by standard of care?
A. Yes.
Q. Okay. Then you said they could have done a chest x-ray, and then you said TEE echo, and after Ms. Tosti interjected you said and a chest x-ray.
A. No, I didn't say "and a x-ray."
Q. Okay. That's what I'm trying to understand. If they had have performed a chest x-ray, do I understand you to say that that would have met standard of care?
A. If the chest x-ray –
Q. If they had done the chest x-ray, now, it's another issue, isn't it, acting upon the chest x-ray?
A. Okay.
Q. You're saying they should have done a chest x-ray?
A. Yes, I do.
Q. If they had done a chest x-ray, would that have met standard of care as it relates to Mr. Long?
A. Yes.
Q. Okay. And the failure to do a chest x-ray or the TEE echo in your opinion fell below standard of care?
A. Yes.
Q. And we're talking about a time frame between

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1910 and 2210?
A. Yes.
Q. Your other criticism of Dr. Muehlebach was that he did not instruct Dr. Hernandez about what Dr. Hernandez' responsibilities were; is that correct?
A. Yes.
Q. And does that go back to the same thing you said about Dr. Cosgrove or is there more to that or something different?
Let me ask it this way, so we're clear. What do you say Dr. Hernandez – or excuse me, Dr. Muehlebach should have told Dr. Hernandez.
A. If he was – if he were checking out of the hospital and leaving Dr. Hernandez in care of this patient, that he should have paid attention to a patient whose hemodynamics had deteriorated and that in my **opinion something should have been done.**
Q. Okay. I'm asking now what Dr. Muehlebach should have said to Dr. Hernandez in your opinion.
A. If Dr. Muehlebach was relieving his responsibilities to the patient in the hospital to Dr. Hernandez, then Dr. Hernandez should have been aware **of what his responsibilities were in this particular patient who was having problems.**
Q. And you don't think he did have that

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understanding?
A. I have no documentation that he did.
Q. Okay. And that's documentation that would have been required, that Dr. Hernandez knew what his responsibilities were to the patient, that that should be documented in some way? Is that what I'm understanding you to say?
A. Well, when I sign *off* to another doctor over a patient, I write on the chart saying I talked to Dr. So and So about the patient and outline the problems **that I think he might have.**
Q. Okay. So you say standard of care required Dr. Muehlebach to write something in the chart along the lines that you just said?
A. Yes.
Q. Okay. And/or verbally communicate that to Dr. Hernandez?
A. Yes.
Q. And the failure to do that was below standard of care?
A. Yes.
Q. And did his failure in that regard cause Mr. Long some injury or harm?
A. If Dr. Hernandez was responsible for him, yes, it did.

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Q. And what did it cause?
A. His brain death.
Q. Okay. How?
A. From a problem that required him to go back to emergency surgery, which he never woke up from.
Q. I understand, but how did Dr. Muehlebach's not writing a note in the chart telling Dr. Hernandez the things you just described cause that brain death?
A. I don't think writing in the chart prevented him from having brain death.
Q. Okay. So the fact he didn't write it in the chart didn't have anything to *do* with writing Mr. Long's – it wasn't a cause of his injury, was it?
A. No.
Q. Okay. And the fact that Dr. Muehlebach didn't tell Dr. Hernandez, if he didn't, what Dr. Hernandez' specific responsibilities were regarding this patient, that didn't cause Mr. Long's brain death either, did it?
A. Uhm, not specifically, no.
Q. Okay. That would be true of Dr. Cosgrove's comments to Dr. Hernandez and Dr. Muehlebach also, wouldn't it?
A. One of those three was responsible for this patient's care.

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Q. Tell me what your understanding was of the arrangement there in terms of Dr. Cosgrove, Dr. Muehlebach, Dr. –
A. Hernandez
Q. – Hernandez. Yes.
A. Dr. Cosgrove was the admitting physician and attending surgeon and surgeon of record; Dr. Muehlebach was someone who was having special training in non-invasive heart surgery; and from my reading or understanding the – was responsible for ffie patient in lieu of Dr. Cosgrove being in the hospital. Dr. Muehlebach was in the hospital till sometime in the late evening. And then Dr. Hernandez was to be responsible for the patient when Dr. Muehlebach was not physically present.
Q. Now, your criticisms of the communication between Dr. Muehlebach to Dr. Hernandez, would that also be there regardless of Dr. Hernandez' level of training, experience, knowledge?
A. If Dr. Hernandez was going to be responsible for the patient, then, yes, that level of communication should be there.
Q. Okay. Again. Regardless of what his level of training was, experience? Do you understand what I'm saying to you, asking you?

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If I understand you, Doctor, what you're saying to me is that – let's assume you are what you are, an attending cardiac surgeon; and if you have a patient in an ICU and you're going to turn that patient over to another, say, attending cardiac surgeon, a colleague of yours, what you're telling me, what I'm hearing you say, is that you need to tell that doctor what his responsibilities are, either write it in the chart for him or actually verbally say to him here's what you need to do for this patient.
A. Yes.
Q. And that's what you say standard of care requires?
A. Yes.
Q. Okay. So I'm clear, we're not just talking about here's the patient's condition. We're saying here's what you need to do with this patient. You need to instruct that person taking over for you, correct?
A. I don't think when I call my partners I have to tell them exactly what to do, but I tell them my concerns about the patient and what we could do if – including please call me if there's a problem with this patient if the nurses call you.
Q. Okay.
A. So I don't need to tell them to do a TEE or a chest x-ray. All I need to tell them is if the patient is not doing well and I'm leaving the hospital and you're responsible for his care, these are his problems right now, and if he has any further problems, please let me know because I did the surgery on him this afternoon.
Q. And if those things are accomplished, either verbally or in writing, standard of care is met?
A. Yes.
Q. Your criticism of Dr. Hernandez, as I understand it, was that he wasn't sure that he knew what his responsibility of the patient was; is that correct?
A. That's right.
Q. What should he have done to meet standard of care in that regard?
A. If I think I might be responsible for a patient, I'll ask somebody to make sure that I'm responsible for him. So he could have asked anybody, I mean including Muehlebach or Dr. Cosgrove, I suppose.
Q. So in order to meet standard of care, Dr. Hernandez should have asked either Cosgrove or Dr. Muehlebach, one of those two doctors, what? What should he had asked them?
A. Am I responsible for this patient after Dr. Muehlebach leaves the hospital.

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Q. And if he had done that, if he would have asked that question, he would have met standard of care?
A. And he would have met standard of care in finding out what his responsibilities were.
Q. And you assume that he did not know what his responsibilities were of the patient?
A. Yes.
Q. If he did, then – if he did know his responsibilities, then I'm assuming that he would not have fell below standard of care by not asking someone what they were; is that true?
A. He would have found out what his responsibilities were.
Q. I understand. I'm saying to you if he knew –
A. Yes.
Q. – what his responsibilities were, then Dr. Hernandez did not fall below standard of care –
MS. TOSTI: Objection.
BY MR. JACKSON:
Q. – in his care and treatment of Mr. Long; is that true?
MS. TOSTI: Objection. In the communications –
MR. JACKSON: I'm not talking about

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communications. I'm not talking about –what was done for Mr. Long at all. You're talking about communications and coverage and who is responsible for the patient.

