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I N D E X

WITNESS: RICHARD W. WATTS, M.D.

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(NO EXHIBITS MARKED)

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(FOR KEYWORD AND OBJECTION INDEX, SEE APPENDIX)

RICHARD W. WATTS, M.D.

of lawful age, a witness 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:

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CROSS-EXAMINATION

BY MISS KOLIS:

Q. For the record could you please state your full name and your professional address?

A. Richard Ward Watts, 3885 Rocky River Drive, Cleveland, Ohio.

Q. As you undoubtedly know, my purpose here today is to ask you a series of questions that I might have regarding a report that you prepared.

Do you have a file regarding the case of Sharon Weitzel, Dr. Watts?

A. I do.

Q. I don't see any papers before you, obviously I am accurate about that; did you bring your file with you today?

A. No.

Q. Is there a reason that you didn't bring your file?

A. Well, it is too voluminous, and the file also exists down here because this is the source of the file.

Q. So do you have a duplicate of the material which you reviewed available to you today for me to look at?

A. Not here in this room.

Q. I misunderstood. I thought that you said the reason you didn't bring it was because there was a duplicate of all the materials that you reviewed here, since this was the source of those pieces of information?

MR. FULTON: I think he meant within the hands of the attornys.

A. Yes, that was the intent of my answer.

Q. Perhaps I didn't understand the answer as well as I should have. There are some things that probably I am going to need to see. We'll discuss them as we get through it.

I have been handed a copy this afternoon of your curriculum vitae, is this your most current document?

A. Let me see.

Yes, I did that last night.

Q. There was one in existence prior to this?

A. Yes, but 1992 or 1991, or something like that.

Q. What additions have you made to this one over what was existing in your 1991 CV?

A. I think I put -- put present appointments. I'm chairman of --

MR. FULTON: You can have that. You keep yours

A. Chairman of Critical Care, Vice President of Ethics Committee is a new appointment, Director of Cardiac Rehabilitation is a relatively new appointment.

Fellow of the Royal Society of Medicine is a relatively new appointment. The honoree of the Richard W. Watts Lectorship is a relatively new appointment.

I think these are the new additions to the 1991 CV.

Q. Additionally I have been handed a bibliography containing looks like 15 --

A. Yes, there's nothing new on that.

Q. I didn't previously have this.

These are the articles that you published?

A. Yes.

Q. Even though I have this CV, let's briefly go through your background.

I note you graduated from college in 1942, Bachelor of Science?

A. That's right.

Q. What did you do between 1942 and 1946?

A. Went to medical school.

Q. Never mind.

You graduated from medical school in 1946, you didn't start medical school then?

A. Yes.

Q. Went to Western Reserve, correct?

A. Correct.

Q. '47 you were a junior assistant resident in medicine at University Hospitals; '47 to '48, junior assistant resident in pathology, University Hospitals?

A. Correct.

Q. '48 to '50 you were in the Army Medical Corps, et cetera, et cetera; '50, '51, assistant resident, University Hospital; '51, '52, Fellow in cardiology at UH, correct?

A. Yes.

Q. Following your Fellowship in cardiology at UH what did you do in terms --

A. Same thing I am doing now. I went into private practice.

Q. When you first went into private practice where were you located?

A. Well, basically the same place I've always been, the Kamm's Corner area. I moved across the street in 1960 when I built the building, but I've always been on Rocky River Drive.

Q. So in 1952 thereabouts you went into private practice, were you associated with anyone at that time?

A. I shared office space with another internist.

Q. When you began the private practice of medicine what were you specializing in?

A. Internal medicine and cardiology.

Q. So from '55 forward --

A. '52.

Q. Excuse me.

It was internal medicine and cardiology at that time, correct?

A. Correct.

Q. And you're pretty much at the same location today?

A. Yes.

Q. So subsequent to when you started in 1952 did

there come a time when you associated with any other physicians?

A. Yes. I took in an associate in 1971, he stayed with me for 13 years and was replaced by another man in 1984; but also in 1979 I took in a second associate who is still with me.

Q. Who did you take in in 1971?

A. Dr. Pyo, P-y-o, he was one of the -- my trainees.

Q. How long did he stay with you?

A. 13 years.

Q. Who did you take in in 1979?

A. Dr. Thomas Comerford, his name is on my letterhead.

Q. And someone else in 1984?

A. 1984 Dr. Suntla, his name also is on the letterhead, replaced Dr. Pyo.

Q. This is in fact today your medical organization?

A. Yes.

Q. As it is constituted?

A. Right.

Q. Today in 1993 describe for me generally the nature of your practice, what are you doing?

A. Well, it's mainly cardiology, we don't divide

our patients up into pieces. When they have noncardiology internal medicine problems that we feel competent to handle, we do. If we feel we need help by a hematologist, rheumatologist, gastroenterologist, or whatever, then we send them off to the appropriate subspecialist.

In general we handle their medical needs within that context, but majority of our patients have primary cardiologic problems; of course, ischemic heart disease being number one, hypertension being a close second.

Dr. Comerford, my associate, does the invasive cardiology for our group, cardiac caths, angioplasty, things of that sort; but otherwise we all function in pretty much the same level of activity.

Q. Throughout your career have you had any teaching responsibilities?

A. Well, on the CV says I am assistant clinical professor of medicine, and that involves teaching in a variety of locations. We have medical students who rotate through our coronary care unit at Fairview, where I am the medical director; and I also, for instance, this morning spent part of the morning at MetroHealth Hospital teaching residents

there.

I -- we also have a family practice training program at Fairview Hospital and all of those residents rotate through the cardiology program, so I have teaching responsibilities in a variety of levels.

MR. FULTON: Can we stop a second.

(Discussion had off the record.)

BY MISS KOLIS:

Q. Currently how many hours a week are you working?

A. Probably about 80.

Q. Shouldn't ask that question, I suppose.

Of these 80 hours, how many are spent treating patients?

