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

- - - - -

IN THE COURT OF COMMON PLEAS

- - - - -

Doc. 427

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

vs.

SAINT VINCENT CHARITY HOSPITAL, et al.,
defendants.

: Case No. 226946

- - - - -

Deposition of ROBERT J. STEELE, M.D., a defendant herein, called by the plaintiffs for the purpose of cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before Frank P. Versagi, a Registered Professional Reporter, a Certified Legal Video Specialist, a Notary Public within and for the State of Ohio, at the offices of Flowers & Versagi Court Reporters, The 113 Saint Clair Building, Cleveland, Ohio, on Tuesday, the 22nd day of September, 1992, commencing at 2:00 p.m., pursuant to notice.

APPEARANCES:

ON BEHALF OF THE PLAINTIFFS:

Charles Kampinski, Esq.
Donna Kolis, Esq.
Charles Rampinski Co., L.P.A.
1530 Standard Building
Cleveland, Ohio 44113.

and

David J. Elk, Esq.
Elk and Elk
Chagrin Richmond Plaza
25550 Chagrin Boulevard - Suite 204
Beachwood, Ohio 44122.

- - - - -

ON BEHALF OF THE DEFENDANT SAINT VINCENT CHARITY HOSPITAL:

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

- - - - -

APPEARANCES: (continued)

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

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

- - - - -

ON BEHALF OF THE DEFENDANT PREM VARMA, M.D.:

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

- - - - -

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

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

- - - - -

APPEARANCES: (continued)

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

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

- - - - -

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

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

- - - - -

ON BEHALF OF DEFENDANT CLEVELAND CLINIC FOUNDATION:

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

- - - - -

I N D E X

WITNESS: ROBERT J. STEELE, M.D.

- - - - -

(No Exhibits Marked)

- - - - -

INDEX of OBJECTIONS

INDEX OF OBJECTIONS (continued)

BY MR. FULTON:	PAGE/LINE	PAGE/LINE	PAGE/LINE
	38/10	93/6	183/4
	39/2	93/10	183/24
	39/4	103/1	184/7
	39/10	110/14	184/13
	40/4	135/22	
	41/21	136/1	
	45/7	137/20	
	45/14	156/18	
	45/21	156/22	
	45/23	161/12	
	47/1	163/4	
	47/10	163/21	
	48/10	166/12	
	55/18	171/2	
	55/24	175/3	
	56/25	175/8	
	57/8	175/18	
	57/12	175/24	
	83/6	176/21	
	88/3	180/13	
	88/7	180/16	
	88/11	181/5	
	91/12	182/6	

INDEX of OBJECTIONS (continued)

BY MR. WARNER:	PAGE/LINE	PAGE/LINE	PAGE/LINE
	34/10	84/13	166/11
	35/19	84/21	183/6
	45/15	98/1	183/23
	48/4	101/15	
	76/6	102/14	
	81/9	163/3	
	83/9	163/20	
	83/22	165/3	

- - - - -

BY MR. COYNE:	PAGE/LINE	PAGE/LINE	PAGE/LINE
	45/24	81/17	163/2
	47/11	83/8	163/23
	47/24	84/16	166/10
	48/3	88/6	183/5
	48/11	88/12	183/22
	57/1	97/25	
	81/8	137/10	

- - - - -

BY MR. OKADA:	PAGE/LINE	PAGE/LINE
	83/13	165/2
	84/15	166/16
	163/8	183/10
	163/25	184/3

INDEX of OBJECTIONS (continued)

BY MR. SEIBEL:	PAGE/LINE	PAGE/LINE
	83/12	166/13
	97/24	183/7
	163/5	183/25
	163/22	

- - - - -

BY MRS. CARULAS:	PAGE/LINE	PAGE/LINE
	83/11	166/15
	163/7	183/9
	163/24	184/2

- - - - -

BY MR. VARMA:	PAGE/LINE
	110/15

- - - - -

BY MR. KAMPINSKI:	PAGE/LINE
	194/21
	211/3

- - - - -

ROBERT J. STEELE, M.D.

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

- - - - -

CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Would you state your full name, please?

A. Robert James Steele.

Q. Dr. Steele, I'm going to ask you questions this afternoon. If you don't understand any of my questions, tell me, I'll be happy to rephrase anything you don't understand.

When you respond you have to do so verbally. He is going to take down everything we say. He can't take down a nod of your head,

A. Yes.

Q. Where do you live, Doctor?

A. I live in Westlake.

Q. Your address, please?

A. 1545 Roseland Way.

Q. Is that one word?

A. Yes.

Q. And the zip?
A. 44145.
Q. What kind of a physician are you?
A. I am a cardiologist.
Q. If you would run through your educational background, starting with high school, that leads you to your current professional status.
A. Well, I graduated from high school arid went into a premedical program in college.
Q. Where did you graduate high school?
A. In Toronto.
Q. When?
A. 1964.
Q. Where did you go to college?
A. I went to a college called Queens University, which is in Kingston, Ontario, from 1964; graduated medical school in 1970.
Q. Was this a joint degree?
A. There was no undergraduate degree, It was you're accepted in a premedical course, and if you passed that, you were streamlined straight into medical school.
Q. So then was it medical school that you went to the entire time at Queensland?
A. Queens University, yes, it was.

Q That would have been from?
A '64 to '70.
Q. Then what did you do?
A. I stayed at Queens University, did an internship for one year, followed by a year of residency in internal medicine.
Q Also at Queens University?
A. Yes. Followed by two years of training in cardiology.
a. Also at Queens University?
A. Yes.
Q. We're now up to what?
a. Well, about '74.
Q. Okay.
A. Followed by a year and a half of further cardiology training in Switzerland.
Q. Where at?
A. Luzein, Switzerland.
Q. Can you spell that?
A. I think it's L-a-u-s-a-n-n-e,
Q. Is that the name of the facility?
a. That's the name of the city.. University Hospital in Luzein.
Q All right. What were you doing your internship in?

A. I was continuing my training in cardiology when I was there. I was basically chief resident in a unit.

Q. That would have been '75?

A '74, '75. Then in 1975, in about October of '75, I went back to Kingston, where I filled in as a chief resident from October until the following July, which would have been July of 1976; whereupon, a was finished and then I came to Cleveland.

Q. What did you do in Cleveland?

A. I initially came here and joined a cardiologist in practice named Henry Zimmerman, who was a cardiologist in town here for many years, I worked for him until 1979. Then I went into practice on my own.

Q. Why did you leave him?

A. Be was going to retire and it seemed to be an opportune time to go off on my own, which had been my goal in life all. along. E wanted to be my own boss.

Q. What was the name of his practice?

A. Just Henry A. Zimmerman, M.D., Inc., I suppose. I guess he was incorporated.

Q. Were you an employee of that corporation?

A. Yes.

Q. Were you a shareholder?

A. No.

Q. When you went off to practice on your own, lander what name did you practice?

A. My own, just Robert J. Steele, M.D., Inc.

Q. So you set up your own corporation?

A. Um-hum.

Q. When was that?

a. 1979.

Q. Have you practiced under that corporation since that time?

A, Yes.

Q. Are there other physician employees of that corporation?

A. None.

Q. When did you become associated with Dr. Rollins and Dr. Kitchen?

A. Dr. Kitchen, in fact, was -- I suppose you can say recruited by me from Canada, as well, to come and work for Dr. Zimmerman; and he in fact came and worked for Dr. Zimmerman a year after I did.

So he came to Cleveland in 1977 and he ended up opening his own practice about six months before I did.

Q. And the two of you are shareholders in another corporation; is that correct?

A. There is another corporation called Cleveland Cardiology Associates, which is not a corporation far the practice of medicine, simply for running our office.

Q. When was that corporation opened?

A. I don't remember the exact date. It was probably in 1980.

Q. Bow is it that you came from Toronto to Cleveland?

A. I was recruited by a placement agency.

Q. So I get this right, did you go to the placement agency?

A. No. Somebody gave them my name. I don't know who, but my name was given or asked for by a placement agency, and I was phoned one day out of the blue and offered an interview in Cleveland.

Q. Did Dr. Zimmerman have other physicians working for him?

A. Yes.

Q. How many others?

A. Well, there were always about four people altogether in the practice.

Q. Physicians?

A. Yes.

Q. Were you replacing somebody?

A. Yes.
Q Who?
A Two physicians left the year that I came. The physicians that left were Dr. Demany and Dr. Cutarelli.
Q. Where was Dr. Zimmerman's practice Located at?
A. Be practiced out of Saint Vincent Charity Hospital.
Q. Where was his corporate offices?
A. The Hanna Building.
Q. Is that where you worked out of?
A. Um-hum.
a. Did he ever change his corporate offices?
A. No.
Q. Where are your corporate offices located?
A. In the Medical Arts Buildiny across the road from Charity Hospital.
Q. And the address is what?
A. 2322 East 22nd.
Q. Do you have privileges at hospitals other than Charity?
A. Yes.
Q. Which hospitals?
A. Lakewood and West Shore.
Q. When did you obtain those privileges?

A, Lakewood would have been about in '82 or '83. West Shore at approximately the same time.

Q. How much of your practice is at the other two hospitals as opposed to Charity?

A. Over 90 percent of what I do is at Charity.

Q. You were telling me how Dr. Kitchen became associated with yourself, how about Dr. Rollins?

A. Dr. Rollins came out of a training program in the Cleveland Clinic, and we knew him and Dr. Kitchen and I offered him the opportunity to come into practice with us and share our office.

Q. Had you had other physicians that you and Dr. Kitchen were associated with prior to Dr. Rollins?

A. Yes. There was a Dr. Ader, who was associated with us at one point.

Q. Can you spell that?

A. A-d-e-r.

Q. When was that?

A. From about 1981 to 1986 or '87.

Q. Why did he leave?

A. He wanted to develop his practice in another direction from us and at our hospitals other than we did.

Q. Where did he go?

A. He works mainly out of Deaconess, Parma, and

Southwest.

Q. Are you Board certified?

A, Yes.

Q. When were you Board certified?

A. 1989

Q. Was that your first attempt to obtain Board certification?

a. No. I had more than one attempt.

Q. How many?

A. I guess three.

Q. Was that both oral and written?

a. No. Just written.

Q. Bow about oral?

A. There were no ora1 examinations,

Q. Just a written exam?

A. Yes.

Q. So there were three previous ones that you did not pass?

A. That's correct.

Q. When did you first take the Boards?

A, Probably, I can't remember exactly, it would have been about 1983 or so.

Q. Wow often did you take them thereafter?

A, Every two years.

Q. '85, '87, '89?

A. Um-hum.

Q. And I am sorry, I apologize, did you tell me when did you ultimately pass them?

a. '89.

MR. KAMPINSKI: You indicated you'll provide me a copy of his CV?

MR. JACKSON: I did.

Q. Did you have any publications that you authored, Doctor3

A. Hot since I was a resident. So that's quite a few years ago.

Q. How many would you say that you authored while you were a resident?

A. I was the major author of one, and participated in several others.

Q. What was the one that you were a major author?

A. It was a study of a drug called Hylorel in coronary artery disease.

Q Do you recall the others that you participated in?

A. They were variations on the same theme because the program that I worked in was involved in researching these drugs extensively.

Q. Have you ever had your license suspended or revoked in any fashion?

A. No.

Q. Have you been involved in other lawsuits?

A. I was named in a suit a few years ago in which I was an consultant, and I was dropped from the proceeding after my deposition.

Q. What was the name of the case?

MR. JACKSON: I am going to object to all of this. You may answer. Go ahead.

A. It was a case involving a neurosurgical patient who had had surgery and subsequently died.

Q. Do you recall the name of the case?

A. No.

Q. Do you remember the name of the attorneys?

A. No, I don't.

Q. Who represented you?

A. I was represented at that time by a company that was provided through my insurance. It wasn't P.I.E. I don't remember who it was.

Q. Do you recall who the plaintiff's attorney was that took your deposition?

A. No, but I can find out.

Q. How could you find out?

A. I can ask. I can probably get on the track of it by finding the surgeon,

Q. The neurosurgeon?

A. That was involved in the case.
Q. Is that here in Cuyahoga County?
A, Yes.
Q. Is that the only case?
A. Yes.
Q. At any time after the removal of the guide wires from Mrs. Weitzel, the one by yourself, one by Dr. Moasis' surgery, did you ever go to the county prosecutor and advise the prosecutor what had occurred with respect to Mrs. Weitzel?
A. No.
Q. Why not?
A. Why should I?
I had no reason to, that I knew of.
Q. why were the wires left in her?
A. I wish I knew the answer to that question. I don't.
Q. Why didn't you know about the wires prior to your returning to town on March 11th or 12th?
A. That is because I hadn't been informed about it. I am not sure that anybody knew at that point.
Q. What is your jab as a cardiologist, Doctor?
A. My job as a cardiologist is to treat patients with cardiovascular disease and to perform investigations to determine the extent of the problem

that they have and what needs to be done,

Q. Are you on occasion an attending physician?

A Yes.

Q. What is your function as an attending?

A To treat the patient and to investigate their problem.

Q. If you as an attending call in consultants, what is your relationship vis-a-vis the consultants?

A If I call in a consultant, it is somebody that is called in for an opinion about another problem that the patient may have that is not my particular field of expertise,

Q. But what is your relationship then vis-a-vis the consultants and anything the consultant would choose to do regarding that patient?

A. Normally any investigation that the -- or anything that the consultants would like to do, normally I would go along with it. We would usually -- I mean in general a consultant will tell you beforehand what he wants to do or what his plans are and you either say fine or suggest something else or say why,. but that's the general way it works.

Q. Well, is the reason that you might question him on occasion is because you as an attending have responsibility for the overall care of the patient?

A. Well, that's -- overall, that's true, but as I said, when you ask for consultation, one of the reasons you ask for it is because you need help or want help in an area that's not your particular area.

Q. Sure. But you're the one that would then coordinate the assistance of the consultation? In other words, if a consult was necessary, you are the one that would determine whether or not it was necessary or not, right?

A. Right.

Q. You mentioned that you and Dr. Kitchen had become familiar with Dr. Rollins when he was a resident at the Cleveland Clinic; is that what you said?

A. Yes.

Q. Was that by virtue of his rotating through Saint Vincent?

A. NO. Dr. Kitchen -- not to my memory anyway. Dr. Kitchen I think met him initially at a meeting that they were both at and heard about him from other people at the Clinic, and he was the one that made the initial contact with Dr. Rollins.

Q. So you hadn't known him before then?

A. No.

Q. What was your relationship with respect to the

residents that provided various services for your patients at Saint Vincent?

A. Well, we are or I and the people that I work with are members of what's called a teaching service, and that means that a patient that comes in the coronary care unit becomes a teaching patient when they are admitted under myself or some other physician.

Q. Automatically?

A Yes.

Q. I'm sorry. Go ahead.

A. What that means is that the junior and senior residents then do the day-to-day care of the patient in the unit under the supervision of myself and the other physicians that teach in the unit,

Q. Are you compensated by being a member -- what did you call that?

A. I said teaching service.

Am I compensated, no.

Q. What is the purpose of your being a member of the teaching service?

A. First of all, to help teach the residents; second of all, to give them exposure to the patients that I admit to the unit.

Q. Second of all relates to the first of all?

A. Right.
Q. Does it have any benefit for yourself in terms of not having to watch the patient as closely because you can rely on the resident for doing *so?*
A. Well, I mean, I suppose on a day-to-day basis the resident could look at the patient first and talk to me, then I can go and see the patient afterwards; but as far as do I leave the care of patients to the residents, I don't, just because I have a patient in the coronary care unit and is being seen by my resident does not mean that I don't see the patient.
Q. Om a daily basis you have responsibility as well for the care of any patient that you are an attending an; is that correct?
A. Yes.
Q. That would be true with respect to Mrs. Weitzel?
A. Yes.
Q. What do you do, if anything, Doctor, to ensure yourself of the competence of any particular resident with respect to various procedures that may have to be done on your patients?
A. First of all, the residents when they rotate through Charity Hospital are, supposedly by the time they get there, screened in certain competence to take care of patients in an intensive care unit setting.

They are directly supervised by a senior resident that also rotates through the units, the senior resident then talks with the attending and usually also with Dr. Rollins because he is -- he is directly involved with specific and planned teaching exercises for the residents in the coronary care unit.

Q. So you make an assumption based on the fact that they are a certain level resident with respect to the procedures they can or can't do?

A. Yes. And usually if a certain procedure needs to be done, the senior resident -- it's the senior resident's responsibility to make sure that the junior resident -- if the junior resident in fact is the one that is going to do it -- it's the senior resident's responsibility to make sure that the junior knows what he is doing.

Q. When you say "responsibility," is that because you delegate that responsibility to a senior?

A. No. That's the chain of command, if you will, OK it's the pecking order, That's the way it's done.

Q. According to whom?

A. It's just standard practice.

Q. Who set up that standard of practice?

A. I have no idea, I mean, it's in any training program. That's basically the way it works.

Q. Well, what do you do to ensure the adequacy or the competence of a senior resident in terms of his ability to supervise a junior resident., or do you assume that as well?

A. There is a certain amount of assuming there because by the time somebody gets to be a senior, they are by definition of being a senior resident supposed to be competent in basic procedures that go on in that setting.

Q. My question was: Their competence in terms of supervision as opposed to being able to do the procedure themselves, because that's what you said that they do, they supervise the junior resident, right?

A. Urn-hum.

Q. So although they may have competence in doing the procedure themselves, how do you assure yourself that they have competence in watching the junior?

A. You very often -- you see that by watching how the group interacts with each other on a day-to-day basis when you are in that setting every day.

Q. Is there some type of written document or contract whereby you are a member of this teaching service?

A. No.

Q. So this is just something that you automatically do by virtue of being at Saint Vincent?

A. No, you don't automatically do it.., You are given the option by the Department of Medicine of having your patients be teaching patients or not, and that's all there is to it. It's simply a question that's asked. Do you want your patient to be a teaching patient or do you not, yes or no. That's how it happens.

Q. Is this an annual inquiry or is this a one time thing?

A. It's a basically a one time inquiry. If somebody wants to change that, all they do is tell the Department of Medicine.

Q Do you hold any position in the Department of Medicine?

A. I am the -- I am the director of the Cardiac Rehab Program.

Q. Have you held any others before that?

A. No.

Q. When you say "Department of Medicine," who in the Department of Medicine would make the inquiry to a physician whether or not they wanted to be in this program?

A. It would come probably from the person in the

Department of Medicine who is responsible for the resident program at Charity.

Q Who is that?

A. Currently it's Dr. Keating.

Q. Who was it when Mrs. Weitzel was in the hospital?

A. It would have been Dr. Keating at that time.

Q. Who asked you?

A' I don't remember, because that was several years ago. I really don't remember whether or not Keating was the director when I first became associated with it or not, I really don't.

Q. Do you make any assumptions as to the ability or competence of a junior medical resident in placing an arterial line?

A. That's a procedure which they should know how to do, and normally when a resident. -- when a resident comes to our unit or any other unit, if an arterial line needs to be placed, the senior resident or the attending will ask the junior resident before they do that procedure, or any procedure for that matter, have you done that before, have you been taught to do that, how many have you done; in the vast majority of cases it's the senior resident that does that.

Q. Does what, asks or --

A. Yes.
Q. -- does the procedure?
A. No. Asks.
Q. Did you ask Dr. Varma if he was competent to do such a procedure?
A. I don't remember ever asking him such a question, no.
Q. Did you assume that the senior resident did?
A. Yes. Probably.
Q. Did you watch Dr. Varrna do a procedure on any patient, the placement of an arterial Line, prior to February 26th?
A. I don't have independent memory of seeing Dr. Varma doing any particular procedure, although I know that. I was around in the unit at the time that things were being done; but as to specifically what procedures and to whom, I couldn't tell you.
Q. Had he taken care of any of your patients prior to Mrs. Weitzel?
A. Yes, because he was rotating through the unit and I generally always have patients in the unit.
Q. How many?
A. Bow many patients do I have in the units?
Q No. How many did he take care of?
A. I have no idea.

Q But it's your testimony you think he took care of some before Mrs. Weitzel?

A. Yes, I am sure he did,

Q When did he start his rotation through the unit?

A, I don't remember the date that he came, The junior residents generally are there with them. The juniors usually are in the unit for about a month at a time, but as to -- sometimes two months -- but as to when exactly each one comes and goes, we don't keep track of that.

Q. Who evaluates the junior residents for purposes of -- once they leave the unit?

A. The senior residents have some input into that. and Dr. Rollins has some input into that because he is a specific teacher for them.

Dr. Sopko could have some input into that because he also does -- he seminars for them; and then any individual attending, if there is some specific either positive or negative point that they want to make, they always have the opportunity to make it; but it's not an -- I do not, for instance, make specific either written or oral recommendations about each resident as they go through the unit.

Q. You said that there were certain teaching procedures and duties that are, I guess, standardized

for these residents by Dr. Rollins; is that in writing?

A. I have no idea, I don't know.

Dr. Rollins conducts seminars with them on a regular basis and discusses patients with them on a regular basis, discusses patient care with them on a regular basis.

Q. When you say "regular," what are you talking about, daily?

A. I believe the formal sessions are twice a week.

Q. Are there informal sessions as well?

A. Yes. I mean if he is in the unit and there is something to be discussed, he'll discuss it with them.

Q. What do those informal sessions consist of?

A. They consist of Dr. Rollins and the residents sitting down at a table in the coronary care unit and the residents -- normally the way it happens, the residents will present the history and physical findings of a case that has been admitted within the last two days, or has been admitted since their last session, and they will discuss the care of this patient and the diagnosis: what needs to be done, what the plans are.

They will also then -- well, they can basically discuss anything they want -- they can also

have specific pre-planned topics of discussion in whatever area they so choose.

Q. As an attending how often would you meet with the residents to discuss your patients?

A. I would talk or have communication with the residents on a daily basis.

Q. What would your review of any procedure by a resident consist of?

A. If I felt that anything needed to be reviewed it would generally consist of the resident doing the procedure under my direct supervision, or my doing the procedure with him watching.

Q. You misunderstood my question. Actually it is my fault.

If a resident, if he did a procedure -- "he" being a resident -- what would you do after the fact to assure yourself that he had done it correctly?

A. Well, the first thing I would do is make sure that if it was a line inserted in a patient, for instance, that line was functioning as it should be; and if there was any question, I would check with both the individual that did it and with the senior to see if there had been any problems or any questions related to it.

Q What do you do on a daily basis regarding your patients in the cardiac intensive care unit; do you check x-rays every day?

A. Not necessarily.

Q. Well, under what circumstances would you and when would you not?

A. Well, it would depend on whether I felt that it was a pressing need to, far instance, see an x-ray every day, If there are -- sometimes there are other consultants on the case who are looking at the x-rays every day, sometimes -- or the residents should look at the x-rays every day and ascertain if an x-ray has been done. The minimum you da is certainly talk to these people about it; but do I actually myself look at each individual x-ray each day, no. You also rely on the report of the radiologist.

Q. Bow quickly do you get these reports after the x-rays have been read?

A. That takes some time to get the official. written report from radiology.

Q. Is there something other than an official written report that you get?

A. Well, you can always -- yes. You can always call the radiologist and speak to him personally, or there is an automated dictation system in radiology

whereby you can get a dictated report by dialing a specific number.