If he was in fact responsible, then he falls below the standard of care in the care of this patient as he didn't do anything about investigating Mr. Long's downward course.

BY MR. JACKSON:

Q. Doctor, that's what I'm trying to understand. You said that he fell below because he didn't know what he was supposed to do with the patient, he didn't know what his responsibilities were. That's what you told me before, and I was exploring that with you, and then my question to you was that prompted Jeanne's comments was were you saying that if – I'm asking you if he knew what his responsibilities were, then he didn't fall below standard of care in not asking or calling someone about that. Is that true or not?

A. If he knew what his responsibilities were, then, yes, I think he knew what his responsibilities were. There is no standard of care if he knew what his responsibilities were.

Q. Okay. Now, there are two ways in which you felt Nurse Young fell below standard of care. One was a

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documentation issue; is that correct?

A. Yes.

Q. That didn't cause Mr. Long any harm, did it?

A. Well, if they had done cardiac outputs at 2230, then maybe he would have gone back to surgery an hour earlier.

Q. So the failure to enter a cardiac output at 2230 was below standard of care?

A. I don't know whether she did it or not, but she didn't enter it in here.

Q. Okay. Did that cause harm to Mr. –that's a documentation issue, is it not?

A. Yes.

Q. Did it cause harm?

A. An hour delay in taking him back to surgery did cause him -- I think cause him harm, yes.

Q. Did her failure to document a cardiac output at 2230 cause an hour's delay in returning him – Mr. Long to surgery, in your opinion?

A. If she had written it down and it would have been poor, would that have changed –you're asking me a question that's – whether she did it or not is the question. Whether she wrote it down or not --

Q. She didn't write it down?

A. She didn't write it down. So you have to

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assume she didn't do it. So, yes, that did cause a delay in him being taken back to surgery.

Q. That singular finding in the chart, I mean with all the other things that were recorded, the fact that that wasn't recorded in your opinion caused an hour delay?

A. Well, he had also had –

Q. Let's talk about the cardiac output, Doctor. I mean I know all this other stuff.

A. I can't say that that singular event of not writing down a cardiac output had anything to do with it.

Q. Okay. The second thing you talked about Nurse Young and you criticized her was that she made Dr. Muehlebach aware of problems, but she didn't make him aware enough, is the way you said it.

What should she have done to satisfy you that she met standard of care in making Dr. Muehlebach aware –

A. She would --

Q. -- or not?

A. That she would have asked Dr. Muehlebach to come take a look at this patient at the bedside because he just doesn't right look.

Q. So she should have asked him to come and take

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a look; is that it?

A. Yes.

Q. What time should she have done that?

A. Well, she talked to him at 2150 and she retalked to him at 2250. So I would say anywhere in between there.

Q. Sometime between 2150 and 2250 she should have told him to come and see the patient?

A. I think an experienced nurse would have, yes.

Q. What was her experience?

A. She was fairly fresh out of training. I don't remember exactly what her training was.

Q. Okay.

A. She was being monitored or proctored by another nurse at the Cleveland Clinic.

Q. And what was the other nurse's level of experience in your opinion?

A. I don't recall,

Q. Didn't make any kind of difference?

A. I assume if they're going to have a proctor of a patient, she would be an experienced nurse.

Q. I understand, but does that make any difference in your opinions here what the level of training or experience of these nurses were? Because you made a comment a moment ago about an experienced

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nurse. and I assume that had some significance *to* you.
A. I would think an experienced nurse would have asked the attending surgeon or the covering surgeon to come take a look at this patient
Q. I believe we've covered all of your criticisms, Doctor. Have I missed any that -
A. Not that I'm aware of.
Q. We went through Dr. Cosgrove, Dr. Muehlebach, Dr. Hernandez and the nurse.
A. Yes.
Q. And that was Nurse Young, correct?
A. Yes.
Q. When did Mr. Long suffer brain damage?
A. Sometime after 2100 hours.
Q. What do you base that upon?
A. That was the last documentation I could find that he had a relatively normal neurological examination done by the nurse.
Q. You're referring to nurses notes?
A. Yes.
Q. What caused - strike that.
Is that as specific as you can be, 2100 hours?
A. That's the last documented neurologic evaluation I could find, yes.

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Q. So sometime after that; am I correct?
A. Yes.
Q. Are you able *to* tell me what caused the brain damage in Mr. Long?
A. No.
Q. Are you able to list possibilities for me?
A. Yes.
Q. What are they?
A. That he had hypoxia secondary to the tamponade, hypoxia secondary to blood loss, hypotension as related to both of those.
Q. But to a reasonable degree of medical certainty or probability you can't say what caused brain damage in Mr. Long; *is* that correct?
A. I can't tell you the exact event that caused his brain damage.
Q. At what point in time do you say the injury that he suffered -the brain damage he suffered would have been reversible? What's the latest point in time you say it would have been reversible?
A. I can't tell you that, Since I don't know when it happened, I can't tell you what time it would have been reversible.
Q. Did the brain damage that Mr. Long suffered in your opinion occur before he reached the second

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surgery?
A. Yes.
Q. So it was sometime between 2100 and - when was he taken to the second surgery?
A. 2330.
Q. So would it be fair that your opinion is that it was sometime between 2100 and 2330 that he suffered his brain damage?
A. That would be my opinion.
Q. That is to a reasonable degree of medical certainty or probability in your opinion?
A. Well, in the - being taken to surgery and resuscitated at surgery, 15 minutes before -- I don't know exactly what time it was, so 2345, in that period of time, yes.
Q. So sometime between 2100 and 2345 -
A. Yes.
Q. - with a reasonable degree of medical certainty you believed he suffered his brain damage?
A. Yes.
Q. But you cannot say with any more specificity when in that period *of* time he suffered brain damage, correct?
A. No.
Q. What do you say could have been done or

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should have been done to prevent the brain damage from occurring in that period of time?
A. That he should have been taken back to surgery earlier and that -- and/or some investigative study be done, such as a transesophageal.
Q. My understanding from you was that you gave me a time frame when the transesophageal should have been done.
A. Correct. Yes.
Q. When do you say he should have been returned to surgery?
You gave them between 1910 and 2210 to do the esophageal echo or the chest x-ray, correct?
And after that would have been when they should have returned him to surgery; is that what you're saying?
A. I am not agreeing that the chest x-ray as being the only test again.
Q. All right. Let's take the chest x-ray out of it then.
A. They could have done a TEE.
Q. Between 1910 and 2210?
A. Yes.
Q. You believe that that would have shown something that would have prompted them *to* get him back

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to surgery?
A. Yes.
Q. And they would have had him back to surgery when?
A. Within 15 minutes of when they did the TEE.
Q. And at the earliest then that would be 1925 up to 2225?
A. Yes.
Q. And is it your opinion, Doctor, that had he been returned to surgery in that period of time – can you say that he would not have suffered brain damage?
A. Yes.
Q. How can you say that?
A. Because they would have fixed the problem that caused him to have continuing hemodynamic deterioration.
Q. What is the nature of your current practice, Doctor?
A. I'm a cardiovascular surgeon.
Q. What is your patient population?
A. I'm sorry?
Q. Adults, children?
A. Adults.
Q. Can you be any more specific in terms of age groups?