A. Probably direct treatment I would think certainly 40, anyway.

Q. And the balance of your time, how is that divided?

A. Well, I do all of the administrative work for our office, and I also am the managing partner of our medical building; and I also prepare teaching

materials for a variety of people, giving talks or I'm involved -- I'm, as it says on my CV, affiliate faculty for the Heart Association on both basic life support, advanced cardiac life support, so that means -- that obligates me to attend training programs and also to put on training programs for our hospital personnel for rotation purposes.

Q. So you spend some time every week in the endeavor of writing and researching and the preparation of lecture type materials?

A. Yes.

Q. I just want to go through your present appointments to see what responsibilities you have in regards to those.

It lists that you are assistant clinical professor of medicine at Case Western Reserve University School?

A. Yes.

Q. Do you go down to the --

A. To the medical school?

Q. -- and teach?

A. No, students come -- I either meet students at MetroHealth or they come to Fairview.

Q. How regularly do you do that?

A. Well, we have -- it's variable. I teach at

MetroHealth three months a year, this being one of the months. The students come to me on an option, so that's something it's hard to tell. It's probably four or five months a year.

We just had a student with us last month, for instance. About four or five months a year we have one or two medical students who are in cardiology rotating at Fairview.

Q. I want to make sure.

When you said students come to you on an option, they have --

A. They choose to come.

Q. To Fairview?

A. Yes. That's right. They choose the cardiology rotation at Fairview Hospital, and by choosing -- the second two years are clinical years of medical school, they have a lot of options. They have more options than they have time. There's nothing mandatory about their coming to Fairview, that's their own choice.

Q. So the teaching that you would be doing would be to residents who come through your resident program.

A. These are medical students. The residents are obligated to come in the family practice

training program in Fairview, they're obligated to have one month in the cardiac unit, one month outpatient cardiology rotation; and then we occasionally have residents from MetroHealth, who also have that as a option to come to Fairview.

Q. Says active staff Fairview, first responsibility listed is medical director of Kemper Coronary Unit?

A. Yes.

Q. What are your responsibilities in regards to that position?

A. Well, that's mainly administrative rather than medical responsibilities. In other words, I don't take care of all the patients there, which would be a super human job; but I am in charge of the standards, I review the charts, make sure that things are being done correctly, that we're not abusing the beds by admitting the wrong kind of patients; the patients who are admitted there are getting proper care, use of newer agents and things.

Q. What amount of time per week do you spend on administrative responsibilities as the medical director?

A. It varies, but I think on our average month

it probably runs one or two hours a week, because I am reviewing charts, and that also ties in with my chairman of critical care; critical care involves both coronary care unit and the intensive care units. That's a monthly meeting, which I chaired yesterday.

Q. Just so I would be clear about this, as the medical director of the coronary care unit you look at all patients' files once a week?

A. I don't know that I look at all of them, only the ones that seem -- seem to be a problem, either in terms of admission or ongoing care of the patient.

I look at all the deaths, review the charts of death; but I am the person to whom the nurses turn to when they feel there's something not being done properly. It's up to me to look into it, find out what is going on, do something about it.

Q. Your second responsibility is director of cardiac rehabilitation, what are your responsibilities as regards that?

A. Well, that's to set up the program and to see that the program is being done in -- along the lines of approved standards and that we ensure the

safety of the personnel and we have adequate safety of the participants and the -- have adequately trained personnel.

Q. Approximately how much time a week do you spend in that capacity?

A. Well, that varies a lot depending on the skill and dedication of our personnel.

At the moment we're spending a fair amount of time. We had quite a turnover in personnel; but when it's running smoothly, it takes very little time.

Q. Are you involved in training of the personnel that work in the cardiac rehabilitation area?

A. To some extent I have been, yes, most of them come to cardiac rehab with a considerable cardiology background already.

Q. And once again, the chairman of critical care committee, can you describe for me what those responsibilities entail?

A. Well, that entails the supervision or the -- I should say the evaluation of all the critical care activity in the hospital of course, that come by way of the coronary care unit, so I'm also involved from the standpoint of the intensive care unit.

At the present time we're re-writing the qualifications for physicians on our staff practicing in the intensive care unit. This has been a problem that has not really been addressed up until now and as there is -- as I am the medical director of the coronary care unit, there is a -- my counterpart, the medical director of the intensive care unit, who is also on this committee, but I am chairman of the committee. He and I work together on writing up the criteria for attending staff to have privileges in the intensive care unit.

Q. You seem to indicate in that answer that you were addressing the qualifications of the medical staff working --

A. Yes.

Q. -- and that somehow it's become a problem?

A. Well, it's become a problem because until recent years we didn't do as many invasive things as we do now, and -- in the intensive care unit -- and so the skills required to adequately practice in the intensive care unit have broadened considerably and so we need to direct our attention to defining what skills are appropriate and what aren't.

In other words, we are really working on developing different categories where a physician on the medical staff may have privileges to do this or take care of this kind of patient in the intensive care unit but not take care of that kind of patient. This is a problem that's going to be a big focus for us this year in order to draw up the specifications, and most importantly, of course, get the medical staff to approve of them.

Q. What kind of invasive procedures are you referring to?

A. Well, it goes all the way from obviously central venous monitoring, arterial monitoring, Swan catheters, and of course ventilators, and obviously the surgical procedures that are involved; but we really look at it more from a medical than a surgical standpoint, because the skills that are involved, for instance, of a pulmonologist, he doesn't want to function as a cardiologist, a cardiologist certainly doesn't want to function as a pulmonologist in terms of managing the ventilator; and of course the gastroenterologist is involved from the different standpoint, so it's one of the prices of progress of medicine is that we have so many procedures and

so many different situations of approaching problems that we didn't have even five years ago, and 10 or 15 years ago. It really has to be redefined in the light of 1993 so that everybody understands what they are authorized to do and what they aren't authorized to do.