Q. Now quickly did you get the actual reports, Doctor?

A. The actual piece of paper?

Q. Yes, sir,

A. Often several days.

Q. Well then, would it be fair to say you can't really rely on the radiologist's interpretation, at least by way of the written report, in your reviewing the x-rays?

MR. WARNER: Objection.

MR. JACKSON: You may answer.

Q. You told me a few minutes ago you don't always look at the x-cays yourself every day because you got consultants who look at them, you got residents who look at them, you got radiologists who look at them?

A. Correct.

Q. I take it that the residents who are rotating through your service aren't radiology residents?

A. True.

Q. The consultants, at least I think you were referring to, were not radiology consultants?

A. True.

Q. And the written report from the radiologists

you're telling me could be a number of days after the actual x-rays themselves?

A. Yes.

Q. Well then, how is it that you assure yourself that nothing is being missed on an x-ray?

A. You talk to the residents about the x-rays, number one. If it's relevant, you talk to the other consultants about the x-rays, or you pick up the phone and dial the extension to get to hear what the radiologist report is, because although it may take the actual piece of paper several days to reach the charts, the dictated report is available in a voice form usually within -- well, I would say usually within 24 to at the most -- most, 36 hours after the x-ray being done.

Q. Do you do that every day on your patients?

A. Yes. Usually.

Q. Do you also rely on the radiologist to inform you as the attending if in fact they see any problem with respect to your patient?

MR. WARNER: Objection.

MR. JACKSON: You may answer.

A. Well, normally what happens is, if a radiologist sees something unusual or different in an x-ray, it's certainly not uncommon for them to pick up the phone

and call and say, you know! here is what I see, it's something different. That happens routinely.

Q Because they are consultants, also; are they not?

A. Yes, in a way.

Q. And you use their expertise to assist you in the care and treatment of your patients?

A. Right.

Q. Who is it that makes the orders for various procedures to be undertaken; is it you, is it the senior resident; is it the junior?

a. It could be any one of the three of those,

Q Does the junior resident have the ability and the authority to on his own place an arterial line if he feels that it's appropriate?

A. Generally with placing lines like that, they should, they should at least discuss it or clear it with the senior; but sometimes when things like an arterial line is being placed, which should be a relatively simple and straightforward procedure, I can see it happening where a junior resident would go ahead and put in a Pine in a patient, an arterial line, and tell the senior about it in the morning, let's say, or something like that.

Q. So he can decide on his own if it is necessary

to place an arterial line?

A For an arterial line, yeah, generally.

Q. What are the circumstances that would be appropriate for him to do that?

a. If a patient's blood pressure needs constant and careful monitoring because it may be either toa high or too low.

Q. Are you now talking about the initial placement or the replacement?

A. E am just talking about placement, in general, of an arterial line,

Q. I'm sorry, Go ahead.

That would be the reason?

A. Yes, generally.

Q. If there was one in place already, would it be appropriate for the resident to make a decision on his own to replace it?

A. Yes.

Q. And would it be appropriate For him to make the decision in replacing it to put it in a different site than it was in initially?

A. Yes.

Q. So you don't have any quarrel if in fact Dr. Varma decided on his own to go ahead and put a femoral arterial line in Mrs. Weitzel on February 26,

1989; is that correct?

MR. JACKSON: You may answer.

A. No.

Q. And did you assume that he knew how to do it?

A. Yes.

Q. Did subsequent events indicate to you that that was not the fact?

MR. JACKSON: What was not the fact?

MR. KAMPINSKI: That he didn't know how to do it.

MR. FULTON~ Objection,

MR. JACKSON: You may answer.

A. Subsequent events certainly suggested to me that there had been a problem with the insertion of the line, yes.

Q What events suggested that?

A. The fact that there was an object left in the vascular system, a wire.

Q. A wire or more than a wire?

A. Well, as it turns out, there were two wires; althsugh we didn't know that until the time we actually went to retrieve them.

Our initial impression, or my initial impression was that there was probably one wire in

there that was broken.

Q. The fact that. you found two of them, what does that tell you about Dr. Varma's competence in --

MR. FULTON: Objection.

Q. -- placing an arterial line?

MR. FULTON: Objection.

MR. JACKSON: You may answer.

A. The only thing that I would say to that is that I was -- probably the best word I can use is that I was astounded to find two wires in the patient,

Q. Well, what is the explanation for that?

MR. FULTOM: Objection.

Q. Your explanation?

A My explanation?

Q. Yes.

A. The only possible explanation for how those got in there is that they were inserted at the time that the line was being put in and they were lost at that time, I mean, there is no other reasonable explanation for it.

Q. Well, I mean, that could be an explanation for one of them, couldn't it; what is the explanation for two of them being there?

A. I don't know. Same thing, What -- I have no idea.

Q. Did you put one or more of them in2

A. I beg your pardon?

Q. Well, Dr. Varma denies that the wires that were removed by you and Dr. Moasis were in any way related to any wire that he put in on February 26th.

MR. FULTOM: Objection. I don't think that was his testimony. I think that --

MR. KAMPINSKI: Who cares what you think.

MR. FULTON: Well, I care. Who cares, I do.

MR. JACKSON: Let them argue, Wait until you get a question.

BY MR. KAMPINSKI:

Q. If that's his suggestion, sir, that would infer that you or somebody else put them in.

MR. JACKSON: Wait, that's not a question.

Q. Did you --

a. NO.

Q. Did you put a wire in?

A. No.

Q. To your knowledge did anybody other than Dr. Varma put one in?

a. Not to my knowledge.

Q Did you put two of them in?
A. No.
Q. To your knowledge, did anybody other than Dr. Varrna put two of them in?
A. No.
Q. What is the standard of care required of a physician, whether it be second year resident with a temporary license, or a cardiologist such as yourself, in placing an arterial line3
MR. JACKSON: What aspect? What do you mean?
MR. **KAMPINSKI:** The aspect of the removal of the guide wire.
Q. What is the standard of care?
MR. JACKSON: Do you know?
A. I'm not sure.
Q. There are various steps involved in the placement of an arterial line.
A. Right.
Q. And those steps would constitute the standard of care?
MR. JACKSON: Okay.
MR. FULTON: Well, **I** object to that,
Q. Do you disagree **with** that?

A. Well, there are standard procedures that are followed in the insertion of an arterial line, yes.

Q That would be true regardless of the level of training or knowledge of the physician doing it, correct?

A. Absolutely. They're always put in the same way.

Q. What is the standard of care then in the placement of an arterial line?

MR. JACKSON: As it relates to what?

A. I still don't understand.

Do you want me to describe to you how a line is put?

Q. How the appropriate way to put a line in --

MR. JACKSON: Go ahead.

Q. -- correct.

A. The appropriate way you put a femoral line in is decide, first of all, on the site where you are going to insert it. There are different sites available,

You then isolate the area, you then clean it thoroughly. You then put -- usually you put -- not ~ ~ ~ a-+ You put a local anesthetic in the area, you then puncture the artery with a needle.

You then introduce a guide wire through the needle into the artery, you pull the

needle out, leaving the guide wire partly in the artery. You then thread the catheter that you are going to be using for pressure monitoring into the arteries over the guide wire.

You then remove the introducer and the guide wire, leaving the sheath in the vessel. You suture that sheath into position in the skin, or tape it, and connect it to your monitoring device.

Q. Are you referring to sheath as the catheter?

A. By "sheath" I mean your line that you are measuring pressure with.

Q. And is that the same as a catheter?

A. Yes.

Q. How long of a guide wire is used for the introduction of such a catheter?

A. Depends on where it is being introduced. If it's being introduced into the radial artery, which is the artery in the wrist, it's a relatively small wire; if it's being introduced through the femoral artery at the groin, it's a longer wire,

Q. Haw long?

A. About 18 inches.

Q. 18 inches?

A. Yes.

Q. What is the purpose of using such a long wire

into the femoral artery?

A. Well, sometimes the femoral artery is -- sometimes the femoral artery is twisty and tortuous, sometimes it's difficult to yet the wire through that area and you need a relatively long wire to go in it to assure the proper position.

Q. How long is the catheter?

A. Catheter is about that long, six, seven inches.

Q. How much of the guide wire would you introduce into the artery as opposed to say how much would be outside of the person's body?

A. That's up -- there is no real standard for that, but what you do is you introduce the wire and you make sure that when you thread the line with the introducer over the wire to inject it in the patient. There is always wire at the end that you hang onto as you thread the rest of the material into the patient.

Q That is the appropriate way tu do it so you don't Lose the wire in the artery; is that correct?

A. Right.

Q. Would the loss of such a wire into an artery be a deviation from the standard of care in this particular procedure, in your opinion?

A. Yes, it shouldn't happen,

Q. Assuming that that does occur, even though it is

inappropriate for it to happen, what is the obligation then of the physician who loses such a wire, assuming that such a have physician is a second year resident?

A. They should -- if something like that happens, they should tell the senior arid the attending what happened.

Q. How would you characterize the failure to do that., Doctor?

MR. FULTON: Objection.

MR. JACKSON: You can answer.

A. I was very -- I was angry and upset that I had not been informed about this.

Q. Well, would you characterize that as a reckless disregard for the rights and safety of your patient, Sharon Weitzel?

MR. FULTON: Objection.

MR. WARNER: Objection.

MR. JACKSON: Objection.

A. I don't know. I don't know that the word -- I don't know that the word "reckless" is appropriate. It certainly should not have happened.

Q. What word is appropriate, if not reckless?

MR. FULTON: Objection,

Q. Is there a worse word for this?

MR. FULTON: Objection,

MR. COYNE: Objection.

A. I can't think of a word. All I can is that the wire should not have been Left in the patient in the first place; but you know, sometimes people make mistakes.

Q. Sure.

A. But by the same token, somebody, namely the senior resident and ultimately me, should have been informed that this had taken place.

Q. Well, how many guide wires can you at one time thread through the needle?

A. One.

THE WITNESS: Excuse me, I am going to get more coffee. You can keep going,

Q The fact that you found two, what does that tell you? Does that tell you this procedure was done twice incorrectly?

A. That two attempts were made incorrectly, yes,

Q. Do you know when each of these attempts was made?

a. I assume -- well, I assume they were both made at the same time, when he was introducing this wire into the femoral line.

Q. So can we assume from that, Doctor, that this was not -- his leaving the first one and ultimately

the second one, was not something that he was unaware of?

MR. FULTON: Objection, You got an assumption here that may not be right,

MR. JACKSON: You may answer.

A. As far as I am concerned, there's no assuming at all. There is no way that anybody could do a procedure like this and not know that they had left a wire somewhere. It's impossible,

Q. So Dr. Varma knew full well that he had left two wires in Mus. Weitzel; is that correct?

MR. FULTON: Objection,

MR. COYNE: Objection.

MR. JACKSON: You may answer.

A. It's an assumption on my part because he's the one that did the procedure, and I have to assume that he knew what happened, yes.

Q. And he didn't tell you about it?

A. NO.

Q. Did he tell the senior about it?

A. No.

Q. And you saw no reason to apprise the prosecuting attorney of this?

MR. FULTON: I didn't hear that.

MR. COYNE: Objection.

MR. JACKSON: Don't answer.

Q. And you still had no reason to advise the prosecuting attorney of this county of that?

MR. COYNE: Objection.

MR. WARNER: Objection.

MR. JACKSON: Go ahead, I think it's a little out of line, but go ahead.

A. Quite honestly it didn't occur to me to do that.

Q. Did anyone, to your knowledge, on behalf of Saint Vincent do that?

MR. FULTON: Objection.

MR. COYNE: Objection.

A. I don't know.

Q. Did you leave town at some point during the treatment of Sharon Weitzel?

A. Yes, I did,

Q. When was that?

A. As near as I can figure it, I was gone from the 2nd of March until about the 12th of March.

Q. Where did you go?

A. I was on vacation.

Q. Where did you go?

A. Carribean.

Q. Where?

A, Is this relevant? It doesn't matter.

MR. JACKSON: It's not.

A I went to Nevis with my wife, an island, for a vacation.

Q. Do they have phones there?

A. Sure.

Q. Was any attempt made to contact you by anybody?

A. No.

Q. While you were on vacation?

A. No.

Q. Bid you check in with your office at all while you were down there?

A. No.

Q. During the period of time that you were gone, who did you leave in charge of Mrs. Weitzel?

A. Dr. Rollins was the main one, and Dr. Kitchen also, who you know, shaves call with us; but really the way we generally work is that any patient that is in the unit, since Dr. Rollins is in the unit all the time, he will cover those while I am away.

Q. When did you become aware of the fact that Dr. Varma had introduced a femoral arterial line into Mrs. Weitzel; did you know that the day it happened?

A. We did it at night, during the evening. I believe the actual date was the 26th.

Q. Anytime you need to look at the record, feel free to do so.

MR. JACKSON: It was the 26th.

A. Yes. I believe the date was the evening of the 26th that he put --

Q. Why do you say "The evening"?

A. Because it is annotated that way in the charts.

Q. Could you show me?

MR. KAMPINSKI: While the doctor is looking for that, Mr. Warner has cancelled Mr. Weitzel's deposition for tomorrow.

MR. WARNER: That's correct.

A. All right. Well, it was done -- it was done, according to the nurses' notes, it was done sometime between 5:00 and 6:00 p.m.

Q. Who was present when it was done?

A. According to the nurses' notes, Dr. Varma and another resident, Dr. Jayne were present. There would have been a nurse present too.

Q. And where were you?

A. I have no idea,

Q. When did you find out that it had been done?

A. The next morning,

Q. How did you find out?

A. When I made rounds and I saw it, and they told

me that a line had been inserted; and I had no objection to that. She needed to have her blood pressure monitored and I had no objection at all to the placement of an arterial line.

Q. Could you read the nurse's entry, Doctor?

A. 4:00 p.m. something here,

MR. JACKSON: EKG.

A. EKG continuous manit-or, alarm set, Dr. Varma and Dr. Jayne here to insert femoral, then there's a short form which I don't understand.

Then 5:50 p.m., femoral line intact, dressing per policy done. Then just other stuff that's not particularly related, bed linens changed due to some bloody drainage of insertion site, husband at bedside, Versed drip increased while arterial line being inserted due to restlessness.

Q. Who increased the Versed?

A. It would have actually been increased, as far as the actual physical doing of it, by a nurse; but it would have had to have been done at the request of a physician.

Q. So if I read this correctly, Mrs. Weitzel was restless while the line was being inserted?

A. That's what I would assume, yes.

Q. What medication was she on?

A She was on a medication called Versed, which is a medication used to keep people sedated when they are --- well, it's used to keep people sedated.

Q. She was basically paralyzed from that, wasn't she?

A. It's not a paralytic medication. The medication has anesthetic like properties. It's not a medicine that specifically causes paralysis.

Q. The reason for having given her the Versed in the first place, and I think you countersigned the order, you might have even ordered it yourself, was because of restlessness; was it not?

A, Yes.

Q. Agitation?

A. Yes.

Q. As it related to the --

A. Endotracheal tube and ventilator, that's correct.

Q. That was to prevent her from becoming restless?

A. Yes.

Q. Can you explain then why it is, what it is that caused her to become restless with the insertion of this arterial line, despite having been under Versed?

A. Well, I can't tell. you from this note whether she was restless as a result of the attempts to insert

the arterial. line, or whether, in fact, she was restless prior to that. There is no way of telling, but either is a possibility.

Q. When you became aware of the fact that one had been put in the next morning, did you check it?

A. Yes. I made sure that it was working properly, and it was.

Q. Were there any x-rays on the 27th?

A. I don't believe there were.

Q. Hadn't there been an order to get x-rays every day?

A. Yes, there was. I believe there was an order written by the resident for daily chest x-rays.

Q. Was that because that's what you wanted?

A. That was, as far as I was concerned, more a teaching took between the residents, and probably more than anybody, Dr. Sopko.

Strictly speaking did I think it was absolutely necessary for her to have chest x-rays every single day, probably not.

Q. Are you the one who initiated the order?

A. NO.

Q Was that an order Dr. Varma initiated on his own?

A. I don't know who initiated it at this point.

It's not uncommon in a patient who is quite ill in an intensive care unit for daily chest x-rays or whatever to be requested.

Q. If that is the order, regardless of the reason, do you anticipate that the orders will be followed?

A, Yes.

Q. Do you know why there was none done on the 27th?

A. I have absolutely no idea.

Q. Who is responsible for the conduct of a resident while he is taking care of your patient, are you?

A. I will say that the responsibility for how any individual. resident takes care of a patient goes up the chain from the person actually doing the procedure or doing the caring of the patient, to the senior, to me.

Q. You countersigned Dr. Varma's note on the 27th; did you not?

A. Yes.

Q. What does that mean, when you countersign a note?

A. When I countersign a note it means that I have read the notes, and that usually I have also talked with the person that wrote the note, as to what is going on in the note, what is going on with the patient.

Q. You didn't countersign his procedure note on the 26th; is there a reason for that?

A. Because I wasn't there when it was being done.

Q In other words, had you been there, you would have signed it?

A. Not necessarily.

Q. Well, how do you differentiate what you countersign and what you don't countersign; does that mean you didn't check it, what does it mean?

A. It means nothing really. I usually -- I wouldn't necessarily countersign a simple procedure note that's done if I wasn't there.

If I was there I would have either written the note myself, if I had done the procedure; or I may we11 have countersigned if the resident had done it.

Q. I assume, Doctor, correct me if I am wrong, that you were not told on the 27th by Dr. Varma that he had left two guide wires in Mrs. Weitzel?

MR. FULTON: Objection.

MR. JACKSON: Go ahead,

A. That's correct.

Q. So that based on what you told me earlier, you were deceived by Dr. Varma as to what had occurred in the procedure on the 26th?

MR. FULTON: Objection.

MR. JACKSON: You don't have to quarrel with his words, Doctor, but go ahead if you can answer,

MR. FULTON: You sort of have a convoluted question=

MR. JACKSON: I guess I have some problem with it, but go ahead and answer if you can.

Q. Go ahead.

A. All I can tell you is that I wasn't informed that there bad been a problem with the insertion of the line.

Q. Well, we'll go as slow as we have to.

You told me that there was no way he can put these lines in and not know they were still there?

A. Correct.

Q. And that you talked to him on the 27th, you countersigned his notes?

A, Correct.

Q. You told me that it was his obligation to let you know if there was a problem with this procedure?

A. Correct. Yes.

Q. He didn't tell. you?

A. Right.

Q. So he deeeived you with respect to that?

MR. FULTQN:: Objection.

MR. COYNE: Objection.

MR. JACKSON: Go ahead, Doctor, if you can answer that. Let him draw his own conclusion, but you answer if you have a conclusion along those lines.

A. He should have told me and he didn't.

Q. What do you call that?

MR. FULTON: Objection.

A. Oversight, covering your mistake by not telling anybody about it,

Q. Coverup, right?

MR. FULTON: Objection.

A. I guess that's one word that could be applied to it.

Q. Were you there on the 28th?

A. I believe I was,

Q. Is there some note that you initialed or signed or something that tells us that you were?

A. I didn't actually countersign a note on the 28th but I am sure I was there.

Q. Were you told on the 28th what had occurred as it relates to the guide wire?

A. I was never told what had occurred as it relates to the guide wires,

Q. Did you look at the x-rays on the 28th?

A. No, I'm sure I didn't.

Q. Well, did you call this number that you are referring to earlier to determine what was on the x-rays?

A, I have no independent knowledge of calling that number on that particular day. Her pulmonary status at that time was relatively stable, and she was also being seen by the pulmonary consultants, so I don't remember whether I called or whether I didn't call on that specific day.

Q. What is the danger of a guide wire being left in an artery or two guide wires being left in an artery?

A. Well, there are all sorts of potential problems. The major thing that would concern me would be the -- that the guide wire would be a possible source of infection if it's left in.

Q. It's a foreign body?

A, Yes.

Q. It shouldn't be retained within the body?

A. Yes.

Q. I'm sorry. Go ahead.

A. That clots or thrombosis could form on the

foreign body and could then break off that and migrate who knows where. That the wire itself could move once it's inside and could ultimately obstruct a branch or obstruct a portion of the vessel itself, Those are the main problems.

Q. Was she having an infection problem?

A. She had pneumonia.

Q. That's why you called in infectious disease, Dr. Chmielewski?

A. That's correct.

Q. Exactly what is pneumonia?

A, Pneumonia is an infection of the lung tissue.

Q. Can that become a blood borne infection?

A. Yes.

Q. Mow?

A. By the agent that -- by the agent causing the pneumonia getting into the bloodstream arid spreading.

Q That would be called what, sepsis?

A. Yes.

Q. Did she become septic?

A. She was probably septic, yes. She had -- there were suggestions that she may have been,

Q. When did that occur?

A. I will have to look at the records to be able to tell you.

Q. Go ahead.

A. I don't know exactly when, and I am not actually -- I am not sure that -- that the word sepsis was ever -- or that people ever talked about her actually being septic, but the chances of her being septic, were certainly there with all the problems that she had with her illness and everything else. She was already an appropriate treatment, if in fact she was septic, because the treatment would be the same as the treatment that she was getting with antibiotics for her pneumonia. Sa I mean, it's a bit of an assumption that she may have been septic.

Q. What would a foreign body in the arterial system cause or prevent for someone with possible sepsis, would it prevent you from clearing the infection?

A. It conceivably could make it more difficult because if there were bacteria in the blood stream, they will tend to congregate on the foreign body and that could be a nitus of continuing infection.

Q. Could it also cause sepsis?

A. If it had been inserted in an other than sterile technique, sure it could.

Q. You had the one guide wire which you removed --

A. Yes.

Q. -- sent for analysis; did you not?

A. Yes.

Q Did it have any evidence of infection on it?

MR. JACKSON: Do you need to make a phone call?

THE WITNESS: I can wait a little bit.

A. I don't remember.

Q. Why don't you take a look.

A. The reports -- whether we ever did receive a report about that, to tell you the truth --

MR. JACKSON: Do you have your hands on a copy of that? Does anybody have a copy of it so we don't have to --

MR. KAMPINSKI: I don't.

MR. PULTON:: What are we looking for?

MR. COYNE: Path test.

MR. FULTOM: I don't think it went to the lab. I don't know that. that one was sent,

A. I don't remember ever seeing whether I got a report back on the wire that I sent, but I can tell you that when I removed the wire from her, E certainly had it sent to the lab. Ma question about that.

MR. FULTON: Lynn.

THE WITNESS; No.

MR. JACKSON: No.

A. I don't see anything from the Lab indicating an analysis of the wire, as far as whether there was an infection involving the wire or not. I don't see that anywhere.

Q. Were you involved at all in the surgery that she underwent" were you present, did you talk to Dr. Moasis what should be done with the wire?

A. E wasn't in the operating room when he did the surgery, but he -- we discussed prior to the operation what he was going to do and what would have to be done, and he certainly sent the appropriate samples out from the operating room, that's standard procedure.

Q. I'm sorry. Sent it where?

A. He would have sent the wire to pathology, as well, I am sure, when he removed it, because that would be absolutely standard procedure for him to do it.

Q. Do you see the reports pertaining to the wire which he sent in; the report I just handed you a copy of, the path lab reports, had you seen that before, Doctor?

MR. FULTON: Is this the path lab or culture?