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A. From anything over 14 years of age to 95.
Q. How many surgeries do you perform a week?
A. Ah, all surgeries, 20 to 25 – no. I'm sorry. 20.
Q. 20 surgeries a week?
A. Yes.
Q. For what period of time have you been averaging about 20 surgeries a week?
A. I've been here in Las Vegas for nine years, so at least nine years.
Q. When you say all surgeries, I assume that means some nonheart surgeries are included?
A. Yes.
Q. How many of the 20 are heart surgeries as opposed to nonheart surgeries?
A. Maybe three or four heart operations a week.
Q. And the remainders would then be nonheart?
A. Yes, vascular, pulmonary.
Q. I didn't hear the first word.
A. Vascular, pulmonary.
Q. Has that been true for you the entire period of time that you've been here this last nine years?
A. It's been pretty stable, yes.
Q. Where do you perform your surgeries?
A. There are four hospitals that do heart

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surgery in Las Vegas, and I'm pretty equal at all four of them.
Q. Okay. So that you don't – you don't do your three or four hearts a week at one particular hospital?
A. Not necessarily.
Q. Which hospitals do you perform the hearts at?
A. Sunrise Hospital, Desert Springs Hospital, Valley Hospital, and University Medical Center.
Q. What university is that associated?
A. It's called – it's associated with the University of Nevada.
Q. What are the types of heart operations that you perform?
A. Coronary bypass, valve replacements make up the ..valve replacements and repairs will make up the vast majority of the heart surgeries.
Q. Okay. Do you specialize in any particular valve replacement procedures?
A. No.
Q. All types of heart valves?
A. Yes.
Q. How many valve operations did you do last year?
A. I don't know how many I did last year.
Q. How many of your three to four a week are

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valves?
A. I could go two weeks without doing one and I could do two in a week. So I don't know the answer to it.
Q. You're unable – are you able to tell me how many heart operations you did last year?
A. A hundred and sixty-eight.
Q. You can't tell me how many of those were valves, though?
A. I can't tell you.
Q. And I assume that then you wouldn't be able to tell me how many were bypass?
A. That's right. I couldn't give an exact number, no.
Q. What is the bypass procedure that you use? I mean do you do it on – strike that.
Explain to me the bypasses that you do. What type of bypass operations do you do?
A. Coronary bypass.
Q. Do you use a heart/lung machine?
A. On occasion, yes.
Q. Okay. Do you do it on a beating heart and – also?
A. Yes.
Q. Okay. What percentage have you –

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A. I would say – oh, seven to eight percent would be beating heart.
Q. What are your morbidity statistics for valve operations?
A. I don't know what they are.
Q. How about your mortality for valve operations?
A. I don't know what they are.
Q. How about your morbidity for bypass operations?
A. I don't know what it is.
Q. How about your mortality for bypass operations?
A. I don't know what it is.
Q. Do you not keep those statistics?
A. No, I don't.
Q. In terms of the heart surgeries that you do, valves, do you do valves through a sternotomy?
A. Yes.
Q. Do you do any minimally invasive procedures?
A. Rarely.
Q. How many minimally invasive procedures have you performed? Let's talk about valves first.
A. Less than five.
Q. Is that over your entire career?

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A. Yes.
Q. Have you done minimally invasive surgery for any heart operations other than for valves?
A. I consider the beating heart minimally invasive for CABG.
THE COURT REPORTER: For what?
THE WITNESS: For CABG, for coronary artery bypass.
BY MR. JACKSON:
Q. How many of your CABG – we'll use that, C-A-B-G – operations do you do using the minimally invasive techniques?
A. I said seven to eight percent before.
Q. Okay. And you consider those – those are all bypass?
A. Yes.
Q. Now, the five valves that you've done using in minimally invasive –
A. I said less than five is what I said.
Q. I'm sorry. Less than five. Which valves do you replace?
A. Aortic valve.
Q. Aortic.
What was your success in those five or less than five operations?

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A. I don't recall any problems with it.
Q. When was the last time you did an aortic valve using a minimally invasive technique?
A. Incision – minimally invasive incision?
Q. Incision, yes.
A. 18 months ago probably.
Q. Over what period of time did you do the less than five valves? What time –
A. They would all be in the past three or four years.
Q. Why do you not use that technique anymore?
A. I just find it difficult to get to the valve.
Q. Do you see advantages to that technique?
A. To doing a minimally invasive?
Q. Yes, for valves.
A. Yes, there are advantages.
Q. Where were you trained in minimally invasive techniques for valves?
A. Through reading and courses that I've taken.
Q. Your preference apparently then is *to* use a sternotomy incision?
A. Yes.
Q. Is that because it's easier to get to the heart in your opinion using the sternotomy than the minimally invasive techniques?

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A. Yes.
Q. The other surgeries you perform, the majority of your surgeries are vascular and pulmonary?
A. .Yes.
Q. Tell me the pulmonary procedures that you do.
A. Lung resections for cancer, benign tumors, blood disease, the whole gambit of lung surgery.
Q. Okay. And how about the vascular surgeries that you perform?
A. The whole gambit of vascular surgery.
Q. Do you do perform vascular surgery?
A. Yes.
Q. How big is your group here, Doctor?
A. There's seven physicians.
Q. Do any of the seven do – specialize in hearts more than you do?
A. No.
Q. If you have or are confronted with a heart patient which you need to refer or feel you need to refer to some other center, where do you send them?
A. The only ones we send out are for transplant, and they go to Stanford, Salt Lake City or Phoenix.
Q. Are the hospitals that you mentioned to me before where you do the hearts, Sunrise, Desert Springs, Valley Hospital, University Medical Center, are those

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teaching hospitals?
A. Uhm, UMC, University Medical Center is a teaching hospital.
Q. Is it a teaching hospital in cardiac surgery?
A. No.
Q. Are any of the hospitals where you do cardiac surgery teaching hospitals in cardiac surgery?
A. No.
Q. To be a teaching hospital in a particular speciality requires that there be a residency program and such and such; am I correct in that?
A. Yeah. Yes.
Q. Okay. Has that been true of the nine years that you've practicing in Las Vegas?
A. Yes.
Q. For example, none of the places where you have done hearts were at one time a teaching hospital for cardiac surgery and have now changed?
A. No. Yes.
Q. Is that -
A. Yes.
Q. The answer is that they haven't changed?
A. Right.
Q. Okay. Thank you. Is that true for the pulmonary surgery that you do also, that they are not

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teaching hospitals? I mean is there - let me try to - let me try to ask a better question.
They're not teaching hospitals in cardiac surgery. Are they teaching hospitals in vascular surgery?
A. Yes.
Q. Are they teaching hospitals in general surgery?
A. Yes.
Q. Do you teach?
A. No.
Q. Have you?
A. Yes.
Q. When did you last teach?
A. When I left San Antonio.
Q. Haven't done any teaching in the last nine years then?
A. Oh, very little, when I first came to Las Vegas, but it was short-lived.
Q. When you do cardiac surgery, do you work with assistants?
A. Yes.
Q. Tell me the nature of the assistants that you use. Are they fellow cardiac surgeons or what?
A. There's oftentimes a fellow cardiac surgeon:

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there's most often a physician assistant; and then we have two scrub nurses that we - that are employees of ours that may or may not be at the case.
Q. Okay. Employees of your group?
A. Of our group.
Q. Okay. How frequently is your - are your cardiac surgeries done with a fellow - a fully-trained cardiac surgeon? Let me put it that way.
A. I'd say at least 80 percent of the time.
Q. Why do you do that?
A. Well, up until about eight months ago it was a state statute requiring it.
Q. Okay. You had to have another fully trained cardiac surgeon with you in an operation? There had to be two?
A. Yes.
Q. And the state statute has apparently changed?
A. Yes.
Q. Is it your practice still to have two?
A. Yes.
Q. Why do you do that?
A. It's helpful to have another opinion. It speeds the case up, when the physician can be closing the leg up while the other surgeon is helping with the heart surgery.