Q. You provided to, I assume Mr. Fulton and Miss Moore, a bibliography of articles that you have written. I haven't had a chance to go through the list.

Can you tell me which if any of the ones that are listed have any relevance to the issues in this case?

MR. FULTON: Directly, peripherally?

Q. Well, how about any application to the issues in this case?

A. Well, I think the only one that comes close to it is Article Number 11, the role of the cardiologist in the care of the surgical patient. This was published in the Philippines. I spent part of the Summer of 1969 giving a series of lectures in the Philippines, four of which were at the Santo Thomas University, and this had to do with the preparation of the patient with heart

disease for noncardiac surgery, and I am almost embarrassed to to refer to it because an awful lot of things have happened since 1969 when I put the talk together. I looked at it for the reasons that I am referring to now, because in other lawsuits that I have been involved, this has been an article that -- there has been other cases when I had to look at it in light of present day cardiac patients undergoing noncardiac surgery, and of course it is considerably out of date.

MR. FULTON: Look at number 6. I just got this myself.

A. Well, number 6 has to do with our first six months of what I then called the coronary care constant monitoring unit.

MISS KOLIS: I have the list, thank you.

Q. Let's go back to -- I hadn't quite finished asking you questions about number 11.

Are you indicating to me in some fashion by your answer that the material as it's written in that 1970 article is no longer applicable?

A. Well --

Q. You indicated you were embarrassed?

A. Well, I emphasized so much has happened since then that some of the things that are -- well, I will say all of the things that are mentioned in the article are true, were true then, they're still true today, but others have gone far beyond what I did in a rudimentary fashion to sharpen the definition of how to evaluate a patient who is facing surgery in terms of the risks and that sort of thing.

So the field has moved considerably beyond where I staked out the position in 1969.

Q. So that I will be clear on this when I read this particular article, everything that's in it is still as true today as when it was pass but there are additional things that you would consider?

A. Right.

Q. Can you rattle them off for me, what the additional things are that I will need to appreciate your article in light of today's medicine?

A. Well, as a matter of fact, one of the things I forgot to put on my CV, I'm Chairman of the Centennial Cardiology Conference going to be held in Cleveland on May 8. Centennial refers to the fact that Fairview General is now 100 years old,

this is part of a celebration, and one of the -- my speakers coming from Boston is going to be talking on this very subject, because it has been a subject I have been interested in for a long time. He is an associate of the person who really put this into the proper context, Dr. Goldmann, back in 19 -- early 1970.

What Goldmann gave us was an index which he gives numbers where we used to have only general feelings, that would help to define exactly the risks of the -- to the patient undergoing noncardiac surgery based on his cardiologic situation.

Since then other people have taken it beyond Goldmann, but he really was the one who was -- established the way to evaluate the risk to the cardiac patient.

Q. Doctor, I don't know that you actually responded to my question. You're referring to the Goldmann Index, which I wasn't actually looking at.

I simply want to know what you would add in terms of that which exists in the publication that we speak about, as things to evaluate in terms of surgical risk in the cardiac patient?

A. That I can give you an answer. It's in the state of flux.

For instance, using Persantin testing for myocardial viability in the presence of Persantin challenge would be one of the ways; echocardiography did not exist in 1969, that's certainly a very valuable way to evaluate the status of the heart for patients which you are going to consider for surgery. The concept of cardiac catheterization before a vascular procedure was something that was unknown until the past ten years, so there have been a lot of additions.

I don't want to spend all afternoon giving you a speech on this.

Q. We may have to get back to that issue briefly later anyway.

Your counsel here today, Mr. Fulton, indicated that perhaps Article Number 6 had some relationship to this case, can you tell me a little bit about that article?

A. Well, I really don't think it applies. The coronary care unit at Fairview Hospital opened in October of 1964. At the time it was the -- only the second one in the State of Ohio, one of the first 25 in the country, and because of it being

such a new concept, as a matter of fact, CCU was not even in existence then in terms of terminology, so I called it the Coronary Care Constant Monitoring Unit. I thought that was a verbal description of what we were doing.

So two cardiac Fellows and I, Iciapone and Floris, published an article in the Ohio State Medical Journal. We did it on the first six months of our experience, from October of '64 to May of '65. We wanted to get the information out quickly so that doctors around the state at least would know that there was such a thing and they were indeed able to save lives that otherwise were being lost.

We, as you might say, rushed into print with this article, which kept me busy for several years going around the state giving talks; but showed, we felt, obviously still feel, a significant upgrade of the care of cardiac patients, but I don't know that it has any relevance in this particular context.

Q. I'll read it and see, I guess.

Doctor, referring you to the report that you prepared in this matter, do you have a copy of your report in front of you?

A. I do.
Q. That report is dated January 24, 1993?
A. It is.
Q. Can you tell me when you were first contacted regarding the Sharon Weitzel matter?
A. I think this was by George Gore from Arter & Hadden. There was also a letter from me to him, I think it was last Summer.
Q. So you were contacted sometime last Summer by Mr. Gore?
A. I think so.
Q. Did Mr. Gore discuss the case with you at that time?
A. Yes.
Q. Did he provide you with any documentation or materials at that time?
A. My letter to him lists everything I was provided.
Q. All right.
A. I don't have it in front of me. It exists somewhere.
Q. There's a listing here of things that you have.
A. That was to Mr. Gore.
Q. No. This letter is obviously addressed to

Mr. Fulton --

A. Yes.

Q. -- that sets forth materials that you claim to have reviewed in this regard, were those materials supplied to you by Mr. Gore or by Mr. Fulton?

