1 IN THE COURT OF COMMON PLEAS OF 1 CUYAHOGA COUNTY, OH 2 3 CIVIL DIVISION ى ب 4 5 ESTATE OF LAWRENCE* 6 BROWN, plaintiff * No. 346342 7 vs. 4 8 ERIN FUREY, M.D., * 9 et al., 10 Defendants 11 12 13 DEPOSITION OF 14 CYRIL H. WECHT, M.D. 15 JULY 16, 1999 16 17 18 19 20 21 22 Any reproduction of this transcript 23 24 is prohibited without authorization by the certifying agency 25

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3	DEPOSITION
2	OF
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4	CYRIL H. WECHT, M.D., was taken on
Ę	behalf of the Defendants herein,
E	pursuant to the Rules of Civil
5	Procedure, taken before me, the
8	undersigned, Denise J.
9	Khorey-Harriman, a Registered Merit
10	Reporter and Notary Public in and
11	for the Commonwealth of
12	Pennsylvania, at St. Francis
13	Hospital, Room 300A, 1200 Center
14	Avenue, Pittsburgh, Pennsylvania, on
15	Friday, July 16, 1999, at 11:00 a.m.
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3 A P P E A R A N C E S 1 4 DONNA TAYLOR-KOLIS, ESQUIRE -1370 Ontario Street 4 Ē Cleveland, OH 44113 COUNSEL FOR PLAINTIFF Е 7 MARC W. GROEDEL, ESQUIRE f Reminger & Reminger ç 1 C 113 St. Clair Building Cleveland, OH 44114 11 12 COUNSEL FOR DEFENDANTS 13 14 1 5 16 1 7 1 8 19 2 c 2 1 22 23 24 25

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7 PROCEEDINGS 1 2 3 CYRIL H. WECHT, M.D., HAVING FIRST BEEN DULY SWORN, TESTIFIED AS 4 FOLLOWS: 5 6 DIRECT EXAMINATION 7 BY ATTORNEY GROEDEL: 8 Would you state your name? 9 Ο. Cyril H. Wecht. 10 Α. Doctor Wecht, my name is Q. 11 Mark Groedel. I represent the 12 Defendants in the lawsuit that 13 14 you're going to be rendering some opinions on and I know you've been 15 deposed before, so I'll skip the 16 usual introductory admonitions. I'm 17 18 going to ask you some questions about the opinions that you hold in 19 20 this case. First of all, let me ask you this. Where is your 21professional address? 22 1200 Center Avenue, 23 Α. 24 Pittsburgh, Pennsylvania 15219. 25 Q. And is that your only

8 professional address? 1 2 Α. No. The other one would 3 be the Allegheny County Coroner's Office, 542 Fourth Avenue, also in |4|5 Pittsburgh 15219. Q. Okay. What was your 6 7 assignment in this matter? 8 To determine the cause of Α. death of Mr. Brown. 9 Q . Was that the only issue 1 0 you were asked to address? 11 Well, it's the only issue 12 Α. that I was asked to address in terms 13 14 of any possible subsequent testimony, but I did review the 15 entire case and I did express other 16 opinions to Mrs. Taylor-Kolis, but 17 the only one that I was asked to 18 address for purposes of testimony, 19 should that have fallen into place 20 --- of course, nobody could know 21 that going in --- that would have 22 dealt with the cause of death. 23 Okay. So if there's a Q . 2.4 trial in this case, would I be fair 25

9 1 to assume that your testimony will be primarily limited to your 2 thoughts regarding the cause of 3 death in this case as opposed to 4 standard of care issues? 5 That is correct. I shall 6 Α. not be addressing any questions that 7 relate to standards of care of the 8 treating physicians. 9 Q . Do you have your entire 10 file before you right now? 11 12Α. Yes. Q . Has anything been removed 13 from it? 14 I think probably some of 15' Α. the billing things. My secretary 16 keeps those. In fact, I think 17 there's even something you had sent 18 in that I saw fadingly. She just handles that. Otherwise, everything else is here that I have received. 21 Can I take a look at what 22 Q . you have there? 23 24 Α. Yes, sure. Q . 25 Thank you. You've written

10 a report dated April 15, 1999. Ιs 1 2 that the only report that you've written in this case? 3 No, there are two Α. 4 supplemental reports and they are 5 attached there. Those were 6 submitted following review of 7 deposition transcripts that had been 8 9 sent to me at two different times. ATTORNEY GROEDEL: 10 Okay. Why don't we do 11 this? Why don't we mark 12 some of the things that I 13 don't have. Let's mark 14 that A. 1 5 (Exhibit A 16 marked for 17 identification). 18 ATTORNEY TAYLOR-KOLIS: 19 I guarantee you you 20 21have those but you can mark them anyway, the 22 23 supplemental reports. 24 ATTORNEY GROEDEL: 25 No, I don't have

11 1 these. These weren't sent 2 to me. 3 If you need to get Α. something Xeroxed now, I can have 4 that done. 5 ATTORNEY GROEDEL: 6 We can do that later. 7 I mean, one copy here will 8 be sufficient for my 9 purposes. Why don't we 10 mark your report, first 11 12 report B. And then let's label this C, D. Okay. 13 (Exhibits B, C and D 1 4 marked for 15 identification). 16 BY ATTORNEY GROEDEL: 17 Q. Why don't we identify for 18 19 the record what we've got in your file here. And Doctor, if you 20 2 1 would, would you briefly identify for us what we've got marked as 2 2 Exhibits A, B, C and D for us? 23 A is the submission letter 24 Α. I received from Attorney 25

12 Taylor-Kolis dated March 18th, 1999 1 in which she listed the materials 2 that were being sent to me for 3 review. B is a copy of the report 4 5 that I sent dated April 15th, '99. C is a supplemental report I 6 submitted on May 13th, '99. D is a 7 second supplemental report I 8 submitted on June 9th, 1999. 9 Okay. Are there any other 10 Ο. reports that you've authored in this 11 12 case? No. 13 Α. Q . What are your charges for 14 getting involved in medical/legal 15 16 cases? Α. In any kind of a death 17 case, civil or criminal, 1 ask for a 18 submission fee of \$3,500, that 19 20 covers the review, the analysis/examination of autopsy 21 22 report, microscopic tissue slides 23 and preparation of a written 24 report. Q. Have you charged Ms. Kolis 25

anything above the initial \$3,500 1 2 initial retainer fee? I believe there most 3 Α. probably would have been 4 supplemental charges for the 5 subsequently received deposition 6 7 transcripts and the written reports. As I look at the materials 8 9 that were reviewed and the reports, 10 probably between \$350 to \$500 each. Once the initial retainer 11 Ο. fee is used up, I assume you charge 12 an hourly rate for reviewing 13 materials like this? 14 I do not charge by the 15 Α. I charge by the work and my 16 hour. secretary has been with me for 17 almost 30 years and I just have a 18 feel based on what we do. If I'm 19 20 asked to charge by the hour, I do. It's not a matter of principle or 21 anything. I just don't do it 22 routinely. So it's not a matter of 23 the submission fee being used up. 24 That is a submission fee and no 25

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14. matter what happens, I ask for that 1 when the records are submitted. 2 So regardless of whether 0. 3 the records are voluminous or not so 4 voluminous, the charge is going to 5 be \$3,500? 6 Yes, that's right. Now, 7 Α. there are extremes. Once in a while 8 I'll receive like a trunk full of 9 materials and I probably will charge 10 more. Sometimes if it's just 11 several pages and somebody just 12 wants to know a very specific 13 answer, I will charge less. But 95 14 percent of the cases will just be 15 \$3,500 and I don't charge by how 16 voluminous the records are. 17 All right. So since your Ο. 18 initial review which included 19 2.0 reviewing the slides, the medical records and which depositions? 21 22 Α. There were reports from 23 Doctor Gluck, Doctor Mendelson, 24 Doctor Downs, Doctor Hoyt, 25 deposition transcripts of Doctor

15 Furey and Lee. 1 All right. So your review 2 Q . of all of that material and the 3 preparation of your initial report 4 was encompassed within your initial 6 fee of \$3,500? That's correct. 7 Α. And the additional Q. 8 materials that you received after 9 10 that, you charged extra for? 11 Α. Yes. And that would have Q . 1 2 included reviewing the depositions 13 of Doctors Vande Pol, Doctor Downs 14 and Doctor Hoyt and issuing two 15 additional reports? 16 17 Α. Yes. And you believe that that 18 Ο. additional work would have led to an 19 additional charge of somewhere in 20 the area of \$700 to \$1,000? 21 Yes, probably by \$500 for 22 Α. the first report because it dealt 23 with two depositions and the second 24 one probably about \$350. 25

16 Q. All right. How many hours 1 2 would you say you've spent working on this case? 3 Probably about 10 to 12 Α. 4 initially with all the records and 5 6 the autopsy report and the slides, 7 probably about two to three hours for the two deposition transcripts .8 and probably about an hour and a 9 half to two hours for the third 10 11 deposition transcript of Doctor Hoyt. So all together then I would 12 say probably somewhere between maybe 13 14 15 to 18 hours. By the way, do you know 15 Ο. Doctor Hoyt? 1 6 I met him, I do believe, Α. 1 7 at a conference. He's at our parent 18 19 hospital, but I don't really know him in a personal way and I've not 20 worked with him because the two 21hospitals are separate in their 22 23 operations. Okay. And what hospital 24 0. 25 is he at?

17 St. Francis Health System 1 Α. 2 I guess is the name of the parent 3 hospital, and we're St. Francis central. 4 5 Is it part of the same 0 6 system? Yes. We are owned by 7 Α. them, but we function, you know, 8 autonomously. Some of the 9 physicians move between the two 10 hospitals, but most of the people 11 are only on one staff and not both. 12 Q. Are you on the staff at 13 his hospital? 14 No, just here. 15 Α. Q . Do you know anything of 1 6 his reputation in the community as 17 an intensivist? 18 No, I mean, other than he Α. 19 is a specialist and I believe he is 20 21 an expert in his field and a 22 competent person. Your report makes 23 Q. 24 reference to your review of I think it was six slides from Mr. Brown's 25

1 8 autopsy; is that correct? 1 2 Α. Yes. Ο. Have you reviewed any 3 additional slides? 4 No. Α. 5 Q. And do you have those 6 slides now or did you return them to 7 Ms. Kolis? 8 9 Α. They were returned per the request I guess of Attorney 1 0 Taylor-Kolis. 11 Are there any other 1 2 Q. materials that you've reviewed for 13 this case that I've yet to touch 1 4 1 5 upon? Well, you didn't touch 16 Α. upon them orally but you touched 17 upon them tactically. 1 8 Okay. 19 Q . 2 0 Α. Everything that you have here is what I have in my file. 2 1 Q . Okay. So you've reviewed 2 2 23 the depositions of Doctor Vande Pol, 24 Doctor Downs, Doctor Hoyt, Doctor 25 Furey, Doctor ---

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1	ATTORNEY TAYLOR-KOLIS:
2	Lee.
3	<u>BY ATTORNEY GROEDEL:</u>
4	Q Lee, and you reviewed
5	the expert reports that you've made
6	reference to. You've reviewed the
7	autopsy, the death certificate?
8	A. And the hospital records.
9	Q. And the hospital records?
10	A. Right.
11	Q. And the slides?
12	A. That's correct.
13	Q. Anything else?
14	A. No, I think that's it.
15	Q. Did you review any medical
16	literature specifically for the
17	purpose of this case?
18	A. No. From time to time,
19	when I get a case, I may reach out
2 0	for a textbook in my office, but I
2 1	do not recall utilizing any specific
2 2	book and I do not have any
2 3	particular reference in mind for the
2 4	discussion today to a particular
2 5	book or a chapter or article.

20 Q. Okay. I'd like to ask you 1 2 some questions about the first report that you wrote dated April 3 15, 1999. You mention on the second page of your report at the top, that 5 there was a high arterial-alveolar 6 oxygen content difference prior to 7 Mr. Brown's surgery. Can you 8 9 explain what you mean by that? Well, the alveolar oxygen 10 Α. and alveolar carbon dioxide levels 11 are separate and apart from the 12 arterial oxygen and carbon dioxide 13 levels. And in a case where there 14are pulmonary emboli producing 15 pulmonary vascular profusion 16 changes, you will have an increased 17 difference between the alveolar 18 levels and the arterial levels. 19 20 Q . How would you characterize the abnormality here? 21 22 Α. I think it was strongly suggestive of pulmonary emboli 23 producing some compromise of the 24 25 pulmonary vascular flow.

Do you believe that there Q. 1 2 was any other etiology contributing to that.finding besides pulmonary 3 emboli? 4 He did have heart disease 5 Α. and that may well have contributed 6 to those differences. 7 You also make reference to Q . 8 the fact that ---? 9 In fact, I just want to Α. 10 say that yes, he had heart disease 11 and he had had heart attacks and 12 13 previously as we came to know during his hospitalization and at autopsy, 14 so certainly quite conceivable that 15 that contributed. 16 Q. Did he have any other type 1 7 18 of pulmonary disease that would have contributed to that abnormality? 19 2 0 Α. He had some pulmonary 21 emphysema noted at postmortem and as I recall clinically, too now I 22 started to say clinically whether 23 24 they were --- I don't think they ---25 I don't think he had any diagnosis

of any significance clinically 1 2 referable to the pulmonary system per se. At autopsy he had just some 3 mild or minimal emphysematous 4 changes. I don't think it would 5 have been enough to have contributed 6 measurably to those laboratory 7 differences. 8 How would you characterize 9 Ο. the degree of pulmonary disease that 10 Mr. Brown had at the time he had his 11 12 surgery? Α. He had pulmonary 13 14 hypertension. He had the pulmonary 15 emboli. How would I characterize it? I don't know, I'm not a 16 17 pulmonologist so I don't want to get into clinical descriptions from a 18 19 pathological standpoint. I would say that he had significant 20 pulmonary disease. 21 Q. You mentioned that he had 22 pulmonary artery hypertension. 23 What was the cause of that? 2.4 That would have been 25 Α.

associated, I believe, mostly with 1 the pulmonary emboli at this time. 2 That, by the way, is a concomitant 3 of pulmonary emboli too. 4 Q. You mean if you have 5 pulmonary emboli, that will often 6 cause pulmonary artery hypertension? 7 Yes, yes. If you have 8 Α. significant embolic phenomenon, in 9 many instances it will lead to 10 pulmonary hypertension. He also did 11 12have right-sided enlargement and that would go along with a pulmonary 13 14 hypertension too. Q. How would you characterize 15 the degree of pulmonary 16 hypertension? 17 I think that it was 18 Α. 19 significant. And what is it about 20 0. pulmonary emboli that causes 21 pulmonary artery hypertension? 22 Well, it's the change in 23 Α. the pulmonary hemodynamics. 24 The obstructive phenomena leads to a 25

1 greater degree of pressure having to 2 be exerted in order to accomplish 3 the functions of the pulmonary system, toiletry pulmonary 4 physiology, and that then can lead 5 to increased pressure within that 6 7 confined system, and that is what we know as the pulmonary pressure. 8 When it's elevated, then pulmonary 9 hypertension. 10 Q . In your report you make 11 12 reference to chest x-rays which you characterize as showing chronic 13 disease with bullae. What are you 14 referring to there? 15 Well, of course I'm just 16 Α. taking it, you understand, from 17 their report. I'm not reading --- I 18 19 did not read the x-rays myself. Are you asking me what does that mean? 20 Q. Yes. 2 1 Well, bullae are larger 22 Α. blebs. Think of a little 23 outpouching of lung tissue, and when 24 25 they are larger than a couple of

centimeters, then you may call it a 1 2 bullae or plural bullae. Are these chronic 3 Ο. Yes, they would have been Α. 5 there for a while. These are not 6 things that generally develop 7 overnight. 8 9 Q . And what usually causes these findings? 1 0 Well, I don't know his 11 Α. history. Whether some older people 1 2 13 will get some emphysema. I don't know whether this man worked in an 14 environment in which he might have 15 17 diseases, I don't know. And I don't recall whether he was a smoker or 1 could have contributed to. So there 20 2 1 are different etiologies of 22 emphysema. Q. Okay. His nursing record 23 indicates that he had a smoking 24 25 history of four packs per day, quit

three to four years ago. How would 1 you characterize that? 2 Four packs a day is a 3 Α. 4 heavy cigarette smoking habit. 5 Q. Would that be consistent with the findings that you made 6 reference to on his chest x-ray? 7 Yes. The emphysema, yes. Α. 8 Q. Also in your report, you 9 10 make reference to a portable duplex ultrasound. I take it that you 11 12 haven't actually reviewed any film from the ultrasound itself, have 13 14 you? No, I do not do those 15 Α. tests. I was just repeating things 16 that are contained in the records. 17 Okay. And on that study 0. 18 19 it says that the common femoral, superficial femoral and popliteal 21 veins revealed acute clot and acute thrombus superimposed on chronic 2.2 changes of old clot. Did you see 23 that in your report? 24 25 Yes. Α.