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Q. Okay. I'm not talking - I'm sorry. I didn't - maybe I missed - didn't give a clear enough question. I'm talking about two surgeons, not a physician's assistant and a surgeon.
A. That's what I'm saying. If the second - the first assistant is a cardiac surgeon, he can help with the heart surgery while the physician assistant is doing other things, closing the leg incision, doing whatever. So it speeds up the operation, gives us another opinion as to a difficult problem. We certainly always have another surgeon when there's a difficult problem.
So I would say those are the two reasons, to speed the case up and to provide another opinion.
Q. Are the surgeons that you work with surgeons in your group?
A. Yes.
Q. Who do you - are the patients group patients or are they a particular patient of one of the surgeons? In other words, you have two surgeons. Whose patient is it?
A. Uhm, there are some referrals from the cardiologist directly to a surgeon, but it's more often than not who is available at a particular time to do the surgery.
Q. When you do heart surgeries on patients -

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well, where do you do – you may have said this and forgive me if you did. Where do you do most of your hearts?

A. I'm pretty split amongst all.

Q. Okay.

A. I'm sure Sunrise is the least, but the other three I can't separate out

Q. About the same?

A. Yeah.

Q. Where does a patient go from heart surgery at your hospital, when they come out of the OR at any of these hospitals?

A. At two hospitals they go to a recovery room and at two they go straight into the intensive care unit

Q. Which two do they go to the recovery room?

A. UMC and Sunrise.

Q. Is that a general surgical recovery room for all-comers or just hearts?

A. It's an all-comers area. There's one area for hearts. It's partitioned off by a wall, but it's – the recovery room is the recovery room for all patients.

Q. Are there nurses or personnel that are specially trained in hearts –

A. Yes.

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Q. – that deal with those patients?

A. Yes.

Q. Exclusively with those patients?

A. I think if there is not a heart patient there, they might do other cases.

Q. Understood. If you have a heart patient there, the personnel that deal with them in the recovery room or the ICUs where you work are specially trained in hearts?

A. Yes.

Q. Okay. Which *two* have the ICU?

A. Desert Spring and –

Q. Valley?

A. Yeah.

Q. Is that an all-comers ICU or is that a cardiac surgery ICU?

A. It's an all-comers.

Q. Again, same question regarding personnel who deal with the heart surgeries, are they specially trained in heart patients?

A. Yes.

MS. TOSTI: John, could we take a five-minute break?

MR. JACKSON: Sure.

(Brief recess.)

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BY MR. JACKSON:

Q. We were talking about ICUs and that and personnel staff,

You said that you haven't taught for the last nine years or so?

A. Yes.

Q. But you did teach at one time when you came here?

A. It was a very brief thing. I thought I wanted to do that, but I couldn't see eye to eye with the director of the program, so it was very short-lived.

Q. Okay. How about publications? Do you have any pending publications?

A. No.

Q. When did you last publish?

A. I think the last paper came out after I was here, but I couldn't tell you an exact date,

Q. Are you actively involved in research, publication, anything of that nature?

A. No.

Q. Have you ever published anything involving cardiac surgery?

A. Yes, I think. Yes.

Q. Anything involving valve surgery, cardiac valve surgery?

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A. Not really, not directly related to it.

Q. Anything involving bypass surgery?

A. Yes.

Q. Is it in your CV?

A. Yes.

Q. Your CV is laying there somewhere. If you would just cite to me which article you're referring to.

A. "Presume Kalisaki's disease resulting in multiple coronary artery aneurysms in an adult."

Q. When was that published?

A. 1990.

Q. Now that you got your CV in front of you, are you able to tell me when your last publication was?

A. They're not in exact order. There's one in 1994. I guess that's probably the last one.

Q. Article?

A. Yes.

Q. Any articles about postoperative care of a cardiac patient?

A. No.

Q. What areas of medicine or surgery would you consider yourself to be an expert, Doctor?

A. Adult cardiac and cardiovascular and thoracic surgery.

Q. In terms of medical/legal matters, how many

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cases have you reviewed in your involvement with medical/legal matters?
A. For an attorney you mean?
Q. Yeah. Yes.
A. Uhm --
Q. Where you are retained as an expert for either plaintiff or defendant.
A. Oh, I would say five.
Q. Over what period of time?
A. Since '91.
Q. And the five cases that you have reviewed, have those been for plaintiffs or defendants?
A. This is the first plaintiff.
Q. For whom did you do the other four cases?
A. Two of them were for attorneys here in town; another one was an attorney in North Dakota, I think; and the other attorney - this one is the fifth one.
Q. Okay. So you've done two local, one in North Dakota and this one? That would be four.
A. Then there's three local ones then.
Q. Three local?
A. Yes.
Q. So you were defending a local doctor or health care provider in those cases or you were asked to defend them?

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A. I think one of them was from out of town, I don't think it was local.
Q. I would assume that's the North Dakota.
A. Well, I think one of the ones here in town was someone from out of town, too.
Q. Oh, I see.
A. From northern Arizona, I think it was.
Q. Okay. Have you ever testified in court?
A. Yes.
Q. How many times?
A. As an expert witness you mean?
Q. Yes.
A. I have not testified in court as an expert witness.
Q. You've testified - I take it that you've testified in cases in which you've been sued then?
A. Yes.
Q. How many times have you been sued?
A. Once.
Q. What was that about?
A. It's still under litigation, so I don't want - don't think I should discuss it.
Q. Well, it's a lawsuit that's pending against you right now?
A. Yes.

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Q. Okay. But a lawsuit has been filed?
A. Yes.
Q. Okay. I will tell you that I'm entitled to explore that, Doctor. If there was some kind of a claim that hadn't gone to a lawsuit, we might have an argument about that. But if there's a lawsuit that's been filed, I'm entitled to explore that with you.
MS. TOSTI: It's a case that is in litigation at the current time.
BY MR. JACKSON:
Q. All right. I'm not going to try to put you in a bad position here. I'm going to ask you what it is that you've been accused of doing, what's the claim against you.
MS. TOSTI: You can tell him what the allegation of the -
BY THE WITNESS:
A. The allegation was that we left a sponge in someone's chest at the time of surgery.
BY MR. JACKSON:
Q. Was a sponge left in?
A. No.
Q. That's the only time you've been sued?
A. Yes.
Q. And that's a local case?

