

IN THE COURT OF COMMON PLEASCUYAHOGA COUNTY, OHIODIANE M. CARRICK, EXECUTRIX,  
et al.,

Doc. 454

Plaintiffs,

-vs-

JUDGE J. KILCOYNE  
CASE NO. 185330THE CLEVELAND CLINIC  
FOUNDATION, et al.,

Defendants.

- - - -

Deposition of JAY B. WISH, M.D., taken as if  
upon cross-examination before Aneta I. Fine, a  
Registered Professional Reporter and Notary  
Public within and for the State of Ohio, at the  
University Hospitals, 2074 Abington Road,  
Cleveland, Ohio, at 3:00 p.m. on Thursday,  
December 5, 1991, pursuant to notice and/or  
stipulations of counsel, on behalf of the  
Plaintiffs in this cause.

- - - -

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APPEARANCES:

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On behalf of the Plaintiffs;

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On behalf of the Defendant  
Cleveland Clinic Foundation;

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On behalf of the Defendant  
Robert Riley, M.D.

1 MR. KAMPINSKI: Let the record show  
2 that Mr. Spisak received notice of this  
3 deposition some time ago and that his  
4 office called me this morning to reconfirm  
5 that it was going forward at the time and  
6 place designated. He's not arrived and  
7 we're going to go ahead and get started.

8 It's 3:08, we're going to start  
9 without him as Mr. Gore indicated.

10 JAY B. WISH, M.D., of lawful age, called  
11 by the Plaintiffs for the purpose of  
12 cross-examination, as provided by the Rules of  
13 Civil Procedure, being by me first duly sworn,  
14 as hereinafter certified, deposed and said as  
15 follows:

16 CROSS-EXAMINATION OF JAY B. WISH, M.D.

17 BY MR. KAMPINSKI:

18 Q. Okay. Doctor, would you state your full name,  
19 please?

20 A. Jay Wish.

21 Q. And your current position, sir, is what?

22 A. Associate professor of medicine at Case Western  
23 Reserve University and director of the  
24 hemodialysis unit at University Hospitals.

25 Q. Have you been involved, sir, in providing expert

1 testimony previously for Mr. Gore or anyone in  
2 his firm?

3 A. No.

4 Q. All right. You have never testified for Arter  
5 Hadden before?

6 A. No. I have testified in the capacity of a  
7 material witness in one case but not as an  
8 expert witness.

9 Q. What does that mean, as a treating physician?

10 A. I was involved in a case that was being  
11 adjudicated.

12 Q. Were you a defendant?

13 A. I was not a defendant.

14 Q. All right. What was the case?

15 A. It was a patient who was being evaluated for  
16 renal transplant who had advanced renal failure  
17 who was admitted for elective cholecystectomy  
18 prior to transplant and subsequent to his  
19 cholecystectomy he had a cardiac arrest.

20 Q. And your involvement was as a treating  
21 physician?

22 A. As a treating physician.

23 Q. So it was a lawsuit against somebody else and  
24 you merely testified as to your involvement?

25 A. Exactly.

1 Q. Have you testified as an expert witness in other  
2 cases?

3 A. In other cases, yes.

4 Q. Have they been for the plaintiff, defendant or  
5 both?

6 A. Both.

7 Q. What percentage would you say would be for the  
8 defense?

9 A. I would say two-thirds for the defense, one  
10 third for plaintiffs.

11 Q. All right. And are we talking about malpractice  
12 cases?

13 A. Yes, all.

14 Q. How many cases are we talking about, roughly?

15 A. A dozen.

16 Q. And do you have a list of those cases?

17 A. I have a file.

18 Q. And would it be difficult for you to make up a  
19 list then from your file of the cases where you  
20 have acted as an expert?

21 A. No, I could do that.

22 - - - -

23 (Thereupon, a discussion was had off  
24 the record.)