27 1 Q. Are you able to tell us of all the clots that were there what 2 percentage were chronic and what 3 percentage were acute? 4 No, I can't tell you that 5 Α. from that report. 6 7 Do you have any way of Q. 8 knowing that one way or the other? No. 9 Α. Ο. So it's possible that the 10 degree of acute clot present on that 11 ultrasound may have been relatively 12 small? 13 Α. There are different 14 possibilities. The spectrum is 1 wide. I cannot tell you. You'd have to get that from the people who did the test and who read or studied these tests, analyze the results. Ι could not tell you that. 21 Q. Okay. I don't remember of that 22 Α. 23 kind of analysis being contained in their report 24 Q. Okay. So based upon 25

case, there's nothing that you can 3 tell from that report which would 4 allow one to say that there was a 5 significant amount of acute clot in б his leqs? I cannot tell you anything 7 Α. 8 more than what is in the report. 9 Which doesn't say anything Q. 10 about the degree or the amount of acute clot present; correct? 11 That's my recollection. 12 Α. 13 I'd like to, for a few ο. 14 moments, talk about the autopsy findings. You've got it there? 15 16 Α. Yes. 17 Okay. First of all, Ο. 18 having looked at the slides that you 19 looked at and having reviewed the autopsy findings as documented in 20 this report, is there anything in 21 22 the report that you take issue with or disagree with? 23 No, I don't think there's 24 Α. 25 anything within the autopsy report

29 that I take issue with. 1 Do you know Doctor Vande 2 Q . Pol? 3 4 Α. No. Q . Based upon what you've 5 seen from the slides and the report, 6 7 and everything else that you've seen about this case, do you believe that 8 it was a competently performed 9 autopsy? 10 Yes. I have no 11 Α. 12 substantial or relevant criticisms of the autopsy report. 13 Okay. I'd like to ask you 14 Q. 15 a few questions about the findings that Doctor Vande Pol made with 16 respect to the cardiovascular 17 18 system. In his report he makes 19 reference to an acute infarction of the right posterior ventricle. Did 20 you see that? 21 Yes. 2.2 Α. Q. Do you have an opinion as 23 to when that infarction occurred? 24 Yes. You're talking about 25 Α.

the one in the right --- did you ask 1 me about the right ventricle? 2 З Ο. I did. Yes, that's correct. Yes, 4 Α. Ξ I do have an opinion. Q. What is your opinion? 6 7 In my opinion, there is a Α. remote infarction that probably goes Е С back several weeks or longer and then there is a superimposed acute 1 C infarction of about seven days. 11 Ιn other words, just what is contained 1 2 in the microscopic report. 13 ATTORNEY TAYLOR-KOLIS: 14 He's reading page 15 seven, I'm sorry. I think 16 you're looking at 1 7 18 different pages. ATTORNEY GROEDEL: 19 20 Yes. Yes, it's page seven of 21 Α. the autopsy report. 22 BY ATTORNEY GROEDEL: 23 **So** you believe he had one 24 Q. 25 infarct in the right ventricle that

was several weeks old and then a 1 - - - ? 2 Several weeks or months, 3 Α. yeah, right. 4 Q. Okay. 5 That's correct. 6 Α. So you would essentially 7 Q. agree with the microscopic 8 description provided ---? 9 Yes, that's right. Α. Yes. 10 Okay. Are you able to Q. 11 characterize the degree of the 12 13 infarctions from a pathological standpoint or from any standpoint, 14 based upon your knowledge? 15 Well, I can only go by the Α. 16 description on page --- let's see. 17 Beginning on page five and let's 18 see, when you say characterize, you 19 2 c mean in degree? Q. Degree of severity. 21 Yes. Well, it's not a Α. 22 huge infarct. It's not a huge 23 infarct, it's not a tiny one. 24 Q. Which infarct are we 25

1 talking about?

2 Did you ask me about the Α. 3 right ventricle, did you not? Q. Yeah. Well, there's two 4 infarcts. There's the remote one 5 and there's the more recent one? 6 That's right. Well, I 7 Α. can't tell you --- from the slide, I 8 can't tell you the size. I can only 9 see evidence of the two. I have to 10 look at the gross description. 11 On page five? 1 2 Ο. The bottom of five, onto 13 Α. six and the prosector does not 14 distinguish if she been between 1 5 acute and remote. So I'm talking 16 about both of them combined because 17 it would appear that they were in 18 the same anatomic location and 19 20 indeed she uses the word 2 1 microscopically superimposed, so we are talking about the one area. 22 Ι don't know what to tell you. I 23 24mean, it's not a tiny infarct, it's 25 not a huge one. It's nothing that

33 1 Q. Minor infarct? 2 Yeah, we don't usually use 3 Α. those words unless you have 4 5 something that is very massive that is close to or does rupture through б the outer of the cardial lining. 7 It's an infarct. I don't know what 8 9 to tell you. If you want to use average, moderate, I have no problem 10 with that. 11 Q . The fact that it's 12transmural, does that have any 13 significance? 14Well, focally transmural, 15 Α. that means that it's into the wall 16 but is otherwise subendocardial, 17 just beneath the inner lining of the 18 endocardium. So the fact that it's 19 20 focally transmural indicates that it 21 is not a deeply penetrating or deeply extensive infarct. 22 Q. And we know from the 2.3 autopsy that there was also an 2 4 25 infarct in the left ventricle?

34 Yes. 1 Α. 2 Q. And this was a recent infarct? 3 No, this one is a ---Α. well, recent in --- let me tell you 5 6 that I agree with what is in the 7 autopsy report on page seven, greater than ten days. I would go 8 along with that. So I don't know 9 10 what you mean when you say recent. 0. Okay. 11 I classify them generally 12 Α. as acute, subacute and chronic. 13 This one I would call subacute 14 because it is, you know, ten days or 15 so. So it's not recent in the sense 16 of being an acute infarct. 17 Okay. How would you Q . 18 characterize the size of that 19 infarct based upon the gross 20 21 description? Α. As you can see on the 22 bottom of page five, it's just a 23 little smaller than the one noted on 24 the right side. 25 And then

35 microscopically, we are told and I 1 would agree that it's transmural and 2 in fact, she uses I see the word 3 remote. Again, a moderate type of 4 5 infarct. 6 0. Okay. Of the slides that you reviewed, did any of them 7 involve cardiac tissue? 8 I'm trying to remember. 9 Α. Ι 10 think they were of the pulmonary arteries as I recall and of the 11 12 pulmonary emboli. Q . Do you recall reviewing 13 any slides involving the microscopic 14 examination of the heart? 15 No. I think they were of Α. 16 17 the lungs and of the pulmonary emboli. 18 really not in a position then to 20 agree or disagree with the 21 22 microscopic examination of the Well, no, except that I Α. 24 have no reason to disagree based 25

upon the clinical history and based 1 2 upon the preciseness of the wording 3 and the description and the fact 4 that the senior pathologist, Doctor Vande Pol, was subsequently deposed 5 and expressed no disagreement with 6 7 what is set forth in the autopsy report. So you know, as I said at 8 the beginning when you asked me did 9 I have any disagreements or 10 criticisms of the autopsy report, I 11 12 do not. I accept it as being accurate and presented 13 appropriately. 14 Did you take any photo 15 Q . micrographs of any of the slides 16 that you reviewed? 17 18 Α. No. Q . Have you been asked to do 19 that? 20 21 Α. No. 22 Q . The autopsy report 23 mentions the presence of cor 24 pulmonale. Do you have an opinion 25 as to the cause of that condition?
37 That would be associated 1 Α. 2 with the pulmonary hypertension, the emphysema, the overall enlarged 3 That's what would have 4 heart. 5 caused over a period of time the development of cor pulmonale. 6 7 Q . How long of a period of time are we talking about? 8 9 Α. Oh, probably years. The autopsy report also 10 0. 11 makes reference to marked dilatation of the right atrium. What was the 12cause of that finding? 13 Well, that right atrium is 14Α. not really significant. That could 1 5 be terminal dilatation. It's of no 16 consequence when the atrium is 17 18 enlarged, what counts is the thickness of the ventricles. 19 There's no ---. 20 0. The right ventricle was 2 1 22 markedly dilatated? Well, that's the 23 Α. 24 definition of cor pulmonale, when 25 the right ventricle is thickened.

38 So the right atrium is of no 1 That's just --- we see consequence. 2 3 that often when people die with 4 whatever the cause may be, whether cardiac or respiratory failure. 5 Q. The autopsy report appears 6 7 to suggest that Mr. Brown had а biventricular hypertrophy. What would be the cause of that 9 condition? $1 \ 0$ 11 Α. Well, I would say that he had to have had high blood pressure 1 2 to get an enlarged heart and then 1 3 the right-sided heart we've talked 1 4 15 about. Sometimes you can get right ventricular hypertrophy secondary to 16 left ventricular hypertrophy in the 17 absence of any lung disease. So he 18 19 would have had that component, plus 2 0 he did have the lung problems. So that was the other component. 2 1 So together they led to the right 22 23 ventricular hypertrophy. The left ventricular hypertrophy would be a 2425 phenomenon associated with

hypertension usually in the absence 1 of the valvular disease or some 2 3 other cause. That would be my most logical conclusion as to the cause 4 of the left ventricular 5 6 hypertrophy. So there was 7 biventricular hypertrophy. How would you characterize 0. 8 the degree of it from a pathological 9 standpoint? 10 This was an enlarged heart Α. 11 and I would say significantly 12 enlarged. 13 Q . What's the normal weight 14 of the heart of a gentleman that 15 weighs 81 kilograms? 16 He's a big man, this Α. 17 gentleman, 81 kilos over six foot. 1.8 19 Probably about 400 grams, something like that. 20 So Mr. Brown's heart was 21 Ο. close to double the size of a normal 22 2.3 heart? The heart was measured at Α. 24 700 grams which included a 25

significant amount of adipose 1 tissue. I think that should be 2 removed because that's not really 3 part of the heart at all. It's just fat overlying the heart. 6 Q. Well, you don't know if they weighed the adipose tissue and 7 included that for that number, do 8 9 you? Well, there's no reason to 10 Α. believe they did not. It says the 11 heart is 700 grams greatly enlarged 12 and invested with an increased 13 amount of adipose tissue. There's 14 nothing here to suggest that they 1 5 dissected it away and weighed the 16 heart without the adipose tissue. 17 18 I'm sure they would have said that. How much do you think the

of adipose tissue, you can be 22 talking about 100 grams. I don't 2.3 know, you'd have to ask them. But 24 25 I'm just going by their

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1 description. The heart was enlarged 2 so whether it was 600 grams or 700 grams, it was enlarged, I do not 3 dispute that at all. 4 5 Okav. What is meant by Ο. the term organizing emboli? 6 It's an embolism that has 7 Α. been there and the clot is beginning 8 to be resolved. 9 Ο. Did you say resolved or 10 resorbed? 11 Well, resolved then 12 Α. resorbed. We use the term somewhat 13 interchangably. 14 15 Q. Okay. More technically correct 16 Α. would be resorbed. When you say 17 it's organized ---. 18 19 Q. Well, let me stick with organizing first. 20 Organizing means that it 21 Α. is beginning to form more of a solid 22 adherent clot as opposed to 23 something that just came there and 24 has had no time to begin to solidify 25

to b'ecome adherent to the wall. 1 3 changes that one sees between the clot and the arterial wall that it's 4 attached to? 5 Α. Yes, and within the clot 6 too, both. 7 Q. What are the findings that 8 one sees pathologically that allows 9 10 a pathologist like yourself to say that we have an organizing clot? 11 Well, you look for 1 2 Α. evidence of inflammatory cells. You 13 look for evidence of fibrosis. 14 You look for any recanalization through 15 clot. You look for adherence to the 16 wall microscopically. Is it really 17 backed up with a kind of a cellular 18 infiltrate in that region indicating 19 20 that there is a genuine adherence. So I'm saying inflammatory cells, 21 22 fibrosis, any recanalization, any infiltration into the wall, the 23 vessel itself, these are the kinds 24 of things that you would look for. 25

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43 1 Ο. What is recanalization? 2 It means some opening of a Α. 3 size through the clot, so that there 4 is some opening of a new channel, a 5 recanalization through the clot. 6 Q. And how long does it take before we see a clot that's 7 organizing? How long does a clot 8 have to be in the pulmonary artery? 9 Well, clots can begin to 10 Α. 11 show some evidence of organization after four days. It varies but 12 probably after about four days you 13 can begin to see some real --- well, 14 the earliest organization will occur 15 sooner. I should differentiate that 16 from perhaps the earliest changes or 17 stage of resorption. Organizing 18 probably would begin in a matter of 19 some hours. A few hours after a 20 clot has been there, you'll begin to 2 1 see some of this organization, 22 namely some infiltration of 23 inflammatory cells that will start 24 25 within a few hours. Then the

fibrosis, that will take longer, 1 2 the adherence and then you move into 3 the early stages of resorption and that's what I was referring to 4 actually when I said about four days 5 or so after the clot has lodged at б that point in the vessel. 7 Is there any textbook that you could direct me to that would teach me about the process of 10 organization in pulmonary arteries? 11 I would say any of the 12 Α. textbooks on basic pathology and 13 14 then ---. What would they be ---? 15 ο. 16 Α. I know there are ---. What are the ones that you 17 Ο. rely on the most? 18 Well, textbooks, W.A.D. 19 Α. Anderson is a two-volume set. 20 21 Robbins is a two-volume set, I 22 believe. Then there are textbooks on pulmonary pathology, but I can't 23 think of the name offhand. 24 25 Q. But the Anderson and the

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45 Robbins, ---1 Anderson and Robbins. 2 Α. Q. --- those are generally 3.1 4 accepted reliable texts? Yes, they are. 5 Α. And generally speaking, 6 Q. 7 when a pathologist uses the term organizing emboli, he's referring to 8 an emboli that's been present for 9 about four days or so? 10 Yes. I would say if you $1\,1$ Α. talk about organizing --- well, no, 12 no, no, no, no. Beginning 13 organization, you'd have to define 14 it, but if you're talking about 15 seeing some changes such as 16 infiltration of inflammatory cells 17 and so on, that would begin within a 18 matter of a few hours. Resorption 19 would begin in a matter of about 20 four days approximately. 21 22 0. In this case, you had the chance to look at the slides of the 23 decedent's pulmonary arteries? 24 25 Α. Yes.

46 1 Q. And it's your belief that 2 Mr. Brown had an organizing thrombus in the main pulmonary artery that 3 was approximately three to five days 4 old? 5 6 Α. Yes, that's correct. 7 And that opinion was based Q. upon what?' 8 Based upon the description Α. 9 in the autopsy report and my 10 examination of the slides. 11 Q. Okay. Would you be able 1 2 to tell us where in the pulmonary 13 arteries this organizing thrombus 14 was situated? 15 Well, no. I mean, I can 16 Α. only tell you from the autopsy 17 report that the clots were noted in 18 the main stem branches as well as in 19 20 smaller branches, she says larger and smaller. So by that, I assume 2 1 she means what we call secondary and 2 2 tertiary branches. Then the slides 23 24 as I recall were not marked as to specific location. However, I noted 2 5

1 that the organizing embolus of a longer duration of an older time was 2 in the smaller arteries and the main 3 pulmonary artery, based upon the 4 5 size, three to five days old. So when you ask me where, you have the 6 main pulmonary artery which then 7 8 branches into primary right and left main stem arteries so it was one or 9 the other. And as I recall, slides 10 did not say right or left. But 11 they're essentially the same except 12 one's to the right and one's to the 13 left. They come off the main 14 pulmonary artery. 15 16 Q. So what you're referring to then would be two, hold on here, 17 two thrombi. You're talking about 18 an organizing thrombi that's three 19 20 to five days old and then you're also making reference to an older 21 organized embolus in the smaller 22 arteries? 23 Well, yes, that's what I 24 Α. 25 referred to in my report. There

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were more than two emboli. If you 1 2 will look at the autopsy report, you have the thrombi, thrombo-emboli in 3 the main branches and then a medium 4 5 and small. So you've got more than two. 6 7 Q. I understand. But if you're asking me 8 Α. about the ones to which I referred 9 insofar as the dating is concerned, 10 11 then yes, the one appeared to be three to five days in the main 12 pulmonary artery, right or left, and 13 14 in the smaller arteries seven to ten 15 days. 16 Q . All right. If I were to give you this picture of the lungs, 17 would you be able to draw for us 18 where you believe the organizing 19 20 emboli was or just draw it yourself?