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A. Yes.
Q. Has an expert been retained against you on the other side?
A. Not a cardiac surgeon.
Q. Has an expert been retained?
A. Yes.
Q. What speciality?
A. Infectious disease and cardiologist.
Q. Both of whom criticized your care of the patient?
A. Yes.
Q. Is it your position that you were not negligent in the case?
A. Yes.
Q. Do you have an expert on your behalf?
A. Yes.
Q. Now, you said you testified in court. Would that have been for patients of yours then?
A. That's in this particular case.
Q. Okay. Then have you testified by way of deposition or actually been in court?
A. I testified in court.
Q. Okay. You have to explain that for me. If it's a pending case -
A. The trial ended in a hung jury and is to be

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retried.
Q. Got you. Thank you.
What is the plaintiffs name?
THE WITNESS: Do I have to give that?
MR. JACKSON: It's public record.
BY THE WITNESS:
A. Krause, K-r-a-u-s-e.
BY MR. JACKSON:
Q. That's pending in Las Vegas?
A. Yes.
Q. Do you know the name of plaintiff's lawyer?
A. Yes.
Q. What is his name or her name?
A. His name - Sutter is the last name, S-u-t-t-e-r. I think it's John, but I wouldn't swear to it.
Q. How many times have you given depos before in medical/legal matters?
A. In that - in that case, and that's the only time.
Q. Have you ever given a deposition in a case where you've been an expert?
A. No.
Q. This is your first depo other than when you were a defendant?

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A. Yes.
Q. Have you been contacted as an expert witness before and chosen not to do it?
A. And?
Q. And chosen not to take cases over the years?
A. Ah, I think there was one, yes.
Q. Just decided you didn't want to do it?
A. Yes. I didn't even review it. I just didn't have the time.
Q. What prompted you to take this case?
A. I was called by Mr. Becker's office.
Q. And?
A. And asked to review the case.
Q. What were you told when you were called?
A. A summary of the facts that they knew of the case,
Q. What did they tell you?
A. I don't remember the exact details of what was said on the telephone.
Q. Whatever it was, it interested you in the case apparently because you agreed to take it?
A. I told him I would take a look at it and give my opinion.
Q. Did you talk about other experts in the case?
A. No.

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Q. Did they talk to you about whether they had contacted other experts in the case?
A. I don't recall any discussing of other experts.
Q. Was there any discussion about a time deadline for you to get your report in?
A. I think –
MS. TOSTI: Are you asking him if we told him when he had to have a report in?
MR. JACKSON: Was he under the gun? That's what I am asking.
MS. TOSTI: We told him we had a date he had to provide a report by, just like we do in any case.
BY THE WITNESS:
A. I don't remember a specific day. I just remember we need this in some period of time. It could have been weeks.
BY MR. JACKSON:
Q. How did they get your name, Doctor?
A. Uhm, they told me, but I've forgotten the reason. I don't recall the reason or how.
Q. Pardon me?
A. They – I asked them that question, and I've forgotten how they got my name. From somebody else, another attorney somewhere. But I don't recall who it

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was or what the circumstances were.
Q. Have you worked with other attorneys in Ohio?
A. Not in Ohio, no.
Q. Do you remember when you were first contacted?
A. I don't remember the exact date, no.
Q. Was it by telephone?
A. Telephone.
Q. Did you only have one conversation by telephone before writing a report or were there more?
A. I think I called back to get more information or there was another phone call that they were sending more complete records before I prepared my report.
Q. Do you have your report in front of you?
A. Do I have my?
Q. Your report there.
A. Yes.
Q. Your report makes reference to a telephone call of August 31st, '99.
A. Okay.
Q. Was that the initial call that you received?
A. I think it must have been.
Q. Okay. You say: "Per our discussion I have reached an opinion, which is discussed below." Tell me about the discussion you had on August 31st, 1999.

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A. They asked me to review the case and to make an opinion of it.
Q. Who asked you?
A. Uhm, Mr. Becker and Kathleen Mulligan, I think is who I talked to. Kathleen Mulligan.
Q. Who is Kathleen?
A. An attorney in the office, I guess.
Q. Okay.
MS. TOSTI: Let me correct that. She's an assistant. She's not an attorney.
BY MR. JACKSON:
Q. Was that conversation recorded?
A. No, not on my end.
Q. Was it recorded on their end, do you know?
A. I don't know.
Q. Were you told it was being recorded?
A. No.
Q. What materials were sent to you as a result of that telephone conversation?
A. The synapsis and -or shortened version and then complete records of the hospital course of Mr. Long.
Q. Okay. You've got two three-ring binders in front of you. The green ring binder is a -what?
A. Just a very -- just has the pertinent facts,

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pertinent medical history and things of the case. The bigger one's got the entire page.
Q. Did you get them both at the same time?
A. I think I got them at two separate times.
Q. Okay. Which came first?
A. The green one, the shorter one.
Q. I understand you would have reviewed the green one and asked for more or not? Or how did that work?
A. As I recall, I reviewed the green one and wanted more information before I could render an opinion or maybe at the same -the same time they said they were sending - I don't recall whether they were sending it - it didn't come at one time, but whether it was coming shortly thereafter or not, I don't recall.
Q. Is it your understanding that you reviewed the entire medical chart?
A. Yes.
Q. Did you review depositions before you issued your report also?
A. Yes.
Q. Did those come with the initial package?
A. I think they came with the second package.
Q Initially then you received an abbreviated version of the medical records?

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A. Yes.
Q. And you would have also received a letter from Mr. Becker, correct?
A. Yes.
Q. And that letter would have outlined a summary of the case for you; is that correct?
A. I don't recall a summary in the letter.
Q. You told me earlier there was some summary in the correspondence that you initially got, as I recall, outlining the facts or summarizing the facts?
A. Yes. Okay. There was an outline of the facts.
Q. That was --
A. That was in the first -
Q. The first letter?
A. The first letter with the green one, I think.
Q. Are you able to tell me how long that was, the outline?
A. How many pages?
Q. Yes.
A. A page and a half or two.
Q. After you did the initial review of the abbreviated records, you would then - you had then called for additional materials?
A. I don't know whether they called me or I

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called them.
Q. Okay. What additional records did you ask for?
A. The complete file.
Q. Okay. Was there additional information - when you say the complete file, you mean the complete medical records?
A. The complete medical records.
Q. Was there additional information in the medical records that were sent to you the second time that assisted you in forming opinions?
A. Yes, because I - I assume so because I reviewed the entire thing.
Q. Which depositions did you review before your report? Are those the ones listed?
A. Yes.
Q. Dr. Hearn, Dr. Muehlebach, Dr. Yared, Dr. Cosgrove, and Nurse Zika.
Who is Dr. Yared?
A. An anesthesiologist.
Q. What was his role in this case?
A. From his deposition he was just covering the ventilator support of the patient after surgery as he was doing many others at the time.
Q. Many other patients you mean?