MR. JACKSON: Surgical pathology consultation report, path number SO763-91.

Q. Is that what you were looking for with respect to the one you removed?

A. Yes.

Q. And you didn't find one?

A. I didn't find one.

Q. Does this tell you anything about whether or not there was any growth determined from the wire?

A. It doesn't tell me whether there was any growth of any organism, no. This is a pathology report. It's not a microbiology report.

Q. Do you know if there were any microbiology reports done to either of the wires?

A. I don't remember seeing any.

Q. Did you lsok afterwards?

A. Yes, but normally takes several days for those to come back.

Q. Have you ever determined whether or not there was any growth from the wires?

A. I don't remember ever having seen any reports of that.

Q. Who was it that ordered the cessation of the daily EKG's on Mrs. Weitzel; was it yourself?

A. I don't know. They weren't -- daily EKG's

weren't necessary.

Q. How often was she getting them?

A, She was getting them probably at first while she was in the hospital, she was getting them every day or every other day, and then on an as-needed basis,

Q. Approximately starting when?

A, I don't know, I have to look at the record.

Q. Like I say, anytime you need to look, go ahead and look.

A. No. The specific EKG's would be -- all right. Let's see,

MR. FULTON: What is your question3 What do you want him to look for? When, what?

MR. KAMPINSKI: Would you.

- - - - -

(Record read.)

A. In the first few days that she was in the hospital she certainly had an electrocardiogram every day, I see a daily one from February the 12th through February the 24th.

Q. Row often after that?

A. February 27th, 28th, and the last one I see is dated the 14th of March.

Q. What is the reason that they stopped becoming daily after you say the 24th?

A. They weren't necessary. Ber electrocardiogram wasn't changing.

Q. What was her cardiac status as of the 24th?

A. As of the 24th she had suffered a heart attack, but from a point of view of her heart function at that time, it was stable, It was not normal, but it was stable; and doing an electrocardiogram every single day after that particular: point wasn't giving anybody any adequate or any added useful information.

Don't forget that she is on a heart. monitor the whole time that she is in the intensive care unit, which gives you information about rhythms and things. So an electrocardiogram is not necessary on a daily basis.

Q. Did she remain stable from a cardiac Standpoint through the decision to have her undergo surgery on the 14th?

A. Yes.

Q. From the pneumonia standpoint, when is it that she first developed pneumonia, do you know?

A. I can't give the exact date. I think that would be impossible to know for sure, but her major problems throughout the hospitalization, or one of her major

problems, in fact, became the pneumonia, A.R.D.S. problem that she had, that the beginnings were certainly there from the time that she was admitted.

Q. Do you know why?

A. That's a very common thing to see in somebody who had a cardiac arrest and is resuscitated.

Q Who was treating her for that problem, was it you and Dr. Sopko?

A. Partly Dr. Soyko and partly Dr. Chmielewski, who is the infectious disease person.

Q. Bow did that condition either get better, get worse, or stay the same through March 14th?

MR. JACKSON: "That condition," the ARDS and pneumonia?

MR. KAMPINSKI: And pneumonia, yes.

A. All of that continued to be there throughout that whole period of time.

Q. Well, she developed a pneumothorax, did she not, bilateral, I believe on or about March the 6th or 7th?

A. Yes, I believe.

Q That was while you were gone'?

A. Yes.

Q. Did she get better or worse after that?

A. Well, any time you develop a bilateral.

pneumothorax you are going to do worse for a while. There is no question.

Q. Chest tubes were put in?

A. Yes.

Q. Did she get better after the chest tubes were put in?

A. Yes.

Q. Did the -- is it pneumothoraxes or pneumothoraces?

A. Yeah.

Q. Did they resolve?

A. With the chest tube being inserted, she did, yes, eventually.

MR. FULTQN: Are you talking about both sides or one side?

MR. KAMPINSKI: I said pneumothoraces, if that's the appropriate plural.

A. Yes.

Q. Well, what if anything was the status with respect to her dependency on the ventilator; did that get to the point where thought was given to weaning her off?

A. Thought is always given to weaning people off a ventilator when they are on the ventilator, but you know, the decision -- that decision is one that has to

be made on the basis of their overall lung function and many other things. That's why Dr. Sopko is always involved in these sort of patients and makes these decisions. Certainly after somebody has a pneumothorax that means that the chances are they're going to certainly have to stay on the ventilator for a period of time.

Q. Did her lung function improve after the pneumothoraces resolved?

A. Yes.

Q. From what to what?

A. Well, it improved from what it was when she had the pneumothoraxes or pneumothoraces, certainly.

Q. How about before? How she was before and how she was after?

A. I can't answer that question. I have to look at the -- all the notes and I can't answer that right now. I don't know.

Q. What did you base your decision to allow her to undergo surgery on?

A. Dr. Moasis and I talked about it and he was of the opinion that it would be a very short or relatively short period of anesthesia, and that her pulmonary function was, at that point it was stable enough that she could undergo this. I felt that that

was appropriate.

Q. You're aware of the studies, are you not, Doctor, that indicate increased mortality following myocardial infarction of somebody undergoing surgery?

A. Sure.

Q. What do those studies suggest?

A. That anybody who has had a myocardial infarction, if they are undergoing surgery soon after having had the myocardial infarction, the chances of having problems are certainly increased.

Q. And the reason for that is what, the induction of anesthesia?

A. That has something to do with it, any direct effects the anesthesia may have on the heart itself.

Q. So you were aware of that at the time that you made the decision to have her undergo surgery?

A. Yes.

Q. Prior to making that decision did you seek assistance from any radiologist to see if they could fish out the wire that you couldn't?

A. No.

Q. Did you seek the assistance of Dr. Kitchen, who apparently had developed some procedure for doing precisely that?

A. Dr. Kitchen was around on the day that I did

retrieve the wire that I did, he was -- for at least part of the time he was there when I was doing it. He and I sort -- well, I wouldn't say that Dr. Kitchen was around the cath lab. I believe he was actually in the room with me for part of the time on -- on the day that I was retrieving the wire that I did.

Q. Is the answer to my question "yes"?

A. Repeat the question.

- - - - -

(Question read as follows: Bid you seek the assistance of Dr. Kitchen, who apparently had developed sonic procedure for doing precisely that?)

- - - - -

A. No.

Q. Why not?

A. Because he was there and we talked about it, and as far as experience in doing something like this, he was no more experienced than I at this procedure.

Q. Well, you were unable to do it?

A. Correct.

MR. FULTON: Could I hear the last answer?

- - - - -

(Answer read.)

- - - - -

BY MR. KAMPINSKI:

Q. When you say you talked about it, when did you talk about it, before you started to do the procedure?

A. Before and during.

Q During? Did he assist you?

A. I don't remember whether he actually put on his gloves and took part in the procedure itself. I really don't remember that specifically. He was certainly around.

Q. Well, I assume when you got back from your vacation you saw the note that he wrote, referring to his conversation with Dr. Rollins where they both agreed that nothing should be done with respect to the wire?

A. At that time,

Q. When you say "At that time," that was on the 8th; is that correct, or 9th?

A. Yes. I guess, Well --

MR. JACKSON: 9th.

A. 9th, okay.

Q. Why don't you find the note.

A. The 9th.

Q. Okay.

MR. JACKSON: What is your question?

Q. It says Rollins aware yesterday and because of patient's condition decision not to attempt removal at this time?

A. Right.

Q. Wave you talked to either Dr. Rollins or Dr. Kitchen since I have taken their deposition?

A. No.

Q. Wave you read their depositions?

A. No.

Q. But I assume you read this note, correct?

A Correct.

Q. And I assume you talked to both of them?

A. At the time, sure.

Q What changed between the time they wrote the note and the time you decided to have Mrs. Weitzel undergo the procedure to attempt to remove the wires?

A. She was -- she was slowly improving as far as her pulmonary status was concerned, and I felt that because of that, at the time that I went ahead and tried to go, that it was appropriate that I do that because I was concerned that if the -- these foreign objects were left in for -- well, basically, the longer they were left in, the more likely they were ultimately to cause her additional problems.

Q. Such as?

A. Such has infection, clotting, migrating of the wires, the things that I talked about before.

Q. Were any of those processes there at the point in time that you decided to remove them?

A. No.

Q. Including infection?

A. There was no suggestion or no way to prove that there was an infection directly attributable to the wire at the time that I removed it.

Q. Well, so if there was no immediate problem, tell me once again why it is you decided to remove it.

A. That's because I felt that it had been in, it was -- now it's the 13th of March, it will be in for two weeks, and I had felt that it was -- that that was a long enough period and we should get those wires out of there if we could.

Q. And what specifically had changed about her pulmonary function that caused you to conclude she can undergo such surgery on the 13th as opposed to the 9th?

A. Her pulmonary function improved, her oxygenation saturation had improved. In fact, that's specifically referred to in a note, Dr. Rollins' note on the 11th.

Q. Mow had it improved, give me the numbers, if you would?

A. Dr, Rollins on the 11th says continues to make progress respiratory-wise. The setting had been changed on the respirator. The FIO2 had been decreased, which means the amount of oxygenation that was delivered through the lines to her had been able to be decreased. Her oxygenation was 95 percent, which was good.

Q. What had it been on the 9th?

A. I don't know what the actual. numbers on the 9th were.

Q. Why don't you find them.

A. PO2, 74. The FIO2 at that time, that would be in the nurse note on the 9th, if you find that note.

Dr. Sopko writes a note on the 9th saying the oxygenation -- sorry, the PO2, the oxygenation in the blood is 74 and that he talks about reducing the FIO2 to 55 percent.

So by the time Dr. Rollins writes this note on the llth, the FIO2 is down to 40 percent, So that's a significant change.

Q. What's the FIO2?

A. The FIO2 is the amount of oxygenation, basically the amount of oxygenation that is delivered through the ventilator to the patient.

Q. Is that the same thing as saying weaning off the

ventilator?

A. In a way. It's part of the weaning procedure, yes.

Q. So she had gotten significantly better from a pulmonary standpoint then from the -- I'm sorry -- the 9th until the --

a. Well, this is the 9th to the 11th, to the 13th when I did the procedure.

Q Wow was she on the 13th?

MR. JACKSON: Here's the nurses' notes, Doctor.

A. On the 13th oxygenation saturations were normal, and the FIO2 was down to 35 percent.

Q So she has gotten even better?

A Yes, she improved. *Yes.*

Q. Well, what then in your opinion in the absence of surgery was her prognosis for recovering from the problems that she was in the hospital. for?

A. You mean for an ultimate complete recovery?

Q. Or whatever recovery you think she would have made, what was her prognosis at that time?

a. Well, she was still a very severely ill lady, despite the fact that things were going in the right direction.

Q. Yeah, And did you anticipate that they would

continue going in the right direction under your care?
A. I certainly hoped they would, yes.
Q. Well, I mean --
A. Did I anticipate, yes; barring further problems, yes.
Q. So the probabilities are that this lady would have recovered then at that point in time, based upon what you are telling me, in terms of her progression?
MR. WARNER: Objection.
A. I ani not quite sure how to answer that,
Q. Mbw about truthfully.
MR. JACKSON: There's no need for that kind of comment.
MR. KAMPINSKI: I wasn't trying to be facetious.
MR. JACKSON: Yes, you were.
A. I am not quite sure how to answer that question, because despite the fact that the lady was improving to some extent as far as her oxygenation needs on the ventilator went, she had still suffered a heart attack, she still had a lung problem that required her to have a ventilator in place, and so what her -- ultimately we felt that this lady's recovery was still going to be a long and involved and complicated process.

Q. Were the probabilities that she was going to recover at this point in time?

A I think that -- that at this point in time it was probably 50/50.

Q. So given the fact that it was 50/50, you decided to have her undergo the surgery?

A. Yes.

Q. So she had significant problems that may have continued in terms of the long term recovery, and yet you cleared her for surgery; is that right?

A, That's correct.

Q. How long did the operation take, two hours and ten minutes?

MR. JACKSON: If that's what it took.

A. I don't know.

Q. Take a look.

A. I don't know how long it took.

Q. Why don't you find the anesthesia anyhow, because I'm going to ask you questions about it. Actually the nurse's note.

MR. JACKSON: From anesthesia?

MR. KAMPINSKI: Yes, I think so. I think it is in that volume.

A. Were.

Q Where did you pull that. out of?

A Right here.

Q All right. How long was the operation?

A. Lasted from 2:15 to 4:00, or just -- well, just a little bit after four o'clock. So a little less than two hours.

Q. Is that what you anticipated it was going to be?

A, I had no idea.

Q. Well, I thought you told me before that it was going be a very short operation?

A. The surgeon told me that it should be a relatively simple procedure to go in and retrieve the wire. You know, the actual length of time that this surgery took, I don't know that.. There was rao way of him knowing that ahead of time, Simply he said it shouldn't be a difficult procedure, so I went ahead and did it.

Q. Bow long of a wire is reflected being removed during the surgery, and now I'm referring to the cardiovascular laboratory nurse note?

A. §he said approximately six inches.

Q. Is that true?

A. Which means it wasn't measured. I'm sure it is. I'm sure it's approximately that.

Q. You are?

A. I can only go by what is written here and what I remember. I remember a length of wire being removed, I didn't measure it.

Q. How long was the one you removed?

A. This is the one that I removed,

Q. That. she is referring to, you removed one approximately six inches long?

A. I don't know the exact length of it because I didn't measure it,

Q. You know how Long six inches is as opposed to 18 inches is, right?

A. Yes.

Q. Quite a difference?

A. Sure. There's a difference.

Q. It's a foot?

A. Right.

Q. How long was the one you removed, Doctor?

A. I don't remember specifically how long the wire that I removed was,

Q. Was it closer to six inches or 18 inches?

A. I would think -- I don't know. Probably closer to a -- my memory of it would be probably closer *to* -- I really don't remember, LO or I1 inches maybe. It is hard for me to say.

All I know, I remember I removed a

length of wire that was approximately so long.

Q The record can't take down "So long."

A. Say 10 or 11 inches.

Q. Mere's a ruler?

A. All right.

Q. Bow long?

A. About that long.

Q. About a foot?

A. Yeah,

MR. FULTON: Is that a competitor's from another court reporter?

MR. KAMPINSKI: Yes.

Q Approximately 30 centimeters long.

A. Approximately.

Q. Wave you seen the wires that are being retained by Saint Vincent at the current time?

A. No, I don't believe I have.

Q. If they have got a wire that they claim was removed from Mrs. Weitzel that's 48 centimeters long, or 18 inches long, do you know where they got that wire from?

MR. FULTON: When you say "who," who --

A. Who are we talking about?

MR. FULTON.: Saint Vincent?

MR. KAMPINSKI: Yes. The one that your client was shown.

MR. FUETON: I'm representing Varma.

MR. KAMPINSKI: That's what I am talking about. That's what I said.

A. I have no reason to believe any wire that Saint Vincent has that they say are from Mrs. Weitzel, as far as I am concerned, are from Mrs. Weitzel.

Q. The gospel according to Saint Vincent?

MR. COYNE: Show an objection.

MR. WARNER: Objection.

MR. JACKSON: Don't respond to that. That's one of his --

MR. PULTON: Let's get in a little theology here, Ecclesiastical court.

BY MR. KAMPINSKI:

Q. I mean, so in other words, you put blind faith in their assertion?

MR. COYNE: Objection

MR. JACKSON: No. No, you don't have to answer that,

Q. Why didn't you know that there were two guide wires in Mrs. Weitzel prior to you going on vacation?

A. Because I hadn't been informed of any problem

related to the procedure of the insertion of the femoral line.

Well, she is your patient, right?

A. Yes.

Q. Should have known?

A. I should have known, if I had been told, yes.

Q. Don't you have an independent obligation to know if there are two guide wires, two foreign objects, inside your patient?

A. I had no reason to suspect that any situation like that would exist prior to my leaving.

Q. I'm sorry. What day did you leave, sir?

A. The 2nd.

Q. So that on the 27th, the 28th, the 1st and the 2nd, were you there the 2nd or left the 2nd?

A. I was there the 2nd and left that day.

Q. Sa for those days you did not look at the x-rays; would that be a fair statement?

A. That's probably true.

Q. I can show you the x-rays; have you seen them since?

A. Since?

Q. Yes.

A. Yes.

Q. And the guide wires are there, aren't they?

A. Yes.
Q. Had you looked, you would have seen them, wouldn't you?
A. Yes.
Q. Is it credible, Doctor, to assume that any physician, whether he be a resident, or a physician such as yourself, looking at those x-rays, would not see the guide wires?
MR. FULTON: Objection,
Q. Is that correct?
MR. COYNE: Show an objection.
MR. WARMER: Objection.
MR. JACKSON: Objection.
MRS. CARULAS: Objection.
MR. SEIBEL: Objection.
MR. OKADA: Objection.
A. It's entirely probable people looking at the x-rays would not have realized or might not have seen, may not have recognized what that was or what the situation was,
Q How about a radiologist?
MR. WARNER: Objection.
a. A radiologist?
Q. Yes.
MR. WARNER: Same objection,

A. A radiologist -- a radiologist would look at that and would know what it was.

THE WITNESS: May we have a two-minute break?

MR. JACKSON: Sure.

MR. KAMPINSKI: Sure.

- - - - -

(Discussion had off the record.)

- - - - -

(Record read.)

BY MR. KAMPINSKI:

Q. Just so the record is clear, a radiologist looking at those x-rays would know what these wires are; would he not?

MR. WARNER: Objection.

MR. OKADA: Objection.

MR. JACKSON: In your opinion.

MR. COYNE: Show my objection.

A. In my opinion they should.

Q. You were not apprised of any wired by any radiologist in Mrs. Weitzel?

A. No.

MR. WARNER: Objection.

Q. -- or the nursing staff?

A. No.
Q. Did you review the x-rays before you did your procedure on the 13th?
A. Yes.
Q. Going back to the 26th?
A, Yes, I did.
Q. Were you able to determine whether or not the wires had migrated at all from the time they were inserted?
A. It didn't like as if they had,
Q. There is no x-ray from the 26th or 27th, so you don't know where they were initially, do you?
A. That is correct,
MR. JACKSON: You said the 26th or 27th?
MR. KAMPINSKI: 26th.
MR. JACKSON: After the insertion of the guide wire?
MR. KAMPINSKI: Correct.
A. True.
Q. You can't tell where they were initially?
A. No.
Q. In your review of the x-rays prior to doing the procedure on the 13th, did you believe that there was one wire, two wires, one broken wire; what was your

thought process?

A. My initial impression was that there was one wire that was broken, that was bent back upon itself, broke.

Q. That was from looking at the x-rays?

A. Yes.

Q. Were you then surprised when you encountered two wires?

A. Yes.

Q. You were able to remove the one that looks like it has a loop at the bottom of it, correct?

A. I was able to remove one. I don't remember whether is looked like it had a loop at the bottom of it, I do -- all I remember is removing one wire.

Q. Do these wires have J's on one end of them?

A. Some of them do.

Q. Do the ones that you use in the cardiac intensive care unit have J's on the end of them?

A. I don't remember specifically whether it is a J, whether they routinely had a J on them or not.

Q. Did the wire you removed have a J on it?

a. I don't remember.

Q. Did you do the removal?

A. Yes.

Q. I mean, you don't have a real good distinct

recollection of that, or do you?

A. I remember the procedure. Whether the wire had a J on it, I must admit I don't remember.

Q. You are somewhat nebulous about the length of the wire, as well?

A. Somewhat.

Q. How many times had you ever retrieved guide wires like this, ever3

A. Once.

Q. When was that?

A. Several years ago.

Q Under what circumstances did that occur?

A. A wire, I believe, had been left in a patient, who was not my patient, I was asked to see the patient in consultation because of this, and to see if there was any possibility of removing it; and in fact, I was able to.

Q. Was that left in by a resident as well?

A. I have no idea. It's quite sometime ago.

Q. In light of the fact that you testified a few moments ago that it's possible that a resident might not appreciate the existence of guide wires on an x-ray, isn't it more important for you then as the attending to review these x-rays on a daily basis as opposed to leaving that up to the residents?

A. What's more important is that the resident, if they have a problem with the procedure, report it to the people that they should report it to.

Q. So you are assuming some measure of honesty on their part?

MR. FULTON: Objection.

A. Absolutely. You have to.

Q. Which you didn't get; is that correct?

MR. COYNE: Objection.

MR. FULTON: Objection.

MR. JACKSON: Objection.

MR. WARNER: Objection,

Q. Correct?

MR. FULTON: Objection.

MR. COYNE: Objection,

MR. JACKSON: Objection.

A. I would have to say no, I didn't-

Q. Were you requested to retain the guide wire that you removed by someone?

A. No. I removed the guide wire and I sent it to the lab. That's the last I personally saw of it.

Q. How did you first find out there was a guide wire that was left in Mrs. Weitzel?

A. I went -- on the morning that I came back from vacation, I went and made rounds and looked at some of

the x-rays and realized that there was something in there and then I was -- I believe when I brought it up, it was initially to either Dr. Kitchen or Dr. Rollins, and they said yes, something is there, is a wire there,

Q. In other words, you brought it up to them. They hadn't brought it up to you before you made rounds?

A. Correct, because 1 hadn't seen them before I made rounds.

Q. What day was that, the 12th?

A. I believe so.

It was the 13th.

Q. If you look at the 12th, there is a doctor's note by a junior medical resident, GI nutrition?

A Yes.

Q. Did you countersign that?

A. Yes.

Q. But you don't have a note on the 12th?

A No.

Q. Why not?

A. Because I don't believe I was there, buts --

Q. Wait a minute.

You just testified that you were there on the 12th?

A. Well, the first -- I can't remember whether I

returned on the 12th or the 13th. It was one of the two days. What day was -- does anybody have a calendar?

It would you have been on whatever the Monday is, whether the Monday of that week was the 12th or the 13th.

I see Dr. Rollins countersigned the note on the 12th.

Q. Well, if you weren't there on the 12th, why would you have countersigned a note for the 12th?

A. It's quite possible I countersigned that note later on. What happens normally with charts is that they go to Medical Records, and they're reviewed in Medical Records by reviewers, who -- this happens with any chart in the hospital -- and if you have forgotten to sign an order or to countersign a particular note or something, they will send the chart subsequently back to you and request that you countersign it.

E can't tell you for sure whether that's what happened with this. It's certainly possible.

Q. After you found out whether it was the 12th or 13th, did you speak to any of the residents?

A Yes.

Q. Who did you talk to?

A. Dr. Varrna, I asked him what had happened.
Q. Be said?
A. He said he had inserted the wire and that he had not had any problem with inserting the wire, and he didn't know how the guide wire or wires were left in the patient.
He said he had no idea how they had gotten there.
Q. What was yaur response to him?
A. I said that I found that rather hard to accept and believe, but he swore that that's what the situation was.
Q. Well, is there an alternative explanation, other than he is lying?
MR. FULTON:: Objection.
A. The only other explanation would be that somebody else had done that procedure, and Dr. Varma admitted that he did the procedure of putting the femoral Line in; therefore, as far as I am concerned, there is no other logical explanation for how they got there than they got there when he put in the femoral line; so he did it, yes, as far as I am concerned. I find no other logical explanation in my opinion.
Q. What about Dr. Jayne, she was there assisting; have you talked to her?