A. Well, I think it breaks down into two parts, certainly the Samaritan Hospital, Mr. Gore; Saint Vincent and the autopsy report I feel sure they were supplied by Mr. Gore; beyond that I am not sure.

Well, obviously the depositions, Drs. Varma and Steele, were not provided by Mr. Gore, and I am not sure about the things in between.

Q. The fourth item says a memorandum of chronology of events of March 14 and 15, 1991; today as we sit here, can you tell me who prepared the memorandum that you reviewed?

A. Well, I think it was Mr. Fulton, but I am not sure.

Q. You did not bring your copy of that memorandum today?

A. No.

Q. I would like to see a copy of the memorandum

that you reviewed, can you produce one?
A. I presume I have it at home if I listed it here.
Q. Same thing, the next item, memorandum of condition of Mrs. Weitzel, February 11 to March 15, 1991, do you know who prepared that memorandum?
A. No.
Q. Do you recall today what the memorandum said?
A. No, I can't recall anything that it said. It was otherwise derived from the record that I already reviewed.

I think as you all know, these memoranda were prepared as a effort to focus on a particular aspect, obviously one month, and the two last days of her life; and the other one -- it's been a long time since I looked at it, so I can't really faithfully duplicate what it was, but obviously both of them were derived from the Charity Hospital record.
Q. Doctor, I will request that you also make certain that I get a copy of the addendums since you reviewed them in conjunction with preparing this report.

Is this the sum total of all documents and depositions that you reviewed in

preparation for this report and this deposition?
A. No, because since then I have been furnished with a number of letters, both by plaintiffs' experts and defense experts, and I think I may have been provided some depositions, but I am not certain about that part.
Q. How come you are not certain about that part?
A. I am not certain because -- well, I think the answer is no, I haven't been provided with any deposition, but I spent quite a bit time last Sunday reviewing this case. I also was reviewing another case from out of town, so I am not certain that I reviewed any other depositions on this case; but I know that I reviewed a number of letters from -- both from experts on both defense and plaintiffs' side.
Q. First of all, can you remember the names of the experts whose reports you have read?
A. Dr. Markowitz was one, Dr. Holland was one; Dr. Locke, who is a former trainee of mine was one; Dr. Carol Buchter, and I think --
MR. FULTON: I think you may have gotten -- I don't think those are in here, in this case.
MISS KOLIS: Yes.

MR. COYNE: All of them.

Q. Any other experts?

A. There was some others. They were names that were not familiar to me so they are not recallable at this time.

Q. Did the reading of these other reports that were given to you substantially or at all change the opinions that you held when you authored this report?

A. Dr. Kohn. I shouldn't leave out Dr. Kohn.

Did they alter my opinion, no.

Q. The report that you wrote is noticeably devoid of any fact, and I was curious whether you were instructed to write a report that didn't have facts in it?

A. Yes. I thought it had a lot of facts.

Q. I don't see any, so let's go through this.

A. Well, besides all the facts that listed things that we have just talked about, those are facts.

I thought the fact that I have said based on my training and experience with similar patients, and so on, that's a fact.

Let's see, going down to the third line of that paragraph, Mrs. Weitzel had an

extremely limited life expectancy from the time of her heart attack on February 11, that's a fact.

Q. I was going to get to these opinions that you hold. I don't know that those are actually facts.

A. All right. Well, no, your question was, was I instructed in this, and it's no, this is what I usually do.

Q. Generally speaking, and we'll leave it at that, did you have an opportunity prior to preparing your report to review the entire hospital chart of Sharon Weitzel?

A. I did.

Q. For what purpose do you believe that you were asked to review the chart?

A. Mr. Gore asked me to review the chart because he said that he was involved in the defense of Saint Vincent and the employees.

Q. Was an inquiry made of you to give an opinion on issues? In other words, what was the purpose for which you were asked to look at the records?

A. My understanding is -- purpose was to see if I would be willing to identify myself as an expert on the defense.

Q. An expert in what regard?

A. In the care rendered by the employees of the

hospital in the case of Mrs. Weitzel.

Q. Did you render such an opinion as to the standard of care or the lack thereof?

A. Did I?

Q. On the participation of the employees?

A. I did.

Q. That opinion is not contained within your report, is it?

A. It was stated in my letter to Mr. Gore.

Q. Subsequently were you contacted by Mr. Fulton after Mr. Gore?

A. I was.

Q. Did he essentially ask you to do the same thing?

MR. FULTON: No. I didn't represent the hospital.

MISS KOLIS: Well, that's why I am asking.

Q. Mr. Fulton contacted you; is that correct?

A. Yes.

Q. Can you remember approximately when you were contacted by Mr. Fulton?

A. I think it was very shortly before the preparation of this letter, so that takes us back to early January of this year.

Q. Sometime in the beginning of the year in 1993 Mr. Fulton contacted you?

A. That's correct.

Q. For what purpose did Mr. Fulton wish to retain your services?

A. He mentioned that he was defending Dr. Varma, not Saint Vincent Charity Hospital, otherwise -- well, not any of the other defendants in the case.

Q. Did you indicate to him at that time that you had previously looked at this matter from a different perspective?

A. Well, I think he knew it because he's the one who told me Mr. Gore and Arter & Hadden were no longer in the lawsuit.

Q. Did you re-review the chart then at that time?

A. Certainly did.

Q. Doctor, let me ask some questions not about your report for a couple of minutes.

Is this the first case that you have reviewed on behalf of defendants in a medical negligence case?