22 Α. Well, the organizing one insofar as the main pulmonary 23 artery, you see that you have the 24 25 left pulmonary artery and the right

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1 pulmonary artery. So it could be anywhere in this zone. I can't tell 2 Just that that's where you can you. 3 see the main stem. And then the 4 smaller, I can't tell you. It's one 5 of the branches but I can't tell you 6 how far out it goes. 7 8 Ο. Okay. All right. But this is a good Α. 9 description, a good schematic 10 representation that shows you the 11 pulmonary trunk coming up as I said 12 and then it branches and you see one 13 to the right and one to the left and 14 that's what we call the right main 15 and the left main. And then you 16 17 have the secondary and ultimately tertiary branches, but I can't tell 18 you the exact anatomic location. 1 9 Q. Would you be able Okay. 2 c to --- so then I take it then y'ou 21 wouldn't be able to tell us the 22 23 degree of blockage in the right pulmonary artery caused by the 24 organizing emboli; correct? 25

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	5 0
1	A. Well, no, that's not
2	correct. I can tell you that from
3	the autopsy description which says
4	that there was 90 percent luminal
5	blockage on the right and 80 percent
6	luminal blockage on the right and
7	that is specific reference to the
8	main stem branches. I think that's
9	quite clear in the autopsy report on
1 0	the bottom of page six.
11	Q. So do you?
12	A. Within the luminal, the
13	proximal right and left. So she
14	does even tell us proximal which of
15	course means closer, closer to the
16	trunk. So she makes it very clear
17	that it's proximal right and
18	proximal left, and you have 90 and
19	80 percent blockage respectively.
20	Q. And do you believe that
2 1	that blockage was caused by
22	organizing pulmonary emboli?
23	A. Yes, with superimposed
24	acute emboli.
25	Q. All right. Is there

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anywhere in the autopsy report that 1 2 makes reference to a superimposed acute emboli? 3 No, I don't see that 4 Α. specific language. 5 Is there anything in what 6 Ο. you looked at on the slides which 7 8 would allow you to say that there was a superimposed acute embolism? 9 10 Α. In looking at the slides only, I would not know. I could not 11 say, from the slides alone, I could 12 not say that. 1.3Okay. Now, you made 14 Q. reference to the organized remote 15 pulmonary embolisms that were out 16 more into the periphery of the 17 lungs. What sort of findings would 18 19 one need to *see* microscopically before you would characterize a clot 20 as organized? 2 1 Those would be more Α. 22 fibrotic, completely adherent, 23 granulation tissue already in 24 25 place. More fibrosis scarring,

1fewer red blood cells, decreased inflammatory infiltrate which has 2 already done its job in scavenging 3 the dead cells. So it depends on 4 5 how old. What's the minimum age? Q. б 7 I would say for --- well, Α. in this case I would say the minimum 8 would have been seven to ten days so 9 the minimum then would be about a 10 11 week. 120. Okay. Of the slides that I saw. 13 Α. 14 Sure. Q . She did not make sections 15 Α. of all of the slides so I can't tell 16 you if some go back longer. 17Q. Do you have an opinion as 18 to what was causing the embolisms? 19 20 Α. Yes. Q. What is your opinion? 21 Blood clots breaking off Α. 22 from the legs, most probably the 23 24 left femoral area where they noted 25 deep venous thrombosis. Deep venous

thrombosis is generally considered 1 to be the etiology of pulmonary 2 emboli, perhaps in 95 percent of the 3 So here, they did see it in 4 cases. the left femoral vein, so there's no 5 reason to doubt that that was the 6 source of the clots. 7 Do you have an opinion as Q . 8 to the cause of the deep vein 9 thrombosis? 1 0 No. DVT, as it is 11 Α. referred to, is not an uncommon 12 13 condition, It's more common in older people, people who are 1 4 immobilized, people who have heart 1 5 problems, cardiovascular problems 16 and so on, but younger, healthier 1 7 people can get it too. He was 64, 1 8 not 74 which I listed and which I 19 took from the hospital record 2.0 without noting his birth date, but 21 anyway, so he was an older man and 22 he was immobilized and did have a 23 heart problem. So, those are all 24 conditions which certainly could 25

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the development of his DVT. 2 Q. I noticed in the 3 description of the lungs that they 4 described his lungs as being gray 5 and pinkish in color. What's the 6 7 normal ---? ATTORNEY TAYLOR-KOLIS: 8 I'm sorry, page six, 9 what's the page or 10 whatever page so the 11 doctor can find it? 12 I can find it. 13 Α. ATTORNEY TAYLOR-KOLIS: 14 All right. He can 15 find it. 16 Gray-pink, a pretty normal 17 Α. color. It's just no ---. 18 BY ATTORNEY GROEDEL: 19 20 Q. Nothing unusual about that? 21 No. 22 Α. Okay. How about the black 23 Q. pigment? 24Well, that's anthrocotic 25 Α.

pigment which all city dwellers 1 2 have, somewhat industrialized, not as much as Pittsburgh, we'll all 3 have some of that. It doesn't seem 4 to be a lot. She says mottled, but 5 you'll find anybody who's this man's 6 age who has lived in a big city is 7 going to have some of that. Ιt 8 doesn't mean anything. 9 The report makes reference 10 Q. to the presence of multiple intimal 11 webs at the larger and smaller 12 branches of the right and left 13 pulmonary arteries. What are 14 15 intimal webs? That's on page six and five, Doctor? 16 Yeah, I saw that. Α. It's 17 not a description that I use. 18 Ο. Do you know what they're 19 referring to? 20 Just taking the two words, 21 Α. web and intimal, I take it to mean 22 that there were some connections of 23 these smaller branches which she 24 describes then as intimal web like a 25

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56 spider web, just some interconnected 1 2 branching between and among the 3 vessels. Q. Is this making reference 41 5 to perhaps old organized pulmonary emboli? б Α. I would not think so but I 7 really would be engaging in 8 9 conjecture. 0. Okay. 10 I just can't tell you what Α. 11 she means by that. 12 Q . Okay. Fair enough. 1 3 Can 1 4 you turn to page seven of the autopsy report? Under the section 1 5 1 6 describing the lung, the microscopic diagnosis of the lung, it says in 1 7 part many small and medium-sized 1 8 vessels are obliterated by organized 19 20 thrombo-embolus. Can you tell us what is meant by that? 2 1 Yes, that the lumens are 22 Α. completely blocked by the organized 23 24 clots. Q. Okay. And these would 25

57 have been the clots that would have 1 2 been at least ten days old or in 3 that range? 4 I would say organized, Α. 5 probably seven to ten days and possibly older, but minimally that, б 7 yes. And then it goes on 8 Q. Okay. to say while others, and I assume 9 10 she's referring to the vessels, showed marked changes of pulmonary 11 hypertension including intimal 12 proliferation. Can you explain 13 that? 14 Α. Yes. The inner lining of 15 the blood vessel is called the 16 intima. And when the intima becomes 17 thickened, then you could say 18 intimal proliferation, and I believe 19 that when she talks about marked 2.0 changes of pulmonary hypertension, 21 she's talking about an overall 22 increase in the thickness of the 23 pulmonary arterial wall which will 24 25 become an anatomic manifestation of

58 1 pulmonary hypertension. The wall 2 will become somewhat thicker. Q . 3 This is a chronic finding? 4 Α. Yes, it's not something that occurs in a matter of hours or 5 days. 6 7 Ο. And then it also says a section of the left parietal plaque 8 shows dense fibrosis with focal 9 lymphocytic aggregates. What does 10 that mean? 11 That's quite unrelated. 12 Α. Somebody speculated that could have 13 been some asbestosis. People get 14 1 5 plaques from different things and indeed asbestosis exposure is a 16 common cause of plaques. Parietal 17 means that it's on the inner lining 18 of the chest wall as opposed to the 19 visceral lining. It's of no 20 relationship whatsoever to the 21 22 thrombo-emboli cause, formation, aging stage, it's a totally 23 unrelated finding and fibrosis of 2.425 scarring and lymphocytes are just

59 the one kind of inflammatory cell. 1 Okay. The next line talks 2 Ο. 3 about the left and right pulmonary artery showing organizing thrombus 4 5 and then it says with characteristic lines of Zahn and intimal 6 7 proliferation. Can you explain what 8 is meant by characteristic lines of Zahn and intimal proliferation? 9 As a clot begins to 10 Α. organize, then cellular deposits 11 12 form the inflammatory cells and they're called lines of Zahn after 13 the person who first described 14 them. And intimal proliferation we 15 16 just talked about the inner lining of the walls. 17Q . How long does a clot have 18 to be present before we begin to see 19 lines of Zahn? 20 Within a few hours you'll Α. 21 begin to see some early changes that 22 23 can be so characterized. Q. And do those changes go 2.4 away over a matter of days or do 25

60 1 they just stay there? 2 Well, they'll stay there Α. for some days and then as you move 3 ahead with more organization and 4 then resorption, the lines of Zahn 5 will go away. 6 7 Q. At what point do they go 8 away? Oh, probably within a 9 Α. couple of days or more they will 10 11 become somewhat blurred and eventually obscured. 12 Q. The microscopic 13 description talks about marked 14 vascular congestion of the left 15 lower lung lobe. What is that 16 17 referring to? Α. That there's blood 18 engorged in the vessels within the 19 lower lobe. 20 Q. What caused that? 21 22 Α. That's a terminal event as the heart fails and the blood backs 23 24 up, you get congestion. Engorgement 25 within blood vessels is congestion

61 as differentiated from hemorrhage blood outside the vessels. Q. Now, I take it from your report that it's your opinion that 4 c Mr. Brown sustained a superimposed acute embolus shortly prior to his F death? Yes. Е Α. What's the basis for that ç Ο. opinion? 1(Α. The basis for the opinion 11 is that I do not believe he would 12 have lived if he had had pulmonary 13 emboli from some time before that 14 produced 90 percent and 80 percent 1 5 occlusion of the right and left main 1 6 stem pulmonary arteries 17 respectively. With that kind of 18 bilateral occlusion you cannot 1 9 20 survive. If miraculously it stretched the point and say well, 2 1 maybe he might have survived for a 22 little while or so on, I do not 23 believe that you can get that kind 24 25 of massive bilateral occlusion

62 without developing then pulmonary 1 infarcts. No pulmonary infarcts were found at autopsy. The cause of death I 4 C believe must be considered, therefore to have been some Е pulmonary emboli for which we have 7 quite tangible unequivocal evidence ٤ including emboli in the main stem ç 1 C pulmonary arteries, but with additional acute emboli coming up to 11 produce the greater, much more 12 13 substantial blockage, resulting in the traumatic change in this man's 14 condition leading to his death 15 16 within an hour approximately. Then coming in from 17another direction, what alternative 18 considerations are there? 19 We see of course in the records the 20 transcripts and so on, opinions that 21 22 people talk about a heart attack. Well, that's just in my opinion not 23 24 accurate here. The autopsy and the 25 microscopics clearly show that there

3 or misinterpreted by somebody, but4 the records clearly demonstrate that

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back several weeks or months. So it 7 is not correct in my opinion based 9 upon the autopsy report to talk about some kind of terminal acute 10 myocardial infarction. What goes 11 along with that and which is 12 completely consistent and very 13 corroborative of what I've just said 1 4 is the fact that there was only 15 significant atherosclerosis noted in 16 one coronary artery, about 50 17 percent in the left anterior 18 descending coronary artery. We are 19 20 not given percentages of blockage in the other coronaries so I can't give 2.1 you the number, but it is quite 22 clear that there was no significant 23 blockage on page six in the first 24

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coronary arteries have a normal 1 distribution and development. Their 2 3 ostia are in the usual location and 4 the arteries are patent. There is approximately 60 percent stenosis by 5 atherosclerotic plaque of the б proximal 1.5 cm portion of the left 7 main coronary artery but no evidence 8 of thrombosis or occlusion. 9 So we do not have a 10 thrombotic occlusion of any coronary 11 artery. We do not have a hemorrhage 12 into a pre-existing plaque. We have 13 significant but not great blockage 14 of only one branch. There simply in 15 my opinion is no basis from an 16 anatomic standpoint for anybody to 17 infer that he had a terminal heart 18 attack. There's no finding 19 whatsoever to support that 20 contention. 21 So when you put that 22 together with what we do have in the 23 24 pulmonary arteries and the lungs, then I come to the conclusion that I 25

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So I think that the 1 well. 2 additional 40 percent approximately on the right side and the additional 3 30 percent approximately on the left 4 side would have represented the 5 final acute component that led to 6 those sizes of blockage. 7 Q . Are MIs that occur shortly 8 prior to a patient's demise all 9 10 recognizable pathologically? Α. No, they are not. 11 12 Ο. And why is that? Because it takes a while Α. 13 14 for the changes to be manifested grossly and microscopically. 15 16 Ο. What changes are those? Well, the changes of 17 Α. coloration. Microscopically some 18 evidence of early degeneration of 19 the myocardial fibers, and some 20 infiltration of inflammatory cells. 21 These would be the early changes. 22 Microscopically too you might see 23 some marked congestion, some focal 24 hemorrhage interstitially, that is 25

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1 2 initially microscopically before 3 you'd see them with the naked eye. 4 Ο. And how long does it 5 6 usually take those findings to develop? 7 Microscopically we'd 8 Α. 9 probably begin to see some changes within about 45 minutes, something 1 0 like that. Grossly it would 11 probably take over an hour to two 12 1 3 before you'd begin to see some 14changes grossly. Your reference to the 1 5 Q . statement that you don't believe a 1 6 person could live with an 80 to 90 17 18 percent blockage in his pulmonary arteries? 19 Yes, of both. 20 Α. Of 'both, right. Is there 21 Q. any textbook or literature that you 22 could refer me to which you believe 23 2.4 would support that proposition? 25 I would think that any Α.

1 discussion, any textbook that is or chapter within a textbook that talks 2 about pulmonary function, pulmonary 3 physiology, should have some 4 reference to it, but I can't give 5 you a particular name. I don't have 6 a name in mind. 7 Q. That's fine. Is an acute 8 embolus the kind that occurs within 9 an hour prior to a patient's death, 10 something that's recognizable by a 11 12 pathologist on autopsy? Are you referring now to a 13 Α. pulmonary embolism? 14 Q . 1 5 Yes. It would be Yes. Α. 16 recognizable if you are very careful 17 in looking for it **by** opening the 18 pulmonary artery in situ, that is 19 20 before any manipulation or handling of the heart and great vessels is 21 done. And be very gentle in 22 removing the heart and the great 23 vessels, dissecting them in place 24 and then carefully examining the 25

1 clot, then in such an instance, most 2 of the time you would see the fresh 3 clot.

believe that that method wasn't 5 carried out in this case? 6 Well, the answer to the Α. 7 question in which you have phrased 8 it then would have to be yes, and 9 10 that reason is that there is no 11 mention of what in my opinion should be and would be mentioned if one 12 does it the way in which I have 13 14 indicated, and that is to say that the pulmonary artery is opened in 15 That is the standard situ. 16 language, could vary it a little 17 18 bit, but in my opinion, the pathologist should so examine it and 19 make mention of it in that fashion. 2.0 I would make note of something else 21 22 too to be complete if I may, and I want to say something that might be 23 relevant in this discussion and that 24 25 is that you are aware, of course,

	7 0
1	that there was active
2	resuscitation. Some ribs were
3	broken,.some blood was in the
	pericardial sac and I'm not saying
5	that critically. They did what they
6	had to do. But that kind of
7	activity, that kind of pressure can
8	very easily dislodge a fresh clot
9	that has not had time to become
10	adherent. That could be very easily
11	accomplished.
12	Q. Where does it go?
13	A. Oh, it just moves on.
14	It's a fresh clot. It's quite
15	loose. It has a very loose
16	consistency and it just moves on
17	in. In this particular anatomic
18	site, it would just be pushed down,
19	some blood going off into the
2 0	different branches, into fragments.
2 1	I think, in fact, that was referred
22	to by Doctor Vande Pol and that
23	description is correct.
24	Fragmentation, a breaking up is very
2 5	easily done with a quite fresh clot.