A. Yes, I talked to her at the same time, and it was my understanding that Dr. Jayne was simply in the room with him basically observing, not taking. an active part in putting the femoral Pine in.

Q. Well, did you ask her if she witnessed the placement of two Pines?

A. She said that she hadn't noticed anything, but she also said, if my memory serves me, that she hadn't been there far the whole time, I don't think she was -- I know she was there for part of the time, wasn't there for the whole procedure.

Q Tell me as best you can recall what was said,

a. She said, as far as I can recall, she said that she had been in the unit, and had been in the roam during part of the procedure, but not the whole procedure.

Q. What did she say in terms of what she observed of whatever part of the procedure she was in the room far?

A. As far as I remember, nothing. She didn't observe anything untoward.

Q. How about Dr. Varma, what did he say in response to your indicating that you found that not to be believable?

A. He didn't know how to respond to that, but I

just felt that it was -- I couldn't believe that this had happened and that nobody had admitted to the fact that it had happened.

Q. What do you think about the fact that he is now practicing at Mount Sinai and is going to be doing a Fellowship at St. Louis?

MR. FULTON: First of all, the question is wrong. I object.

Fellowship as Saint Luke's?

MR. KAMPINSKI: St. Louis,

17

MR. FULTBN: Did you say Louis? I misunderstood you.

I have an objection.

Q What do you think about that, Doctor?

MR. JACKSON: Go ahead and answer.

A. I have no relevant opinion at this time. I just -- I wouldn't want to -- I have no opinion at this time about that. I hope that --

MR. JACKSON: You answered the question.

Q You hope what?

a, Nothing. I have no opinion.

MR. FULTON: Hope he gets to meet with you again some day.

Q. Can you explain to me why it is Dr. Rollins, who was taking over for you while you were gone, didn't discover the existence of this guide wire in your patient?

MR. JACKSON: I'll abject to that. You've already taken Dr. Rollins' deposition.

Q. Go ahead,

MR. JACKSON: Go ahead and answer.

A. Probably for exactly the same reason that I didn't, he wasn't. informed about it.

Q. Would you have expected him to Look at these x-rays?

MR. JACKSON: Objection, You may answer.

A. Not necessarily on a daily basis.

Q. We are talking about ten days.

A. He would have gone, I'm sure, by what the residents told him and what the other reports about the x-rays were.

I can't answer for Dr. Rollins as to how often he goes and specifically looks at x-rays or doesn't, or how he decides to do that. That's up to him. I have no --

Q. Well, between you and DE. Rollins, who were the

attendings, neither one of you looked at the x-rays or at any details of this lady, is that appropriate for someone who is in the intensive care unit?

MR. JACKSON: Objection. You may answer.

A. Well, that's not strictly -- that's not correct.

First of all, whether Dr. Rollins looked at this --

MR. KAMPINSKI: Excuse me, Mr. Fulton, is there a problem with my conducting examination?

MR. FULTON: Yes, there is; but other than that, I'll try to keep my voice down.

BY MR. KAMPINSKI:

Q. I am sorry, Doctor, I just couldn't hear you.

A. That's not -- I don't think that that's correct.

First of all, Dr. Rollins, I don't know whether -- I don't know whether Dr. Rollins did or did not Book himself at any x-rays, but I wasn't there so I can't comment on that.

MR. JACKSON: That's sufficient. You answered his question.

Q. Well, should either you or Dr. Rollins, had you looked the x-rays, realized that a guide wire was there?

MR. JACKSON: Objection. You may answer.

Q Between February 28th and March the 9th, I guess?

MR. JACKSON: You may answer.

A. If I had -- if E had seen an x-ray with a guide wire in the position that that was, I would have realized what it was, yes. If I had actually seen the x-ray.

Q. That would be the standard of care appropriate for yourself, as a cardiologist, attending physician of Mrs. Weitzel?

MR. JACKSON: Objection.

A. Well, again, it is not routine to look at x-rays every single day. It's not part of the normal daily procedure to necessarily look at the chest x-rays myself, or yourself, but here meaning me, every single day.

Q. How about every other day?

A. There is no fixed --

Q. How about every third day?

MR. JACKSON: He just said there is no fixed thing.

a. Depends on how the patient is doing, what the overall clinical situation is, who else is involved in

the care of the patient, I can't tell you any hard and fast statement about that.

Q. Whenever you wanted to Look at it is okay?

MR. JACKSON: Don't answer that question.

Q. Well, you had some consultants involved, didn't you, Dr. Chmielewski, and Dr. Sopko?

A. Yes.

Q. Did they look at the x-rays?

A. I don't know, I assume they must have, but E don't know.

Q Well, did they indicate to you or Dr. Rollins that they saw the guide wires?

A. I think I have made it very clear that prior to my leaving nobody said a word to me about a guide wire in the patient, and it wasn't. until I came back to the hospital from vacation that I had any knowledge at all about that there was a guide wire there.

What happened while I was away, who informed him who, when, or what the -- what time, I don't know because I wasn't there; but I know that the first that I was aware of it was the day that I came back.

Q. Well, had Dr. Chmielewski or Dr. Sopko laoked at x-rays, would you have anticipated they would have

recognized a guide wire?

MR. SEIBEL: Objection,

MR. COYNE: Show an objection.

MR. WARNER: Objection.

MR. JACKSON: Objection.

A. I don't think you can assume that because they do not routinely put lines into patients, and so they may or may riot have recognized it. I don't think you can assume that either of them would have realized it for what it was and where it was,

Q. What is Dr. Sopko's specialty?

A. He is a pulmonary physician.

Q. Be doesn't put lines into people?

A. He puts lines in, yes. I misspoke.

We certainly does put lines in, but whether he would have realized it being there and what it was and that it was not in the right place, I really don't know.

Q. Have you talked to him about this?

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

Q. How about Dr. Chmielewski?

A. No.

Q. Haw about Dr. Rollins?

MR. JACKSON; He answered that question once.

A, I answered that.

Q. How many times did you discuss it with Dr. Rollins?

A. Ir. Rollins told me about this when I came back to work.

Q. I thought you said you inquired of him about this as apposed to him telling you about this.

A, It makes no difference, I ran into Dr. Rollins or I saw Dr. Rollins on the day that I came back to work, I saw Dr. kitchen on the day that E came back to work, and we all discussed the fact that this was there.

Q. What did they tell you?

A. They told me there was a guide wire that was in Mrs. Weitzel's aorta and that they had not done anything about retrieving it, but that it was there.

Q. Is this a good thing to have in a person's aorta who had a heart attack?

MR. JACKSON: Is what a good thing?

MR. KAMPINSKI: To have a good --

MR. JACKSON: Is that a question you really want him to answer or are you just trying --

MR. KAMPINSKI: I want to know the

answer to that,

A, First of all, whether she had a heart attack or not is absolutely irrelevant, the thing --

MR. JACKSON: Wait. Just answer his question is it a good thing to have a guide wire in someone's aorta, that was his question.

A. No.

Q. Didn't help her at all?

A. True.

MR. JACKSON: You don't looked surprised at his answer.

a. Where in your removal note does it indicate what the length of the wire is?

A. It doesn't.

Q. Why not?

A. Because I didn't measure it.

Q. Do radiologist have more experiencing in fishing out wires than cardiologists?

A. Nobody has a lot of experience in doing this sort of thing because thankfully it's not a common occurrence.

MR. JACKSON: That's all.

Q. Is there any type of conflict at all between invasive radiologists doing procedures such as non-cardiac arteriograms as opposed to cardiologists?

A. Would you repeat that?

MR. KAMPINSKI: Frank.

- - - - -

(Question read as follows: Is there any type of conflict at all between invasive radiologists doing procedures such as non-cardiac arteriograms as opposed to cardiologists?

- - - - -

MR. KAMPINSKI: I meant angiographic procedures,

MR. JACKSON: What is your question then, please? Why don't you restate.

Q Is there any type of conflict between radiologists and cardiologists in terms of who does angiographic procedures?

A. No. As far as I am concerned, no.

Q. Do they both do them?

MR. WARNER: Objection.

A. Radiologists do not do cardiac catheterizations.

Q. Right. Do they do other types of angiography?

A. Sure.

Q. Have you ever used a radiologist at Saint. Vincent to do invasive angiography?

A. Yes.

Q. Under what circumstances?

A. If people need angiograms of their carotid arteries, for instance, or of their abdominal aorta, then that's something that is usually done by a radiologist.

Q. Why didn't you seek the assistance then of a radiologist when you couldn't get the second wire out, to do it without submitting Mrs. Weitzel to an anesthetic surgery?

A. Because I don't feel that -- I don't feel that a radiologist would have had anything to contribute in any way. That's not a negative comment on a radiologist, It is just a flat statement that I don't feel that they would have had anything to contribute as far as trying to get this wire out of there.

Q What did you do in your procedure on the 13th?

A. I also don't think they would have wanted to.

MR. WARNER: Objection.

A. That's just my opinion.

Q. That's like Dr. Rollins and Dr. Kitchen, nobody wanted to touch this until you came back --

MR. JACKSON: Objection,

Q. -- because this was a pretty hot potato.

MR. JACKSON: Objection. They already told you why.

A, I have --

Q Well, Dr. Varma indicated that Dr. Kitchen disagreed with Dr. Rollins and felt it should come out.

MR. FULTON: Objection.

Q. Did Dr. Kitchen tell you that he agreed with your decision to go ahead and remove it?

MR. JACKSON: Dr. Kitchen didn't say that, neither did Dr. Rollins say that.

MR. KAMPINSKI: Dr. Varma did.

MR. JACKSON: I don't care what Dr. Varma said about Dr. Kitchen's comment. It may have been --

MR. KAMPINSKI: I have to explore all the different stories that are being told here, trying to get to the truth.

MR. FULTON: Search for the truth.

MR. JACKSON: What is your question of this doctor?

Q Did Dr. Kitchen tell you that he felt that the wire had to come out?

A. At this particular time I told -- when? I don't understand.

Q That he felt that back on the 9th, he felt it ought to come out, he didn't want to do anything until

you came back?

MR. JACKSON: I object. That is not the testimony.

Q. Is that what he told you?

A. No.

Q What did he tell you?

A. Be told me there was a wire in there. He didn't tell me anything about what he felt back on the 9th about it should have had to come out.

Q. What did you do in your procedure to remove the wire?

A. I introduced a sheath into the femoral artery, which is a tube that about this long.

Q. You have to say how long.

MR. JACKSON:: Let me estimate the distance.

MR. KAMPINSKI: No. Let him do it.

A. A sheath is anywhere -- depending on the sheath -- from four to six inches long into the artery, through a sheath.

Q. How did you enter the arteries?

A. I punctured the artery with a needle.

Q. Where?

A. The femoral artery.

Q. But where was your site of entry, the same place that the catheter had been?

A. The site of entry was over the left femoral artery.

Q. But was it the same place that the catheter had been introduced into the artery?

A, It would have been in the same general area,

Q. Well, was it above where the catheter went in?

A. It would have been within an inch either way probably of where that other catheter had been.

Q Was there a catheter in the femoral artery at the time that you did the procedure?

A. No, there wasn't.

Q. When had it been removed?

A. I don't know exactly,

Q. Why don't you take a look and let me know.

MR. JACKSON: Why don't you take a look, if it's significant.

MR. KAMPINSKI: No, This is Dr. --

MR. JACKSON: We're not going to play this game with you. If you know when it came out --

MR. KAMPINSKI: This is his patient's chart. He is going to tell me either he

can't find it or tell me he can find it.

MR. JACKSON: It wasn't there, he told you that.

BY MR. KAMPINSKI:

Q. When was it removed?

A. I don't know.

Q. Well, take a look?

A. I don't know whether I will find that, quite frankly, It would more likely in my opinion be in the nurses' notes.

Christ, I don't know. It could be anywhere.

MR. JACKSON: Which date is this?

MR. PULTON: There goes your chart, Coyne.

A. There. There on the 7th.

Q. The catheter's there on the 7th?

A. Yes.

Q. As a matter of fact, if you look at the procedure notes on the 7th by Dr. Varrna, if you want to turn to that.

MR. JACKSON: Well, if you knew it was there, why are we playing this game?

MR. KAMPINSKI: We're not playing

a game.

MR. JACKSON: If you know when it's there, when it was taken out point, we'll address it.

Q. Do you see his procedure notes, Doctor?

A. Yes.

Q. Actually put another one in, didn't he?

MR. FULTON: Put another one what?

A. That's what it looks like.

Q. Now could he put another in, if there's two guide wires already in the femoral artery?

a, That's very simpLe, because the guide wires were not in the femoral arteries, they were in the aorta, and putting another line into the femoral artery, the fact that the guide wire is being in there, had absolutely nothing to do -- that's riot where they were.

Q. I see. But they started in the femoral artery when he first introduced them back on the 26th?

a. Yes, they would have had to have started there.

Q. So they did in fact migrate then?

A, Yeah, I guess they would have had to have moved to some extent.

Q. So there wouldn't have been any prohibition or

any difficulty in his introducing another catheter then on the 7th, right, into the left femoral artery?

A. That's true.

Q. So we know another one was put in on the 7th, my question to you was when was it removed?

MR. FULTON: When you say "another," you mean cath, E take it?

THE WITNESS: Go ta the 13th, see what cath lab has,

MR. JACKSON: This is CGU notes.

THE WITNESS: I know, but there should be a nurse note from the top here.

A. All right. There's no mention of anything in the cath lab, but nurse note -- well, if you tell me what you are getting at with this question, WE could answer whatever it is you are ultimately getting at,

Q. I don't see where it was removed and you're telling me it wasn't there.

A. Yes. As far as I remember, it wasn't there, but quite frankly whether -- I don't see what relevance that has to -- maybe if you think there is, you can just tell me what you think it was. I can try to answer your question,

Q. Well, E mean, part of the relevance is did you have any idea what was going on with this patient?

You look at me incredulously, but you didn't know there were guide wires in your patient for ten days, I mean --

A. Absolutely correct, because I was out of town.

Q. Does that make her not your patient because you are out of town?

A. No.

Q. Are you responsible for the person that substituted for you?

A. I have to pick somebody to substitute for me who I feel is --

Q. Competent?

A. Yes.

Q. Who will take care of your patient, look after her?

A. That's correct.

Q. Make sure you're aware if there's any problem with your patient?

a. Yes.

Q. Such as a foreign body inside of her?

A. I have to pick somebody who I feel is competent and he looks --

Q. He knows what was going on with your patient, whether it was a removal of the catheter and where was the catheter at this time and why was it moved from

the left femoral artery to anyplace else in her body, under whose instruction; do you want anymore relevance?

MR. JACKSON: Why is any of that important?

MR. KAMPINSKI: I don't know. I'd Like to find out the answer first.

MR. JACKSON: Even I don't know.

A. First of all, let me say, that the changing of any intra-arterial line can be done on a somewhat routine basis because it's the general feeling that after they have been in for a number of days, that coukd be potential source of infection, and so the lines are changed on a fairly routine basis,

Q. Let me ask yau this: Dr. Varma's story is somebody put these lines in or these guide wires, lek's find out whether or not anybody did?

MR. FULTON: Objection

MR. VARMA: Objection.

MR. FULTON: I don't know that's what he stated.

MR. JACKSON: Sitting here we can't find it. If you have a note that you can look at.

MR. KAMPINSKI: No. I mean,

Mr. Jackson, I appreciate what you are saying, but one thing I am allowed to do is ask questions here.

MR. JACKSON: You are right, you are.

MR. KAMPINSKI: So I'd like an answer to my question. If it takes a while to go through this, I'm in no hurry,

MR. JACKSON: Its that it?

THE WITNESS: No. They're talking about lines that are in the right internal jugular. That.'s 3-13, that's my procedure.

Where is the rest of that one? 3-13, 2:20.

Well, that's -- no, that's not it because she arrived on 3-13 in the cath lab at 12:30. So that's only indicating the end of my procedure, That has nothing to do with anything else,

MRS. CARULAS: There's a 3-11-91 order. I found it, Discontinued arteria9 line, it looks like.

MR. JACKSON: Well, thank you for finding that, That's probably it.

Now, let me look at that.

MR. KAMPINSKI: It's in the end.

THE WITNESS: Yes. All right.

This is ordered here on 3-11 to discontinue the arterial Line, so.

BY MR. KAMPINSKI:

Q. By whom?

A. It is written by, I presume, one of the residents. I can't read the signature,

Q. You don't know who that is?

A. No, I don't know who wrote that.

Q. Countersigned by anybody?

A, There is another signature on there, but I am sorry, I can't read either of the signatures. I don't know whose signatures those are.

Q. Well,. why would an arterial line be stopped? Why is there an order stopping an arterial Line?

A. For one of two reasons: either it was felt that it was not needed anymore because of the patient's overall condition; or that it was time to move it somewhere else because it had been in for a while.

Q. What was the reason in this case?

A. That's not made clear here. All the order said is to remove the arterial line.

Q. And you don't know who made the order?

A. I can't read the signature, no.

Q. Well, in your opinion what was the reason for the order on discontinuing the arterial line on your

patient?

A. My -- I would have to assume that at that particular tine her blood pressure was stable enough that: they felt -- all right. Here is why.

Dr. Chmielewski wrote a note on the 11th. In that note he says -- suggests that: you remove all lines that are not absolutely essential, and then he says, for instance, the arterial line; and so I am sure that that's why the line was removed; and that pertains to what I was telling you a moment ago about if they are left in for any significant length of time, they can be potential sources of infection, any line.

Q. That's why he wanted them removed3

A. Yes.

Q. You were telling me how you went about removing the wire.

A. Yes. All right. The -- I think that we got to the point where I had put the sheath in the femoral artery and then through the sheath I inserted a catheter that had a guide wire attached to it, such that you can form a small loop or a small snare and that was what we or what I managed to get the one thing with, and pull it back out.

Q. Then what did you do?

A. Then after that we took the sheath out and sent Mrs. Weitzel back to the coronary care unit.
Q. Why didn't to attenpt to remove the second one?
A. I did.
Q. You just told me you snared the one.
A. Right.
Q. You didn't tell me you tried to get the other one?
A. I tried to get both of them.
Q. How did you try to get the other one?
A. In exactly the same way.
Q. Did you do any type of fluoroscopy to tell you what was going on in the arteries while you were doing this procedure?
A. Yes.
Q. What did you do?
MR. JACKSON: What did you about what?
A. The whole procedure was under fluoroscopic control.
Q. How, explain to me how that's done.
A. You position the x-ray tube over the area where you are interested in and you turn on the x-ray tube and you do the procedure.
Q So where are you looking at the x-ray?

A. On a T.V. monitor right there.
Q And is there a permanent film made of this?
A. NO.
Q Why not?
A. A permanent film is only made when you're doing an -- basically an angiographic procedure.
Q. Could you have done a permanent film on this?
A. Yeah, I suppose so, but there was no reason to.
Q Who had to set up the fluoroscopic procedure so that you can watch it while you were doing it, was it the radiologist?
A. No. Radiologists have nothing to do with what goes on in the cath lab?
Q. You do that?
A. I don't know, I am not who sets it up. You mean book the lab or book the place, book the room; what are referring to?
Q. No. Actually do the procedure where you are watching the arteries while you are going in to try to fish out -- let me back up,

Can you take a permanent film of this procedure?

A. Theoretically, sure.
Q. What do you have to do to do that, just hit a button?

A. You have to load film into the camera that's attached to the fluoroscopic unit and take a picture.

Q. And do you know for a fact that that wasn't done here?

A, Yes.

Q. Why?

A Because it never occurred to anybody to do it. Myself included.

Q. E take it she was well enough to take to the cath lab in your opinion?

A. Yes.

Q. Where is the cath lab in relation to the intensive care unit?

A. Just down the hall an the same floor.

Q. But she wasn't well enough to take to the cath lab back on the 9th?

A. That was the judgment of the people at that time, and -- or that the wire didn't need to be removed at that time.

Q. Well, nothing changed as to the wire, had it?

A. Not as far as the wire was concerned.

Q. Why is it you were not able to get the second wire out with this procedure and you were able to yet the first one out?

A. I don't know. Et just had to do with obviously

what -- the way the wires were sitting within the arteries. Why I was able to snag one and not the other, I can't tell. you €or sure. It was probably up against a wall of the artery such that I couldn't get my little snare underneath it. That's impossible to say. All I can say I managed to get one, not the other.

Q. Bow long did this procedure take?

A. It took -- we worked for over an hour.

Q. When you say "we" who was "we"?

A. There's always a nurse in the cath lab with you when you're doing any procedure like this.

Q. Who was the nurse?

A I have no idea. I don't remember who the nurse was. We have a whole staff of nurses who come in and out of the cath lab, or in and out of the rooms. The nurse who was with me, nurse was named Mrs. Lane, and she is an employee of the cath lab. She signed the nurse note.

Q. Is she still at the hospital?

A. Yes.

Q. Why don't you describe the wire that you removed for me as best you can recall, was it intact?

A. Yes, the wire was definitely intact.

Q. Was it a complete guide wire?

A. Yes, it was.
Q. Was it frayed in any way?
A. No.
Was it broken?
A, No
Q. Doctor, I'm going to be referring to the record. What I'd like to do is review some of it with you, if you can turn to your expiration summary.
A. I believe --
MR. FULTON: What date are you talking about? Can you help us?
THE WITNESS: That should be yellow
Q. I think it might be at the beginning of the chart here, Doctor.
You got it?
A. Yes.
Q. On the second page of that you indicate that the patient to improve respiratorily?
A. Okay.
MR. FULTON: What date is that, please?
A. This is something that is dictated after the fact. It's like a discharge summary.
Q. It's dictated October 7, 1991, right?

A. That's what it says, yes. Yes.
Q. About seven months after she died?
A. That would be, yes.
Q. Is there a reason it took you that long to dictate it?
A. I didn't dictate it.
Q. Is there a reason it took that long to get dictated?
A. There is no -- not especially. There is always a very large backup of charts in the Medical Records Department and a very large number of charts that need to be dictated, and they are just worked on as time allows.
Q Are there any requirements at your hospital in terms of how long after a patient is discharged for whatever reason that the discharge summary is to be done?
A. They're supposed to be done as timely a fashion as possible.
Q. 24 hours?
a. That, I don't know, whether it's -- there's a specific rule about 24 hours, but I'm obviously -- you try to get them done as soon as you can, but there's always, as I say, a huge backlog.
Q. Who is Dr. Ogus?

A. A resident,
Q. So you had the resident dictate this?
A. If it's a resident on a teaching case or case in the coronary care unit, part of the residents' duties are to dictate the discharge summary, the patient's discharge from there, or if they happen to die.
Q. Did Dr. Ogus have anything to do with the care that Mrs. Weitzel received?
A Not to my knowledge, Dr. Ogus probably just happened to be the resident that was rotating through, and I mean, this is not uncommon, they Just dictate discharge summaries as they can,
Q. You mean rotating through in October?
A. Yes.
Q. What about the residents who were rotating through in March when she died?
A. Well, I mean, certainly that's probably who should have dictated it, but obviously it wasn't-
Q. What's your explanation for the seven-month delay?
A. I just explained to you the seven-month delay.
Q. I am really not sure I understand it. Maybe you can explain.
A. What happens when a 'patient is discharged and/or dies, the chart goes to Medical Records, and if it is

a teaching patient, the resident is supposed to dictate the discharge summary, or in this case the expiration summary. That's part of his duty.