A. No.

Q. How often do you review cases on behalf of defendants?

A. I think it runs about ten a year.
Q. How long has it been about ten a year?
A. About the last ten years.
Q. So for approximately ten years you have been running ten cases a year on behalf of defendants?
A. Yes. Before that I had two or three cases a year.
Q. For what period of time did you have two or three cases a year?
A. Probably about three or four years.
Q. Before that did you review cases at all?
A. No.
Q. So probably within the last 14 years or so you began to review medical cases?
A. Yes.
Q. Do you review cases on behalf of plaintiffs?
A. Yes.
Q. How many a year?
A. Only about one or two.
Q. What is the last plaintiff's case that you reviewed and wrote a report in?
MR. FULTON: That may be privileged.
MISS KOLIS: I was referring to cases that were filed, if he wrote a positive

report on behalf of plaintiff, let's phrase it that way.

A. I am going to have to give you a little broader than your question.

I reviewed a case for a plaintiff in early February. He and I talked this week and I haven't written a letter yet that would identify me as an expert, but I am willing whenever he wishes me to do so.

There was a previous case several years ago, and I am not sure that I wrote a letter on that, that was settled relatively early. It was -- the suit was filed but we didn't get to the deposition, all that sort of thing, and I am not certain that I wrote a letter on that. I may have or not.

Q. Have you ever testified in a court of law on behalf of a plaintiff in a medical malpractice case?

A. No.

Q. Have you ever given a deposition in any pending legal case or now closed one, rendering an expert medical opinion on behalf of a plaintiff?

MR. FULTON: Are you talking about medical malpractice cases?

MISS KOLIS: Yes.

MR. FULTON: Just so we understand what we're talking about.

Q. Have you ever given such a deposition?

A. No.

Q. What would be your best estimate, we'll say estimate, of the number of reports that you have written favorably to a plaintiff in a medical negligence case?

A. I think it's either going to be zero or one, depending on that suit of several years ago.

Q. All right. These ten cases that you review a year, customarily who are you reviewing cases for, what law firms?

A. Well, several. I do some work -- probably most of the work is Reminger & Reminger. I also have done work with Arter & Hadden. I've also done work with law a firm in Elyria, Tattersall something, I have worked with them. It is Gallagher, Fauver & Tattersall, something like that.

Q. Correct.

A. And I also have several cases with Buckingham, Doolittle & Burroughs down in Canton; and I reviewed lawsuits from Dayton, from

Cincinnati, and I think that's about it.

There has been one or two law firms in town where I had just one case three or four years ago.

Q. Have you done any reviews for the law firm of Jacobson, Maynard?

A. Not in the last five years or so.

Q. In the past ten years, how many times have you testified at trial on behalf of the defendant doctors in a medical malpractice case?

A. I would think it's somewhere between five and ten. It is certainly not over ten.

Q. What is the last case you testified in; if you can recall?

A. I think that was actually not a malpractice case, that was an Industrial Commission case against the State of Ohio, and I testified for the State of Ohio.

Q. When is the last case --

A. Malpractice?

Q. -- right. Last malpractice case that you testified in on behalf of a doctor?

A. I think there was one, that would have been about three years ago.

Q. Do you remember what attorney was involved

for the plaintiff or defendant?
A. Yes. I think there was Marc Groedel from Reminger & Reminger. I don't recall the plaintiff's attorney.
Q. Do you remember anything about the plaintiff's case?
A. I remember a lot about that case.
Q. But you just don't remember the lawyer?
A. No. It's probably just as well for him, too.
Q. Other than going to trial five to ten times in the last ten years, how many depositions would you say that you have given on behalf of defendant physicians in medical malpractice cases?
A. I don't know. Must run five or six a year, something like that.
Q. Do you keep a record someplace of the number?
A. Evidently, I don't. I keep -- obviously I keep a ledger so I know who I billed, who paid me, things like that; but I really haven't broken it down into depositions and trials and so on. Those questions I am really answering out of my best estimate.
Q. So your best estimate is in the last ten years that five to six times a year you give a deposition in a case on behalf of a physician in a

malpractice case?
A. Yes.
Q. You indicated that the last time that you testified was in a court on behalf of the Industrial Commission, are you occasionally retained by the Industrial Commission of Ohio to examine claimants, then render opinions in that regard?
A. Yes.
Q. How much time do you spend doing that?
A. That runs -- I guess it would probably average one a month, or maybe two or three every two months, or something like that.
Q. For how long have you been engaged in doing independent examinations for the state?
A. Just this past year.
Q. Do you exam claimants on behalf of any other insurance companies?
A. No.
MR. COYNE: Show an objection.
MISS KOLIS: Nationwide?
Q. On behalf of insurance companies, I should say?
MR. COYNE: Objection.

A. No.
Q. The answer is no?
A. No.
Q. Doctor, have you yourself been sued as a result of medical negligence?
A. Yes.
Q. How many times have you been sued?
A. Four.
Q. Do you have a recollection of each of those four cases?
A. Very clear.
Q. Beginning with the first case that was filed against you, can you tell me approximately what year that was?
A. 1964.
Q. Who represented you?
A. This law firm. As a matter of fact --
Q. Gallagher, Sharp?
A. -- Mike Gallagher.
Q. Do you recall who the plaintiff's lawyer was?
A. No.
Q. Do you recall the nature of the allegation against you in that case?
A. Well, it is a very interesting case.
This was a young man with

congenital heart disease and mental retardation and I did a cardiac catheterization on him. In those days they were doing, of course, only right heart catheterization, and right heart catheterization involved mainly measuring oxygenation content and pressures inside the circulation to the right side of the heart.

We had new equipment at Fairview at that time and in order to make it possible to flood the vascular areas with materials which would show up on a x-ray film, in other words, do a right-sided coronary angiogram, and the material was delivered not as they do now by hand injection, but delivered by a pressure injector, I think it was 80 pounds per square inch or something like that, high pressure obviously, the catheter we were using -- I hope this isn't too much detail.

Q. Well, it's kind of a lot of detail.

MR. FULTON: You asked him, he's going to tell you.

Q. Generally what was the allegation against you?

A. I have to give you a little more, three more sentences before I get to the allegation.

MR. FULTON: Very

complicated.