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A. Yes.
Q. Other than the depositions that are listed in your report and the medical chart did you review any other materials before issuing your report of September 21, '99?
A. No.
Q. Did you do any research?
A. No.
Q. Did you read any articles?
A. No.
Q. Did you do any type of an on-line computer check or med-line search or anything of that nature?
A. No.
Q. So everything you reviewed, everything you read, everything you looked at to formulate your opinions is listed in your report, that being the medical records and those depositions?
A. Yes.
Q. Since your report of September 21, '99, have you reviewed any additional materials?
A. Yes.
Q. What?
A. The expert, expert opinions from Dr. Lyons, L-y-o-n-s, and Dr. Oz, O-z.
Q. Do you know any of the – do you know

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Dr. Hearn?
A. No.
Q. Do you know Dr. Muehlebach?
A. No.
Q. Do you know Dr. Yared?
A. No.
Q. Do you know Dr. Cosgrove?
A. I have met him.
Q. You have met Dr. Cosgrove?
A. Yes, sir.
Q. Under what circumstances?
A. I came to the Cleveland Clinic to observe him do several surgeries in a one- or two- or three-day period.
Q. When was that?
A. '95, '96. It was cold, snowing. I don't remember exactly when it was.
Q. What type of surgeries were you learning from Dr. Cosgrove?
A. Minimally invasive surgery.
Q. So you learned to do this minimally invasive technique from Dr. Cosgrove?
A. Not entirely. I observed him on several cases.
Q. Did you observe other physicians doing the

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surgery?
A. At the Cleveland Clinic.
Q. Either at the Cleveland Clinic or elsewhere.
A. Yes, elsewhere.
Q. Where?
A. Billings – not Billings. Missoula, Montana; Phoenix; San Diego; Charlotte, North Carolina. That's about the ones I can remember.
Q. Did you observe other physicians at the clinic doing surgeries, minimally invasive surgeries?
A. I think I peeked in on one between cases, but I don't remember who the surgeon was.
Q. Do you know Dr. Oz?
A. No.
Q. Have you ever heard of Dr. Oz?
A. I have heard of his name before.
Q. Under what circumstances?
A. That he's a cardiac surgeon. This is a different – odd name, and that's why I'm sure I remember it. I never met him. I don't know that I've ever heard him talk before.
Q. Do you know Dr. Lyons?
A. No.
Q. Doctor, in your report of September 21st – and I have a three-page report. I think that's the same

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one you have in front of you.
A. Yes, sir.
Q. Is that your only report, your only draft of a report?
A. Only report I made, yes.
Q. Did you review your report with Mr. Becker or anyone from his office before you wrote it?
A. No.
Q. Before you completed it and sent it out?
A. No.
Q. You make no statement in here anywhere that the care rendered from the Cleveland Clinic fell below standard of care. Was that intentional?
A. I wasn't asked to state standard of care.
Q. What were you asked to state?
A. My opinion as to the cause of his demise.
Q. Okay. So you weren't ask to render an opinion regarding standard of care?
A. No.
MS. TOSTI: I'm going to object. His report stands for itself. If you're asking if he put the words standard of care here, he has not.
MR. JACKSON: Jeanne, you know better than to do that. And he didn't, and he just acknowledged that he didn't.

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BY MR. JACKSON:
Q. Was that intentional, not putting the words standard of care there? You said yes because you weren't asked to, right?
A. Right.
Q. Were you asked between the time you wrote your report and today to formulate standard of care opinions?
A. Yes.
Q. When did that happen?
A. Somewhere between then and now.
Q. When?
A. I don't remember.
Q. How is it – was it by telephone? Did it happen today?
A. I think it – no, it wasn't today.
Q. Did you – did you write to them about standard of care?
A. No.
Q. How did the standard of care issue come up Doctor?
A. I think in a telephone conversation.
Q. When? You can't tell me?
A. I don't know.
Q. Did they write you correspondence after they

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got your report talking about standard of care?
A. No.
Q. Are you sure *of* that?
A. I'm – I don't remember any correspondence after this about standard of care.
Q. You got a call from them after you wrote you report about standard of care?
A. I think the discussion was what do you think the standard of care – what *is* your definition of standard of care.
Q. Okay. And you can't tell me when that came up?
A. No.
Q. All right. And in that discussion then you spelled out what you thought standard of care issue! were?
A. Yes.
Q. Because the things that we covered today regarding standard of care are not in your report, are they?
A. Yes, there is I think standard of care problems in this report.
Q. Well, Doctor –
A. I make a discussion as to what exactly I would have done. Prudent care would be standard of care

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possibly.
Q. We'll get to that in a moment.
A. Okay.
Q. You make no comment in your report –
A. The words standard of care are not in the report.
Q. – *of* standard of care. You make no comment in your report about Dr. Cosgrove not instructing either Dr. Muehiebach or Or. Hernandez, do you?
A. No.
Q. You make no comment in your report about Dr. Cosgrove not instructing the nurse, do you?
A. No.
Q. You don't make any comment about Dr. Muehlebach not acting on abnormal findings or doing something to help the patient, do you?
A. No.
Q. You don't make any comment in your report about Dr. Muehlebach not instructing Dr. Hernandez?
A. Any of those doctors' names are not in there, no.
Q. That's true, but nor do you say anything about any doctor instructing another doctor, correct?
A. No.

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Q. You make no comment in there about any of the doctors such as Dr. Hernandez not knowing what his responsibilities were for the patient, do you?
A. No.
Q. You make no comment in there at all about the nursing care, do you?
A. No.
Q. So all these opinions that we heard today that you talk about standard of care are opinions that were formulated sometime between the time you wrote your report and today or at least you were asked to express them sometime between your report and today –
MS. TOSTI: Objection.
BY MR. JACKSON:
Q. – is that correct?
A. You asked me the questions about the standard of care today, yes.
Q. That's right, I did. But it's – they're net included in the report, correct?
MS. TOSTI: Objection. They are included in his report.
MR. JACKSON: They aren't included –
MS. TOSTI: You can see that standard of care in the –
MR. JACKSON: Jeanne, I'm –

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MS. TOSTI: – includes what he considers prudent care to be. So I object to your characterization that standard of care is not in his report.
BY MR. JACKSON:
Q. Doctor, I just went through all the questions about standard of care and the criticisms you had for standard of care just a few moments ago, and you agreed with me that none of those issues are in this report.
MS. TOSTI: The doctor said the names –
MR. JACKSON: Jeanne –
MS. TOSTI: – of those particular doctors aren't in the report.
MR. JACKSON: Jeanne, you know better than to do that. You shouldn't do that.
MS. TOSTI: John, don't patronize me.
MR. JACKSON: Stop this. You know better.
MS. TOSTI: Allow me to make an objection on the record.
MR. JACKSON: You can make your objection, but you know better than to make those kinds of objections.
MS. TOSTI: I'm going to object when you say that his report does not have standard of care in it because it is word for word here. "Prudent care in my

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estimation of this patient should have included," and then he delineates it.
BY MR. JACKSON:
Q. Doctor, there are three things that you say in your report. You never mention standard of care. We've gotten that established, haven't we?
A. The words standard of care are not mentioned. **Prudent care is in prudent care.**
Q. Prudent care. But you never make a mention about these instructions or somebody failing to instruct somebody else, do you? That's not mentioned in your report, is it?
A. **No.**
Q. Okay. Now, you make no mention in your report – and I've asked you this once and we'll go back again – about the nursing care, do you?
A. **No.**
Q. Okay. What you say in your report on the second page is that they should have done a repeat chest x-ray, one – they should have done one or more of the following, correct – repeat chest x-ray; two, a TEE or a surface echo; three, return the patient to surgery?
Those are the three things that you talk about in your report, correct? Am I correct? .
A. **Those are the three things, yes.**