71 Q . 1 So I want to get an 2 understanding, where does the fresh clot qo if it's been broken off as a 3 4 result of CPR? Well, some of it can even 5 Α. go backward, in a regressive fashion 6 7 so to speak, toward the main trunk. Main trunk? What's that, 8 0. main trunk of what? 9 Of the pulmonary artery 1 0 Α. coming out of the right ventricle. 11 And other small pieces can go off 1 2 then into the secondary and tertiary 13 branches, just little bits and 14 1 5 pieces here and there to break up those portions of the clot. This is 16 not liquid blood, but it's just the 17 first step beyond liquidity, and 18 it's not something that is solid. 19 It's not adherent to anything, and 20 in this instance, it would have been 21 blood coming up, additional clot and 22 23 becoming enmeshed with pre-existing clots in that area so it would not 24 take much manipulation of one kind 25

72 or another for that amount of clot 1 2 to be just dislodged from its temporary site of attachment. 3 4 Q . But this was a pretty big 5 clot, this acute embolus, wasn't it? 6 Α. Well, yes, but this embolism was not all fresh. 7 But the one that b'roke off Ο. 8 that we don't see, that was a big 9 clot, wasn't it? 10 Well, fairly big, sure. Α. 11 As I've said before, at a minimum of 12 about 40 percent of the one and 30 13 14 percent of the other, taking the 50 percent cutoff as a beginning 15 point. So it's not insignificant, 16 but it is not by itself a huge 17 clot. It's in conjunction with some 18 pre-existing clot which I recognize 19 20 was there and with which description 21 I agree. 22 Q .. Is there anywhere in the autopsy report where there's a 23 description of these acute emboli 24 25 that broke off and travelled to
1 other parts of the body? 2 Α. In the autopsy report, no. 3 Q. But you believe Doctor 4 Vande Pol says that there were acute emboli that had broken off and were 5 in other parts of the body? 6 Well, let me see. 7 Α. Yeah, I 8 have in my own report so without going into his deposition, he 9 testified that quote, it does not 1 0 rule out the possibility that that 11 embolus may have broken up in a way 1 2 that contributed to its further 1 3 clinical impact as an acute event. 14 15 He was asked about this business of a fresh embolus'. And I just want to 16 ___ there's another reference. 17 He also set forth when he 18 was asked about the final event, he 19 said that, quote, some rather not so 20 significant additional emboli which 21 22 may have come up from his legs or 23 elsewhere; or could have been from that large embolus fragmenting and 24 25 dispersing in a more effective

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74 fashion than the initial 1 presentation of the clot, unquote. 2 So again, I'm not going to 3 try to speak for Doctor Vande Pol or 4 overinterpret what he's saying, and 5 you or anybody else may have a 6 different interpretation, but I 7 gather from his language which for 8 me is not completely clear, that he 9 is acknowledging this same kind of 10 concept, as this concept of a 11 breaking off, of a fragmentation, of 12 a dispersal and I think this is my 13 inference from what he was saying 14 15 and in any event, I'm speaking for myself here today. 16 Q. Okay. Are you saying 17 based upon the report that Doctor 18 19 Vande Pol and the prosector did not examine the pulmonary arteries on an 20 in situ basis? 2 1 Α. That would be my 22 inference, yes, in the absence of a 23 specific comment to that effect, I 24 25 believe that the pulmonary artery

75 most probably was not opened in 1 2 situ. Okay. If it was opened in 3 0. situ, you believe the pathologist 4 should have been able to recognize 5 fresh embolus in this case? 6 7 I think if it was opened Α. in situ, there would have been a 8 9 greater opportunity to so recognize the completeness of the clot, but I 10 would add something that I said 11 before which is not to be ignored in 1 2 13 this case. There was significant forceful cardiopulmonary 14 resuscitation as manifested by 1 5 fractured ribs and hemopericardium. 1 6 17 That's great pressure and that's right in the area where the clotting 18 is and that could very easily have 19 20 dislodged a fresh clot or a fresh 21 component of a larger clot. Q . It's possible, isn't it, 22 to be able to see acute clots even 23 if you don't evaluate the arteries 24 25 on an in situ basis?

76 Yes, sure, it's possible. 1 Α. It would depend on how big it is, 2 where it is, so on, but it's 3 4 possible. Ο. And what's the basis for 5 your opinion that this acute 6 embolism was about I think you said 7 8 less than an hour in age prior to the patient's death? 9 Is that what you said? 10 Yes. Well, the basis for 11 Α. that then is what we call clinical 12 pathological correlation. The basis 13 for that is that we do have this 14 sudden death. He was there and 15 relatively stable, no major changes, 16 and then at about 4:50 a.m., 17 arrhythmia, hypertension, and 18 unresponsive to cardiopulmonary 19 resuscitation, dead at 5:30. 20 Let me say this, too, and 21 22 this is not an absolute, but it's a valid and quite relevant point. 23 Most people given prompt 24 professional assistance, ie., 25

cardiopulmonary resuscitation as 1 would have occurred here within a 2 hospital by trained people and in 3 the absence of some massive infarct 4 and in the absence of a really badly 5 6 diseased heart will generally respond. Whether they survive or so 7 on, but the statistics are out а there. That's the whole concept of 9 911s and coronary care units and so 10 on and so forth. 11 12 I can't say with absolute certainty that if, in fact, if his 13 problem was a heart attack that he 14 would have responded, but there's 15 more than a 50 percent chance that 16 if this was really a cardiac event, 17 he would have responded. He would 18 not have gone on to die in 40 19 20 minutes or so. In contrast, there's 21 22 nothing you can do with a massive bilateral pulmonary embolism. 23 Ι 24 personally have known cases, one of my oldest friends --- well, let me 25

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just --- I personally have known 1 2 cases where a doctor has been at the bedside when somebody threw off a 3 pulmonary embolism and there wasn't 4 5 a thing that can be done. They talk б about emergency embolectomies going 7 into the chest. That's so rare as to not even be considered. This 8 clinical picture, the dramatic 9 nature and the unresponsiveness to 10 11 CPR are all just so very consistent with a massive bilateral pulmonary 12 embolism, you just can't do anything 13 about it. That clot is there. 14 When you have this massive Q. 15 embolism on an acute basis, you 16 17 would expect that to cause hypertensive changes, severe 18 hypertensive changes with the 19 patient? 20 Well, yeah, it certainly 21 Α. could, sure, because the physical or 22 the physiological as well as the 23 24 emotional aspect can certainly lead 25 to some rise in the blood pressure.

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1 Which by the way, too, I think would 2 be more consistent with a pulmonary embolism than with a myocardial 3 infarction where more often the 4 5 blood pressure will drop. Q. So if the patient is going 6 to die from an MI, you would expect 7 to see some episode of hypotension 8 prior to the final event? 9 Yes. Prior to death, if Α. 10 the blood pressure continues to be 11 taken, they go into shock, I would 12 expect more often than not some drop 13 in blood pressure. 14 15 Q. Okay. Just so I'm clear, 16 and I think you answered this and if so I apologize, there's nothing on 17 the slides that you saw that allow 18 you to come to your opinion that 19 20 this was an acute embolus at the end, is there? 21 That's correct. If I were 22 Α. looking at the slide alone and knew 23 24 nothing at all about the case, I 25 would not be able to say that there

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had been an acute or recent 1 component of the embolism. 2 3 Q. Okay. Do all pulmonary 4 emboli originate from the deep veins 5 of the legs? As I said, about 95 6 Α. percent in the general population. 7 If you narrow it to certain kinds of 8 disease states and so on, you have 9 other potential causes. 10 The second most frequently involved anatomic 11 area would be the pelvic veins in a 12 man around the prostate and so on. 13 14 In a woman, around the uterus and so And the third most common then 15 on. would be from the right ventricle 16 itself, some mural thrombi that just 17 break off and pass on up into the 18 pulmonary artery but overwhelmingly 19 it's from the legs and usually from 20 the deep veins, the femoral and 2122 popliteal regions. 23 Q. Can you rule out thrombi originating from the heart in this 24 25 case?

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1	A. Yes, I would say because
2	no clots were found in the right
3	side of the heart. And he did not
4	have valvular disease, so I don't
5	think there's any basis at all to
6	think that he had a clot on the
7	right side of the heart.
8	Q. Is the blood flow within a
9	pulmonary artery affected when there
10	are emboli within that artery?
11	A. Well, yes. The blood flow
12	then is obstructed by the clot.
13	Q. Does the blood flow slow
14	down as a result of the clot?
15	A. Well, it's slowed down.
16	It's markedly impeded with a
17	significant clot. It's a lumen and
18	it's his passageway for fluid that
19	is the blood. So it will, yes, slow
20	down. With a large clot, you get a
21	marked diminution of the amount of
2 2	blood getting through.
23	Q. Can you have a slowing
24	down of the blood flow in an artery
25	that's say 50 percent blocked?

Α. I would say there would be 1 relative slowing down, yes. 2 Can a slower than normal 3 Ο. blood flow within a pulmonary artery 4 5 cause thrombus to develop on an in situ basis? 6 7 You can have some clot Α. 8 forming when there is slowing down. 9 That can happen. Is that a possible 10 Q. scenario for this case? 11 12 Α. I could not rule out some additional component being formed 13 there at the site, namely thrombotic 14 activity. However, that's a more 15 16 slowly evolving process and not, in my opinion, one that would have led 17 to such a substantially increased 18 amount of clot over and above that 19 20 which maximally in my opinion could have existed without some 21 demonstration of severe respiratory 22 distress and the development of 23 24 pulmonary infarction and so on. So 25 I can't rule it out 100 percent but

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84 Anatomically, the filter 1 Α. in the inferior vena cava would not 2 relate to what's going on in a 3 pulmonary artery right there, that's 4 correct. 5 Q. You mentioned that you 6 read Doctor Vande Pol's deposition. 7 And I think in his testimony he 8 thought that there were three 9 10 potential causes of death; correct? 11 Α. As I recall, yes. But he wasn't able to Q . 12state which one was the most likely 13 cause. Was that your understanding 14of it? 15 Yes, that's my Α. 16 recollection. 17 18 Q . Okay. And one of the possible etiologies of Mr. Brown's 19 death that he gave was a shifting or 20 fragmentation of the embolus within 21 the pulmonary artery on an in situ 22 basis which caused a more 23 significant hemodynamic blockage and 24 led to his death. 25 Do you recall him

1 saying that? Something along those 2 Α. 3 lines, yes. 4 Q. Do you agree that that's a 5 possible scenario in this case? Well, it's not clear to me 6 Α. exactly what he's saying. I had 7 8 commented on that previously. I agree to the extent that what he 9 is saying is that a large embolus 10 11 fragmenting and dispersing. I'm not sure then what your question is. 12 Are you asking me now --- well, I'm 13 not sure. I should let you tell me 14 what you think Doctor Vande Pol 'said 15 16 and then I'll respond. 0. Yes. My interpretation of 17 what Doctor Vande Pol was saying is 18 that on an in situ basis, the clot 19 shifted or fragmented and so that 20 when this occurred, there was a more 21 significant blockage from a 22 23 hemodynamic standpoint and that's what the terminal event was, as 24 opposed to something travelling up 25

1 from the deep veins as the acute 2 event. 3 No, I really don't Α. understand that from an anatomic or 4 5 pathological sense what he means by a shifting. You're in the main stem 6 7 pulmonary artery. The main branches, right and left, from the 8 pulmonary trunk. I can't accept 9 that because I really don't 10 understand the anatomic basis for 11 that description. 12 0. Okay. When it comes to 13 attempting to ascribe a specific 14 cause of death in a case, should the 15 pathologist who performed the 16 autopsy or the one who's responsible 17 for the autopsy be in the best 18 position to come to that conclusion? 19 Yes. I would agree. 20 Α. The pathologist performing the autopsy 21 should do so. And you know, again, 22 23 you know, going back to the autopsy report and then the death 24 25 certificate which was filled out by

1 the doctor there, you know, it seems 2 to me that they recognize the 3 pulmonary embolism as being the cause of death at that time. 4 Well, first of all, the Q . 5 death certificate was filled out б before the autopsy; true? 7 Yes, that's indicated. 8 Α. 9 Findings were not available, that's 10 correct. Q. 11 And the autopsy itself makes no reference to there being an 12 acute embolism as the final event; 13 true? 1 4 Well, let's see. 15 Α. It's interesting the way it's set forth 16 17 here. They just list everything, so here again, I'm not going to attempt 18 19 to speak for them. 20 Q . Well, I'm not asking you 21 to speak for them. I'm asking you based upon your reading of the 22 report, do you see anything in that 23 report which says that the patient 24 died of an acute embolus? 25

88 Well, now, that statement 1 Α. 2 is ... well, let me say this. Under anatomic diagnoses as I'm looking on 3 page one at the bottom, it says 4 primary and then it's continued at 5 the top of page two. And the first 6 thing that's listed is massive 7 organizing pulmonary embolism, right 8 9 and left main pulmonary arteries, so I would say that that is what they 10 considered to be the primary cause 11 of death. 12 And organizing pulmonary 13 Ο. 14 embolisms usually are three to five days old? 15 16 Α. That's correct. That's 17 right. I won't repeat everything I've said before. 18 Q . I know. We've talked 19 about that. You've read the report 20 of Doctor Mendelson? 21 22 Α. Yes. Is there anything in that 23 Q. report that he says that you 24 disagree with? He comments on his 25

89 interpretation of the slides. 1 2 Α. No, the interpretation that he gives of the slides is 3 correct. I disagree with it only in 4 the sense that I don't think that he 5 --- it's not really a 6 7 disagreement. I should say more correctly that he doesn't go on in that report to talk about other 9 ramifications or considerations. 10 Insofar as he describes what he sees 11 on the slides, I don't disagree. 12 13 Ο. Can I take a look at those reports again? 14 Yes. 15 Α. Thanks. If a pathologist 16 Ο. performing an autopsy had seen a 17 fresh embolus such as the type that 18 you believe was evident in this 19 case, is that something that should 20 be noted in the autopsy? 21 Yes. 22 Α. It's an important finding? 23 Ο. 25 Q. In your report, Doctor,

90 the one dated May 13, 1999, as 1 Exhibit C, you're commenting upon 21 3 Doctor Downs. By the way, do you know Doctor Downs? 4 5 Α. No. 6 Q. You don't know him by 7 reputation? No. 8 Α. 9 Q . You mention in your report, the third paragraph, you 10 state he has given medical/legal 11 testimony in a number of cases 12 13 exceeding 100 since 1981. Do you 14 attach any significance to that? 15' Α. No. Q . 16 Because you've probably 17 given even a few more depositions than that in medical/legal cases; 18 true? 19 Since '81, probably, yes. 2.0 Α. No, I think more doctors should do 21 22 that. 23 Q. What do you mean? Should be interested and 24 Α. 25 be willing to review cases for

91 1 attorneys. 2 Q. As a service to the system 3 so to speak? Yes, really. Yes. 4 Α. 5 Ο. I want to direct your 6 attention to page three of your report dated May 13, 1999. 7 ATTORNEY GROEDEL: а Donna, can you show 9 that to him? 10 ATTORNEY TAYLOR-KOLIS: 11 12 Yes. BY ATTORNEY GROEDEL: 13 14 Q . The second full paragraph where it starts with 50 percent 15 occlusion. Do you see that there? 16 Α. Yes. 17 Is that your opinion or 18 Ο. are you simply parroting what Doctor 19 Downs is saying in his deposition? 20 No, this is a parroting. 21 Α. 22 I'm discussing what he has said. I'm extracting, you know, certain 23 portions of what he has said. 24 25 Q. Okay. Drawing your

92 attention to your opinion section on 1 2 page three of that report, are you 3 there? 4 Α. Yes. Q. You say Doctor Vande Pol 5 6 is correct in stating that the saddle pulmonary embolus showed 7 organization, based on its adherence 8 to the wall with some inflammation 9 in the wall of the blood vessel. 10 What embolus are you referring to 1 1 there, Doctor? 12 The one that we have been Α. 13 talking about that had been there 14 15 before and which showed, you know, some early evidence of organization. 16 So this was the embolus 17 ο. that was in both the right and left 18 pulmonary arteries? 19 Yes, he says saddle right 20 Α. which means, you know, right and 21 22 left. In other words, it 23 Ο. traverses over from the right to the 2.4 left? 25

93 1 Α. Yes. 2 Ο. That's why they call it a saddle embolus? 3 Exactly. Just think of 4 Α. somebody sitting on a horse with a 5 6 leg on each side, right. Q . 7 And then you go on to say here the central portion of the 8 embolus was fresh. What are you 9 referring to there? 10 That's my opinion now. 11 Α. This is entitled opinion, that's 12 13 right. 14 0. And why do you believe it was the central portion of the 1 5 embolus was fresh? 16 Well, because that's where 17 Α. it would come up. It would come up 18 into the middle, and since you have 19 20 adherence to the wall, the clot, you know, can't come into that area. So 21 the space has been occupied. But 22 coming up through the middle where 23 there's no adherence, that's where 2 4 25 it can come up and hook on, so to

speak. In other words, the 1 peripheral margins are blocked to it 2 because the previous clot has made 3 its attachment and the space for the 4 new stuff is down the middle. 5 Q . Circle the area on this 6 and label it with an A where you 7 believe the acute embolus was. 8 Well, just, you know, 9 Α. somewhere in the middle. As I told 10 you before, I can't tell you, you 11 know, where the clot was, but going 12 - - -13 14 Q. Just put an A or a one just so we can document what you're 15doing there. 16 Well, I'll put a one then 17 Α. on each side. 18 19 Ο. Okay. Just to show you what I'm 2.0 Α. 21 talking about. I mean, down the 22 middle as opposed to the peripheral margins where the prior clot had 23 become attached to the wall. 24 Q. On Exhibit D you have an 25

95 opinion here which I assume you're not going to be giving at trial based upon what you've told me previously. You talk about 2 C insertion of an inferior vena cava filter ---E Α. That's correct. F Q. ... was an urgent С indication? That's correct. I shall 1(Α. not be addressing that matter. 11 12 Q . So you won't be addressing any standard of care issues or 1 2 whether there should have been the 14 15placement of an inferior vena cava filter? 16 17 Α. That's correct. ATTORNEY GROEDEL: 18 19 Why don't you mark 20 this whatever next, E, I 21 think we're up to. (Exhibit E marked for 22 identification). 23 BY ATTORNEY GROEDEL: 24 Just for the record, 25 Q.