25 - - - -

1 Q. And would that include or would you be able to  
2 set forth the names of the attorneys involved?

3 A. Sure.

4 Q. Okay.

5 MR. KAMPINSKI: Do you have any  
6 difficulty with his doing that?

7 MR. GORE: No. I will get it from  
8 the doctor and get it to you.

9 MR. KAMPINSKI: Okay.

10 A. You want me to indicate on each whether I was  
11 testifying for the plaintiff versus the  
12 defendant?

13 Q. Please.

14 A. No problem.

15 Q. And if you would set forth the attorneys  
16 representing the various parties?

17 MR. GORE: To the extent that you  
18 know them.

19 MR. KAMPINSKI: Yes.

20 Q. To the best of your knowledge were you deposed  
21 in each of those cases, doctor?

22 A. No, not in all of them. Some it was just that I  
23 would write an expert opinion letter.

24 Q. Okay. Did any of them go to trial?

25 A. Only one went to trial.

1 Q. And what was the name of that case?

2 A. I can't remember the entire name. I seem to  
3 remember the name Connie Adams as being the  
4 plaintiff, though. It was a Columbus case.

5 Q. All right. What were the allegations in the  
6 case?

7 A. I was actually testifying for the plaintiff in  
8 that one and it was several years ago so I would  
9 have to refresh my memory by looking at the  
10 file.

11 Q. All right. Do you recall who the plaintiff's  
12 attorney was?

13 A. Again, I don't, but I can look it up.

14 Q. Okay. Have you ever been a defendant in a  
15 malpractice case, doctor?

16 A. No.

17 Q. How is it that you were contacted in this  
18 particular case?

19 A. Mr. Gore called me.

20 Q. All right. And asked you to review --

21 A. Review the records.

22 Q. All right. You set forth the records that you  
23 reviewed in your April 9, 1991 report. Have you  
24 reviewed any records since that time?

25 A. I was given two letters that Mr. Gore had

1 received from Dr. Heyka and from the surgeon,  
2 and I read those letters.

3 Q. Okay. Do you have them with you?

4 A. Yes. It was Dr. Heyka and Dr. Broughan that I  
5 received subsequent to my report.

6 Q. Do you have the cover letter sending these  
7 letters, doctor?

8 MR. GORE: I handed it to him.

9 Q. You were about to reach for something?

10 A. I was going to see if I do but if they were  
11 handed to me then I don't. I have all my  
12 correspondence and I can tell you if I have a  
13 cover letter.

14 Q. Why don't you get your whole file out if you  
15 would, doctor?

16 MR. GORE: I'll object to him  
17 producing correspondence between me and  
18 him.

19 MR. KAMPINSKI: Why is that?

20 MR. GORE: Because I think that  
21 that's work product.

22 MR. KAMPINSKI: Do you?

23 MR. GORE: Yes. But the rest of  
24 the file that he reviewed, I have no  
25 problem with it.



1 MR. KAMPINSKI: Well, all right.

2 We can deal --

3 MR. GORE: No, there's no cover  
4 letter to those reports.

5 Q. Given what Mr. Gore just indicated, why don't  
6 you identify, if you would, the dates of the  
7 letters between yourself and Mr. Gore?

8 A. The only letter from myself to Mr. Gore is the  
9 one that you have.

10 Q. Okay. How about then from Mr. Gore to yourself?

11 A. From Mr. Gore to myself, I have it in  
12 chronologic order here, November 29, 1990 where  
13 Mr. Gore introduced himself and asked me to  
14 review the case. December 7, 1990 which was the  
15 cover letter for the materials that he sent for  
16 me to review.

17 Q. Well --

18 A. March 22, 1991 --

19 Q. Doctor, let me stop you just for a second. I  
20 mean what you just referred to as a cover letter  
21 is how many pages, the December 7, 1990 letter?