A. The catheter that we used to do the right heart catheterization was also used to make the pictures, and unbeknownst to us there was a wire inside the catheter for those cases for reasons that no one ever really understood.

The wires were shipped from the manufacturer with a wire inside the catheter and the wire projected out of the proximal end of the catheter, had a 90 degree bend. The central supply people at the hospital and perhaps other hospitals as well, thought -- we re-used the catheter, they weren't throwaways as they are now-a-days.

So when they went back to central supplies they would put a wire back in the catheter, then autoclave the catheter, put on the sterile dressing then we'll re-use it.

Apparently somebody in the central supply broke off the tips sticking out of the catheter, so unbeknownst to us there was a wire inside the catheter which was not visible from either proximal or distal end, so when we put 80 pounds per square inch through that catheter, the wire shot out of the catheter like an arrow, lodged in the right side of the heart like an

arrow, was not seen by the radiologist on subsequent films when we were trying to figure out why this boy who was not well when he came to the hospital was getting progressing worse.

It was discovered when my cardiology Fellow went down to look at the film trying to figure out why he was not doing well, pointed out this wire in radiology; they said well, we didn't report that because you people have wires all over the place anyway.

Anyway, the patient subsequently died. I was the defendant. The lawsuit was settled before deposition or anything else for $7,000.

Q. So a settlement is how that lawsuit resolved? Was it a settlement on behalf of yourself?

A. I am not sure. I'm not sure what your question means.

We paid the plaintiff $7,000. Liberty Mutual paid the plaintiff $7,000.

Q. What's the next suit you were involved in?

A. The next lawsuit was a man who was scheduled for surgery and surgery was cancelled at the -- surgery was over -- he had osteomyelitis of the

head of the femur, and the surgery was cancelled because he was in such unstable condition.

So then I was called as a consultant with the implication by the orthopedist that he had to get the patient operated as quickly as possible because there was danger of the osteomyelitis, which had been smoldering, progressing for months, breaking into his hip joint which would almost certainly obligate amputation of the leg from the hip; and so we spent eight days intensively tuning up this person from his congestive failure, which really hadn't been adequately treated before he went to surgery, and when anesthesia was induced, he went into bradycardia and died.

The upshot, outcome of the lawsuit was, jury finally went to trial, found in my favor.

Q. The jury found in your favor, you mean?

A. Yes, they did.

Q. What year was that?

A. It was 1980 -- well, the incident was 1981. I think it was, let's see, about 1984 I think the trial was.

Q. Who represented you in that case?

A. Jacobson, Maynard, Tuschman & Kalur.

Q. Do you happen to remember what lawyers?

A. Steve Charms was involved but he wasn't the one who tried the case.

Gosh, I thought I'd never forget his name. Nice fellow. I am not certain of the name.

Q. Can you recall who the plaintiff's lawyer was?

A. I'll never forgot him, David Guidubaldi.

Q. Next lawsuit?

A. Next lawsuit was a patient of mine who came in with a stroke, had a severe right hemiplegia and aphasia. He developed urinary tract infection that generated into an osteomyelitis, probably an osteomyelitis, never proved.

He had severe hip pain and I treated him with antibiotics. He couldn't verbalize the words for his pain in his hip but it was obvious, and so we gave him a nonsteroidal anti-inflammatory compound that was complicated, as sometimes it is, by a gastric hemorrhage, which was treated by emergency hemigastrectomy, which he recovered from and still survives today, but we were sued and that was settled out of court for like $20,000.

Q. What year was that lawsuit?
A. That was about 1987, something like that.
Q. And your lawyer in the case?
A. Also Jacobson, Maynard, Tuschman & Kalur.
Q. Do you recall who in the firm represented you?
A. Fine young man who has gone down to the Cincinnati office, whose name I don't recall at the time.
Q. And the plaintiff's lawyer in that case?
A. I don't recall.
Q. And the last lawsuit?
A. That was the mother of a doctor here in town who was -- I'm trying to think. This is sort of a tough case to make short.

She was in her late 80's, nursing home, he was taking care of her, she had high fever for a week or so. He for whatever reasons finally decided he needed help. So the nursing home was in the vicinity of Fairview Hospital. So he had her transported there and asked if I would take care of her. I was out of the country at the time. My associate said yes. He knew I would be willing to.

She, so far as we could ever make

out, really was brain dead and the nursing home felt that she had been for a long time, but her doctor son insisted on everything being done; within several days of being in our hospital she developed respiratory arrest and was put on a ventilator. He insisted on everything being done except a neurologic consultation.

So she stayed in our coronary care unit for one year, part of which time we tried to convince him that a chronic respirator unit would be more appropriate for his mother, and she finally was moved to a chronic respiratory center in Columbus; lived for another year.

We were sued for malpractice.

Q. What year was that lawsuit?

A. That was, let's see, she came in in 1987. I guess the lawsuit worked its way through the court in 1990.

We had a summary judgment in our favor. He appealed, the judgment was upheld; he went to the Ohio Supreme Court and judgment was upheld by the Supreme Court.

Q. So that just terminated?

A. Right.

Q. All right. Let's deal with the report that

you wrote in this matter.

After you had listed what materials, your first sentence of your report says based on my training and experience with similar patients, et cetera, et cetera.

MR. SEIBEL: First sentence of your report.

MISS KOLIS: Of his report. You have a different report than I do, Mr. Seibel?

MR. SEIBEL: No.

MR. FULTON: I'm the only with a different one.

Q. Is this in fact the only report that you wrote for Mr. Fulton?

A. It is.

Q. You seem to indicate an expression of thought in that sentence that based upon your training and experience with similar patients as Mrs. Weitzel, what similar patients, what kind of patients are you describing?

A. Out of hospital cardiac arrest, resuscitation, transportation to hospital with continued requirement for ventilator and other types of support.