There is always a backlog of charts, however, and the dictation of discharge summaries is something that residents usually only get to do on an intermittent basis when they have no other more pressing duties to perform.

So they do them whenever they can and that's the way the procedure works.

Q. So there was this seven-month backlog of charts; is that what you are saying?

A. I guess there was.

Q. What does it mean the level of PEEP required to maintain good oxygenation arid ventilation was steadily decreased to 7.5?

A. PEEP is a setting which -- PEEP means positive end-expiratory pressure; and the setting on the ventilator, that has to be used when people are severely ill from a respiratory point.

Basically what it does, it causes extra pressure to be put through the ventilator into the lungs, so as to help expand the lungs as much as possible.

Q. When was it reduced to 7.5?

A. I don't know the date at which it was finally gotten down to 7.5, That's something that is not managed by myself, that's managed by Dr. Sopko and the respiratory technician.

Q. Would that have been before your decision to remove the wires?

A. I don't know.

Q. Was she on the ventilator when you removed the wires?

A. Yes, but I can find out when it was decreased to 7.5, there should be respiratory notes.

Here they are.

Q. The level of PEEP?

A. The level of PEEP in fact was at 7.5 from 3-2-91 through 3-14-91. It was at 5 prior to that.

Q. What does that mean?

A. That means that when she had the -- or following -- what was the date of the pneumothorax?

Q. I believe it was on the 7th.

A. Right.

Well, it means that to maintain the -- to maintain the oxygenation where they wanted to maintain it, that this end-expiratory pressure was kept at this level.

Q When they moved it from 5 to 7.5, did that mean

they wanted more oxygenation being delivered?

A. It has nothing to do with actual amount of oxygenation Level. It's slightly more pressure being delivered to help keep the lungs properly expanded.

Q So that means she was getting better or worse from a respiratory status?

a. You can't extrapolate just from the level of PEEP whether somebody is getting better or worse.

Q. You say that it was kept at 7.5 until the 14th?

A. Right.

Q. Well, was she then on the ventilator when you did your procedure?

A. Yes.

Q. Getting PEEP?

A. Yes.

Q How is it that you were able to transfer: that from the intensive care unit over to the cath lab?

A. We moved the ventilator with her.,

Q. So that could have been done, for example, on the 9th, right?

A. I suppose it could have been. We moved her on the vent, with the ventilator on, so.

Q. Why is it that this doctor said it was steadily decreased' to 7.5? When 1 say "This doctor," you are the one that signed it?

A. Well, the -- that's probably either a typo or a -- the person typing it didn't quite understand what they said.

I mean, it could -- I say it could be a typo because obviously the level was increased to 7.5 and you wouldn't decrease it to 7.5.

Q. Did you read it before you signed it?

A. Yes, we usually read through them.

Q. Was this changed a number of times before this particular one found its way into the chart?

A. Not to my knowledge.

Q. On the first page it indicates patient's cardiac status, it's the last paragraph, continued to improve, she was taken off of the Pronestyl without any development of significant ectopia, she was supported on ASA, Digoxin, arid Nitrate; do you agree with that?

A. Well, Pronestyl is an agent that she was being given that was eventually discontinued, that's -- that is correct.

Q. So her cardiology status had improved?

A. It stabilized, yes.

Q Says "Continued to improve"?

A. Yes.

Q. Do you agree with that?

A. Yes.

Q. Whose decision was it to do surgery, yours or Dr. Moasis?

A. Well, after I couldn't get the second wire with the procedure that I did, it was felt that the old -- only other way to get it then was to retrieve it surgically.

Q. Whose decision was it, yours or Dr. Moasis?

A. It was both of our decision. We both realized that the only way to retrieve this thing was surgical.

Q. Doctor, your first note in this chart was February 13; is that correct?

MR. JACKSON: You mean after he got back?

MR. KAMPINSKI: That would be February 13.

MR. JACKSON: I'm sorry. I thought you said March 13.

A. My first note is actually the 12th. There is an admission note by a resident at the same time, Dr. Mayhley, and I have a notation that I agree with the note that he wrote, and that he and I discussed the case.

Q. I see, In fact, you countersigned it?

A. Well, that's my writing, "Agree with above and discussed with Dr. Mayhley."

Q. Mow was her mental status before you put her on Versed?

A. She had had an episode of cardiac arrest and she was, you know, she had brain -- almost certainly had some brain damage because of that.

Q. Permanent?

A. Probably.

Q. How do you know that?

A. Because anybody who has had a cardiac arrest with any sort of prolonged resuscitation will have inevitably some degree of -- some degree of neurologic damage.

Q. Did you call in a neurologist to evaluate her?

A. Mot at that point, no.

Q. Well, as opposed to supposition, I guess my question earlier was: What is it that you know about her neurologic status; was she able to comprehend questions?

A. No, she really wasn't able to respond to questions at all. She was I suppose one might say semiconscious.

Q. This is before you put her on Versed?

A. Yes, this is when she was admitted,

Q. I didn't ask about when she was admitted. I asked before you put her Versed. If you don't

understand my question, tell me.

MR. JACKSON: He answered your question, his understanding of it.

A. I'll have to -- to find out. I can't tell you the exact date that she was put on Versed, so we'll have to find that, then I can answer your question.

MR. FULTON: While he's looking, does the Land Title garage close at 6:00, do you know?

MR. WARNER: I think they said 8:00.

A. All right, She was basically -- how I answered your ~uestionwas correct -- because she was given Versed from 2-13, that's when the order for Versed appears on the chart.

Q. Doctor, would you agree that a patient opening her eyes, understandingp mouthing words and writing in the air, being alert and oriented times three, would be someone reflecting evidence that she didn't have neurological damage; would those be good neurological signs?

A Those -- if somebody was able to, you know, to respond to stimuli like that, then there is obviously some degree of awareness there.

Q. But it's your testimony, sir, that as of

February 13 she was neurologically impaired; that's your testimony of your patient?

A We felt that there was some degree of neurologic impairment. The exact amount or exact degree of neurologic impairment was not something that had been fully assessed at that time.

Q Are you looking and the nurse notes of February 13?

A. Yes.

Q. Where it says "Patient awake and alert, able to nod head, stable, no neuro deficit"; is that what you're looking at?

A. I haven't found that.

Q. Keep looking.

A. Here says she is responsive when her name was called, and she is able to follow simple commands, but she has a -- she is not grasping with her right hand and that she has a weak grasp with her left hand, arid she bas some random movement of her Lower extremities. That's on the day of admission.

Q. 12th?

a. Yes.

Q. I thought you were looking at the 13th.

A. This is the 12th, the day of admission.

Q I thought you were responding to me on the 13th?

A. Well, I am sorry. I was --

MR. JACKSON: He thought he was looking at the 13th.

THE WITNESS: This is the 12th.

MR. JACKSON: He was looking at the 12th.

MR. KAMPINSKI: If he doesn't know the chart, that's all right.

MR. JACKSON: What is your question?

MR. KAMPINSKI: How was she on the 13th.

MR. JACKSON: So that we're clear, also there is notes on the 12th that indicates she was administered Versed on the 12th.

A. Okay. There is a note on the 13th that she opened her eyes and seemed to understand, so I am sorry, what was your question now?

MR. JACKSON: Mow was she on the 13th, is what his question was. You were trying to see when Versed, were you not, was, the administration of Versed. He will clarify for us in a moment. Apparently he doesn't know the answer,

BY MR. KAMPINSKI:

Q. Is it your testimony that she was put on Versed

continuously on the 13th; is that your testimony?
A. Versed was ordered as an intermittent I.V. injection on the 13th.
Q. Intermittent? Was she started on it at any point in time continuously? I think we talked about this earlier, and you put her on it because she was agitated in terms of the intubation; isn't that true?
A. Yes. I believe that subsequent to this she was in fact put on a Versed drip. Initially it was ordered intravenous injections every -- I believe the order said every two to three hours as needed.
Q Wow about when she was put on the drip, when was that?
A. I'll have to find that.
Q. Don't put that -- we'll yo back to the nurse note on the 13th. We're not done with it.
MR. JACKSON: I didn't think you were.
MR. KAMPINSKI: Even though you tried to interject, get me off track. That's all right. We'll go back.
MR. JACKSON: what are you suggesting, I interjected.
MR. KAMPINSKI: Yourself.
MR. FULTBN: I wish you both

would keep your voice up.

MR. JACKSON: He was saying I interjected myself to throw him off course, a think was his comment.

MR. FULTON: It's hard ta believe that he would admit that he could be thrown off course.

THE WITNESS: That's just an intravenous injection of one milligram. What we're looking for is when the Versed drip was started.

MRS. CARULAS: I have it here, 2-25.

MR. JACKSON I'm sorry,

MRS. CARULAS: 2-25, at the bottom af the page.

MR. JACKSON: What are you Looking at?

MR. SEIBEL: Physician order,

THE WITNESS: 2-25 start Versed drip.

BY MR. KAMPINSKI:

Q. Getting back to my question and responding to Mr. Jackson's question: Prior to the Versed drip, what was her neurological status?

A. She was agitated and she was seemingly able to

respond to simple commands but was confused and was not moving all her extremities appropriately.

Q. Was she alert and cooperative?

A. She was intermittently conscious and seemed to follow simple commands, but that's -- that was the extent of it.

Q. Do you have a distinct recollection of that?

A. I have to be -- to some extent I have to go by what the note says, because do I remember each individual time I saw this patient, no, I don't have a distinct remembrance of what exactly she was like every time I looked at her, no,

Q. Did she try to write?

A, Not while I was ever with her.

Q. What would that indicate to you if she did?

A. That that was certainly some degree of -- that she was awake, if she was trying to write, obviously.

Q. Some degree of cognition?

A. Yes. Of course we don't know necessarily if what she did write, if she was going to respond was appropriate *as* to what anybody may ask, but some degree of cognition.

Q. All right.

MR. JACKSON: Do you want to see this?

Q. You wrote a note on the 13th; is that correct?

A. Yes.

Q. Why don't you read it?

A. Okay. I'm sorry. Do you want me to read this?

Q. Please.

A, 2-13, events of last night and this morning noted, had recurrent ventricular tachycardia bast evening, is relatively stable overnight, then had episode of hypotension and ventricular tachycardia this morning. Presently on Verapamil, which is an anti-arrhythmic, 4 milligrams Pronestyl when she had ventricular tachycardia this morning, Dopamine was running because of the hypotensive episode, this may have caused or aggravated the arrhythmia.

Then when I looked at the patient presented with -- well, her blood pressure was 90 over 60, her heart rate was 110 beats per minute, she was awake, She had normal heart sound and she did not have any heart murmurs; examination of her lungs showed what are called bronchi, which are abnormal breath sounds.

And then under problems I put number one, recurrent ventricular tachycardia, relatively stable at the moment on Bretylium, would continue these for now, if she is stable, try to wean off

Versed drip, I believe, she was further trached, might have an agent such as Amantadine.

Second problem hypoxia, the level of oxygenation in her blood was low despite the fact that she was being given a lot of oxygenation, that's what that means.

Yesterday chest x-rays were examined but this morning she was suctioned for a lot of tan secretions.

My -- then that -- at that point I wanted Dr. Sopko, who is a respiratory doctor, to see her. Her white count was elevated, the white count was 27.1 with 71 percent poly, 16 percent bands, we need to culture -- that notes means that her sputum had been cultured, but at that point at that particular time she was not running a fever.

Possible myocardial infarction, electrocardiogram from Ashland on 2-11 shows sinus rhythm and nan-specific S-T changes; the morning EKG shows what are called Q waves in V 1 and V 3, and enzymes pending.

Q Your next note would be when, February 13 at 5:00 p.m.?

A. Yes.

Q. Would you read that, please?

A. Pressure, blood pressure still somewhat Labile, she's maintaining sinus rhythm at the moment, increase I.V. somewhat since her urine output is better than it had been.

Q. You next countersigned Dr. Varma's note of the 14th; is that correct?

A. That's correct,

Q. You said agree with above?

a. Urn-hum.

Q. So you reviewed his notes, you agreed with it?

A. *Yes.* We talked, we would have talked that morning about what was going on.

Q. Then there's a procedure note of Dr. Varma on the 14th; do you see that?

A. Urn-Inurn.

Q. Did you read that note?

I assume you read all the notes?

A. Yeah, Yes, I would have read it.

Q. Whose writing is it in the black?

A. I think that's the writing of the senior resident.

Q. When you read this, did it concern you at all in terms of his notations in there?

MR. FULTON: Objection.

MR. JACKSON: You may answer.

Q. Certainly you're concerned about the competence of Dr. Varma?

MR. FULTON: Objection.

MR. JACKSON: Go ahead.

Q Where it says "Procedure explained to patient, risk discussed," that certainly indicates that the patient was capable of having a discussion?

A. Not necessarily, The senior resident has added here that the husband was involved in this discussion. Now, presumably, or one could infer the husband may have been in the room at the same time, and that he was there when Dr. Varma was explaining this.

Q. Well, infer from what, infer from the corrections made by the senior, because if you don't have those --

A. Yes.

Q -- I mean, you wouldn't necessarily know that, right?

A. That's true,

Q. If you go down to his correction here at the bottom, 1.5 amps; do you see that?

A. Yes.

Q And crossed out MA?

a. Yes.

Q. What's the difference between amps and MA's?

A. MA is milliamps.

Q. Is that a million or a thousand?

A. It's a thousand.

Q. Did you discuss this with Dr. Varma?

A. No. I don't remember discussing anything about this with Dr. Varrna,

Q. Number one, he didn't know the difference between amps and milliamps; number two, if he would have discussed it with you, you would have found out he thought the milli was a millionth of an amp as opposed to a thousandth of an amp.

MR. COYNE: Show an objection.

MR. VARMA: That wasn't a question,

A. That --

MR. JACKSON: He didn't ask. a question.

Q. Well, I mean, when you see corrections like this, doesn't that cause you some concern about the competence of the resident that was watching your patient?

MR. FULTQN: Objection.

A, That didn't -- that didn't come up at that particular time because this is something that the senior resident in all likelihood discussed with him.

Q. I don't have him here, I just have you here.

My question is: Did you discuss it with him?

A No, I don't remember discussing it, anything about this with him.

Q. Why not?

MR. JACKSON: Why doesn't he remember?

Q. Why didn't you?

A I can't answer that. I don't know.

Q. What is your next note, sir, the 15th?

A. Yes.

Q. Would you read that far me, please?

A. Agree with the note on previous page, growing staph from the sputum and she is on -- which is Staphylococcus -- she is on Vancomycin, hemodynamically she was relatively stable, she was maintaining her blood pressure and has no ventricular arrhythmia, and Procainamide, 2 milligrams a minute, would continue this dose for now.

Respiratory status is she is extubated, will arrange cardiac cath, ultimately will need EPS.

Q. What is that?

A. EPS stands for electrophysiological study, which

is a study that is done when somebody is having significant rhythm disturbances in their heart to try to determine the origin of the rhythm disturbances and what can be done to treat them.

Q. Did you ever determine what was the nature or the origin of the rhythm disturbances?

A. Not definitely. They were probably related to her severe coronary artery disease.

Q. That, you determined on autopsy?

A. That was determined ultimately on autopsy, but she had a myocardial infarction, so she by definition had Some degree of coronary disease.

Q. Next note would be what, Doctor?

A, On 2-16 there's a notation that I agree with Dr. Varma's note, There is an annotation.

Q. Whose note is this on 2-16 right before his note?

A. That's Dr. Sopko.

Q. Next one is the 17th; is that correct?

A. Yes.

Q. Will discuss Dr. Varma, agree with above discussion?

A. Yes.

Q. Next one?

A. On the 18th.

Q. That's your note?

A. That's correct.

Q. Would you read it, please?

A. Doing well, no anemia overnight, hemodynamically okay.

The next number indicates her intake and her output, then blood pressure 120, heart rate in the 90's and sinus; her pulmonary wedge pressure is 15 and there are chest x-rays or notations about parameters with respect to that.

Continue present treatment plan, we should recheck the chest x-rays and we think the respiratory should be done as per Dr. Sopko's plan,

Q. Let me stop you there.

Why were you rechecking the chest x-rays?

A. Because when somebody has the Swan-Ganz catheter in, number one; and number two, when they would -- had the problems that she had, we need to be aware of what's going on with the chest x-rays.

Q. Did you recheck them?

A. Yes. I'm sure I did. I would have either looked at the x-ray or discussed the x-ray with the residents; which of those two I did on that particular date, I can't tell you.

Q. Doesn't that say attempt respirator wean or says respirator wean, per Dr. Sopko?

A, Okay.

Q. A I correct about that?

A. That's correct. Respirator wean, per Dr. Sopko.

Q. What did that mean?

A, It means that the respirator and the settings and weaning from the respirator will be managed by Dr. Sopko,

Q. Doesn't mean that she was going to be weaned, it meant that he would be taking care of that?

A, That's correct.

Q. Your next note?

A. Next note is on 2-21, agreeing with the note that Dr. Varrna has written.

Q. Why were there no notes between the 18th and 21st?

A. In all likelihood, if we can get a calendar that was probably a Saturday and Sunday, which I was -- wasn't on call and wasn't there.

Q. So somebody else would have been on call. and covering for you?

A. Right

Q. Next note is when? I got the 25th.

A. Yeah, that's the next time I see my handwriting

here.

Q so was it 2-23 and 24 also a weekend?

A. I have no idea whether that was a weekend or not because --

Q Well., wait.

You just told me that the reason I didn't see any notes between the 18th and 21st is that was probably a weekend.

A. I said it may have been a weekend.

Q. If that may have been a weekend, then the 2-23 and 24 couldn't have been a weekend?

a. True.

Q. Were you losing interest or what?

a. No, absolutely not.

Q. What's your note on the 25th?

A. Agree with the above note, that is the note by Dr. Chmielewski; from a cardiac point of view she is stable at the moment, will have to consider having trach soon.

Q. Next note?

A, 2-27, agree with note on previous page, hemodynamically stable, main problem remains ARDS and pneumonitis.

Q. Which notes were you agreeing with?

A. With the note by both -- Dr. Varma.

Q. Okay. Next,

A. 2-27, Again, indicating that I had read Dr. Varma's note and had basically agreed with what he had written there.

Q. Where it says agreed, then your --

A. Right.

Q. -- initial or signature?

A. Right.

Q. So you had two of them on the 27th; is that correct; you just read me one a minute ago, now you got a signature on Varma's?

A. Yes. Okay.

Q. Do you know what time --

MR. JACKSON: These are apparently out of order.

A. These are out of order, that's why that's 2-26.

Q. Please don't change the order that you find them in, If they're out of order, that's fine. We can deal with that some day, but just leave them the way you find them.

MR. JACKSON: It's 2-27, then 2-28, then it goes to 2-26.

MR. KAMPINSKI: We've already established that at the previous deposition. Just leave them the way --

MR. FULTON: What did we establish?

MR. JACKSON: Apparently they were copied and they were put back out of order.

MR. FULTON: Who's the last person to copy them?

BY MR. KAMPINSKI:

Q. What times is your notes on the 27th, Doctor?

A. I don't know, because it isn't annotated to the time.

Q. When is your next note then?

MR. JACKSON: Wait a second.

THE WITNESS: That's the one I already referred to,

MR. JACKSON: Let's clarify something.

MR. KAMPINSKI: You know when you'll have an opportunity --

MR. JACKSON: We're going to clarify something.

The notes on the 27th which talks about agreeing with notes on the previous page, since this page is obviously out of order, his answer referred to a note on Dr. Varrna, he Looked at this one which was the 2-26.

THE WITNESS: Yes. These --

MR. JACKSON: Obviously if they're out of order, that was not the note he was referring to.

MR. KAMPINSKI: I don't know what he was referring to.

MR. JACKSON: We're going to clarify that for you.

BY MR. KAMPINSKI:

Q. Tell me.

A. Let me tell you the fact that these pages in the progress note are somewhat out of order right now, means that they could have gotten out of order at any time, and when multiple people have looked at this chart and it could have gotten out of order at any time.

There is no big significance to that one way or the other, see.

Q. Doctor, I really asked you to keep them in the way you found them. Why did you just do that?

MR. JACKSON: He is trying to get some reference point.

A. Trying to get them in --

MR. JACKSON: Don't infer he is doing something inappropriate, because he is not.

MR. KAMPINSKI: Well, I am suggesting he did what he did, whether it's inappropriate or not.

THE WITNESS: What I did was turn it over to try to --

MR. JACKSON: Coordinate the dates.

THE WITNESS: Yes.

MR. KAMPINSKI: That's fine.

MR. JACKSON: You apparently are trying to get some suggestion here that his nates about the reference to the previous page refers to a page other than what it refers to because it's out of order.

MR. KAMPINSKI: I don't know what it refers to. If he wants to tell me, that's fine,

MR. JACKSON: That's what we're attempting to do.

THE WITNESS: I would have to say that it refers to this note by Dr. Varma dated 2-27, which is the one that at present is also out of order.

BY MR. KAMPINSKI:

Q. Which particular note is that? Why don't you read it so that we'll know which one you were talking

about.

A. No significant change past 24 hours; neuro, heavily sedated with Versed; cardiovascular, the heart rate 120's, normal S-1, S-2, no S-3; blood pressure 154 over 83; respiratory, still bronchi in lung fields, few crackles.

MR. FULTON: Lung or something?

THE WITNESS: Beg your pardon?

MR. FULTON: Says lung after that?

A. Few crackles anterior lung. Then at this point I am not quite sure what the next two little words are.

Ventilator, it is written down here what the ventilator settings are at the current time.

Q What are they?

A. AC, 16.5; PEEP, FIO2, 85 percent; title volume, 800; oxygenation saturation, 93 percent; renal intake and output, 38, 46, and 3800; then a notation about the electrolytes.

MR. JACKSON: Let me point something out to you.

MR. KAMPINSKI: Wait a minute.

MR. JACKSON: You can wait a minute.

MR. KAMPINSKI: I'm not asking you about this note.

MR. JACKSON: You can wait a moment.

MR. KAMPINSKI: Don't you like his answer?

MR. JACKSON: It have no problem with his answer.

MR. RAMPENSKI: Why don't you let me ask him another question?

MR. JACKSON: As soon as I clarify.

MR. KAMPINSKI: Why don't you quit flipping these --

MR. JACKSON: These are the last notes of 2-27 on this page. Then your note of 2-27, then the note of 2-28.

Question is: Does your note of 2-27 refer to these notes or that note, because these two notes of 2-27 are from Dr. Chmielewski, and I can't --

THE WITNESS: Steffee.

MR. JACKSON: Steffee, comes after apparently the doctor notes which you are reading?

THE WITNESS: Right.

MR. JACKSON: These would apparently be in this order as I am holding them?

THE WITNESS: That's reasonable.

MR. JACKSON: Does your note of 2-27, what does it refer to?

THE WITNESS: Right now for me to know at which exact point -- this note probably refers to all of these, basically because --

MR. KAMPINSKI: Do you want to change your answer'?

MR. JACKSON: He is not changing his answer.

THE WITNESS: No. I'm just trying to say it's difficult the way these presently are.