22 A. Yes. It basically itemizes all the items that  
23 were sent to me.

24 Q. All right. How many pages does that consist of,  
25 doctor?

1 A. Three.

2 Q. Okay. I'm sorry, go ahead. And the first one  
3 was one page?

4 A. Yes. The December 7 letter also basically  
5 outlines the areas that he wants me to address  
6 in my response.

7 Q. Okay. As a matter of fact, you refer to that in  
8 your report?

9 A. Right.

10 Q. Okay.

11 A. March 22, 1991 where he just, Mr. Gore gives me  
12 a date when he hopes my response will be ready;  
13 April 15, 1991 where he acknowledges receipt of  
14 my report; June 5, 1991 where again he gives me  
15 an update of what is going on; and October 25,  
16 1991 which confirms today's deposition.

17 Q. All right. All of the letters at least from  
18 what I could see that you referred to, other  
19 than the December 7, 1990 were just one-page  
20 letters, correct?

21 A. That's correct.

22 Q. All right. And apparently, the questions which  
23 you responded to were set forth in his December  
24 7, 1990 letter?

25 A. That's correct.

1 Q. All right. Was there any information of a  
2 factual nature set forth in the December 7, 1990  
3 letter?

4 A. No. It's only the questions, and the  
5 itemization of the reports that I'm to review.

6 Q. All right. So that at least for purposes of  
7 your retention, I mean your -- or the questions  
8 that were posed to you were posed in the  
9 December 7, 1990 letter?

10 A. That's correct.

11 Q. All right. And I take it that you saw your  
12 function as addressing those questions?

13 A. That's correct.

14 Q. All right. What else do you have other than the  
15 letters in the file, doctor?

16 A. I have all the records that were sent to me on  
17 December 7.

18 Q. Okay. The ones referenced then on your report?

19 A. Right. They include the hospital records from  
20 Cleveland Clinic, the hospital records from  
21 Lakewood Hospital, a number of depositions with  
22 summaries provided by Mr. Gore's firm, and  
23 that's it.

24 Q. Okay. To what extent did the letters from  
25 Dr. Broughan and Dr. Heyka influence your

1 opinions?

2 A. They didn't at all because I hadn't received  
3 them when I wrote my letter.

4 Q. Do you remember when you received them?

5 A. No. It was subsequent to my preparing the  
6 letter, though.

7 Q. Do you have any notation or any indication in  
8 your file at all indicating what period of time  
9 you would have gotten these?

10 A. It was -- it must have been after I sent the  
11 response in April so --

12 Q. It was between then and now?

13 A. Between then and now. That's the best I can  
14 do. It was in the spring.

15 Q. Okay. Just give me a moment if you would.

16 A. Okay.

17 - - - -

18 (Thereupon, Plaintiff's Exhibits 1  
19 and 2 were mark'd for purposes of  
20 identification.)

21 - - - -

22 Q. Do you know why you were given these letters,  
23 doctor? I mean did you ask for the opinions of  
24 Dr. Broughan and Dr. Heyka or --

25 A. No. I think I was given them to show, for

1 Mr. Gore to demonstrate that my opinion was  
2 consistent with those, of those individuals.

3 Q. Okay. You do indicate in your report that you  
4 reviewed Dr. Heyka's and Dr. Nakamoto's  
5 depositions, correct?

6 A. That's correct.

7 Q. Do you agree with Dr. Heyka's opinion that  
8 Dr. Riley failed to adhere to the appropriate  
9 standard of care required of him in the  
10 treatment of Mr. Carrick prior to his coming to  
11 the Cleveland Clinic and that that failure  
12 contributed to cause Mr. Carrick's death?

13 MR. SPISAK: Note my objection.

14 A. I wasn't asked to --

15 Q. I know that. That's why I'm asking the  
16 question.

17 A. There are several aspects of Dr. Riley's care  
18 that I find fault with, whether those were a  
19 proximate cause of Mr. Carrick's death, I  
20 couldn't say that they definitely were.

21 Q. Well, proximate is a legal term?

22 A. Yes. Whether they led to his death, I couldn't  
23 say that.

24 Q. Well, did they contribute to cause his death?

25 A. I think they contributed to make him very sick,

1 but whether they contributed to his death, no.