Doctor, identify E for us. 1 Well, this is a colored 2 Α. two-dimensional photo that you 5 demonstrate where I thought the clots were in the right and left 6 main stem bronchi, pulmonary 7 8 arteries. And then where I believed the fresher component of the clots would have been within those two major branches. 11 Q. Thank you. Do all 12 pulmonary embolisms of 80 to 90 13 percent occlusion cause pulmonary 14 infarction? 15 Well, first of all, I Α. 16 don't think you'd live. So my 17 answer would be I don't think 18 19 anybody would live with that kind of occlusion. And so the answer 20 21 therefore would be no, because it takes 12 hours and more for an 22 23 infarct to develop but, if you 24 wanted me to accept the possibility of anybody surviving, then I believe 25

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97 there would be in almost all such 1 cases the development of an 2 infarct. 3 Q. Do you have an opinion 4 with respect to what Mr. Brown's 5 probable life expectancy would have 6 been had he not died following his 7 surgery? 8 No. I think that gets 9 Α. into the area of clinical medicine 10 and would have to take into 11 consideration then some of the 12 things which will get into standards 13 of care. So I think it's best that 14 I do not express any opinions like 1 5 that. 16 17 Q. Okay. Would you describe for me your current practice now, 18 Doctor? 19 Well, I'm here at St. Α. 20 Francis Central Hospital in 21 pathology. I'm the elected coroner 22 of Allegheny County. I do 23 medical/legal autopsies for coroners 24 2 5 in five other southwestern

98 Pennsylvania counties. I do private 1 autopsies at the request of 2 3 families, attorneys, and agencies. I do medical/legal consultations 4 with attorneys in civil and criminal 5 cases as well as in Workers' Comp 6 7 type cases. And I do some teaching 8 and some writing. Q. What percentage of your 9 professional time would you say is 10 spent actually working as a 11 pathologist in non-medical/legal 12 matters? 13 Well, considering 14 Α. pathology here at the coroner's 15 office, autopsies and so on, I would 16 say all of that comes out to be 17 about maybe two-thirds to 18 three-quarters of an average 80-hour 19 work week. So somewhere like, I 20 don't know, somewhere 55 to 65 hours 22 actually, so something like that. And ---? 23 Q . Most of what I do is Α. 24 25 related directly to pathology.

99 1 Q. Sure. The medical/legal work that you do, would you say that comprises the difference? 3 Yes, except for a little 4 Α. bit of writing and teaching but 5 probably about then some --б 7 Twenty-five (25) percent Ο. to a third? 8 --- 25 again of an 80-hour 9 Α. work week would be related to 10 medical/legal matters, many of which 11 of course involve pathology too in 12 the sense of looking at slides and 13 14 autopsy reports. 15 Q. Sure. 16 But I understand what Α. you're asking me, and then these are 17 medical/legal, whether they be civil 18 or criminal. 19 20 Ο. Of the medical/legal work that you do, approximately what 21 percentage of that is in the medical 22 malpractice arena? 23 Well, it's about 50/50 24 Α. 25 criminal and civi.1, and then on the

1 civil probably about 50/50 between medical malpractice and other kinds 2 of personal injury, who died first, 3 who died when, disease related to 4 accident, product liability, stuff 5 like that. So then of the total 6 consultation work, the answer would 7 therefore be approximately the 8 one-quarter of all that would be in 9 medical malpractice. 10 Q . And of the medical/legal 11 12 work that you get involved in on the civil side, approximately what 13 percentage of it is on behalf of 14 15 Plaintiffs and what percentage for Defendants? 16 It's about 80 percent 17 Α. 18 overall Plaintiff, and in malpractice cases, probably about 85 19 20 percent, somewhat more Plaintiff than in all other kinds of personal 21 injury, something like that. 22 I've had a chance to look 23 Q. through your CV, and I didn't find 24 25 any articles that you wrote that

1 you'd consider relevant to this 2 case. Were there?

5	purely or mainly on the question of
6	pulmonary embolism. I'm sure that
7	there are various articles, you
8	know, references to this disease,
9	sometimes with medical/legal
10	consequences, but I do not believe
11	there's any article that would
12	relate to the specific issues that
13	we have talked about here.
14	Q. Would it be fair to state
15	that the vast majority of the
16	articles that you've written deal
17	with medical/legal issues as opposed
18	to scientific articles in the field
19	of pathology itself?
20	A. Yes, more are
21	medical/legal and forensic, well,
22	forensic scientific. I think the
23	forensic sciences are very
24	scientific, a lot more so than some
25	other fields of medicine such as

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102 psychiatry and other things, but I 1' think I understand what you're 2 saying that they're not purely 3 medical, they're not purely research 4 or largely research. They are 5 medical/legal and forensic 6 scientific to a great extent. 7 Q. 8 Have you written any articles, any peer review articles 9 on pathology issues? 10 Yes, some. There are a 11 Α. few contained in the articles that 1 2 I've written. 13 Q . Approximately when was the 14 1 5 last time you wrote an article on pathology that was published in a 16 peer review journal? 17 Well, I have written Α. 18 19 several there in --- are you 20 cleaving out forensic pathology you mean? 21 2 2 Q. When you say forensic pathology, what are you referring 23 24 to? Α. Forensic pathology is a 2 5

103 purely medical field. I mean, it's 1 2 a recognized subspecialty field since 1959 with required training 3 and national examination by the 4 American Board of Pathology. 5 so it's no different than other 6 subspecialties in that sense in 7 pathology like neuropathology, 8 hematology, and so on. So I can't 9 tell you when was the last one, but 10 11 I've had different articles published, but as I said before, 12 most of them are in the field of 13 forensic pathology as opposed to 1415 being purely anatomic or clinical pathology. 16 Q . Okay. Approximately how 17 many autopsies do you perform on a 18 yearly basis? 19 Myself, now I do about 250 20 Α. 21 autopsies and then as the second 22 pathologist at the coroner's office, 23 about 100 approximately where I participate but where one of the 24 25 other staff pathologists is the

1 primary pathologist. I participate

do by myself, these are private and 5 for the five other coroners in 6 adjacent counties. And then in a 7 secondary role, in about another 8 9 100. The ones that you do for 10 Q. coroners in outlying counties, how 11 is it that you get involved in those 12 autopsies? 13 In essence, I'm their 14 Α. 15 forensic pathologist. They don't have their own 16 Ο. 17 pathologist? Α. Exactly. 18 Okay. 19 Q. 20 Α. I am their forensic pathologist. 21 22 Q. Okay. How many autopsies 23 would you say you do per year for medical/legal reasons? 24 Well, most of the ones I 25 Α.

105 do are for medical/legal. 1 I guess that's so. 2 Ο. The coroner's cases are 3 Α. then medical/legal. The black lung 4 retired coal miner's cases are for 5 legal purposes. Probably about 20 6 percent are cases where families 7 want to know things ranging from 8 Alzheimer's to other matters, but 9 the three-quarters or more would be 10 what I would call medical/legal 11 autopsies. 12 Ο. Okay. Approximately how 13 many medical malpractice cases do 14 you review on a yearly basis? 15 Oh, maybe I get on average Α. 16 17 two to four a month to review. Q. And about how many 18 depositions would you say you give 19 in a medical malpractice case on a 20 yearly basis? 21 Α. Oh, probably about maybe, 22 1 don't know, six to ten, something 23 like that, depositions. 24 Q. And what's your charge for 25

\$1,500 charge ---. 2 3 For the first two hours. Α. And after that? 4 Q . Then \$500 for each hour 5 Α. 6 thereafter. That's what I charge. Whether it's malpractice or homicide 7 or personal injury, I do charge less 8 10 lung cases, but all other cases, that's the charge. 11 Q . About how many times do 12 you testify in Court on a yearly 13 basis? 14 Oh, maybe, well, I would 15 Α. say probably about six ---. 16 17 Q . I'm talking about civil 18 cases now. Oh, in civil? I was going 19 Α. to exclude the coroner's cases from 20 21 other counties. In civil cases, 22 testifying in Court, probably about maybe four times a year. It's not 23 very often. 24 And what do you charge for 25 Q.

107 1 a Court appearance? 2 When I go out of town, I Α. charge \$3,500 plus reimbursement of 3 travel expenses. 4 5 Q . What percentage of your overall income would you say you 6 7 derive from working in medical malpractice matters? 8 9 I could not tell you that Α. 1 0 because whatever income I get all goes into the one professional 11 1 2 account and there's no categorical breakdown that I keep or my 1 3 1 4 secretary. 1 5 Ο. Okay. You know, overall it's not 16 Α. 17 a very big percentage. As we talked before, the number of cases that I 18 19 do and the percentage of time that I 20 spend overall on consultations and so on, so it's not huge. I just 21 can't even give you some idea. 22 23 Q. Okay. Well, then would 24 you be able to give an approximation 25 as to what percentage of your

108 overall income you derive from your work in medical/legal matters? 2 3 Overall medical/legal, Α. then it probably comes out to be -4 we talked of the medical/legal 5 б cases, it's kind of fairly consistent or correlative with the 7 time spent, maybe about 20 to 25 8 percent of my income. 9 Would it be fair to say 1 0 Q. that you've given hundreds of 11 depositions in your career? 12 13 Α. Over 37 years, yes, that would be accurate. 14 Okay. Now, you're an 15 Q. attorney? 16 17 Α. Yes. You don't practice law, 18 Ο. 19 though? No. There is a Wecht law Α. 20 2 1 firm, my son and my wife. If there are some medical things, I will look 22 over the medical reports, hospital 23 records, but I'm not doing anything 24 more than that. I don't have the 25
109 1 time. So I am associated with that firm in name and that's the extent 2 of the role that I play. 3 Q. Have you been a member of 4 5 ATLA? Yes, I was, for years. 6 Α. I think I ceased being a member more 7 than ten years ago as I recall, 8 maybe around 1988 or so. 9 Why is that? 10 0. Well, I didn't have time 11 Α. to attend meetings. I didn't feel 12 there was a need for the 13 publications which were not 14 particularly necessary for me, so 15 16 I'd say a combination of time and I began to think about all the money I 17 was spending maybe with some 18 professional organizations. So all 19 20 in all, I decided it really did 21serve no purpose in my professional life to continue with the 22 membership. I had enjoyed going to 23 meetings earlier when I had time, 24 25 but found that I hadn't been going

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110 to meetings for several years and 1 2 just decided it made no sense. ATLA's the association of Ο. 3 essentially the Plaintiff bar? 4 5 Α. Plaintiff civil cases, defense attorneys in criminal cases, б 7 and Claimant's attorneys and Workers' Comp. 8 Q. You mentioned on your CV 9 here that you were a fellow of the 10 American College of Legal Medicine. 11 What is that? 12 It's a national Α. 13 organization consisting of people 14 who have both M.D. and J.D. degrees 15 16 and from the United States universities. 17Q. There's also a reference 18 to an American Association of 19 Medical/Legal Consultants of which 20 you're the vice-president. What is 21 that? 22 Α. Yeah, they're no longer in 23 existence. If it doesn't have a 2.4 cutoff year, it should. Does it 25

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1 say? 2 I thought it said 1972 to Ο. present but ---? 3 Well, it should be ---4 Α. they ceased existence a couple of 5 years ago. It was an organization 6 7 set up by a small number of people, a Plaintiff's attorney, a defense 8 attorney, a couple of M.D./J.D.s. 9 They were quartered in 10 Philadelphia. They received cases 11 from doctors, hospitals, attorneys 12 and they would then have them 13 reviewed by a primary reviewer, and 14 then if necessary, a secondary 15 reviewer. By the way, one of the 16 founders of that group was a very 17 distinguished defense attorney from 18 Cleveland, Crawford Morris, who was 19 one of the foremost malpractice 20 21 defense attorneys in the United 2.2 States for a long time as I recall. Were you the editor of a Q . 23 24 text entitled <u>Preparing and Winning</u> Medical Negligence Cases? 25

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	112
1	A. One <i>of</i> three co-editors,
I	yes.
	Q. And were you the editor of
	a test entitled <u>Handling Soft Tissue</u>
5	Injury Cases, The Medical Aspects?
б	A. Yes, again, I believe one
7	of three co-editors.
8	Q. Have you written or edited
9	any books that pertain to the
10	defense of medical negligence cases?
11	A. Well, the winning and
12	whatever, preparing, winning is for
13	all attorneys. I mean, it's not
14	just for Plaintiff's attorneys, it's
15	for everybody who does this work.
16	Either side can win. Winners aren't
17	always Plaintiff's attorneys. In
18	fact, statistics show winners are
19	more frequently defense attorneys so
2 0	
21	Q. You mean the book wasn't
22	geared toward the Plaintiff's bar?
23	A. Not my portions. It's a
24	three-volume set. The other two
2 5	co-editors were Plaintiff's

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113 1 attorneys. One is fully retired, 2 one is partially retired. So I think probably that one, it 3 certainly does come in from their 4 perspective and their experience. 5 The two volumes which I dealt with 6 are purely medical and a variety of 7 8 medical experts dealing with their specialties and there's no Plaintiff 9 10 or defense spin on any of that. That's just straight medical stuff 11 in volumes two and three. 12 13 Ο. Did you write a chapter on obstetrics? 14 15 Α. Me? Q . Yeah. 16 Gee, did I? I forget. Ι Α. 17 wrote some and I don't remember. Ιf 18 my name's there as the author, I 19 did. If it's not, then I did not. 20 21 I just don't remember. Q . Okay. All right. You've 22 got something here in your CV that I 23 24 just have to ask you about. You wrote a book entitled Who Killed Jon 25

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1141 Benet Ramsey? Α. Yes. Q. 3 You co-authored that with Charles Bosworth? 4 5 Yes. Α. What was your conclusion? 6 Q. My conclusion is that it's 7 Α. 8 one or more of the parents who did it and the other parent covering 9 up. There is no outside intruder 10 and no unknown outside murderer. 11 Q. And I see you've been 1 2 involved in an organization known as 13 14 Citizens for Truth About the Kennedy Assassination, in fact, you're on 15 the board of directors? 16 Α. Yes. 17 Q. I take it then you're of 18 the opinion that there were more 19 20 than one person responsible for the death of the late president? 2 1 22 Α. Yes. And have been active in 23 Ο. trying to get that belief out to the 24 public, I guess? 25

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115 Α. Yes. 1 2 Ο. I know we stopped talking about the medicine about 15 minutes 3 or so ago, Doctor, but getting back 4 to it, have we covered all of the 5 opinions that you intend to render 6 7 in this case at trial? Yes. As far as I am 8 Α. 9 aware, there's no area that, you know, has not been touched upon. 1 0 Obviously I can't know whether 11 Ms. Taylor-Kolis or you may come up 12 with other questions, but there's no 13 area that has not been discussed 1 4 that I have thought about and that 15 Ι would think would be pertinent to my 16 involvement regarding cause of 17 18 death. ATTORNEY GROEDEL: 19 20 Okay. Thank you. We're done. 2 1 22 ATTORNEY TAYLOR-KOLIS: 23 Would you like to read this deposition, Doctor? 24 That's really up to you. 25 Α.