BY MR. KAMPINSKI:

Q. A minute ago you didn't have any difficulty in arranging them before Mr. Jackson interjected.

A. That was initially. I didn't know these were out of order.

Q. This answer you gave was after you noticed it was out of order, it was an attempt to tell me the correct order, now you want to change that and say that's incorrect?

A. Well, no, I am not saying that's incorrect,

because if I -- I would have talked to Dr. Varma on this date, and probably there is no really --

MR. JACKSON: Let me make a statement to help Mr. Rampinski. This is clearly a continuation of the --

MR. KAMPINSKI: Don't go Out Of character.

MR. JACKSON: He signed and agreed below that note, so obviously his note of 2-27 doesn't refer to one that he already agreed with. That's very simple.

MR. KAMPINSKI: It might be for you, but apparently the doctor doesn't know what he agreed to.

THE WITNESS: Well, I --

MR. JACKSON: That's not true.

THE WITNESS: That is not true, because at the time right now there is confusion because the pages are out of order. At the time that he's discussing what is going on with the patient day-by-day, these are in -- it's obviously in the right order, and so --

Q. And you read these to make sure you understood them and agreed with them?

A. Yes.

Q. What were the two words you couldn't read?

MR. FULTON: You are talking about the reports of Dr. Varma?

MR. KAMPINSKI: Yes.

A. Very small notation, which right now I can't read.

Q. If you can't read what he wrote, how can you read or agree?

MR. COYNE: We said he discussed it with him, didn't he tell. you.

Q. Do you want to answer?

A. We always discussed what he did.

Q. What did he tell you?

A. What is --

Q. What did he tell you those words meant?

MR. FULTON: Lung fields.

A. I don't have any idea of what those words meant.

Do you want to put them --

Q. What is the --

MR. FULTQN: Looks like lungs fields, here.

MR. JACKSON: You changed them.

Q. Isn't that the way they were?

A. I'm not sure. You can put them whatever way you like to.

MR. FULTON: Mine are in order if anybody wants to see them correctly.

MR. JACKSON: Apparently that's not what he has in mind,

MR. KAMPINSKI: Are you guys done?

MR. JACKSON: You're done, is that what you said?

MR. KAMPINSKI: No. Are you guys done?

MR. JACKSON: Go ahead.

BY MR. KAMPINSKI:

Q. Have you reviewed this chart before today, Doctor?

A. I haven't. I have not gone -- yes.

Q. When?

MR. PULTON: Yours is lung fields also.

A. I certainly reviewed it when we -- when Mr. Jackson and I had meetings about this in the past few months.

Q. When is the last time you reviewed it?

A. I read through -- I read through most of the -- it, most of the -- these notes this morning in a copy of the chart.

Q. As you sit here today! you don't know what your

notes refer to on the 27th?

MR. JACKSON: Those were in order-

Q. Is that right?

MR. JACKSON: Do you want him to put them in order to answer that?

MR. KAMPINSKI: I am not going to answer your questions, He is going to answer mine.

MR. JACKSON: They are not in -- we'll put them in order for him.

MR. KAMPINSKI: No. No. No. This is -- Mr. Jackson, this is not appropriate.

MR. JACKSON: Yes, it is. We're not playing a silly game here of shuffling these things around, They're obviously out of order.

NR. KAMPINSKI: You are the one shuffling things. This is how they were presented to me.

MR. JACKSON: That's clearly not the case.

MR. COYNE: We should put in the record again that these records are the original hospital charts which counsel, Mr. Rampinski, has asked that we bring to all these depositions, and I have done that as the attorney for the hospital.

Prior to this deposition today all. of the lawyers here I believe have separately ordered copies of the original chart. This chart has been dismembered and separated and copied at the hospital several times, upon each request that would be received from counsel., which is customary.

Also prior to today this hospital chart has been sent to a professional photocopier lab at Mr. Kampinski's request. Couple other lawyers asked for copies, and it was Kinko who was the photocopying company. Again they had to separate this whole chart and do this one page at a time.

So if there is a page out of order, for the life of me I don't see any importance of it, it could be that whenever, whoever copies these put them back together, it seems to me that a page or two could be put out of order.

And I just think that should be made part of the record. That we're not representing, that the hospital is not, that this chart has never been sorted out, never been changed in any manner by way of chronological putting these papers back together, because several people have photocopied them. A clerk could put a couple pages in the wrong place.

I just wanted that on the record.

BY MR. KAMPINSKI:

Q On either of these notes that you have on the 27th or in your discussion with Dr. Varma, did you discuss the procedure that he did on the 26th?

A. He would have -- again, I have to say that I don't have any independent memory of this when I came in on the 27th. He would have acknowledged that he put in a femoral line the night before or the day before later in the afternoon.

Q Are you guessing or --

A. No, I am not guessing. I am sure that's what happened. When I will go in, see the patient, I would see there's a femoral line in, and they will say they put that in the evening before.

Q. Would you do a physical examination on your patient, that's how you would have noticed a femoral line in there?

A. I would have noticed a femoral line when I went in to see the patient in the room, yes.

Q. Would you have noticed any other potential problems on the patient's body if they existed?

A. Quite possibly.

Q. Dr. Varma testified that he attempted to insert a femoral line in the right femoral artery but that he couldn't get any blood return, that's not reflected in

his note, is it?

A. No.

Q. Would that have Left a mark somewhere in the right groin area?

A. There almost certainly would have been a small needle puncture mark, yes,

Q Did you see any such thing?

A, No, I don't remember seeing any such thing.

Q. Has your review of the nurses' notes reflected that any such thing existed?

A. I'll have to --

MR. JACKSON: He asked you does your review, do you have any memory of it?

A. I don't have any memory of.

Q. Did your discussion with Dr. Jayne or Dr. Varrna after you found out that he had left two guide wires in, in your discussions with either of them did they say he attempted to put one in the right side and couldn't?

MR. FULTON: Objection.

A. I don't remember that point being brought up.

Q. If in fact that had occurred, would you have expected to see that in his note?

MR. FULTON: Objection.

A. Not necessarily.

Q. Do patients get charged for catheters in their ultimate bill?

A. There's a hospital charge.

Q. Would a physician, for example, inserting two guide wires have to somehow be able to explain the existence of a charge for two wires out of two kits?

A. I don't know how to answer that.

Q. Bo you know how the charges are made?

A, The charges are made by the hospital, depending on what equipment is used, what medication is given to the patient, what procedures are done. There is a hospital charge for these things that are done, by the billing department.

Q. I mean, for example, if a kit is used, how is it that the charge for that kit, you know, gets on the bill, do you know'?

A, I don't know the mechanics of it, no.

Q. The nurse would take care of that?

A. Yes.

Q. Your next note then, Doctor, after the 27th is when: is that the lst?

A. Yes.

Q. That's your note?

A. I, am acknowledging Dr. Varma's note of the lst.

Q. But you don't know when you signed that?

A, In all likelihood I signed it on the 1st, but I can't tell you that for sure.

Q. It could have been October 1st?

MR. JACKSON: Don't respond to that kind of comment.

MR. KAMPINSKI: That's not at all facetious.

Q. You told me earlier that oftentimes if these records are not completed you will be called by the nurses or the Medical Records to come down and countersign a note, right?

A. The usual orders, if I have -- I have countersigned on a note, that means that I --

Q That you were there?

A. That I was there and that I discussed it.

Q. Got you. All right.

MR. FULTON: Just a moment off the record.

MR. KAMPINSKI: Let's keep everything on the record.

MR. FULTON: Fine. Since I have an automobile down in the garage at Land Title and my office is the farthest away from this building, I'd just like to know if you're going to go past 6:00, so I can --

MR. KAMPINSKI: I thought they told you it was open to 8:00.

MR. FULTON: We got 6:00 on the ticket, Mr. Kampinski. Do you want to see that to be sure I am telling you the truth here, my friend. Show him the ticket. Is that --

MR. KAMPINSKI: That's a 6?

MR. FULTON: Or is this ticket out of order and it's a 9.

MR. COYNE: Looks like a loop to me.

MR. WARMER: Looks like a J.

MR. FULTON: Are you going past 6:00?

MR. JACKSON: We're going to finish tonight.

MR. KAMPINSKI: Is that all? Are we?

MR. JACKSON: I expect to, yes. Don't you?

MR. KAMPINSKI: I hope so. I hope to be finished within the next 20 minutes or so.

BY MR. KAMPINSKI:

Q. Your next note, Doctor, March 2nd?

a. 3-2, agree with above notes and plans, that is

referring to the note of Dr. Chmielewski where he makes some suggestion about changes in antibiotics.

Q. Your next note?

A. I believe my next note is 3-13 or 3-12.

On 3-12 there is a --

Q. Nutrition note?

A. Yes.

Q. We went over that earlier?

A. Right. Then on -- next one on 3-13.

Q. All right. Would you read that one?

A. Agree with Dr. C's notes on previous page, which refers to Dr. Chmielewski; reviewed x-rays yesterday afternoon, there is guide wire in the left iliac artery which goes proximally to the area of the left carotid area; retrieval will be attempted from the left femora1 artery, will insert a sheath and try to snare the end of the wire with either myocardial infarction biopsy forceps or a snare.

Q. Next note is yours also?

A. That's correct,

Q. Would you read that?

A. Wire retrieval, number 8 sheath inserted in left femoral artery, snare using NIH catheter and guide wire was advanced to the area of the wires.

One wire was successfully snared and

removed, but the other piece could not be snagged, will ask vascular surgery to be -- to make sure left femoral artery is okay and to discuss option for retrieval of the other piece,

Q. What did you mean, NIB catheter and guide wire was advanced to the area of the wire, that's what the snare consisted of?

A. The snare consisted of a guide wire and a catheter attached to it.

Q You didn't lose a guide wire in there, did you?

A. Absolutely not.

Q. So there were two in there when you went in?

MR. FULTON: Objection,

A. Yes.

MR. JACKSON: He can't help himself with his questions.

MR. KAMPINSKI: I don't know if I got anymore.

Q. Your next one, Doctor?

A. 3-14, has good left tibial posterior pulse this morning, heart. rate 110; I20 blood pressure, normal; temperature normal; lung scattered bronchi; Dr. Moasis consult, appreciate it, plan to go ahead with retrieval of other wire today.

Q. Next one,

MR. FULTON: I don't see that. Let me see something. What does that look like?

THE WITNESS: That's the last one of my notes.

Q. That's the last note of yours?

A. Yes.

MR. FULTON: That's the end of the 3-14 notes?

MR. JACKSON: Yes.

Q. When did she die, Doctor?

A. She died on the morning, early morning of the 15th.

Q. What was the time of the operation on the 14th?

A. It was in the afternoon. I believe it started around two o'clock.

Q. To approximately 4:00?

A. Yes.

Q. Is that then by definition an operative mortahity?

MR. JACKSON: Objection. You may answer, Doctor.

A, When a patient dies within 24 hours of an operation, that -- that is, yeah, that's considered an operative mortality.

Q. So that -- well, the retrieval then of the guide

wire by Dr. Moasis contributed to cause Mrs. Weitzel's death then, didn't it?

MR. COYNE: Show an objection.

MR. WARNER: Objection,

MR. FULTBN:: Objection.

MR. SEIBEL: Objection.

MR. JACKSON: Objection.

MRS. CARULAS: Objection.

MR. OKADA: Objection.

MR. JACKSON: You may answer.

A. I don't know the answer to that question.

Q. Well, if it's an operative mortality and the operation was for purposes of --

MR. JACKSON: Do you have to make a call?

THE WITNESS: It can wait.

Q. -- for purposes of removal of the guide wire, then the operation was a contributing cause of her death?

MR. JACKSON: Objection.

MR. WARNER: Objection.

MR. FULTON: Objection.

MR. SEIBEL: Objection.

MR. COYNE: Show an objection,

MRS. CARULAS: Objection.

MR. OKADA: Objection.

MR. JACKSON: Go ahead.

A Again, I am not trying to be difficult, but it is difficult to make that extrapolation.

When you talk about an operative mortality, and I am saying that it is considered an operative mortality if somebody dies within 24 hours of an operation being performed, that calling it an operative mortality is a device for saying yes, the patient died within 24 hours of the surgery.

It's another question whether the surgery that was done within 24 hours of the patient's death A, caused; or B, contributed to what degree; or C, didn't contribute to the death of the patient.

That's all I am trying to say.

Q. What caused her death?

A. She had an arrhythmia.

Q. What is that?

A. That means that her heart started beating very rapidly and very irregularly, and she had a cardiac arrest and was not able to be resuscitated.

Q What caused the arrhythmia?

A. The -- I don't know exactly why it happened.

Q. Did the operation probably contribute to cause it?

MR. JACKSON: Objection. You may answer.

MR. OKADA: Objection.

MR. WARNER: Objection.

A. It may have.

Q. Were there arrhythmias previous to the operation?

A. There were arrhythmias when she was first admitted.

Q. On the 12th?

A. They consistently had a problem on the arrhythmias immediately prior to surgery.

Q. When you say "immediately," for how long had she not had problems with arrhythmias?

A. The arrhythmias had not been a problem for sometime during that hospitalization, although they were at the time that she first came in.

Q. I understand, but I mean we're now a number of weeks after her -- almost a month after her admission, actually more than a month, right?

A. A month and three days.

Q. And it's your testimony that you don't believe that the surgery probably contributed to cause the arrhythmias that killed her?

MR. JACKSON: Objection.

A. That's not my testimony. My testimony is that the surgery may have contributed to her death, but that it's hard to say that for sure,

Q I'm not asking for sure. I'm asking if it probably did.

A. It may have.

Q. Why are you drawing a distinction between "May have" and "probably," is there a 51 percent --

A. I don't know haw sure you can be.

Q. A 51 percent chance or probability that it did?

MR. COYNE: Show an. objection.

MR. WARNER: Objection.

MR. FULTON: Objection.

MR. SEIBEL: Objection.

MR. JACKSON: Objection.

MRS. CARULAS: Objection.

MR. OKADA: Objection.

MR. JACKSON: You may answer,

A. I don't know.

MR. JACKSON: I need to take a break.

MR. KAMPINSKI: I'm done, I think, almost.

MR. JACKSON: Let's take five.

MR. KAMPINSKI: Almost, I just

need to check my notes.

MR. JACKSON: Then you want to take a break.

MR. KAMPINSKI: This is a good time to break.

MR. FULTON: You got a couple more questions?

MR. KAMPINSKI: Be needs to make a phone call.

MR. JACKSON: Then you can review your notes.

MR. FULTON: Is that all you need to do?

MR. KAMPINSKI: Yes.

MR. FULTON: Everybody happy?

- - - - -

(Brief recess had.)

- - - - -

BY MR. KAMPINSKI:

Q. Doctor, did you review the physician orders before coming here today for your deposition?

a. I didn't go through each page of the order, no, if that's --

Q. I have seen two orders where you either signed or countersigned, one was on February 17.

A. Okay. Let me find that.
Q. Do you see that?
A. Yes.
Q. That's your signature at the bottom?
A. Yes.
Q. What is that?
A. It's an order for *a* suppository, for *a* stool softener.
Q. By Dr. Varma?
A. Yes.
Q. Verbal, why did you countersign that?
A. I am almost sure when I countersigned that -- that was countersigned after the fact. As I explained to you before,. when orders -- when a chart, when any chart goes to Medical Records, the Medical Records reviewer reviews the charts, if -- and if there is an order on the chart that is not signed, if it's a verbal order and it's not signed by the person that wrote the order, then that chart. comes back into the system for a signature,
Q Right. The other one that I saw of yours was on February the 25th, that's the one you were Looking for before, ***of*** the Versed?
A. Yes.
Q. That *was* a verbal order by Dr. Oneykwere?

Q. Would that have been then the same reasoning?

A. Yes.

Q. Am I correct then that you didn't sign or countersign any of the orders in this chart, other than the ones that you were asked to countersign later because they hadn't been signed?

A, That's correct, because this is a -- basically a policy that on teaching patients, that a11 orders are written by the residents, The attendings are in fact encourayed not to write orders.

Q. How about reviewing the orders, do you review them?

A. Yes.

Q. When?

A. Well, as you are reviewing the charts and making rounds and discussing the case each day with the residents.

Q. You just don't sign anything indicating that you do?

a. That's correct.

Q. After you found out that the wires had been left in Mrs. Weitzel, you told me that you had a discussion with Dr. Jayne and with Dr. Varma, did you have any discussion with Dr. Oneykwere, the senior resident?

A, I don't believe I did.

Q Why not?

A. Because this was a something that had been done by Dr. Varma, and he was the one I needed to talk to, to find out what had gone on.

Q. Well, you told me that in terms of the hierarchy, the senior resident should have known about this, as we113

A. Yes, he should have, but only if -- only if he had been told would he know about it.

I don't remember specifically talking to the senior resident. I may have. I don't remember doing it. I certainly remember talking to Dr. Varma.

Q. Did you talk to Dr. Varma on more than one occasion?

A. I believe I did.

Q. When was the other time you spoke to him?

A. Probably within 24 hours of the first time I spoke to him.

Q. What was discussed at that time?

A. The same thing. Are you sure that there wasn't a problem when you inserted that femoral Pine, and can you tell me how those -- how the wire, wires, got into her system,

Q. What did he say?

A. He consistently said that he had no idea how it had happened.

Q. What was your response?

A, My response was that I find that difficult to accept and believe.

Q. So basically you just told me essentially what you told me about the first conversation?

A. Right. They were essentially the same conversation.

Q. Where were both of these conversations held?

A. The coronary care unit.

Q. You mean he was still there?

A. Yes.

Q. Was he still taking care of Mrs. Weitzel?

A, Be was, yeah. He was as far as I remember, he was still there, yes.

Q. Why?

A. Because that was the way the system worked. As far as residents help to take care of patients, Be had been involved with this patient's care from the start, but -- that was why.

Q. That's not what I meant.

Had he done a good job on this patient's care?

MR. FULTON: I didn't hear that

question.

Q. Had he done a good job on that patient's care?

MR. FULTON: Objection.

MR. JACKSON: You may answer.

A. I would have to say by what happened that he had in fact not done a good job.

Q. How could you have allowed him to continue to care for her?

A. Only because I was back, I was there, I was watching over what went on and so was the senior resident who knew about this too.

Now, as I say, I don't remember specifically myself talking to the senior resident, but I know that the senior resident would have been aware of this and he was keeping close tabs on things, too.

Q. Did you have any further discussion with Dr. Varma after those two?

A. I don't remember anything after that.

Q. Anymore discussion with Dr. Jayne other than the one you told me about?

A. No.

Q. Any further discussion with Dr. Rollins or Dr. Kitchen other than the one you already told me about?

A. No, none that I can remember specifically.
Q Any other physician that you discussed this with?
A. No.
Q. How about Dr. Chmielewski or Dr. Sopko?
A. No.
Q. Did you ever prepare any statement regarding what occurred in this case?
A. Yes, I did.
Q. When?
MR. JACKSON: Objection. You don't have to answer that,
All after the fact?
THE WITNESS: Yes, Well after the fact.
MR. JACKSON: Come here.
His answer was yes.
MR. KAMPINSKI: Can I ask something?
MR. JACKSON: Pardon me?
MR. KAMPINSKI: Are you guys ready?
MR. JACKSON: Yes.
MR. KAMPINSKI: Do you mind if the record reflects that the two of you just conferred

about how *to* answer this question.

MR. JACKSON: I mind the record reflecting that, yes, because the record can accurately reflect that I conferred with my client. You draw your own conclusion on the basis of that. I certainly have a right to do so. I don't think you would disagree that I do.

MR. KAMPINSKI: I don't know what you told him.

MR. JACKSON: That's none of your business at this time,

MR. KAMPINSKI: Obviously not, that's why you were whispering so nobody could hear,

MR. FULTON: I wish you people would keep your voices up, It's most interesting.

MR. JACKSON: He is upset. He appears *to* be.

MR. FULTON: Maybe it's just a knack.

BY MR. KAMPINSKI:

Q I think my last questian was when?

A. After the fact.

Q. Okay. When after the fact?

MR. JACKSON: Just the date, if you remember, as close as you can get to it.

A. In the first week in April.
Q. And the context of your preparing that statement was what?
MR. PULTON:: Objection to that.
MR. JACKSON: Just answer for whom you prepared the statement, and then that alone.
A. I prepared a statement for Dr. Keating.
Q. And the purpose of that statement was what?
MR. FULTON: Object to that, Ask that you discuss this with your client on the basis I think it gets into peer review.
MR. JACKSON: Just say in what capacity did you communicate with Dr. Keating, what capacity was she acting.
A. She is the overseer of the residency program, as we had talked about earlier.
Q. But the purpose of her getting a statement from you was what, do you know?
MR. FULTON: Objection.
MR. JACKSON: You may answer, just if you know what the purpose was of it.
A. It was at her request.
Q. But I mean why is it that she asked you to prepare a statement, do you know?
MR. FULTON: Objeetion with

respect to peer review. I don't know how he would know why she did it.

MR. JACKSON: You may answer if you know as to why she asked you.

A. Because I had made my concerns about what had happened known to her.

Q. What were your concerns that you had made known to her?

A. That wires had been left in this patient, and that I was concerned about that and that's what I had made known to her.

Q. Have you had any communications with anyone else?

a. No.

MR. JACKSON: Exclusive of counsel, I would assume?

MR. KAMPINSKI: Yes.

A. No, I haven't.

Q. Have you bad any communications with, anybody from Mount Sinai to apprise them of what had occurred?

A. No.

MR. FULTON: Objection.

MR. KAMPINSKI: Is that also peer review?

MR. FULTON: No. I just think

it's rather unnecessary.

MR. KAMPINSKI: I think it's very necessary.

MR. FULTON: Why?

MR. KAMPINSKI: Well, maybe to save some other lives.

MR. VARMA: If you think it's necessary, you inform them yourself.

MR. KAMPINSKI: Does that adequately answer the question, that's why.

MR. FULTON: What?

MR. KAMPINSKI: To save lives,

MR. FULTON: What, that the guide wire caused the death?

MR. KAMPINSKI: My answer to your question as to why he ought to tell somebody at Mount Sinai or maybe the prosecutor's office,

MR. FULTON: Why don't you swear out a warrant on the --

MR. KAMPINSKI: Can I do that?

MR. FULTON: I think you can. Sure. Make a citizen's arrest, as a matter of fact,

BY MR. KAMPINSKI:

Q. What is your insurance coverage, sir?

MR. JACKSON: Do you know the

limits of your coverage?

A. I believe it's one and three, one million, three million.

Q. One million, three million excess?

A. Yes.

Q. Have you been apprised of any problems with the amount of your coverage?

MR. JACKSON: Objection. You may answer.

A. No, I am not aware of any,

Q. Have you made any demands on your carrier to pay within your policy limits to avoid exposure on your part in excess of those limits?

MR. JACKSON: Objection. That, you don't have to answer.

MR. KAMPINSKI: As to whether he has made a demand?

MR. JACKSON: Right.

Go ahead, if you want to.

A. The answer to your question is no.

Q. Are you aware of the fact that the same attorney represents a number of other physicians in this case in addition to yourself?

MR. JACKSON: That, you don't have to answer, Doctor.

You don't have to answer that question.

Q When do you recall speaking to Mr. Weitzel?

A. I have spoke to -- well, I specifically remember speaking to Mr. Weitzel on the morning that I was going to take her to the cath lab to retrieve the wire.