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Q. I am looking for my note, Doctor, about how many aortic valves you've done through a minimally invasive technique.
Oh, here it is. Less than five?
A. **Yes.**
Q. Are you able to be more specific than that?
A. **No, I can't – I can't. I've helped my partners with some and I get confused as to I was doing them or they were doing them. Less than five is certainly a true fact.**
Q. So the less than five would include not only you've done, but –
A. **No. I've done less than five.**
Q. You personally?
A. **Personally.**
Q. If you were asked by someone to do an aortic valve using a minimally invasive technique today, would you feel qualified to do it?
A. **Yes.**
Q. Would you do it?
A. **Depends on the circumstances.**
Q. Okay. Not having done one for some 18 months, you would still do it?
A. **Yes.**
Q. What additional material since your report

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have you looked at?
I know you said you looked at some, and I don't think I got an answer because I didn't explore, I don't think – that's my fault – as to what in fact you did see since your report.
A. **I think we discussed the two experts on the other side.**
Q. Okay. Anything else?
A. **A copy of a chapter.**
Q. "Minimal access cardiovascular surgery"?
A. **Yes.**
Q. When did you review that?
A. **The past two weeks.**
Q. Where did that come from?
A. **From Mr. Becker.**
Q. They sent that to you?
A. **Yes.**
Q. Anything else you reviewed?
A. **No.**
Q. Why did they send you that? Why did they ask you about that?
A. **They asked me just to be aware of what** incisions – different types of incisions were possible.
Q. Okay. Did it educate you in terms –
A. **No. No.**

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Q. Did you look at anything else?
A. No.
Q. I'm trying to understand then in terms of the possible incisions, what did you do to educate yourself on the possible incisions that can be made?
A. The ones that are in there are the ones that I already knew.
Q. Okay. They just wanted you to be sure that you're aware of those?
A. Yes.
Q. Did you request that type of material from them or did they send it to you?
A. They sent it to me.
Q. Did you have a conversation with them about the article?
A. Just that they were going to send it to me.
Q. After you read it?
A. Not after I read it, no.
Q. Did that help you in any way in terms of your -
A. I said no -
Q. - opinions?
A. I said no before.
Q. Well, it didn't educate you about the incisions. I was wondering if there was anything else

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in there that helped you.
A. No.
Q. Any other materials that you reviewed since your report of December - September 21 the till today?
A. No.
Q. In preparing for your depo what did you review and when?
A. The complete medical records, the depositions of Muehlebach and Yared and the two experts and my note.
Q. Your note meaning your report?
A. My report.
Q. Did you keep any notes, handwritten notes of this?
A. No.
Q. Do you prepare notes when you - when you review something like that?
A. I scratch things down on a piece of paper before I start dictating,
Q. And when you dictate, what happens to them?
A. They're illegible to anybody but me, and they get tossed as soon as I dictate it.
Q. How long did you take to prepare for your report - your review of this deposition?
A. Two hours.
Q. How long did you spend with Ms. Tosti before

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we came in here, before I came in here?
A. She got here at 12 - 12:30. I don't know what time you came in.
Q. Doctor, first of all, I would like to get a copy of this, if I may, the article you referred to.
A. I'll tell you in advance that all the pages aren't here, so I'm not holding any pages away from you.
Q. It's not all there?
A. No, it's not all here.
Q. Okay. Well, let me just - I'll tell you what I need then. Let me just have the two front sheets, because the rest of it will be easy to find.
You highlighted some. Is that your highlighting or was that done for you?
A. No, That's my highlighting.
Q. What was the significance of what you highlighted?
A. Why we're doing - why we're doing this kind of surgery, noninvasive, and that adequate exposure is essential.
Q. What does that - what significance does that have in this case?
A. Nothing in this case.
Q. Okay. It was just a note you made yourself - I'm just wondering why you highlighted that. Does it

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have some significance that it -
A. To this case, no.
Q. Okay.
A. To my partners and cardiologists in this town, yes.
Q. Why?
A. Because we're always arguing about this, and I've never seen it written down as to why we're doing this.
Q. Okay. And that stated why?
A. For the - "Driving forces behind the current interest in minimal access cardiac surgery include surgeon's intellectual curiosity and desire to provide superior care, publicity in the right press, patient's request for small incision, a faster recovery and third-party payer's desire to cut costs."
Q. Which side of the debate do you come down on, for it or against it?
A. I'm for it.
Q. This is the copy of the autopsy?
A. Yes.
Q. Of what significance in this case was the autopsy or the findings of the autopsy to you?
A. None.
Q. Did they add anything to your thoughts or

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opinions here?
A. No. They only did the heart examination.
Q. I understand. But was there anything about the heart that **was** *of* any significance?
A. No.
Q. In these materials that were sent to you –
A. I know them pretty well. I could point you to the direction you're looking.
Q. I know what I'm looking for. Was there anything in this – in any of these binders that **was** removed before the depo?
A. No.
Q. I'm looking at this last tab here, and it says – this **is** in the green one, It would have been the one you received first from Mr. Becker's office. It talks about – well, frankly, I can't quite make it out. But it's – can you tell me what that is?
A. I have no idea.
Q. I can't either.
But these are apparently handwritten notes with certain values on them.
A. Yes.
Q. Do you know what those are?
A. They're not notes from me.
Q. Pardon me?

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A. I assume they're nurses notes.
Q. All right. But these are not notes that came out of the Cleveland Clinic chart. Someone else prepared these apparently. Do you know where they came from?
A. If they're in the book, it came from Mr. Becker's office.
Q. Okay. And there's apparently four pages of it, which I would like copies before we leave. Can we get copies of these?
A. Yes.
Q. Don't do it at this minute, but before I leave.
There's a note at the bottom of the first one. Would you read that.
A. "I think the window of opportunity for this man was between 19" – I guess that's "1930 and 2140."
Q. That says we. I think you said I. It says we.
A. I'm sorry.
Q. And that's double starred.
Is that your writing?
A. No.
Q. Whose writing **is** that, do you know?
A. I don't know.

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Q. Do you agree with that statement?
A. No. I think the times I've said are different than this.
Q. You believe the window of opportunity **was** what?
A. I think we decided 1950 to 2150.
Q. Okay. Are you planning to come to Cleveland for the trial of this case, Doctor?
A. If I'm asked.
Q. Have you been asked?
A. I've been given a court date, potential court date.
Q. Have you made plans to be there?
A. I just found out today, so I haven't made plans.
Q. Okay. Is it your belief that Mr. Long had a tamponade?
A. Yes.
Q. Based on what?
A. Hemodynamic changes leading to his arrest in someone who's been bleeding and he was doing very poorly despite interventions.
Q. Okay. What would be the significance of a low SVR relative to tamponade?
A. I don't think there is a relation.