2 Q. You can't say one way or the other?

3 A. No.

4 Q. So you don't agree or disagree with Dr. Heyka's  
5 opinion, you just have no opinion regarding --

6 A. I have no opinion.

7 Q. Okay. What about the adherence to the standard  
8 of care? I mean I tried to listen closely to  
9 what you just said.

10 A. Yes.

11 Q. You do, I take it, then find fault with his --

12 A. I find fault with his care.

13 Q. All right. What do you find fault with, doctor?

14 A. That he didn't appropriately evaluate the nature  
15 of the arthritis. He was treating gout  
16 empirically without getting a diagnosis and I  
17 made a reference to that in my letter that he  
18 probably should have done a joint aspiration,  
19 examined to see whether there were uric acid  
20 crystals there.

21 He didn't work up the renal disease. The  
22 patient had progressive renal failure, probably  
23 should have had a renal dialysis bio and  
24 referred to a nephrologist for that  
25 investigation.

1 Q. He had been treating him for I think 15 years?

2 A. Yes.

3 Q. And what step of the process should that have  
4 been done?

5 MR. GORE: What, the referral to  
6 the nephrologist?

7 A. The referral to the nephrologist?

8 Q. Yes, sir.

9 A. Probably when a serum creatinine was around two  
10 or three.

11 Q. And that I believe was in the early 80's?

12 A. Uh-huh.

13 MR. GORE: You have to say yes or  
14 no, doctor. You can't just say uh-huh.

15 A. Oh, I can't remember when that was.

16 Q. Okay. In your report you also indicated,  
17 doctor, that there was some confusion at least  
18 in your mind from reading Dr. Riley's deposition  
19 apparently as to the extent to which he  
20 prescribed Indocin.

21 I don't want to paraphrase you  
22 incorrectly. If you need to look at your report  
23 at all, you know, feel free to do so.

24 A. Okay.

25 Q. What I'm referring to is page two of your

1 report, it's really the, what, the middle  
2 paragraph starting with whether.

3 A. Well, I said, It is known that continuous use of  
4 these agents may lead to chronic interstitial  
5 nephritis. However, it appears from Dr. Riley's  
6 records and deposition that Mr. Carrick was  
7 treated only intermittently with these agents.

8 Q. Okay. When you say it is known that continuous  
9 use of these agents may lead to chronic  
10 interstitial nephritis, what do you mean by  
11 continuous use? I mean give me some parameters  
12 of what you're talking about?

13 A. Use over a long term without interruption.

14 Q. Well, would use over a period of 15 years  
15 without interruption fit the definition of  
16 continuous use?

17 A. Yes, it would.

18 Q. And would it require any particular dosage over  
19 that period of time or is that --

20 A. It's a dose-related effect but could occur at a  
21 low dose as well.

22 Q. Having been used for that period of time?

23 A. Yes.

24 Q. Okay. I take it you weren't provided with the  
25 deposition of Mrs. Carrick?



1 A. No, I was not.

2 Q. Were you provided with any information other  
3 than Dr. Riley's testimony as to how often  
4 Mr. Carrick was using Indocin?

5 A. No.

6 Q. You weren't provided?

7 MR. GORE: Riley's records?

8 MR. KAMPINSKI: Yes.

9 A. Riley's records and deposition?

10 Q. Sure. You weren't provided with the --

11 A. Pharmacy receipts or anything like that?

12 Q. Right.

13 A. No.

14 Q. If, in fact, the use was continuous as we have  
15 just defined it, then would that affect your  
16 opinion contained in this paragraph?

17 A. Yes, it would.

18 Q. All right. How would it affect it, doctor?

19 A. It would make me feel that it was more likely  
20 that the Indocin contributed to his renal  
21 disease.

22 Q. And ultimate death then?

23 A. No.

24 Q. No?

25 A. Because he didn't die of renal failure.

1 Q. Well, do you believe that the  
2 hyperparathyroidism was secondary to the uremia?

3 A. Yes.

4 Q. And if -- and what is uremia?

5 A. Uremia?

6 Q. Yes, sir.

7 A. Is a clinical syndrome characterized by a  
8 variety of biochemical abnormalities, signs and  
9 symptoms that are due to the failure of the  
10 kidney to perform its normal functions.