Q. That was on Narch 13?

A. Correct.

Q. Ever talk to him before that?

A. Yes.

Q. When?

A. I had talked to him intermittently before that, letting him know in general what was going on; but as to specific date or times, I can't tell you that.

Q. Well, when you say "intermittently," I assume that means you talked to him more than once?

A. Yes.

Q. More than twice?

A. I am sure I talked to him more than twice.

Q. More than three times?

A. Probably.

More than four times?

A. Like I said, I don't know the exact number, but I did talk to him as time went on while she was at the

hospital.

C What did you tell him when you were going to take her to the cath Lab?

A. I told him that 1 was going to take her to the eath lab to remove a wire from her aorta.

Q. Did you tell him how the wire got there?

a. I told him that 1 didn't know how the wire got there.

Q. That's not true, you knew,

A. Well, that I wasn't sure what it was doing there.

Q. Did you tell him that a resident put it in and had covered it up?

MR. FULTON: Objection.

A. No, I didn't specifically tell him that.

E6 Q. Why not?

MR. FULTON: Objection.

MR. JACKSON: Objection. You may answer.

A. Well, as far as I am -- I was concerned, the point at that particular time was to -- for me to make sure that I told Mr. Weitzel that 1 was taking her to the cath lab to do this procedure, to remove a wire that had been -- that was in there. I didn't elaborate anymore than than at that time to him as far

as how long it had been in there, why, or whatever. That --

Q. When did you tell him?

A. As to how long it had been in there?

Q. Yes. How it got there?

MR. FULTOM: Objection.

A. I don't know. I don't remember when I said anything about exactly how long it had been in there, how it got there.

Q. Did you ever?

A. I don't know. I don't remember,

Q. Well, how many more conversations did you have with him?

A. I talked to him. I talked to him on the day that I removed the wire, before and afterwards, and I talked to him the following day,

Q. What did you tell him after you removed the wire?

A. Told them that that were in fact two wires in there and I only had managed to retrieve one of the them.

Q. On that occasion did you tell him how the wires had gotten in there?

A. I don't -- I don't remember exactly what I said to him. I probably told him that they had -- had been

put in when a line was being put into the patient and somehow left there, but I don't; remember my exact words and I don't remember the exact conversation.

Q Well, did you give him any sense of the fact that a resident had put them in and had Left them in there, had covered it up and hadn't told you about it?

MR. FULTON: Objection.

MR. JACKSON: Objection.

A. I don't remember saying that.

Q. Is there a reason that you didn't tell him those things?

MR. JACKSON: He said he didn't remember saying that,

A. That's what I said. I don't remember saying that.

Q. Well, are you suggesting that you may have said that?

A. I don't remember. I don't remember saying that.

Q. Does that mean you didn't say it?

A. E don't know. I don't remember exactly what I said to him.

Q Well, how about in general, did you say that?

A. In general I said that there were two wires that were in there' and I don't remember what I said to him about how long they had been there or exactly who had

put them in, just the fact that they had been introduced and left in there during a procedure.

Q Do you feel he had a right to know that. there was a coverup involving the wires?

MR. FULTON: Objection.

MR. COYME: Show an objection.

MR. WARNER: Objection.

MR. SEIBEL: Objection.

MR. JACKSON: Objection.

MRS. CARULAS: Objection.

MR. OKADA: Objection.

MR. JACKSON: You may answer that.

A. It was certainly his right to know that there were wires left. inside her, inside her aorta, absolutely. As a matter of fact -- well, it was certainly his right to know that.

Q. That wasn't my question.

A. Please repeat your question.

Q. Sure.

Did he have a right to know that there was a coverup regarding these wires?

MR. COYNE: Show an objection.

MR. WARNER: ~bjection

MR. FULTON: Objection.

MR. SEIBEL: Objection.

MR. JACKSON: Objection.

MRS. CARULAS: Objection.

MR. OKADA: Objection.

MR. JACKSON: You may answer.

A. Yes, ultimately he has a right to know.

Q. Did you tell him?

MR. FULTON: Objection.

A. I don't remember that I told him that, no.

Q. What did you tell him after the removal of the wire other than you told me that you said that there were actually two and that you were only able to get one, anything else?

MR. FULTBN: Objection.

MR. JACKSON: You may answer.

A. Well, that the second wire was going to have to be removed and we'll have to remove it surgically.

Q. Did you tell. him any of the risks of removal of that wire?

A. I told him that any surgery in a lady as sick as his wife, there's an element of risk to it, but there was also -- in my opinion -- there was also risk in leaving this thing in there indefinitely, so that was why we felt it needed to come out.

Q. Do you remember telling him that?

A. Yes, I do remember talking to him about that.
Q. What did you tell him the risks were?
A. I said that it was -- it was a certain risk in going ahead and doing the surgery, there was also risk in leaving the wire.
Q. Did you tell him that there was an increased risk of doing surgery on someone who had a heart attack?
A. I said that there was an increased risk in her, being that she was very sick with all these other intercurrent problems, yes.
Q. I am not sure that was responsive to my question.
MR. JACKSON: I think it was.
Q. Did you understand the question?
A. Yes. I understand your question, and your question as I understood it was asking me if I had made specific reference to the fact that she had had myocardial infarction.
I don't remember specifically saying that she -- that there was increased risk because of her myocardial infarction. What I do remember saying, there was an element of risk because of everything that had gone on with her in the hospital, whether pulmonary status, cardiac status, and everything.

So it was sort of an inclusive, an all inclusive thing,

Q It was your opinion that she should undergo the risk because of the potential detriment?

A. Yes.

Q. Any additional discussion with Mr. Weitzel?

a. I don't remember any other discussion with him.

Q. How about after she died?

A. I believe that after she died, when I came in the next morning he had already gone home, and I don't remember any other specific discussion that I had or I don't remember -- I don't remember any other discussion that I had with him.

Q. Did you call him, did you write him anything?

A. I didn't write him a letter, and I don't remember whether I called him or not. I don't remember calling him.

Q. Why not?

MR. JACKSON: Why he doesn't remember calling?

A. Or why didn't I call?

Q. Either one, whichever the case is?

A. Because -- because he talked to -- he talked to the physicians in the hospital at the time that she died, and then he left the hospital after that.

Q. Who did he talk to?

A. He talked to the residents who conducted the resuscitation efforts when she died.

Q. To the residents?

A. Yes

Q. That's part of their responsibilities, too?

A. Yes, it is.

MR. KAMPINSKI: That's all, Doctor. Some of the other attorneys may have some questions for you

MR. FULTON: Anybody asking any down there?

MR. WARNER: I got a few.

Doctor, my name is Rob Warner. Again, I represent the radiologist.

- - - - -

CROSS-EXAMINATION

BY MR. WARNER:

Q. As I understand DE. Rollins and Dr. Kitchen, it was their understanding that her condition did not permit them to remove the guide wire at the time that they became aware of it,

My question is: Do you agree with their decision to not to remove the guide wire at the time they became aware of it?

A. That's a retrospective -- has to be a retrospective thing, and it was their feeling at the time that they didn't want to go ahead and remove it when they first discovered it. I have to go by what their judgment at the time was since I wasn't there.

Q. So you -- you think it was appropriate of them?

A. I would have to say yes,

Q And I think you indicated earlier, you talked about potential problems that the guide wire could cause, but as far as you are concerned in examining the patient, in reviewing the chart, none of those potential problems, embolism, infection, developed particularly with the guide wire or these two guide wires?

A. That's true,

Q. As I understand it, the patient would be at risk or increased risk in undergoing surgery at whatever time the guide wire was going to be removed! when it was first inserted, until when it was removed, anytime during that time span of 10 days or 12 days, whatever it is, she would be at increased risk?

A. Sure. Yes.

Q. Do you have an opinion whether or not if it had been removed earlier that there would have been a different outcome or in all probability the same

outcome would have occurred?

A. I really can't have an opinion one way or the other about that,

MR. WARNER: I don't have any other questions.

MR. OKADA: I have no questions.

MRS. CARULAS: No questions.

MR. SEIBEL: I have no questions.

MR. JACKSON: Mr. Fulton, do you have some?

MR. KAMPINSKI: You missed Mr. Seibel.

MR. SEIBEL: No. I said I didn't have any,

MR. FULTON: I am Burt Fulton --

MR. JACKSON: He spoke softly since we're down at this end.

MR. FULTON: I represent Dr. Varma. I want to start at the admission of Mrs. Weitzel.

- - - - -

CROSS-EXAMINATION

BY MR. FULTON:

Q. When she was admitted she had had a cardiac arrest; is that true?

A. Yes.

Q What is a cardiac arrest?

a. A cardiac arrest means that she -- her heart had stopped effectively beating and she had to be resuscitated to restore her heart beat.

a. As a matter of fact, there was a development of Q waves upon her hospitalization; is that not true?

A. Q waves developed in the electrocardiogram, yes.

Q. That's an indication that there is a myocardial infarct?

A. That's correct.

Q. Just by looking at the Q waves themselves, even without enzyme tests, you know that an MI has occurred?

A. That's true.

Q. So upon her admission from a physical standpoint she was in very bad shape?

A. That's true. She was not in good shape.

Q. Even from a neurological standpoint, from a mental standpoint she was in bad shape?

A. She had had some degree of neurological damage,

yes.

Q And do I understand that you were the attending physician at the time of her coming to the hospital?

A. Yes.

Q. Now, I am skipping over to the operation.

My understanding is, if you had a chance to review any of these records with respect to her hemoglobin, what occurred to that, what was it prior to the operation?

A. I know her hemoglobin went up and down during her hospital stay. Specifics I have to refer to the chart.

Q. If the hemoglobin just prior to operation was 5.2, would that indicate that a person would have to be transfused for an operation?

A' Yes.

Q. Do you know at the tine of her death what the hemoglobin was? If it was 6.1, that's a pretty low hemoglobin?

A. That's very Low.

Q. That would indicate that you might need transfusion?

A. Yes.

Q. Now, in the operation note, and you can look at that, I may be incorrect, but I think the surgeon

indicated 200 cc's of blood were lost, 200 cc's would be half a Pepsi or Coke can of blood?

A. Yes.

Q. Are you aware that the autopsy indicated that there was approximately -- I may be wrong, I don't have the autopsy report -- somewhere close to 500 cc's of hematoma was found in the area of the operative site?

A. Well, the different -- difference between that, 250 cc's and 500 cc's is not much. It is a difference, but it's not an extreme difference.

Q. If a 500 cc hematoma is found at the operative site, that was indicating a considerable bleeding?

A, There was some bleeding.

Q. I used the word "considerable," would that be fair?

A, Not being a surgeon who does this, whether that's an acceptable amount of bleeding after an operation such as this, I don't know.

Q. With the existence of a hematoma and a fallen hemoglobin, can this result in the problem of someone creating a situation of hypoxia and possibly arrhythmia?

A. Yes.

Q. And prior to her operation, as a matter of fact,

isn't there somewhere in the record someone wanted to talk about a liver biopsy and they were concerned that maybe that. shouldn't be undertaken, liver biopsy, because of her condition?

A. I think there was a mention of that possibility by the consultant, but that was never performed.

Q. What can happen to someone if they have a liver problem with respect to when they're under anesthesia, is there some problems sometimes that anesthesia can somehow --

A. There may sometimes be a prolonged effect of the anesthetics that are metabolized by the liver.

Q Which can create a cause of death?

A. Possibly.

Q. Now, going back, if my notes are correct, you left on 3-3, right?

A. Yes. Either late in the day on 3-2, or 3-3, one of the two.

Q. There was an x-ray that was read on 3-1 by Dr. Wirtz which indicated that there was a foreign object seen. You can look.

A. I am familiar with that. x-ray report. I've since read that.

Q. And there was also an x-ray report I believe on 3-3 which also indicated existence of some foreign

object; am I not correct?

A. Yes, I believe you are.

Q Wow about 3-2, was there one? I don't remember if there was one on 3-2.

You indicated on -- your indication about the Swan-Ganz being placed in the chest, this is that you followed up with an x-ray to determine the placement; is that standard procedure?

A. That's pretty standard procedure.

a. How about with respect to arterial lines?

A. No.

Q. Is there no standard procedure, right?

A. Correct.

Q. Now, we do know that there was a kine that was placed in the 26th of February, that was by the records here?

A, Yes.

Q. We do know that there was an x-ray on the 26th which is early-on, which shows no existence of foreign objects?

A. Yes.

Q. We do know that there was no x-ray taken on the 27th?

MR. KAMPINSKI: I'm going to object. There is none in the chart nor is there a

report. We don't know whether one was done,

Q. There's riot an existence of an x-ray on the 27th?

A. Correct.

Q. Wad an x-ray been taken later on the 26th, it undoubtedly, if it was taken correctly, would show the existence of something that might be there, if a foreign body was in fact there?

A. I would have to say yes, if it was taken after the procedure was done.

Q. Now, an x-ray was taken on the 28th which indicated the existence of something khat was read on as one, later on the 1st was read as one wire, right?

MR. JACKSON: Talking about the x-ray?

Q Whatever the x-rays on the 28th were! there's no reading there of any existence of two wires?

A. I believe that's correct. I'd have to review the actual x-ray report to be able to remember that,

Q. Now, when you attempted to retrieve this wire -- and I will get to that -- when you attempted to retrieve this you were going to utilize another guide wire with a loop to try to snare it and pull it out, that's a procedure that's accepted, right?

A. That's correct.

Q. If that had been tried on the 27th, there's always the possibility that someone attempting to pull it, that wire could come loose and go up into the artery?

A, That is not true.

Q. You don't believe that?

A. No.

Q. That couldn't happen?

A. No.

Q. You are saying that by virtue of what! your experience of having taken out one wire in the past?

A. Yes, E am saying that by virtue of the fact that it would be physically impossible to lose the wire in the circulation that's been used in trying to snare things with, because part of the way that wire is used is that it sticks out the proximal end of the catheter, which is the end of the catheter that you are holding onto, an operator in fact is holding onto that guide wire to manipulate it at all times; therefore, it's physically impossible for that wire to at any time be lost in the circulation,

Q. When you insert one of the arterial lines, don't you hold onto the end of the guide wire when you're pushing the catheter over it?

A. Absolutely.

Q Then you're holding on to it, aren't you?
A, Yes.
Q. That shouldn't be loose in any fashion?
A. That is correct.
Q. so if somebody did lose the wire that was in the catheter, there's the possibility of that wire being Post in attempting to retrieve it?
MR. JACKSON: Are you talking about the retrieval wire?
MR. FULTON: Yes.
A. No, I don't believe that.
Q. You don't believe that?
A. No, I don't.
Q. With respect to your report when you did retrieve it, you mentioned only one wire?
A. That's correct.
Q. And you mentioned a broken wire?
A. My impression.
Q. Well, you mentioned a broken wire; did you not?
A. Yes, I had previously mentioned a broken wire.
Q. E want to be sure what I have in the report is correct.
Your retrieval said here, 3-13, says one wire was successfully snared and removed but the other piece could not be snared; it says that, does it

no?

A. Yes.

MR. JACKSON: Doesn't say "broken."

MR. FULTON: It says -- here, that's the next page,

Q. Will ask vascular surgeon to see to make sure the left femoral artery is okay to discuss options for retrieval of the other piece of wire; it says that, does it not?

A. Yes.

Q. Is there anywhere in there with respect to the length of the wire?

a. No, there isn't. I didn't note that.

Q. And you did send it down to path; did you net?

A. Yes.

Q Have you that path report in front of you?

a. No, I don't.

Q. Well, let me refer to it here.

That path report doesn't show any length of the wire! does it?

A. No, it doesn't.

Q. It does show that it was cultured; does it not?

A. Yes, it does.

Q. It shows the existence of no what, bacteria, at

least the wire was clean?

A. It says no growths, two days.

Q That means what?

A. It means that the culture from the wire did not grow any bacteria in 48 hours.

Q. Which would be a good sign?

A. Yes.

Q And it does show below that somehow there was a urine specimen taken that did show that the presence of sepsis or bacteria or something?

A. That's not -- sepsis is not the correct word.

Q. I'm struggling.

A. What it showed, there were bacteria in the urine, yes, that's true. There was a urinary tract infection.

Q. She was diagnosed as having sepsis prior to the 26th of February, right?

a. Prior to the -- prior to the 26th of February she had pneumonia, and there was a suspicion that she was probably septic, yes,

Q. There is something in this record that I'd like to ask you what it means.

What does it mean when they say someone is a -- when you say a coroner's case?

A. That means that if there is a death within -- if

there's a death in the hospital within 24 hours of a surgical procedure, the coroner's office is informed of the death.

Q. Do you know why that she was noted as a coroner's case on 2-14, Just after, shortly after she was admitted?

A. On 2-14 I have no idea. I don't know what you're talking about.

Q. Let's look at this nurse notes here, says 2-14. I don't have the -- I'm Looking at a copy. Do you have the 14th on the nurses' notes.

Looks like there's a circle around it of some kind on my chart, which I think is in order.

A. Wait a minute. This is 2-13. Let me Just see. What's the date on that, 2-1?

Q. Nursing record. You will see it says coroner's case on 2-14 there; does it not?

A. That's what it looks like it.

Q. Bow about over on the next page, what does that look like, 2-14?

A. Where?

Q. Here.

A. Yes, That's what that looks like.

Q. 2-14, coroner's case?

A, Yes.

Q. On the original. charts?
A, I don't see that.
Q. What does that show here, 2-14 coroner's case?
A. That's what it looks like.
Q. Next page says 2-14 coroner's case?
A. Yes, that's what it looks Like, but not here.
MR. JACKSON: These are orange, Is that what you're referring to on the original chart?
A. These stickers up there.
Q. They're dated, all dated 2-14; are they not?
A. The stickers are, yes. Now, I don't know why that is. I don't know, 1 don't have any explanation for that.
Q. 1%that hemoglobin had gone from 16.1 to 5.1 or 6.1, that's a pretty significant drop; is it not?
A. Yes.
Q. These last few, I'm winding up.
There is a note dated 3-11-91, you referred to that before with Mr. Kampinski, I think is that the note of Dr. Rollins.
MR. JACKSON: The progress note, are you referring to?
MR. KAMPINSKI: Yes, he is.
Q I think that's the one with the six items are

listed?

A. The one where the six items are listed, Dr. Rollins' notes of 3-11,

Q. And just so I understand it, he has an impression there on 3-11, right?

A. Yes.

Q. What is number one?

A. Atherosclerotic heart disease.

Q. What follows that?

A. Status post, anteroseptal MI.

Q. No?

A. No evidence of re-infarction.

Q. Number two, what is that?

A. Increased blood pressure, then okay on Verapamil.

Q. Which is a?

A. Blood pressure medication.

Q. Medication. What is three?

A. History of supraventricular tachycardia, also on Verapamil.

Q. And would you explain that?

A. Verapamil is a medication that can be used to treat that kind of arrhythmia. It also is an anti-hypertensive.

Q. That kind of arrhythmic range is what?

A. Episode of rapid heart beat.
Q. Which is difficult sometimes to control?
A. Sometimes, yes,
Q. What is the number four?
A. Respiratory, ARDS, remarkable turnaround, weaning continues, need to wake her up.
Q. It says you need to wake her up?
A. Yes.
Q. Fifth one is?
A. Hepatosplenomegaly, increase liver function test.
Q. That means it's getting big, which is sign of what, infection?
A Well, it can be, It is not necessarily. We don't know the cause of why that was happening specifically. In that note that's what that means, query, cause.
Q. Number six says guide wire retention, only mentions one guide wire, right?
A. Right.
Q. What follows after that?
A. This needs to be removed under fluoroscopy. No problems for now and will leave it to Dr. Steele to schedule collective removal. No evidence of vessel perforation at this point.

Q. Mine is cut off. What is the next thing?
A. Looks like no decreased hemoglobin.
Q Says there's no decreased hemoglobin?
A. That's correct.
Q. We do know later on it did go down to 5.1 and 6.1?
A. *Yes.*
Q. Now, when that was done it says leave it to you to remove, were you present on the 11th?
A. No. What he meant was that he was going to leave plans for the retrieval of the wires to me when I came back.
Q. Wad he discussed it with you prior to this at all?
A. No, because I wasn't there.
Q. I understand you weren't there.
Did he discuss it with you at. all. before, by telephone --
A. No.
Q. -- communication?
A. No.
Q. On 3-12 there is a note here by Dr. Fritz that you will be taking over the case today from a cardiac standpoint, did he talk to you prior to that to know you were going to do it?

A. I'm -- where did you yo, I'm looking for that note.

MR. JACKSON:: Here, Doctor.

Q. See at the bottom, note, Dr. Steele will be taking over case today from cardiac standpoint, signed R. Fritz; who is what?

A. Be must have been one of the residents.

Q Countersigned Rollins, how would he know your were going to take over the case?

A. They knew when I was corning back from vacation.

Q. These Last few questions.

Now, when is the first time in these records that two wires are mentioned, that's what I would like to know; do you know? It's been one wire. I'm not talking about what people are seeing in retrospect. You did something on the 13th in the cath lab. At that point in time we knew that. When we first knew that, you were talking about either one wire, a piece broke off, or two wires?

A, My assumption prior to the 13th was that there was one wire that was broken. After I retrieved the wire on the 13th I realized what I had in fact retrieved was a complete unbroken wire.

Q. But I -- sorry. I didn't mean to interrupt you.

A. I probably in retrospect in my progress note

shouldn't have referred to the word "piece." I didn't mean to imply that I was talking about a broken piece, because when I did remove the wire that I removed, I removed a whole wire.

Q. Now, who did you give it to?

A. I gave it to the nurse to send to the lab,

Q. Do you know who she gave it to?

a. She would have given it to the lab,

Q That's the lab report, we have the report?

A. Yes.

Q. It's clear of any bacteria?

A, Yes.

Q. We do know there's a reference to measurement of it; is that not true?

a. I am not sure where that is.

Q. Let me seek if I can find it. Nurses' notes?

A, There is -- yeah, Mr. Kampinski and I talked about that, There was some reference in the nurses' notes from the cath lab to an approximate length of the wire.

Q. Well, the approximate length, as I remember, was six inches?

A. That's what the nurse note in the cath lab said.

Q. Which is, that's one-third of P8, right?

A, Right.

Q. Now, she writes -- that's the cardiovascular nurse note?

A. Yes.

Q. Says the cardiologist was Steele, right?

A. Yes.

Q. You didn't countersign this, did you?

A. NO.

Q. Is there any requirement that you countersign it?

A. No, there isn't.

Q. Is there anything to say that you should read it?

A. Not specifically.

Q. You are presuming, are you not, if there is something that is incorrect, you have the right as a physician to have the head cardiologist there to make any change, right?

A. Yes.

Q. Does say here 12:30 p.m., arrive from I.C.U., with RN and pulmonary services, ventilator set by pulmonary.

I suppose she was an a ventilator, as you indicated?