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Q. No relation?
A. No.
Q. Would a low SVR argue against tamponade?
A. No.
Q. It would not in your opinion?
A. No.
Q. I want to be sure, Doctor. I know this is ad nauseam for you. But are there any other opinions that you have been asked to express regarding the cafe that Mr. Long received at the Cleveland Clinic that we have not discussed?
A. Uhm, I don't think so.
Q. If you formulate other opinions either because you come up with them or you're asked to, would you agree that we should be notified and be given the opportunity to talk to you about those, question you about those opinions?
A. I –
Q. Is that agreeable with you and does that make sense?
A. I don't know. Yeah, I guess. You're asking me legal stuff now.
Q. **No.** I'm asking you common sense stuff no.
A. No, you're not asking me common sense stuff.
Q. I am because –

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A. I don't know what my responsibilities to you are. So that's a legal problem, not a common sense probbm.
Q. All right. Well, it makes sense that we should have the opportunity, doesn't it, to know what your opinions are and inquire of those before you testify in court?
That's a common sense problem, but it has legal aside to it. I agree with you. You're absolutely right.
A. I guess the flip would be if Dr. Oz or somebody else has an opinion, then they know about it
MS. TOSTI: Don't be concerned about that.
THE WITNESS: I don't know.
MS. TOSTI: He's asking you a typical question for a medical expert. So you've answered the question.
BY MR. JACKSON:
Q. What we try to be careful of, Doctor, is that we come a long way to ask you all your opinions, and there may be opinions that I didn't cover because I was inartful, there may be opinions that you come up with between now and the time of trial, and if that's the case, I want to have the opportunity to find out about those -

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A. Okay.
Q. - so that I don't get blind sided at trial with new opinions that I didn't know you were going to render.
A. Okay.
Q. Okay?
A. Okay.
Q. That's the whole basis of that. And there are legal rules that apply to that, but they don't always work. Every now and then somebody gets on the stand and says something new.
What are your fees for medical/legal matters, Doctor?
A. $400 an hour.
Q. Is that for everything?
A. Yes.
Q. Review, deposition, trial time?
A. I haven't even thought about trial time yet.
Q. Okay.
A. Never done it, never thought about it
Q. Do you advertise your services as an expert in medical/legal matters?
A. No, I do not
Q. Are you a member of any service or group that provides expert witnesses in legal matters?

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A. No.
Q. Have you ever actually met Mr. Becker?
A. No.
Q. In Doctor Oz's report - you have it in front of you there?
A. Yes.
Q. I think you highlighted some things -
A. Yes.
Q. - did you not?
A. Yes.
Q. What was the significance of the - the sentences or phrases?
A. The part I highlighted was, "This center is a world leader in minimally invasive operations and has numerous publications and peer review journals outlining their superb results."
Q. Do you agree with that?
A. Yes.
Q. He's referring to the Cleveland Clinic?
A. Yes.
Q. What was the - what was the point in highlighting it?
A. I can't put a reason on it, except when I was going through it, I thought it was interesting that - I would consider that an advertisement for them rather

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than an opinion as to what was wrong with Mr. Long.
Q. Do you agree it's an accurate statement?
A. I don't know they're the world leader.
Q. It says "a world leader," doesn't it?
A. No. It says, "This center is world leader." I don't think necessarily they are the world leader. It doesn't say "a world leader."
Q. Who would you say is the world leader in cardiac surgery?
A. I don't know.
Q. You also highlighted something in Dr. Lyons' report, if I'm not mistaken, or circled. You highlighted -
A. This - the important parts about his discussion on - and things that I disagreed with.
Q. Tell me what those points were with which you disagreed.
A. "The use of these drugs is common in the postoperative care of cardiac surgery patients."
Q. Referring to Levophed?
A. He's talking about Levophed and Epinephrine.
Q. You disagree with that?
A. Yes.
Q. Why?
A. Because I don't think its common, the use of

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it is common.
Q. Perhaps we're getting into a definition of what's common and uncommon, but why do you take issue? Are those not drugs that are used regularly in cardiac – or postoperative care for cardiac patients?
A. It would be unusual in a patient with aortic stenosis to have a valve replacement to come out of the operating room on no medications except something to keep his blood pressure down, to be started on these medications hours after surgery.
Q. Okay. So you disagree with Dr. Lyons' –
A. Yes.
Q. – comment in that regard?
A. Yes.
Q. What other points there did you highlight and with which you apparently disagree?
A. "I believe the neurologic complication Mr. Long suffered is secondary to the period of hypotension which occurred shortly after his return to the operating room."
Q. You disagree with that?
A. Yes.
Q. We've talked about that, I think, your opinions in that regard.
A. We have talked about them, yes.

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Q. Okay. What else?
A. "Severe left ventricular function."
Q. What is it about that that you –
A. I was going to look up to see exactly what his ventricular function was.
Q. What was it?
A. There is no – I couldn't find any specific thing to say what his ejection function was.
Q. So you disagree with what he said there or –
A. No.
Q. – you're just trying to find a basis –
A. I was just reminding myself to look that up while I was going through the chart.
Q. Okay. What else?
A. "Nor do I believe any other tests would have been helpful in making this decision."
Q. The decision being?
A. Earlier return to the operating room, I guess is what he said.
Q. You take issue with that because of the – your arguments about TEE and echo and –
A. Yes.
Q. – chest x-ray, correct?
A. Yes.
Q. What else? Or is that it?

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A. That's it.
Q. Okay. Have you ever had your privileges suspended or revoked for any reason, Doctor?
A. No, I have not.
Q. In terms of board certification, were you successful at first attempts on your boards?
A. Yes.
MR. JACKSON: Doctor, I don't think I have any further questions.
Do you understand waiver of signature?
MS. TOSTI: He's going to reserve signature and read.
MR. JACKSON: That's his decision and I don't – you know, that's up to him, I guess, but I'm not sure that you're the person that should be advising him one way or the other on that, nor do you have the right to make the comment you just made.
Well, I guess you're going to do it anyway.
MS. TOSTI: Doctor, you have the option, when this is typed up, to read it and to make corrections to it, if it's been taken down improperly, and I would suggest that you do so. But it is your decision as to whether you do that or not.
MR. JACKSON: I can't imagine what you're going to do.

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THE WITNESS: Every deposition I've ever given I've looked at that and I will continue to do that. I thought – I thought I had to sign the thing anyhow.
MR. JACKSON: You don't have to sign it. You can waive signature.
THE WITNESS: I've never done that before.
MR. JACKSON: Okay. That's it.
THE WITNESS: In fact, I find it quite interesting as to how I said thing sometimes.
(Thereupon, the proceeding was adjourned at 4:05 p.m.)

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CERTIFICATE OF DEPONENT

PAGE LINE CHANGE REASON

I, V.C. SMITH, M.D., deponent herein, do hereby certify and declare under penalty of perjury the within and foregoing transcript to be my deposition in said action; that I have read, corrected and do hereby affix my signature to said deposition.

V.C. SMITH, M.D.
Deponent

Subscribed and sworn to be before me this ____ day of _____,2000.

NOTARY PUBLIC

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REPORTERS CERTIFICATE

STATE OF NEVADA)
) ss
COUNTY OF CLARK)

I, Wanda L. Barnes, Certified Shorthand Reporter No. 676, Clark County, State of Nevada, do hereby certify:

That I reported the taking *of* the deposition of the witness, V.C. SMITH, M.D., commencing on March *28,* 2000, at the hour of 1:35 p.m.;

That prior to being examined, the witness was by me duly sworn to testify to the truth, the whole truth;

That I thereafter transcribed my said shorthand notes into typewriting and that the typewritten transcript of said deposition is a complete, true and accurate transcription of my said shorthand notes taken down at said time.

I further certify that I am not a relative or employee of an attorney or counsel of any of the parties, nor a relative or employee of any attorney or counsel involved in said action, nor a person financially interested in the action.

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IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in my office in the County of Clark, State of Nevada, this _____ day of _____, 2000.

Wanda L. Barnes
CCR No. 676, RPR