116 1 If I were going to be testifying, 2 yes, but I don't want to hold you 3 back. I mean, I don't have any 4 problem with the reporter going ahead and just doing it. I don't 5 want to hold it up. 6 ATTORNEY TAYLOR-KOLIS: 7 All right. We'll 8 waive. 9 I mean, it really is your 10 Α. 11 decision. I don't have any problem in not doing it. You decide. 12 ATTORNEY TAYLOR-KOLIS: 13 1 4 I guess we could waive the reading unless 1 5 Mr. Groedel would like you 16 to read it. 17 ATTORNEY GROEDEL: 18 That's not my 19 20 opinion. * * * * * * * * 2 1 22 DEPOSITION CONCLUDED AT 1:23 P.M. * * * * * * * * 23 24 25

1								
2	:							
3	COMMONWEALTH OF PENNSYLVANIA:							
4	: SS COUNTY OF CAMBRIA							
~	CERTIFICATE							
6	I, Denise Jeanne Khorey-Harriman, Notary Public in and for the							
7	Commonwealth of Pennsylvania, do hereby certify:							
8								
9	That the witness was hereby first duly sworn to testify to the truth, the							
10	whole truth, and nothing but the truth; that the foregoing deposition was taken							
11	at the time and place stated herein; and that the said deposition was taken in							
12 13	Stenotype by me and reduced to typewriting, and constitutes a true and correct							
14	record of the testimony given by the witness.							
15	I further certify that the reading and signing of said deposition							
16	were (not) waived by counsel for the respective parties and by the witness.							
'7	I further certify that I am not a relative, employee or attorney of any of							
18 19	the parties, nor a relative or employee of counsel, and that I am in no way							
20	interested directly or indirectly in this action.							
20	IN WITNESS WHEREOF, I have hereunto set my hand and stamp this							
22	10 th day of <u>(lequest</u>)							
23								
24	$\frac{1}{2} \left(\frac{1}{2} \right) \left(1$							
25	Cenese Jame Hody Harring 2							
	Denise Jeanne Khorey-Harriman, Notary Public Cambria County, Pennsylvania My Commission Expires Mar. 5, 2001							
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LAWYER'S NOTES

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SARGENT'S COURT REPORTING SERVICE, INC.

210 MAIN STREET JOHNSTOWN, PA 15901 (814) 536-8908 PHILADELPHIA, PA WILKES-BARRE, PA OIL CITY, PA SOMERSET, PA CLEARFIELD, PA *CHARLESTON, WV*

CURRICULUM VITAE

Cyril Harrison Wecht, B.S., M.D., J.D. NAME: DATE OF BIRTH: March 20, 1931 Pittsburgh, Pennsylvania PLACE OF BIRTH: 5420 Darlington Road HOME ADDRESS: Pittsburgh, Pennsylvania 15217 Phone: (Area Code 412) 521-2881 OFFICE ADDRESS: St. Francis Central Hospital Director of Forensic Pathology 1200 Centre Avenue Pittsburgh, Pennsylvania 15219 Phone: (Area Code 412) 281-9090 FAX: (Area Code 412) 261-3650 Coroner of Allegheny County Allegheny County Coroner's Office 542 Fourth Avenue Pittsburgh, Pennsylvania 15219 Phone: (Area Code 412) 350-4800 FAX: (Area Code 412) 350-4899 EDUCATION : 1943-1948 Fifth Avenue High School - Highest Honors, Valedictorian University of Pittsburgh - B.S. - Cum Laude 1948-1952 1952-1954 University of Buffalo School of Medicine

- 1956 University of Pittsburgh School of Medicine M.D.
- 1957-1959 University of Pittsburgh School of Law -Law Review

I. EDUCATIONAL

- 1962 University of Maryland School of Law LL.B.
- 1962 University of Pittsburgh School of Law J.D.

ACADEMIC SCHOLARSHIPS, HONORS, AND AWARDS:

1948	Daughters of American Revolution History Award
1948	Rensselaer Polytechnic Institute Medal for Science and Mathematics
1948-1949	Allegheny County Achievement Award and Scholarship, University of Pittsburgh

1948-1949	Buhl Foundation Scholar, University of Pittsburgh
1948-1952	Honor Scholarship, University of Pittsburgh
1951	Senior Worthy, University of Pittsburgh (Outstanding Junior Student)
1951	Outstanding Undergraduate of Year Award, Phi Epsilon Pi International Fraternity
1952	Hall of Fame, University of Pittsburgh
1955-1956	State Senatorial Scholarship, University of Pittsburgh School of Medicine
1957-1958	Law School Scholarship, University of Pittsburgh
1958-1959	Owens Fellowship, University of Pittsburgh

II. PROFESSIONAL AWARDS

1972	Who's Who in Israel
1973	Voice of Medicine Award, Pennsylvania Medical Society
1975	Who's Who in Government
1977	Who's Who in America
1978	Honorary Member, Allegheny County Police Department
1978	"Distinguished Service to Law Enforcement Award", County Detectives Association of Pennsylvania
1978	"Distinguished Service to Law Enforcement Award", Pennsylvania State Division of the International Association of Identification Officers
1979	President's Certificate of Appreciation for Meritorious Service, American College of Legal Medicine
1990	The Best Lawyers in America: Directory of Experts
1996	Gold Medal Award, Lifetime Achievement in Legal Medicine American College of Legal Medicine
1996	Career Achievements Award, Contributions to Forensic Pathology and Legal Medicine New York Society of Forensic Sciences

III. COMMUNITY AWARDS

1965	Selected as one of the "Outstanding Young Men of America", National Junior Chamber of Commerce
1966	Honorary Life Member, Italian Sons and Daughters of America
1971	Community Leaders of America
1976	Dictionary of International Biography
1976	"Outstanding Alumnus of 1976", University of Pittsburgh Gamma Circle of Omicron Delta Kappa
1977	Myrtle Wreath Award, Hadassah, Pittsburgh Chapter
1977	"Man of the Year Award", American Legion of Allegheny County
1978	Speaker of the Year Award, Speech Communications Association of Pennsylvania
1979	Meah Club Award, Hebrew Institute of Pittsburgh
1979	Distinguished Alumnus Award, Alpha Phi Omega Fraternity, Beta Chapter, University of Pittsburgh
1982	Board of Directors, Jewish Sports Hall of Fame <i>of</i> Western Pennsylvania
1983	Humanitarian Award, Jewish War Veterans, Pennsylvania Department
1984	Honorary Kember, Honorable Order of Kentucky Colonels
1985	"Man of the Year Award", Israel Bonds ZOA
1991	Special Alumni Award, Zeta Beta Tau Fraternity
199s	Hall of Fame Award for Outstanding Achievements in Professional, Communal, and Governmental Activities, B'nai B'rith, District Three, Philadelphia
1596	Ziggy Kahn Award for Outstanding Contributions to Activities of Young People in Western Pennsylvania, Jewish Sports Hall of Fame of Western Pennsylvania and Sports for Israel

1998	Lifetime Achievement Award,
	B'nai B'rith, Areas of Western Pennsylvania,
	Western New York, West Virginia, and Ohio.

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SOCIAL, PROFESSIONAL, AND HONORARY SOCIETIES:

1948	Phi Epsilon Pi - National Officer - 1958-1970 President, Tri-State Alumni Association - 1962-1963 National President - 1967-1969					
1949	Phi Eta Sigma (Freshmen Scholastic Achievement)					
1949	Alpha Phi Omega (Service to University)					
1950	Druids, President (Sophomore and Junior Activities/Scholarship Fraternity)					
1950	Beta Beta Beta Honorary Biology Fraternity, University of Pittsburgh					
1951	Pi Delta Epsilon (Journalism)					
1951	Delta Sigma Rho (Debate)					
1951	Theatron (Dr ama tics)					
1952	Omicron Delta Kappa (Junior/Senior Activities/Scholarship)					
1954	Phi Delta Epsilon Medical Fraternity					
1956	"Scope and Scalpel", President and Founder (Medical School Theatrical Group)					
1962 -Pres.	Phi Delta Epsilon Graduate Club of Pittsburgh					
	PROFESSIONAL TRAINING:					
1954-1956	Externship - St. Francis General Hospital and Rehabilitation Institute, Pittsburgh, Pennsylvania					
1956-1957	Internship - St. Francis General Hospital and Rehabilitation Institute, Pittsburgh, Pennsylvania					
1957-1959	Resident in Pathology, Veterans Administration Hospital, Pittsburgh, Pennsylvania					
1959-1961	Associate Pathologist, United States Air Force Hospital, Maxwell Air Force Base, Montgomery, Alabama					

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an-constant.	, en el terre en	1961-1962	Research Fellow in Forensic Pathology and Associate Pathologist, Office of the Chief Medical Examiner, Baltimore, Maryland
			PROFESSIONAL EXPERIENCE:
		1961 - 1962	Pathologist, North Charles General Hospital, Baltimore, Maryland
		1962-1964	Acting Chief, Laboratory Service, and Pathologist, Leech Farm Veterans Administration Hospital, Pittsburgh, Pennsylvania
		1964-1965	Acting Chief, Laboratory Service, and Pathologist, Charleroi-Monessen Hospital, North Charleroi, Pennsylvania
		1964-1978	Director, Pittsburgh Pathology and Toxicology Laboratory, Pittsburgh, Pennsylvania
		1966-1968	Associate Pathologist and Associate Director of Laboratories, St. Clair Memorial Hospital, Pittsburgh, Pennsylvania
		1968-1982	Pathologist and Laboratory Director, Podiatry Hospital of Pittsburgh
		1973-Pres.	Chairman, Department of Pathology, and Chief Pathologist, St. Francis Central Hospital (formerly Central Medical Center & Hospital), Pittsburgh, Pennsylvania - 1973-1996. Member, Board of Directors - 1975-1982 Member, Medical Staff Executive Committee -
			1975-Pres. Chairman, Tumor and Tissue Committee -
			1974-1996. Co-Chairman, Transfusion Review Committee - 1974-1996. President, Medical Staff - 1995-1997. Director of Forensic Pathology - 1997-Pies.
		1973-Pres.	Consultant Pathclogist, Mayview State Hospital
		1978-1992	Consultant Pathologist and Director Latrobe Laboratory, REAMDS Health Group, Ltd.
		1985-1991	Consultant Pathologist, Woodville State Hospital
		1992-Pies.	Consultant Pathologist, Torrance State Hospital

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ARMED FORCES:

1959-1961	Captain,	United	States	Air	Force	(Medical	Corps)
1961-1965	Captain,	Inactiv	ve Resei	cve,	United	States	

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Captain, Inactive Reserve, United States Air Force (Medical Corps)

TEACHING APPOINTMENTS:

1957-1959	Teaching Fellow, Department of Pathology, University of Pittsburgh School of Medicine
1959	Lecturer in Legal Medicine, University of Pittsburgh School of Medicine
1962-1965	Clinical Instructor in Medicine (Legal Medicine), University of Pittsburgh School of Medicine
1962-1970	Lecturer, Law-Science Academy of America
1962 - 1972	Clinical Instructor in Pathology (Forensic Pathology), University of Pittsburgh School of Medicine
1972-1973	Clinical Assistant Professor of Pathology, University of Pittsburgh School of Medicine
1973-1985	Clinical Associate Professor of Pathology, University of Pittsburgh Schools of Medicine and Dental Medicine
1985-1996	Clinical Adjunct Associate Professor of Pathology, University of Pittsburgh School of Medicine
1985-Pres.	Clinical Adjunct Professor of Pathology, Department of Diagnostic Services, University of Pittsburgh School of Dental Medicine
1974-1996	Adjunct Associate Professor of Epidemiology, University of Pittsburgh Graduate School of Public Health
1962-1964	Lecturer in Legal Medicine, Duquesne University School of Law
1964-1978	Research Professor of Law, Duquesne University School of Law
1964-1978	Director, Institute of Forensic Sciences, Duquesne University School of Law
1974-Pres.	Adjunct Professor of Pathology and Legal Medicine, Duquesne University School of Pharmacy
1984-Pres.	Adjunct Professor of Law, Duquesne University School of Law

1988-Pres.	Lecturer, Pennsylvania State Police Academy Greensburg Barracks
1991-Pres.	Adjunct Professor, Duquesne University John G. Rangos, Sr. Graduate School of Health Sciences
1991-Pres.	Member, Advisory Committee Duquesne University Graduate School of Health Sciences
1996-Pres.	Clinical Professor of Pathology, University of Pittsburgh School of Medicine
1996-Pres.	Clinical Professor of Pathology, University of Pittsburgh School of Dental Medicine
1997-Pres.	Clinical Professor of Epidemiology, University of Pittsburgh Graduate School of Public Health
	VISITING PROFESSORSHIPS AND SPECIAL GUEST LECTURES:
1964	University of Texas School of Law Law and Medicine Course
1974	Harvard University School of Law
1980	Southern Illinois University Medical and Law School (One of three keynote speakers, along with Supreme Court Justice Harry Blackmun and the President of the Illinois State Bar Association.)
1985	Ministry of Health, Singapore (Special invitee - keynote speaker.)
1988	Royal Society of Medicine Inaugural Meeting, Section on Clinical Forensic Medicine, London (Special invitee • keynote speaker.)
1988	Bicentennial Celebration, Australian Medical Association, Cairns (Special invitee - Plenary Session speaker.)
1988	International Congress on Forensic Sciences, Forensic Medicine Association of China, Beijing (Designated Member, International Organizing Committee, and Vice Chairman - speaker.)
1992	Yale University School of Medicine Grand Rounds

MEDICAL LICENSES:

1957	Diplomate,	National	Board	of	Medical	Examiners

- 1957 Pennsylvania
- 1960 California
- 1961 Maryland

MEDICAL SPECIALTY CERTIFICATION:

- 1963 Diplomate, American Board of Pathology -Anatomic and Clinical Pathology
- 1964 Diplomate, American Board of Pathology -Forensic Pathology
- 1982 Charter Diplomate, American Board of Legal Medicine

MEDICAL SOCIETIES AND SCIENTIFIC ORGANIZATIONS:

1957-Pres.	Allegheny County Medical Society Member, Board of Directors - 1968-1971 Member, Grievance Committee - 1965-1968 Delegate to Pennsylvania Medical Society - 1968-1970 Member, Committee for the Medical Examiner System Member, Anesthesia Mortality Committee Member, Medical-Legal Committee, and Chairman - 1973-1974
	Member, Drug Abuse Committee, and Chairman - 1970-1974 Chairman, Medical-Legal Committee 1998-Pres.
1957-Pres.	Pennsylvania Medical Society Member, Commission on Forensic Medicine - 1969-1977
1957-Pres.	American Medical Association Physician's Recognition Award - 1970-Pres.
1957-Pres.	Pittsburgh Pathology Society
1960-Pres.	Fellow, College of American Pathologists Inspector - 1991-Pres.
1961-Pres.	Fellow, American Society of Clinical Pathologists
1961-1962	Baltimore Pathology Society
1963-1975	Pennsylvania Academy of Science

1963-Pre	s. Pennsylvania Association of Pathologists Co-Chairman, Legislation Comittee - 1965-1966
1964-198	0 Pittsburgh Academy of Medicine
1964-198	5 Pittsburgh Medical Forum
1964-1988	8 American Association for the Advancement of Science
1964-1969	9 Pan American Medical Association
1970 - 1980	D Pennsylvania State Coroners Association
1970-1980) International Association of Coroners and Medical Examiners
1973-1983	American Society of Forensic Odontology
1973-1982	Pennsylvania Association of Clinical Laboratories, Inc. Member, Board of Directors - 1978-1980
1974-Pres	Fellow, American Physicians Fellowship for the Israel Medical Association
1988-Pres	. Royal Society <i>of</i> Medicine Member, Clinical Forensic Medicine Section Member, Accident & Emergency Medicine Section
1991-1995	Charles P. Bailey Chair for Cardiothoracic Surgery, Hahnemann University Member, Steering Committee
1996-Pres	Pennsylvania State Coroners Association
	LAW LICENSES:

1963	Pennsylvania
	(Admitted to practice before all Pennsylvania
	Courts, United States District Court for the
	Western District of Pennsylvania, Third Circuit
	Court of Appeals, and United States Supreme Court.)

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LEGAL SOCIETIES:

1963-Pres.	Allegheny County Bar Association Vice-Chairman, Medical-Legal Committee - 1973,
	and Chairman - 1974-1978
	Member, Medical-Legal Committee - 1973-1990
	Member, Building Committee - 1981-1988
	Member, Health Law Council - 1997-Pres.