A. Yes.

Q. Says here, what is L.P.D., is that licensed

practical nurse?
A. L.P.N. No. No. No. Sorry. That's a TPN, versed drip infusing.
Q. What does that mean?
A. That means that she was being fed intravenously and she also had Versed drip going because of restlessness,
Q. And the nurse noted or that certainly says prep and drape to left groin?
A. Yes.
Q. That's right. It's the area where you were at, right?
A, Yes.
Q. Incidentally, when you talk about the aorta, you are talking about the abdominal aorta in the stomach, right; is that where your abdominal aorta is3
A, When you talk about the aorta, is that portion of the aorta below the diaphragm that's --
Q. That's the portion that you were referring to today about where it was?
A. One end of it.
Q. Below the belly button?
A. Xes. One end, other end was higher up,
Q. What is below the end, what do they call that part of the artery that's lower below the belly

button, you got a --

A At that point the aorta splits into the iliac arteries, one heading down each leg.

Q. You know, do you not -- we don't have x-rays here -- that one end of it was in the iliac arteries?

A. One end of it, yeah.

Q. It says here -- what's it say -- three, plus left posterotibial, that's the pulse that's taken?

A. Yes

Q. Number 8 arterial sheath to left femoral artery, that's what you said you used?

A. Yes.

Q. That says approximately six inches left of guide wire removed by Dr. Steele via left femoral artery, sent to lab?

A. Yes.

Q. Now -- and I will get out of here -- there came a point in time when you discussed this matter with Dr. Jayne and Dr. Varma, you indicated that, right?

A. Yes.

Q. That took place in the cardiac --

A. Coronary care unit.

Q. The what?

A. In the coronary care unit.

Q. And of course that would be after the operation

took place, right?

A. Wrong. I first asked Dr. Varma about the situation on the day I returned and the day that I found out, so it would have been before I tried to retrieve the wire.

Q That would be what date, you returned?

A. 12th.

Q. That date was when, the 12th was what, as you remember best, is that a Monday?

A. As I can best remember.

Q. Did you call him down?

A. Well, he was there.

Q. What? Bow did you get the other doctor in there, did you call her down3

A. I don't remember. She was probably there, too.

Q Well, you indicated Dr. Jayne and Dr. Varma were there, right?

A. Yes.

Q. And you had a discussion with him at that time?

A. Correct.

Q. You knew, however, that on the 7th of March he had already made a note at this point there could be a guide wire in there, you knew that, didn't your you had read the chart?

A. Yes.

Q. There was nothing about the fact -- he had indicated what might have occurred?

MR. JACKSON: What?

A. What had occurred3

Q. That Varma indicated what had occurred?

MR. KAMPINSKI: Objection.

A. That's not my understanding at all. My understanding --

Q. Wait a minute. Wait a minute, Give me your understanding.

MR. JACKSON: Finish your answer.

Q. Finish your answer. I don't want to cut you off.

A. My understanding is that Dr. Varma never acknowledged, in any way, or form, that there was a wire left in the patient.

Q. Let's get to number seven or sight.

MR. JACKSON: You said March 7th?

MR. COYNE: I think the 8th.

MR. FULTOM: 8th.

A. All right. I think I see what you are getting at.

Q. I am really getting at nothing.

I want to know what does it indicate.

MR. JACKSON: Why are you asking questions then?

MR. FULTON: Just so I can charge my hourly rate.

Q. Have I got the 8th.

MR. KAMPINSKI: Which you are willing to waive.

MR. FULTON: I am willing to waive that with you. We'll make a pact.

MR. KAMPINSKI: You waive yours.

MR. FULTOM:: In the past we flipped a coin.

MR. KAMPINSKI: Not you and I.

A, We got it.

MR. JACKSON: Nine o'clock p.m. on 3-8-91.

Q. You may have some trouble reading this, 2-26-91, down halfway in there! if you read it from the top?

A. I see the notes you are referring to.

Q. The 2-26-91, femoral artery Line was placed?

A. No. Where are you reading?

18

Q. I just want --

A. I am trying to read this.

Q. 1 just want you to agree with what it says, if

you do, maybe you don't?

A. Above something, no.

Q. You are reading from the top.

A. Well, that's --

MR. JACKSON: Dr. Varma read this to us.

A. Do you have a problem with my reading from where it starts?

Q. I don't have any problem.

A, I am not quite sure what you want me to do.

Q. Read from it.

MR. JACKSON: What is your question to him, Mr. Fulton?

Q I asked the question isn't it true that on March 8, 1991 he had indicated it's possible that this guide wire was left in, he doubts it, but it was possible.

a. He made mention of the fact that there is a -- as I can interpret this writing -- a persistent wire which is not explainable.

Q. After review, what does that say, after review of what?

A. All right. I'm sorry. After review, I suppose reviewing chest x-rays.

Q. Right. This wire was not?

A. Present on chest x-rays on.
Q. 2-19-9I?
A. I don't know whether that's 9 or 4.
Q. I think a 4, but on 2-26-91, wire was?
A. Present.
Q. On 2-26-91 femoral artery line was placed and subsequent to that this wire was present possibly?
A. I can't see possibly.
MR. VARMA: Possibilities.
Q. Possible guide wire. I don't know what the next word is. Guide wire remains, which I doubt, because I did the procedure, but he does say possible the guide wire remains; does he not3
A. Yeah, I think so.
Q. Now, the last question, finishing up here, when he says down here, he discussed this with Dr. Rollins?
A. Yeah.
Q So at least back as of March 8, 1991, he had made certain admissions as to what he felt might be the existence of a guide wire.
When was the next time you saw him?
MR. KAMPINSKI: Was that a question or what?
MR. FULTON: I thought it was. It's not a question? I don't know.

MR. KAMPINSKI: I don't know. I don't know what --

MR. FULTON: Do you want to rule on it?

MR. KAMPINSKI: What did you just do?

BY MR. FULTON:

Q. When is the next time that you had a meeting with Dr. Varma?

MR. JACKSON: After what?

A. After what?

Q You said you had a first meeting with him on the 12th and --

A. Right.

Q. -- Dr. Jayne was there, you said you had another meeting with him then, was that. in coronary?

A. That's the next day.

Q. You discussed it again?

A. Yes.

Q. Is that noted anywhere in the records with respect to your meeting of the 12th?

A. No, I didn't write a note in the chart --

Q. Is there --

A. -- With respect to that.

Q. Is there anything in the chart with respect to a

meeting on the 13th?

A, No.

Q. Is there anything in any letter or any document you read that indicated you met with Dr. Varma on those two days anywhere in writing?

MR. KAMPINSKI: Wait a minute. By virtue of that question, it seems to me he's waiving anything about peer review.

MR. JACKSON: He's about to answer the question.

A. You have to repeat the question.

Q. Have you ever made any documentation in writing when you met with him, that's all I am asking; have you ever done anything-?

A. I made documentation that I specifically discussed this problem with him. I do not believe that I mention the exact dates, but that's when it was.

MR. FULTON: No further questions.

Could we have one moment?

MR. JACKSON: Yes.

MR. COYNE: Off the record,

- - - - -

(Discussion had off the record.)

E

- - - - -

MR. FULTON: No further questions.

MR. KAMPINSKI: Are you going to have him read it?

MR. JACKSON: Yes.

- - - - -

(Deposition concluded; signature riot waived.)

- - - - -

ERRATA SHEET

PAGE LINE

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

---

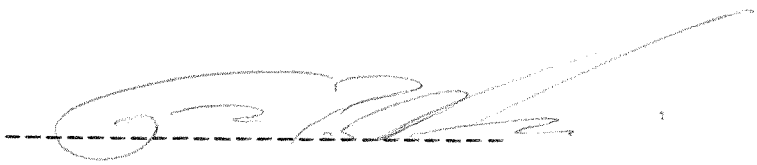
ROBERT J. STEELE, M.D.

The State of Ohio, :

County of Cuyahoga.: CERTIFICATE:

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 1st day of October, 1992.



Frank P. Versagi, Registered Professional Reporter, Certified Legal Video Specialist, Notary Public/State of Ohio. Commission expiration: 2-25-93.

re: doc 427

ROBERT J. STEELE, M.D. INDEX (09/22/92)

09/23 1545 Roseland Way, Westlake.

10/15 Queens University, 1964-1970, joint pro. M.D. school.

11/04 Then one year intern, one year res. in I.M, two years cardiology at Queen's, done in 1974.

11/15 Then one and one-half years further cardiology Luzein, Switzerland, he was basically chief resident until 1975.

12/06 Back to Kingston for one year thru July of 1976.

12/11 Came to Cleve., 1976, and went into cardiology practice with a guy named Zimmerman until 1979.

13/08 In 1979 set up corp. Robert J. Steele, M.D., Inc., and remained ever since.

14/01 Corp. Cleve. Cardio. Associates, runs offices of Steele, Kitchen and Rollins since 1980.

15/24 Also has privileges at Lakewood and West Shore.

17/10 Board certified, but failed three times.

18/04 Was certified in '89.

18/10 No publications authored since residency.

18/17 One major publ.-on a drug called Hylorel in coronary artery disease.

19/03 Named in one prior suit but suit was dropped.

20/18 He didn't know about the wires prior to 3/11 or 3/12 because no one had informed him.

22/01 Agrees that as an attending he has the responsibility for the overall care of the patient, but you ask for consultations because you need help.

23/03 He and the people he works with are part of the teaching service and that means that a patient who comes in the unit becomes a teaching patient automatically.

24/09 I don't just leave the care of a patient to a resident; just because a res. is seeing the patient does not mean that I don't see the patient.

24/15 His responi. to the patient is on a daily basis.

25/10 His belief is that residents have a certain level of skill because they are suppose to be screened, and then supervised by sr. residents.

25/10 The sr. residents' responsibility is to make sure that the jr. res. knows what he's doing.

25/17 It isn't a responsi. he delegates, that's the chain of command - that's the way it's done.

25/22 It's standard practice.

25/24 But he doesn't know who set it that way, that's just how it works.

27/17 He's the director of Cardio. Rehab., Dept. of Medi.

28/04 Keating resp. for resid. program.

28/16 Placing an arterial line is a procedure a JMR should know how to do; and the sr. res. is suppose to ask.

29/09 He assumes sr. res. asked Varma if he knew what to do.

29/13 Has no memory of watching Varma place line on the 26th.

30/03 Has no idea how many of his patients Varma took care of.

30/13 Sr. res. evaluates JMR, as well as Rollins and Sopko when they leave the unit.

32/05 Claims he spoke daily with res. about his patients.

32/19 Regarding procedures he claims to check patients after they occur.

33/04 Doesn't necessarily check cardio. patient X-rays on a daily basis.

33/07 Depends on if he feels it is a pressing matter; consultants are looking, residents are looking on a daily basis, and at a minimum he talks to these people and relies on the report of the radiologist.

35/06 He assures himself nothing is being missed on X-rays by talking to the residents, and then if it's "relevant" talks to the consultants or picks up the phone for the reading itself.

35/17 Does it every day, usually.

35/23 He relies on the radiol. to call him if they see something unusual on X-ray; that happens routinely.

36/09 The orders for procedures to be undertaken can be made by himself, the JMR or SMR.

36/16 Placing an arterial line by a JMR should at least be discussed or cleared with SMR, but he can see it happening without it.

37/02 Now he says a JMR can decide on his own to place an arterial line.

37/15 If one is already in place, then the JMR can make decision to replace it.

38/14 Subsequent events suggested to him that there had been a problem with the placement of the line.

38/21 **As** it turns out, there were two wires.

39/08 He was astounded to find two lines in the patient.

39/16 His only explanation is that they were inserted at the time the line was being placed and lost.

40/22 He put no wires in Mrs. Weitzel.

40/28 No one other than Varma put in any lines to his knowledge.

42/06 Lines are always put in the same way, regardless of level of training or knowledge.

42/17 He describes placement of a line.

43/02 Use a long line **(18** inches) for femoral approach because sometimes the artery is twisty and tortuous.

44/24 Loss of a wire into the artery is a deviation of the standard of care, it shouldn't happen.

45/04 A physician who loses a wire should tell someone

46/18 It appears that two incorrect attempts were made.

46/21 He assumes these two wrong attempts were made at the same time.

47/06 There is no way a person could do a procedure like this and not know they left a wire in. It's impossible.

48/19 He was out of town from March 2nd to 12th.

50/13 According to the nursing notes the procedure was done somewhere between 5th and 6th.

51/22 Mrs. W. was increased on Versed at time of insertion due to "restlessness".

53/01 The note doesn't make it clear what caused her to be restless.

53/06 He checked the line the next morning to make sure it was working.

53/12 He believes there was an order written by the resident for chest X-rays every day.

53/18 Strictly speaking, he didn't think it was absolutely necessary for her to have one every day. (they were more a teaching tool between the residents and Sopko).

54/11 "I will say that the responsibility for how any individual resident takes care of a patient goes up the chain from the person doing it, to the senior to me."

54/18 He countersigned the 2/27 note, discussed with JMR.

55/10 He wouldn't necessarily countersign a simple procedure note if he wasn't there (that's why no counter on the 2/26 note).

56/11 All I can tell you is that I wasn't told there was a problem with the insertion of the line.

57/12 He calls Varma's failure to tell him oversight, covering your mistakes by not telling anybody about it. ~ Coverup

57/22 He didn't countersign any notes on the 28th but he is sure he was there.

58/03 He didn't look at X-rays on the 28th.

58/16 Problems he sees from retained guidewires, infection;
58/25 Clots; 59/02 - wire moving and obstructing the vessel itself.

59/21 She was probably septic.

62/02 He never got a lab report after wire removal indicating that there was infection.

63/10 Surg. path rept. SO763-91 doesn't show whether there was growth or not. (not a micro biol. report.)

64/19 EKG's on Mrs. W. from 2/12-2/24, then 2/27, 2/28 and 3/14.

65/03 Stopped after 2/24 because they weren't necessary.

65/08 As of 2/24, her heart function was stable.

65/17 She remained stable through 3/14.

66/05 Development of pneumonia and ARDS in a person post cardiac is common.

67/12 Her pneumothoraces improved after chest tube was inserted.

68/06 He didn't know to what degree her lung function improved after the tubes.

68/21 He based his decision to have her undergo surgery on the fact that the anesthia period would be short (per Moasis) and that her pulmonary function was stable.

69/17 He was aware that studies suggest an increase mortality following m.i. if one undergoes surgery.

69/18 Did not seek the assistance of a radiologist.

70/16 Did not seek assistance from Kitchen.

72/14 He was aware that Rollins and Kitchen did not think removal should be attempted on the 9th because of the patients condition.

72/17 He decided on surg. because her pul. status was slowly improving and he was concerned about additional problems in wires were left in.

72/05 None of the problems were actually there at the point he choose to remove the wires.

73/21 Oxygenation saturation had improved.

74/12 On the 9th F102 is 55% (Sopko); on the 11th F102 is 40% (Rollins).

74/22 F102 is the amount of oxygenation.

75/12 F102 on 13th is 35%.

76/17-25 Ultimately we felt this lady's recovery was going to be long and complicated.

77/03 At that point (3/13) he felt her chances for recovery was 50/50.

78/08 He had no idea the surg. would be close to two hours.

79/10 He doesn't know the length of the wire he removed cause he didn't measure it.

80/03 He's guessing it was 10 or 11 inches.

81/25 He didn't know there were two wires in Mrs. Weitzel because no one told him.

82/06 He should have known if he had been told.

82/19 He was there on the 27th and 28th, 1st and 2nd, and did not look at X-rays.

83/01 Acknowledges guidewires in films!

83/04 Admits if he would have looked he would have seen them.

84/01 He believes a radiol. looking at films would have to know what those were.

84/23 No radiol. contacted him.

85/01 No one from the nursing staff notified him either.

86/02 His initial impression of the films was that there was one broken wire.

87/02 He doesn't remember much about the wire.

87/09 He had one prior experience with the removal of a guide-wire.

88/18 He was not requested to keep the guidewire.

89/08 Claims he learned about guidewire on the 12th when he looked at X-rays himself.

89/15 He counter signed a note on the 12th.

91/03 He spoke with Varma following the discovery and recalls Varma said he had no problem with the insertion and didn't know how guidewires were left in patient.

91/10 He told him then he found that rather difficult to accept.

92/07 Dr. Jayne said she hadn't noticed anything, and that she also wasn't there for the whole procedure.

94/10 Probably Rollins didn't know about it for **10** days 'cause no one told him either.

96/14 There is no fixed standard as to how often an attending should look at an X-ray.

96/24 Depends on how the patient is doing, and who else is involved.

98/14 Dr. Sopko does put in lines but he doesn't know whether he would recognized one on X-ray.

98/19 Claims he hasn't talked to him about this matter.

98/21 Didn't talk to Chmielewski.

101/22 He has used radiologists to assist him in invasive angiography.

102/09 He didn't feel a radiologist had anything to contribute in terms of getting the second wire out.

107/13 Varma was able to insert another catte. on 3-7 'cause the wires originally inserted had moved out of the fem. artery area in to the aorta.

109/12 He had to select someone competent to care for his patients when he is out of town.

112/01 Arterial line is discontinued on **3-11,** ordered by a resident (unk) and not determined who countersigned.

113/02 Chmielewski suggested removing all lines not absolutely essential on the llth, (Steele suggests that's to avoid infection).

114/19 The wire removal was done under fluoroscopic control.

115/18 A film could have been made, but he saw no reason to.

117/09 The wire removal took about one hour and he has no explanation why he couldn't get the second wire.

118/01 He removed an intact guidewire.

119/03 It took seven months for a discharge expiration summary.

120/03 Dr. Ogus, dictated expir. summary, 'cause residents on the teaching service are required to do that.

121/04 His explanation is that there is always a backlog of charts.

121/17 PEEP means positive end-expitory pressure. Causes extra pressure to be put in lungs to help keep them expanded.

122/14 PEEP was **7.5** from **3/2/91** to **3/14/91,** and was only **5** before that.

123/09 He can't extrapolate from the level of PEEP whether someone is getting better or worse.

123/23 The exp. summary is in error as it states level of PEEP steadily decreased to **7.5.**

124/21 Agrees with summary that cardiac status improved.

125/08 Surg. decision was both his and Moasis.

125/18 His first note in chart is the co-signature on **2/12** of Dr. Mayhley.

126/14 He did not call in a neurologist to evaluate her in the beginning.

127/22 If someone responds by opening eyes, mouthing words and writing in the air, there is obviously some degree of awareness.

128/03 He felt she had some degree of impairment as of the 13th, but kind and amount were no assessed.

131/25 Prior to getting started on a Versed drip, she was agitated and seemingly able to respond to simple commands but was confused and not moving all her extremities appropriately.

131/06 Complete note **2/13** - a.m.

135/01 Complete note, **2/13, 5** p.m. (one line).

135/04 Next counter signed Varma note of **2/14.** (agree w/above)

137/23 Corrections **on** Varma's **2/14** note by the senior didn't bother him.

138/14 Next note **2/15;** agree w/ note on previous page etc., will arrange for cardiac cath, ultimately need EPS (electrophysiological study)

139/07 Never determined the origin of her rhythm disturbances, probably related to her severe coronary disease. (deter. by autopsy).

139/14 Next note **2/16;** notation only that he agrees with Varma.

139/21 Next note **2/17;** notation - will discuss with Varma agree with above discussion.

140/04 Next note **2/18;** a real note! "We should recheck the chest X-ray and we think the respiratory should be done per Dr. Sopko's plan".

140/17 Recheck X-rays because Swan-Ganz was in and "someone had the problems she had, we need to be aware of what's going on".

141/24 Next note **2/21;** agreeing with Varma.

141/24 Next note **2/25;** "agree with note above by Dr. Chmielewski - from cardiac standpoint, she is stable, will consider trach soon".

142/21 Next note **2/27;** agree with note on previous page, hemody. stable, main problem, ARDS and pneumonitis, (agreeing w/Varma).

143/02 **2/27** again; signature indicating he had read Varma's note.

147/02 Clarifying that signature refers to Varma's **2/27** note, "no significant change past **24** hours".

155/18 I would have noticed a femoral line when I went in to see a patient.

156/08 He doesn't remember seeing a puncture mark on the right femoral side and a puncture mark would have been left.

156/21 He doesn't remember either Varma or Jayne telling him a right sided insertion had been attempted.

157/24 Last note is 3/1; his signature acknowledges Varma's note again.

159/25 Note 3/2; agree with above notes and plans (referring to Chmielewski).

160/04 Next note is his signature on a nutrition note of **3/12.**

160/22 Note of **3/13;** describes wire retrieval, left fem. art. okay and discuss option for retrieval of other piece.

161/20 Next note **3/14**; good left tibial pulse etc. Dr. Moasis consul~~t~~, appreciate it, plan to go ahead with retrieval.

Patient who dies within **24** hours of surgery, that is con-
~~161/22~~ sidered operative mortality.

164/17 He ^death was caused by an arrhythmia.

164/23 He doesn't know what caused the arrhythmia.

167/24 Order for a suppository countersigned by Steele (Varma).

168/21 Order **2/25** for Versed countersigned by Steele (Oneykwere)

169/08 No other orders signed or countersigned by him in chart, claims it's basically a policy on teaching patients and attendings are encouraged not to write orders.

169/21 Doesn't sign anything to indicate he has reviewed them.

170/01 Doesn't recall talking with the senior about these wires.

170/21 Talked with Varma a 2nd time, within **24** hours of the wire discovery.

171/01 He consistently said he had no idea how it happened.

175/07 He prepared a statement for Dr. Keating the first week of April.

176/07 He was asked to prepare the statement because he had expressed concerns about the incident.

178/04 Steele's coverage may be one mill/twice mill excess.

He told Mr. W. he didn't know how the wire got there.
180/07

181/12 He doesn't remember if he ever told him how the wire got there or how long it had been in.

181/19 On the day of the procedure afterwards he told Mr. W. there were actually two wires.

182/01 Then "I probably told him that they had been put in when the line was put in".

182/20 Doesn't remember if he told him the resident did it.

Ultimately, Mr. W. had a right to know there was a cover-

184/20 He told Mr. W. there was an element of risk in the surgery but there was also a risk of leaving the wire in there indefinitely.

185/09 He remembers saying there was an increased risk in her being that she was very sick.

186/03 It was his opinion that she should undergo it because of the potential detriment.

186/15 He didn't talk to Mr. W. after the death.

Cross/WARNER:

188/07 Rollins and Kitchens decis. not to remove wire appropriate.

189/02 Has no opinion if the outcome would have been diff. if procedure tried sooner.

Cross/FULTON:

191/13 Hemogl. of 5.2 would indicate a need for transfusion.

191/21 If hemogl. was 6.1 at time of her death, that is very low.

191/23 That might indicate a need for a transfusion.

192/24 The existence of a hematoma and a fallen hemogl. can result in hypoxia and possible arrythmia.

195/18 No X-ray readings indicating 2 wires.

196/12 It would be impossible to use a wire that one is using to snare cause you are holding onto it with your hand.

197/23 His note of 3/13 does say one wire successfully snared but other piece couldn't be snared.

198/20 Path report doesn't show length of wire.

199/04 Culture from wire did not grow bacteria in 48 hours.

199/13 Wire specimen from same time shows bacteria.

200/25 There is an entry on 2/14 in the nurse's notes that says coroner's case.

201/17 Hemoglobin drop from 10.1 to 5.1 or 6.1 is significant.

206/01 **When I removed the wire, it was a whole wire.**

207/07 **He didn't countersign cath lab nurse's note that says wire is six inches.**

215/22 **He didn't write a note in the chart about his conversations with Jayne and Varma.**