Q. So that we don't miss any, let's do this

step-by-step.

The similarities you described were out of hospital --

A. Cardiac arrests.

Q. Next?

A. Resuscitation. Should say successful resuscitation.

Transportation to hospital, continued coronary care unit support, with use of ventilator.

Q. Any other symptoms that you are describing in making your analogy to similarity?

A. I think that would be the broad selection of patients. Obviously Mrs. Weitzel had other complications, the A.R.D.S. and pneumothorax and all these things, but as a starting point this is what lay behind that sentence; because the similar patients, the farther you go in the course in the hospital, obviously the more differences develop, but this is the ground substance of the kind of patient, because we see these patients not infrequently where they're out of hospital cardiac arrests and heart's been resuscitated but the brain may or may not have.

I have a patient in Fairview right

now who I saw this morning who is exactly like this, been there since Tuesday evening.

Q. Exactly like what?

A. Out of hospital cardiac arrest, successful cardiac resuscitation, question about brain survival.

Q. How many similar to Mrs. Weitzel patients do you claim to have had?

A. You mean a number?

Q. Yes.

A. I can't give you a number. I can give you an approximation because it's one of the records I can't really keep.

Q. Okay.

A. How many times a year would that happen, Probably six times a year for 25 years, something like that.

Q. Have you ever had a patient who came into the hospital under those circumstances and ended up with two retained guide wires?

A. No.

Q. Have you ever had a patient who ended up with one retained guide wire?

MR. FULTON: He spoke of a wire, just so -- before this lawsuit. I don't know

that it's a guide wire.

Q. I'm asking retained guide wire.

A. No.

Q. You go on to conclude in that sentence that you can state with reasonable medical probability that Mrs. Weitzel had an extremely limited life expectancy from the time of her heart attack on February 11, 1991, that's what I'd like to address briefly with you.

What was her extremely limited life expectancy in your medical opinion?

A. I am not sure of your question. You mean in terms of days, weeks, or months, or percentage?

Q. You said extremely limited life expectancy, I want to know --

A. What did I think her life expectancy was?

Q. Sure.

A. Well, before I answer the question, let me make one statement, I think that the care she got at Saint Vincent Hospital was superb, it was superb care; for this woman to have presented the way she did and to have lived as long as she did was superb medical care.

Now, going back to your question, I would think that her life expectancy in any

ordinary hospital would be less than one month.

In point of fact, in reading the record at Saint Vincent Charity Hospital, she had numerous episodes in which without prompt effective medical care she would have died on that particular occasion.

Q. We're going on the assumption people get proper medical care for their problems.

My question specifically is what was her life expectancy in your opinion, since you have this report that talks about what this situation was?

A. One week.

Q. One week?

From the day of her admission?

A. Yes.

Q. So you feel that she lived passed her life expectancy?

A. Absolutely.

Q. Doctor, what is the basis of your contention that she had a one week life expectancy from February 11, 1991?

A. Because of her condition.

Q. What about her condition made it such that you believe that she would have only lived

one week?

A. She died once, she was resuscitated, albeit not promptly, in Ashland, Ohio; she was brought up to Charity -- I am just reciting facts you know well -- she was brought up Charity Hospital, she had numerous episodes which if not properly treated would have caused her death at that time; you know, you can only do this so many times and still succeed because you never can fail, you can't fail once, then it's all over.

So I think that without superb care she wouldn't have made it at all, that's why I gave you a one week categorization.

Q. Let me ask a question: You claim to render this opinion based upon your experience with people similar to Mrs. Weitzel, did all of your patients who were similar to Mrs. Weitzel die within one week?

A. No, because they were given superb care, so.

Q. With superb care what was the life expectancy in these patients?

A. Well, I think taking a patient like her who is still on a ventilator one month after she had arrived at the hospital, has had innumerable complications and problems, all of which have been

contained up to that point that she did indeed make it for one month, we know that MI patients have had similar experiences as that; but even so, I think any person with any degree of experience at all would look at this situation and say here is how she presented, here is what happened in this one month, she's still on a ventilator, et cetera et cetera, the likelihood of her walking out of that hospital alive is somewhere near zero.

People who have been on a ventilator for a month, for whatever the reason they're on the ventilator, the likelihood of their ever getting off the ventilator alive is very, very small.

Q. Upon what do you base that opinion that you hold regarding ventilator status?

A. Well, not only is it replete in literature, that's my own personal observation on my own patients, and seeing other patients in the intensive care unit.

Q. Replete in what literature?

A. Well, I think it's the medical literature.

Q. What medical literature in specific?

A. I am not able to give you a particular article because this is not an area of -- in which

I spend a lot of time, but I would think it would be a difficult challenge for somebody to come up with an article that shows that after a person's on a ventilator for a month, their likelihood of their getting off the ventilator and leaving the hospital alive would be anywhere near a 50/50 chance.

Q. You are aware that Mrs. Weitzel did have a pulmonologist involved in her case?

A. I am aware.

Q. Did you ask if you can read the testimony of the pulmonologist regarding what he thought her status was?

A. No.

Q. Is there a reason you wouldn't have asked that question or for that information?

A. Well, the reason I didn't ask is because it wouldn't provide anything to do with what was my role in this case anyway.

Q. What do you think your role in this case is?

A. I think I'm supposed to be looking at it from the cardiology standpoint, because that's my background.

Q. So you are stating to a reasonable degree of medical certainty, or probability I guess is the phrase that you used in here, from a calculation

standpoint that it would be accepted that a person who presented such as Sharon Weitzel had a one week life expectancy?

A. Yes.

MR. FULTON: You say except or accepted?

MISS KOLIS: Accepted.

MR. FULTON: I don't understand the word "accepted."