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1963-Pres.	Pennsylvania Bar Association Member, Joint Medico-Legal Committee Member, Medico-Legal Committee - 1981-1988 Member, Senior Lawyers Committee - 1996-Pres.
1953-Pres. 1963-1988	 American Bar Association Member, Committee on Law and Medicine - 1973-Pres. Vice-Chairman, Committee on Law and Medicine - 1973-1977 Publications Vice-Chairinan, Committee on Law and Medicine - 1957-1977 Products, General Liability, and Consumer Law Committee - 1985-1988 Toxic and Hazardous Substances Committee - 1985-1988 Forum Committee on Health Law - 1985-1988 Association of Trial Lawyers of America Member, National Committee on Professional
	Negligence Insurance - 1968-1975 Chairman, Committee on Liaison with Medical Associations - 1969-1973 Member, Medical Malpractice Committee - 1975-1976 Member, Professional Legislative Affairs Committee - 1975-1976
1953-1985	Pennsylvania Trial Lawyers Association
1963-1985	Western Pennsylvania Trial Lawyers Association
1965 - 1983	American Judicature Society
1965 - 1985	American Arbitration Association
1965-1979	Association of Trial Lawyers in Criminal Court, Allegheny County, Pennsylvania
1966-1976	Federal Ear Association Chairman, Tort Section, Pittsburgh Chapter - 1967
1958-Pres.	American Society of Hospital Attorneys
1972-1979	Member, SCRIBES (Society of Legal Writers)
1973-1978	American Association of Law Schools Member, Law and Psychiatry Section
	MEDICAL-LEGAL SOCIETIES:
1962-Pres	<pre>Fellow, American Academy of Forensic Sciences President • 1971-1972 President-Elect • 1970-1971 Member, Executive Committee • 1968-1973 Interview Coordinator, Mid-Atlantic States • 1966 Chaiman, Legis1ative Affairs Committee, Pathology Section • 1966</pre>

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	Secretary, Pathology and Biology Section - 1967-1969
	Chairman, Pathology and Biology Section - 1968-1969
	Associate Program Chairman - 1969 Annual Meeting Program Chairman - 1970 Annual Meeting Chairman, International Relations Committee - 1977-1982
	Liaison Representative to the Association of Trial Lawyers of America - 1977-1980 Co-Chairman, International Relations Conunittee - 1978-1988 Member, Select Committee of Past Presidents - 1980-1981
1962-1973	Fellow, Law-Science Academy of America Vice Chancellor and Member, Board <i>o</i> f Trustees - 1966-1970
1963-Pres.	Director and President, Pittsburgh Institute of Legal Medicine
1964-1978	Fellow, International Academy of Law and Science Member, Board of Regents - 1966-1969
1964-Pres.	<pre>Fellow, American College of Legal Medicine President - 1959-1972 Vice President - 1968-1969 Member, Board of Governors - 1966-1976 Chairman, Honorary Fellowship Committee - 1973-1977 Member, Legislation Committee - 1974-1978 Member, Medical Malpractice Committee - 1975-1976 Member, Nominating Committee - 1975-1976, and Chairman - 1988 Member, Projects Committee - 1975-1976 Member, Ad Hoc Task Force on Death and Dying - 1978-1979 Program Chairman - 1979 Annual Meeting Member, Select Committee on Policy and Planning - 1983-Pres. Chairman, Judicial Council Committee - 1984-1988 Vice President, Board of Trustees, ACLM Foundation - 1985-1987 Chairman, 1987-Pres. Member, Education Committee - 1989-Pres. Chairman, Ad Hoc Legal Medicine Library Committee - 1989-1991 Member, Finance Committee - 1992-Pres. Chairman, 800-HELP Line Task Force - 1002 Dres</pre>
	1993-Pres. Member, Referral Committee -1995-Pres.

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1965-Pres.	International Academy of Legal Medicine and Social Medicine Vice President - 1976-1979 National Correspondent for North America - 1976-1984
1965-Pres.	International Association for Accident and Traffic Medicine Member, Executive Council Secretary-General - 1966-1969 Vice President - 1970-1973
1965-1992	Fellow, American Society of Legal and Industrial Medicine (Formerly American Academy of Compensation Medicine)
1966-Pres.	International Association of Forensic Sciences Vice President - 1975-1978
1966-Pres.	National Association of Medical Examiners Member, Board of Directors - 1976-1978
1968-Pres.	Association for the Advancement of Automotive Medicine
1971-1973	American Society for Testing and Materials Chairman, Committee E-30 on Forensic Sciences
1972-Pres.	American Association of Medico-Legal Consultants Vice President
1973-Pres.	Fellow, British Academy of Forensic Sciences
1973-Pres.	Fellow, Forensic Science Society of England
1973-1976	National Foundation for the Study of Health Science Liability Member, Board of Directors
1974-1982	The Forensic Sciences Foundation, Inc. Member, Board of Trustees
1979-Pres.	. Pan American Association of Forensic Sciences Member, Organizing Committee
1981-Pres.	American Board of Legal Medicine Chairman, Program Development Committee on Forensic Medicine - 1984-Pres. Chairman, Board of Trustees - 1986-1995.
1987-Pres.	American College of Legal Medicine Foundation Chairman, Board of Trustees - 1989-1995.
1987-Pres.	American Medico-Legal Foundation Member, Board of Directors
1989-1992	United Physicians Association/United Physicians Insurance Member, Board of Directors

1994-1996	International	Society	of	Clinical	Forensic	Medicine
	Vice Presid	ent				

HONORARY LIFE FELLOWSHIPS IN PROFESSIONAL SOCIETIES:

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1970	Society of Psychiatry, Neurology, and Legal Medicine of Columbia, South America
1970	Spanish Association of Forensic Medicine
1972	Society of Legal Medicine and Criminology of France
1974	American Society of Law & Medicine, Inc.
1975	Medical-Legal Society of Rio de Janeiro, Brazil
1976	Mexico Association of Legal Medicine
1977	Society of Legal Medicine of Belgium
1983	Yugoslav Association for Forensic Medicine
	NATIONAL, PROFESSIONAL ADVISORY BOARDS:
1974-1978	The National Center for Professional Seminars Member, Board of Advisors
1975 - 1988	Odyssey House Institute for Law & Medicine Member, Advisory Board
1977-1996	The Milton Helpern International Center for the Forensic Sciences Member, Advisory Board
1977-1996	The Western Conference on Criminal & Civil Problems Member, Scientific Advisory Committee on Legal Medicine
1978-1981	Pennsylvania Commission on Crime and Delinquency Member, Allegheny Regional Advisory Committee
1980-1982	Touro Law School Member, National Advisory Board
1985 - 1995	Amnesty International USA Member, Advisory Committee
1985-1995	Assassination Archives and Research Center Menber, Board of Advisors
1990-Pres.	Citizens for Truth About the Kennedy Assassination Member, Board of Directors

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1994-Pres.	Coalition on Political Assassinations Chairman, Executive Committee
1995-Pres.	The Center for the Preservation of Modern History Member, Advisory Board
	COMMUNITY ACTIVITIES :
1962-1968	Jewish Community Relations Council of Pittsburgh Board Member
1963-1990	American Jewish Committee Member, Board of Trustees, Pittsburgh Chapter - 1963-1967, 1969-1971
1964-1975	Urban League
1965-1967	Jewish Family and Children's Service of Pittsburgh Member, Board of Directors
1965-Pres.	Young Men & Women's Hebrew Association - Jewish Community Center Member, Board of Directors - 1969-1972
1966-1990	American Jewish Congress
1969 - 1975	United Cerebral Palsy Association of the Pittsburgh District Member, Board of Directors
1967-1983	Pennsylvania Guild for Infant Survival, Inc. (Pittsburgh Chapter) Co-Founder and Honorary Chairman
1967-1985	Health and Welfare Association of Allegheny County Member, Suicide Prevention Committee
1975-1980	Chairman, Pittsburgh Conference on Soviet Jewry Member, National Lawyers Committee
1975-1980	Chairman, Allegheny County Council on Alcohol and Drug Abuse
1976-Pres.	Pittsburgh Zionist Organization Member, Board of Directors Vice President - 1983-1991 and 1996-Pres Honorary Board Member - 1994-1995
1977-1980	Allegheny Regional Planning Council of the Governor's Justice Commission
1977-Pres.	United Jewish Federation Member, Cornunity Relations Committee - 1985-1988

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American Red Cross, Pittsburgh-Allegheny County Chapter Medical-Legal Consultant, Executive Water Safety Committee
Kollel Bais Yitzchok Institute for Advanced Torah Studies Member, Board of Directors
National Foundation for Ileitis & Colitis, Inc. Member, Board of Directors
Patrons for a Drug Free Community Member, Board of Advisors
Anti-Defamation League of B'nai B'rith Member, Board of Directors - 1988-1992
Intestinal Disease Foundation, Inc. Member, Board of Directors Honorary Board Member - 1990-1993
Sudden Infant Death Syndrome Alliance Member, Advisory Committee
Childhood Leukemia Foundation Celebrity Advisory Board
GOVERNMENTAL POSITIONS:
Assistant District Attorney and Medical- Legal Advisor to the District Attorney, Allegheny County, Pennsylvania
Chief Forensic Pathologist, Allegheny County Coroner's Office, Pittsburgh, Pennsylvania
Coroner, Allegheny County, Pennsylvania Director of Education, Forensic Pathology Residency Training Program (Officially Approved by the American Board of Pathology and the American Medical Association)
Member, Board of Health Allegheny County, Pennsylvania Member, Pesticide Advisory Subcommittee, and Ad Hoc Committee to Study Health Effects of Air Pollution
Secretary's Commission on Medical Malpractice Member, Health Advisory Panel (U.S. Department of Health, Education and Welfare)
Member, Allegheny County Board of Commissioners
Chairman, Allegheny County Prison Board
Member, Allegheny County Board of Commissioners

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1996-Pres. Coroner, Allegheny County, Pennsylvania

PROFESSIONAL CONSULTANT POSITIONS:

1968 1969 1974	Los Angeles County Medical Examiner- Coroner's Office Robert F. Kennedy Assassination Sharon Tate/LaBianca Case6 Symbionese Liberation Army
1972-Pres.	Forensic Pathologist, Westmoreland County Coroner's Office
1988-Pres.	Forensic Pathologist, Armstrong County Coroner's Office
1989-Pres.	Forensic Pathologist, Fayette County Coroner's Office
1993-Pres.	Forensic Pathologist, Greene County Coroner's Office
1997-Pres.	Forensic Pathologist, Clarion County Coroner's Office
1973	U.S. Public Health Hospital, Panama Canal Zone
1976-1977	Member, Special Expert Panel on American Legionnaires' Disease (Department of Health, Education and Welfare, Center for Disease Control)
1976 1979	ABC National Network - "20/20 Show" John F. Kennedy Assassination Elvis Presley Death
1977-1979	U.S. House of Representatives Select Committee on Assassinations, Forensic Pathology Panel
1978-1993	Consultant in Legal Medicine, Armed Forces Institute of Pathology
1978-1992	Pathology Consultant, MDS Health Group, Ltd. Medical Director, Latrobe Laboratory
1985-Pres.	Forensic Science Consultants International
1985-1992	Consultant in Pathology, and Member, Consulting Medical Staff, Woodville State Hospital
1989-1991	Consultant in Forensic Pathology and Legal Medicine to the Chief Medical Examiner for the District of Columbia
1991-1995	Western School of Health Business Careers, Inc.

1991	Consultant/Technical Advisor, Camelot Produc- tions - "JFK" - Oliver Stone/Alexander Ho, Producers
1993-1995	Firefighter Autopsy Advisory Panel, Federal Emergency Management Agency United States Fire Administration
1998	Honorary Visiting Consultant Coroner to the Ministry of Health, Nassau, The Bahamas
	EDITORIAL POSITIONS - BOOKS:
1969-1979	Series Editor, <u>Legal Medicine Annual</u> (Published by Appleton-Century-Crofts Publishing Co.)
1980-1994	Series Editor, <u>Legal Medicine</u> (Published by W.B. Saunders Co. to 1984; from 1985 Published by Praeger Publishing Co.; from 1989 Published by Butterworth Legal Publishers; 1994 - Published by Michie Company)
1972	Editor, <u>Exploring the Medical Malpractice Dilemma</u> (Published by Futura Publishing Co.)
1980	Editor, <u>Microscopic Diagnosis in Forensic</u> <u>Pathology</u> (Published by Charles C. Thomas Co.)
1982	Editor, FORENSIC SCIENCES - Five Volumes (Published by Matthew Bender & Co., Inc.)
1987-Pres.	Associate Editor, <u>TRAUMA</u> (Published by Matthew Bender & Co., Inc.)
1987	Co-Editor, HANDLING SOFT TISSUE INJURY CASES: MEDICAL ASPECTS - Three Volumes (Published by The Michie Company)
1989	Co-Editor, PREPARING AND WINNING MEDICAL NEGLIGENCE CASES - Three Volumes (Published by The Michie Company)
1991	Co-Editor, <u>Medicoleqal Primer</u> (Published by American College of Legal Medicine Foundation)
1993	Co-Author with Mark Curriden and Ben Wecht, <u>Cause of Death</u> (Published by Dutton Publishing Co., New York)
1996	Co-Author with Mark Curriden and Ben Wecht, <u>Grave Secrets</u> (Published by Dutton Publish- ing Co., New York)
1998	Co-Author with Charles Bosworth, Jr., <u>Who Killed JonBenet Ramsey?</u> (Published by Penguin Putnam, Inc., New York)

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EDITORIAL POSITIONS - PROFESSIONAL PUBLICATIONS:

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1966-Pres.	Editor, <u>Scalpel and Quill</u> (Official Publica- tion of the Pittsburgh Institute of Legal Medicine)
19 66 - 1994	Editorial Board, Milton Helpern International Microfilm Journal of Legal Medicine
1967-1997	Editorial Board, International Reference Organization in Forensic Medicine (INFORM)
1969-1979	Editorial Consultant, <u>Medical Economics</u>
1971-1974	Editor, MXR (Malpractice X-posure Reports) (Published by Didactic, Inc.)
1971-Pres.	Editorial Advisor for the Americas, <u>Inter-</u> <u>national Forensic Sciences Journal</u> (Pub- lished by Elsevier Publishing Co., Amsterdam, The Netherlands)
1972-1967	Editorial Board, <u>The Barrister</u> (Official Publication of the Pennsylvania Trial Lawyers Association)
1972-Pres.	Editorial Board, <u>Journal of Legal Medicine</u> (Official Publication of the American College of Legal Medicine)
1973-1977	Medical-Legal Reviewer, <u>Health Com</u> (Health Communications, Inc.)
1973-1976	Editorial Board, <u>INCL Brief</u> (Published by the Section of Insurance, Negligence, and Compensation Law, American Bar Association)
1974-Pres.	Editorial Board, <u>Journal of the American</u> <u>Society of Law & Medicine, Inc.</u>
1974-Pres.	International Editorial Board, Forensic Science Section, <u>Excerpta Medica</u> (Published by Excerpta Medica, Amsterdam, The Netherlands)
1977-1978	Associate Editor, <u>Leqal Aspects of Medical</u> <u>Practice</u> (Official Publication of the American College of Legal Medicine)
1978 - 1990	Editor, <u>Legal Aspects of Medical Practic</u> e,
1976-1960	Editorial Advisory Board, CURRENT PRESCRIBING (Published by Medical Economics Company)
1978-Pres.	International Board of Editors, <u>International</u> <u>Journal for Medicine and Law</u> (Published by The Society for Medicine and Law in Israel)

1978-1988	Editorial Advisory Board, <u>The Medical</u> <u>Cost Containment Journal</u> (Published by Panel Publishers, Greenvale, New York)
1978-1980	Editorial Board, <u>News and Views in Forensic</u> <u>Patholow</u> (Published by American Academy of Forensic Sciences and Forensic Sciences Foundation)
1978-1989	CME Board of Advisors and Councilors, American Medical Education Network
1979-Pres.	Editorial Board, <u>The American Journal of</u> <u>Forensic Medicine and Patholow</u> (Official Publication of the National Association of Medical Examiners) Feature Editor - 1979-1992
1984-Pres.	Editor/Contributor, Forensic Medicine Section, <u>Law, Medicine & Health Care</u> (Official Publication of the American Society of Law & Medicine)
1984-1990	Editorial Board, <u>Medical Malpractice Pre-</u> <u>vention</u> (Published by World Medical Communications)
1989-Pres.	Peer Reviewer, <u>Journal of the American Medical</u> <u>Association</u>
1989-Pres. 1990-Pres.	Editorial Committee, <u>Medicine and Law</u> (Offi- cial Publication of the International Centre of Medicine and Law of Southern Africa) Editorial Board, IMINTERNAL MEDICINE FOR
	THE SPECIALIST
1990-1993	Editorial Board, <u>Iatrogenics</u> (Journal of the International Society for the Prevention of Iatrogenic Complications)
1990-Pres.	Manuscript Reviewer, <u>American Journal of</u> Obstetrics & Gynecology
1991-Pres.	Book and Article Reviewer, <u>Journal of the</u> <u>American Medical Association</u>
1991-Pres.	Editorial Board, <u>Leqal Medicine Perspectives</u> (Official Publication of the American College of Legal Medicine)
1991-Pres.	Editorial Board, <u>Medical-Legal Lessons</u> (Official Publication of the American College of Legal Medicine)
1998-Pres.	Editorial Board, <u>The Forensic Echo</u> (Monthly Newsmagazine of Psychiatry, Law & Public Policy)

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1.	Wecht, C.H.:	<u>Cancerophobia</u> (Published in the University of Pittsburgh Law Review, March, 1959, Vol. 20, No. 3.)
2.	Wecht, C.H.:	<pre>Workmen's Compensation (Published in the University of Pittsburgh Law Review, June, 1959, Vol. 20, No. 4.)</pre>
3.	Wecht, C.H.:	<u>Medicolegal Aspects of Blood Grouping Tests in</u> <u>Paternity Suits</u> (Published in the University of Pittsburgh Law Review, October, 1959, Vol. 21, No. 1.)
4.	Martin, Alber	t, Jr., and Wecht, C.H.: <u>Vibro Multiformis in Rela-</u> <u>tion to Multiple Sclerosis</u> (Proceedings of Pennsylvania Academy of Science, 1963.)
5.	Wecht, C.H.:	<u>The Medical Assistant and The Law</u> (Published in Pennsylvania Medical Assistants Association Bulletin, April, 1964.)
6.	Wecht, C.H.:	Book Review of "Handbook of Legal Medicine" by Alan R. Moritz, M.D., and C. Joseph Stetler, LL.B., LL.M. (Published in Duquesne Law Review, Fall, 1964, Vol. 3, No. 1, p. 121.)
7.	Wecht, C.H.:	<u>The Role of the Forensic Pathologist in Personal</u> <u>Injury Cases</u> (Proceedings of the 1564 Annual Convention of the American Trial Lawyers Association.)
8.	Bloom, J., Da	vis, N., and Wecht, C.H.: <u>Effect on the Liver of</u> <u>Long-Term Tranquilizing Medication</u> (Published in The American Journal of Psychiatry, February, 1965, Vol. 121, No. 8.)
9.	Wecht, C.H.:	Law and Medicine (Published in Phi Delta Epsilon News, March, 1565, Vol. 57, No. 1.)
10.	Wecht, C.H.:	<u>Relationships of the Medical Examiner</u> (Published in the Cleveland-Marshall Law Review, September, 1965, Vol. 14, No. 3.)
11.	Wecht, C.H., T	Curshen, A., and Rule, W.R.: <u>The Medico-Leqal Autopsy</u> <u>Laws of the Fifty States and the District of</u> <u>Columbia</u> (Published by the Armed Forces Insti- tute of Pathology, 1965.)
12.	Wecht, C.H.:	<u>Official Medical-Legal Investigation in Death Cases</u> <u>in the Commonwealth of Pennsylvania</u> (Published in Bulletin of the Pennsylvania Academy of Science, December, 1965.)
13.	Wecht, C.H.:	The Law of Agency and Its Impact on the Practice of <u>Medicine</u> (Published in Bulletin of the American Association of Medical Assistants, May, 1966.)

- 14. Wecht, C.H.: <u>A Critique of the Medical Aspects of the Investiga-</u> <u>tion into the Assassination of President Kennedy</u> (Published in Journal of Forensic Sciences, July, 1965.)
- 15. Wecht, C.H.: Evaluation of Post-Accident Morbidity and Mortality by the Forensic Scientist for the Purpose of Adjudicating Civil Claims (Published in the Proceedings of the Second Congress of the International Association for Accident and Traffic Medicine, Stockholm, Sweden, August 9-12, 1966, p. 164.)
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- 17. Wecht, C.H.: <u>The Forensic Pathologist: A Medical-Legal View of</u> <u>Autopsy and Expert Testimony</u> (Published in Winning Trial Tactics, American Trial Lawyers Association, 1967, p. 479.)
- 18. Winek, C.L., Collom, W.D., and Wecht, C.H.: <u>Fatal Benzene Exposure</u> <u>by Glue-Sniffina</u> (Published in The Lancet, March 25, 1967, p. 683.)
- 19. Winek, C.L., Collom, W.D., and Wecht, C.H.: <u>Sustained-Release-</u> <u>Barbiturate Risk</u> (Published in The Lancet, July 15, 1967, p. 155.)
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- 21: Wecht, C.H.: <u>Medical Expert Evidence and the Rights of the Parties</u> (Published in Jus Medicum, p. 455. Proceedings of the First World Meeting on Medical Law, Ghent, Belgium, 1967.)
- 22. Wecht, C.H.: <u>Anesthesia Trial Demonstration</u> (Published in Leading Cases, Trials, and Techniques, American Trial Lawyers Association, p. 870. Proceedings from 21st Annual Convention, Minneapolis, 1967.)
- 23. Wecht, C.H.: <u>A Critique of President Kennedy's Autopsy</u> <u>Appendix</u> <u>D</u> (Published in <u>Six Seconds in Dallas</u> by Josiah Thompson, p. 278.)
- 24. Wecht, C.H.: <u>What Are Your Legal Risks in Treating Minors?</u> (Published in Patient Care, January, 1968, p. 50.)
- 25. Wecht, C.H.: <u>Medico-Legal Aspects of Death of Hospital Patients</u> (Published in Law Institute on Hospitals and Medicine, Medical College of Virginia, Richmond, Virginia, February 2, 1968, p. 16.)
- 25. Wecht, C.H.: <u>When You're Asked to Sign a Death Certificate</u> (Published in Hospital Physician, February, 1968, p. 91.)

27.	Wecht, C.H.;	Don't Let Death Certificates Do You In (Published in Medical Economics, February 19, 1968, p. 183.) (Repeat publication of Article No. 26.)	
28.	Winek, C.L.,	Collom, W.D., and Wecht, C.H.: <u>Toluene Fatality From</u> <u>Glue-Sniffing</u> (Published in Pennsylvania Medi- cine, April, 1968, Vol. 71, p. 81.)	
29.	Winek, C.L.,	Collom, W.D., and Wecht, C.H.: <u>Death From Hydrogen</u> <u>Sulphide Fumes</u> (Published in The Lancet, May 18, 1968, p. 1096.)	
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32.	Wecht, C.H.,	Watson, A.S., and Pollack, S.: <u>Medical and Psychia-</u> <u>tric Testimony in Criminal Cases, Part One:</u> <u>The Pathologist</u> (Published by Practising Law Institute, 1968, p. 9.)	
33	Wecht, C.H.:	Leaal Aspects of Medical Staff Bv-Laws and Hospital <u>Committee Activity</u> (Published in The Physician, The Hospital and The Law. Proceedings of the Sixth Annual Meeting of the Pennsylvania Society of Internal Medicine, 1968.)	
34.	Wecht, C.H.:	<u>Who Did It?</u> , Review of <u>Where Death Delights</u> by Milton Helpern, M.D. (Published in TRIAL Magazine, October/November, 1968, p. 55 .)	
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38.	Collom, W.D.,	and Wecht, C.H.: <u>Medical Evidence in Alleged Rape</u> (Published in <u>1969 Leaal Medicine Annual</u> , p. 269.)	
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40. Wecht, C.H.: A Transcript of Remarks Delivered at a Seminar on Criminal Law (American Trial Lawyers Association, New Orleans, Louisiana, May, 1969.) 41. Wecht, C.H.: Medical-Legal Ramifications of Human Tissue Transplantation (Published in DePaul Law Review, Summer Edition, 1969.) 42. Wecht, C.H.: Organ Transplantation and the Definition of Death (Published in Intersections of Law and Medicine, Institute of Continuing Legal Education, Wayne State University, p. 99. Proceedings from Seminar, Autumn, 1969.) Death and Transplantation (Published in Hospitals, Wecht, C.H.: 43. November, 1969, Vol. 43, p. 47.) 44. Wecht, C.H.: The Pathological Report: Its Relation to the Diagnosis and the Record (Published by the Illinois Institute for Continuing Legal Education. Proceedings of Seminar, Chicago, Illinois. November 11, 1969.) 45. Wecht, C.H.: Chapter Introductions, 20 Articles, 1970 Leaal Medicine Annual (Published by Appleton-Century-Crofts, New York.) Dillof, H.H., Friedman, G.A., Siegel, H., and Wecht, C.H.: <u>Medical Malpractice Clinic Materials</u> (Pub-46. lished by Practising Law Institute, February, 1970.) 47. Winek, C.L., Collom, W.D., and Wecht, C.H.: Suicide with Plastic Baq and Ethyl Ether (Published in The Lancet, February 14, 1970, p. 365.) 48. Wecht, C.H., and Dornette, W.H.L.: Your Legal Risks in Tonsillectomy and Adenoidectomv (Published in Patient Care, April 15, 1970, p. 103.) 49. Wecht, C.H., Harney, D.M., Julien, A.S., Horsley, J.E., and Morris, C.: Malpractice Alert: The Newest <u>Trends in Claims</u> (Published in Medical Economics, June 8, 1970, p. 79.) 50. Wecht, C.H., Harney, D.M., Julien, A.S., Horsley, J.E., and Morris, C.: Malpractice Alert: The Hidden Costs of Settlements (Published in Medical Economics, June 22, 1970, p. 102.) 51. Wecht, C.H.: The Role of the Forensic Pathologist in Criminal <u>Cases</u> (Published in Tennessee Law Review, Summer, 1970, Vol. 37, No. 4.) (Republished in <u>Medicine</u>, Law & Public Policy, AMS Press, Inc., New York, 1975, p. 29, and in Acta Medicinae Legalis et Socialis, Official Publication of the International Academy of Legal Medicine and Social Medicine, 1978, Vol. XXVIII/I, p. 1.)

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- 57. Wecht, C.H.: <u>Mishandling Medical Emeraencies</u> (Proceedings from the 1570 Mid-Winter Meeting of the American Trial Lawyers Association, p. 239.)
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- 60. Wecht, C.H.: <u>The Medico-Legal Autopsy Laws of the Fifty States,</u> <u>the District of Columbia, American Samoa, the</u> <u>Canal Zone, Guam, Puerto Rico, and the Virgin</u> <u>Islands</u> (Published by the Armed Forces Institute of Pathology • Revised Edition, 1971.)
- 61. Wecht, C.H.: <u>Book Review of "The Law and Clinical Medicine"</u> by Elliot L. Sagall, M.D., and Barry C. Reed, LL.B. (Published in TRIAL Magazine, January/February, 1971, p. 50.)
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(Republished in PATHOLOGIST, April, 1971, p. 111; and <u>Rubella</u> by Herman Friedman, Ph.D., and James E. Prier, D.V.M., Ph.D., 1973, p. 129.)

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- 66. Wecht, C.H.: <u>Drug Liability Potential Defendants</u> (Practising Law Institute - Condyne Law Tape, 1971, No. 7.)
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- 69. Wecht, C.H.: <u>Therapeutic Misadventure</u> (Published in MXR, October, 1971, Vol. 1, No. 3, p. 1.)
- 70. Wecht, C.H.: <u>Informed Consent</u> (Published in MXR, October, 1971, Vol. 1, No. 3, p. 1.)
- 71. Wecht, C.H.: <u>Editorial</u> (Published in MXR, October, 1971, Vol. 1, No. 3, p. 2.)
- 72. Wecht, C.H.: <u>Editorial</u> (Published in MXR, November, 1971, Vol. 1, No. 4, p. 2.)
- 73. Wecht, C.H.: <u>Editorial</u> (Published in MXR, December, 1971, Vol. 1, No. 5, p. 2.)
- 74. Wecht, C.H.: <u>Chapter Introductions, 20 Articles, 1972 Leaal Medi-</u> <u>cine Annual</u> (Published by Appleton-Century-Crofts, New York.)
- 75. Wecht, C.H., and Winek, C.L.: <u>From the Medical Examiner's Files</u> (Case Report) (Published in Medical Times, January, 1972, Vol. 100, No. 1, p. 27.)
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- 78. Wecht, C.H.: <u>Problems of Confidentiality and Privileged Communica-</u> <u>tions in Psychiatry</u> (Published in MXR, February, 1972, Vol. 2, No. 2, p. 3.)
- 79. Wecht, C.H.: <u>Editorial</u> (Published in MXR, March, 1972, Vol. 2, No. 3, **p.** 2.)

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- 81. Rubsamen, D.S., Sagall, E.L., and Wecht, C.H.: <u>Malpractice Pre-vention: When and How to Obtain Informed</u> <u>Consent</u> (Published in Patient Care, May 15, 1972, p. 72.)
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- 83. Wecht, C.H.: <u>Book Review of "Doctor and Patient and The Law"</u> by R. Crawford Morris, LL.B., and Alan R. Moritz, Sc.D., M.D. (Published in Annals of Internal Medicine, June, 1972, Vol. 75, No. 6, p. 1052.)
- 84. Wecht, C.H., and Winek, C.L.: <u>Drug Deaths Decrease</u> (Published in Journal of the American Medical Association, Letters to the Editor Section, October 16, 1972, Vol. 222, No. 3, p. 361.)
- 85. Wecht, C.H.: <u>Pathologist's View of JFK Autopsy:</u> An Unsolved Case (Published in Modern Medicine, November 27, 1972, p. 28.)

(Republished in Computers and Automation and People, February 1973, Vol. 21, No. 2, p. 25; and IMPACT Magazine, Switzerland, July, 1973, No. 61, p. 10.)

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- 87. Wecht, C.H.: <u>Significance of Autopsy Findings in Evaluating Mal-</u> <u>practice Claims</u> (Published in <u>Exploring the</u> Medical Malpractice Dilemma, 1972, p. 73.)
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- 91 Wecht, C.H.: <u>Foreword of "Handbook of Forensic Pathology"</u> by Abdullah Fatteh, M.D., Ph.D., LL.B. (Published by J.B. Lippincott Co., Philadelphia, 1973.)
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(Republished in FORENSIC SCIENCES, Matthew Bender & Co., 1985, Vol. 2, Chapter 25.)

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- 95. Wecht, C.H.: Drug Abuse Screening: Rapid Diagnosis in Emergency Room (Published in MXR, February, 1973, Vol. 3, No. 1, p. 1.)
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- 97. Wecht, C.H.: <u>The Medical Consultant--Prepare Him Well</u> (Published in The Barrister, Pennsylvania Trial Lawyers Association, March-April, 1973, Vol. IV, No. 1, p. 5.)
- 98. Wecht, C.H.: <u>Medical Malpractice Insurance Dilemma</u> (Published in MXR, April, 1973, Vol. 3, No. 2, p. 1.)
- 99. Wecht, C.H.: <u>Editorial</u> (Published in MXR, April, 1973, Vol. 3, No. 2, p. 2.)
- 100. Wecht, C.H.: <u>Cardiac Arrest and Complications</u> (Published in MXR, April, 1973, Vol. 3, No. 2, p. 3.)
- 101. Wecht, C.H.: Law and Pathology (Published in MXR, June, 1973, Vol. 3, No. 3, p. 1.)
- 102. Wecht, C.H.: <u>Medical Expert Consultation from the Plaintiff's</u> <u>Standpoint</u> (Published in MXR, June, 1973, Vol. 3, No. 3, p. 3.)
- 103 Wecht, C.H.: <u>The Medical Expert in the Courtroom</u> (Published.in The Barrister, Pennsylvania Trial Lawyers Association, June-July, 1973, Vol. IV, No. **2**, **p**. 5.)
- 104 Wecht, C.H., and Smith, R.P.: The Medical Evidence in the Assassination of President John F. Kennedy (Published in Forensic Science Gazette of the Southwestern Institute of Forensic Sciences, September, 1973, Vol, 4, No. 4, p. 9.)

(Republished in FORENSIC SCIENCE, Amsterdam, The Netherlands, April, 1984, Vol. 3, No. 2, p. 105; and <u>1974 Legal Medicine Annual</u>, p. 69.)

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