Q. Is there any other basis which you have in rendering that opinion other than her condition?

A. And my experience, no.

Q. You are not basing it on anything in literature?

A. No.

Q. It's strictly based on your experience?

A. Yes.

MR. FULTON: And her condition.

Q. And her condition?

A. I assume that's part of it.

Q. The last sentence in your report says, "In addition I can state with reasonable medical probability that the presence of retained guide wire posed no significant additional threat to her

life"; can you tell me what that sentence means?

What were you addressing is a better way to ask it?

A. I am addressing -- we all know that she did have two retained guide wires, but I felt that that was not having -- well, as I said, did not pose any additional threat. She already had enough elements against her prolonged survival that guide wires were not going to change that in any particular fashion.

Q. Did you believe that there was any risk to her health whatsoever for the guide wires being retained in her arterial system?

MR. FULTON: Talking about a period of time or what?

Q. During the course that she was in the hospital, of course before she died?

A. Well, the -- there's a potential risk, but there was no evidence that that risk was being shown to actually exist.

Q. What were the potential risks in your opinion?

A. Well, any intravascular foreign body of course runs the risk of either being the site of infection or the origin of clot formation, which

then may break off and embolize.
Q. And you saw no evidence in the chart for any of these risks having materialized?
A. Right. I should mention for sake of completion, completeness, another possibility of course is that the foreign object may eventually perforate the vessel that it's in. Again, there was no evidence that that was occurring.
Q. Dr. Watts, based upon your review of the chart did you come to a conclusion as to how these wires ended up in Mrs. Weitzel's arterial system?
A. They apparently were introduced by way of the left femoral artery puncture.
Q. And you agree that's how they got there?
A. I don't know any other way.
Q. Did you come to a conclusion based upon the chart and the other materials that you reviewed as to who inserted the wires that were in her arterial system?
MR. FULTON: Objection. Go ahead.
A. Dr. Varma.
Q. Do you have any opinions regarding any other physicians in this case that are not listed in this report?

A. As I said before, I thought she had superb care. It's regrettable that she died but the odds were against her from the minute she hit the shop room floor down in Ashland.

Q. Specifically let me ask you this: You reviewed the autopsy in this matter?

A. I did.

Q. And do you have a recollection of the cause of death in this matter?

A. Yes. Ischemic heart disease.

Q. Right.

Was Mrs. Weitzel in your opinion from a cardiology standpoint an appropriate candidate for a noncardiac surgery on the date which she actually had a surgery?

A. Yes.

Q. What is the basis of that opinion?

A. Well, she was as stable as she was going to be in the context of the month that she'd already been in the hospital. I couldn't say that her condition was unstable at that point, it was as good as it was going to be.

Q. As good as it was going to be ever?

A. I think so. They really had done a masterful job just keeping the lady alive.

Q. Do you clear your patients as a cardiologist for surgery?
A. Absolutely.
Q. Is there a period of time subsequent to a myocardial infarction that you honor, some time line for non-urgent surgeries to occur in a patient?
A. Yes.
Q. What is that time line?
A. Three months, at least.
Q. Suffice it to say that Mrs. Weitzel was not three months past her MI, was she?
A. No, she wasn't.
Q. I gather from what you wrote in your report that on the day that the surgery occurred you would agree with me that there was not a necessity for that surgery to occur on that day, was there?
A. I'm not sure I would agree with you. Obviously the attending physician didn't agree with that feeling. They felt the wire should be removed. One wire, as we all know had been removed, and the other wire was not capable of being removed; and so it was believed that a surgical procedure could be done safely to remove the wire, and as you know that's what was -- was

done.

Q. I don't know that you responded to my question, so let me ask it in a different way.

Unless I misheard what you just previously told me, none of the risks that potentially could be attendant to the retained guide wire had materialized?

A. That's right.

Q. So what would be the purpose in going in and surgically removing a guide wire?

A. So that the risks that were potential did not become actual.

Q. So as a preventive measure?

A. Yes.

Q. Did you review the chart carefully as to the care and treatment given to Mrs. Weitzel post surgically?

A. I did.

Q. Do you have an opinion as to the care and treatment rendered to her by the nursing staff?

A. I do.

Q. What is that opinion?

A. I think they met the standard of care.

Q. And the resident that was called and did not respond to the call to come and see the patient,

was that within the standard of care?

MR. COYNE: Show an objection.

MR. OKADA: Objection.

A. I hope not.

MISS KOLIS: I don't have any further questions.

MR. COYNE: I have no questions at this time.

MR. WARNER: No questions.

MR. OKADA: I have no questions.

MR. SEIBEL: Let me think about that for a minute.

I don't have any questions.

MR. FULTON: Do you want to read this?

THE WITNESS: Yes, I always do.

MR. FULTON: Send a copy to me and I'll send the copy out to the Doctor.

- - - - -

(Deposition concluded; signature not waived.)

- - - - -

ERRATA SHEET

PAGE LINE

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

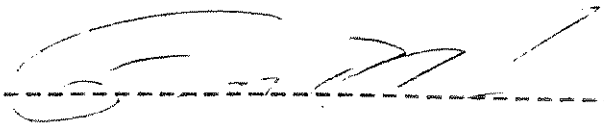
_____

RICHARD W. WATTS, M.D.

The State of Ohio, :

County of Cuyahoga. : CERTIFICATE:

I, Frank P. Versagi, Registered Professional Reporter, Certified Legal Video Specialist, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, RICHARD W. WATTS, 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 16th day of April, 1993.



Frank P. Versagi, RPR, CLVS, Notary Public/State of Ohio. Commission expiration: 2-24-98.

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ERRATA SHEET

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7	Vice President -> Vice Chairman	9
10	Juntla -> Juntala	16
75	Jackson -> El Paso; Flores -> Fleher	7
79	Jacke -> Jack	20
46	mai -> woman	7

I have read the foregoing transcript and the same is true and accurate. When these corrections are made

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