11 Q. Renal failure?

12 A. Yes.

13 Q. So if, and maybe I'm not following what you're  
14 saying, if the renal failure was caused by the  
15 use of the Indocin, assuming that there was  
16 continuous use of it, and the  
17 hyperparathyroidism was secondary to that --

18 A. Well, I didn't say that the renal failure was  
19 caused by the use of Indocin.

20 Q. You didn't. I know you didn't. You responded,  
21 however, to my hypothetical based upon if there  
22 was continuous use?

23 A. Then it would be more likely that the Indocin  
24 was a contributing factor.

25 Q. Renal failure?

1 A. Right.

2 Q. And to the secondary hyperparathyroidism?

3 A. Yes. Which resulted from the renal disease.

4 Q. And his death then?

5 A. Well, secondary hyperparathyroidism didn't kill  
6 him either.

7 Q. What killed him, doctor?

8 A. A number of complications which followed his  
9 hyperparathyroidism.

10 Q. All which stemmed from the treatment of the  
11 hyperparathyroid?

12 A. Right. But not everybody that's treated for  
13 hyperparathyroidism get the complications that  
14 he does. It was an unfortunate sequence of  
15 events but I don't think it was ultimately  
16 related to step one.

17 Q. If step one wouldn't have happened step five  
18 wouldn't have happened?

19 A. That's true.

20 Q. So that if, in fact, his condition was, not  
21 assuming that it was, it was caused or that the  
22 Indocin contributed to cause the problem to  
23 begin with, assuming that had not been  
24 inappropriately given for 15 years, he wouldn't  
25 have had the problem for which he was treated

1           that he ultimately got complications from and  
2           died from?

3       A.   That's correct.

4       Q.   And it would be substandard care in your  
5           opinion, would it not, to provide continuous use  
6           of Indocin to a patient such as Mr. Carrick?

7       A.   No, it would not be substandard care just to  
8           provide the Indocin, it would be substandard  
9           care to provide the Indocin continuously, note  
10          that the renal function was declining and not do  
11          something to intervene at that point.

12      Q.   And that's exactly what happened, isn't it?

13      A.   That's correct.

14      Q.   If what you say is correct, that he was treated  
15           continuously for which I have no direct  
16           evidence, do you agree that if Mr. Carrick had  
17           been stabilized that he would have been a good  
18           candidate for transplant?

19      A.   I found nothing in his history that would be a  
20           contraindication for transplant.

21      Q.   All right. So does that mean you agree or --

22      A.   Well, there's a big if there. If he had been  
23           stabilized. He had a lot of things going wrong  
24           with him.

25      Q.   I said if he had been stabilized?

1 A. I think, yes, if all those things would have  
2 been straightened out he would have been a  
3 candidate for transplant.

4 Q. And do you believe that his uremic compromise  
5 was the cause of his pneumonia?

6 A. No.

7 Q. Why not?

8 A. I think the fact that he had uremia may have  
9 made him at greater risk for developing a  
10 variety of infections but I think the direct  
11 cause of his pneumonia was the combination of  
12 his musculoskeletal pain, his narcotic  
13 analgesics which decreases cough reflex and the  
14 fact that he was a post-operative patient. All  
15 post-operative patients are a great risk for  
16 pneumonia.

17 Q. Okay. Did the uremia contribute to his  
18 pneumonia?

19 A. No. It made him at high risk for developing  
20 pneumonia but did not contribute to the  
21 pneumonia. Broad distinction there.

22 Q. Okay. Did you agree with Dr. Nakamoto's  
23 decision to dialyze Mr. Carrick, I believe it  
24 was on April 14, after the operation?

25 A. Yes.

1 Q. All right. Why would it have been appropriate  
2 then for him to be dialyzed at that time and not  
3 before the operation at some point in time?

4 A. Because his renal function had declined further  
5 after the operation.

6 Q. Okay. Renal function as measured by what  
7 standard?

8 A. His serum creatinine.

9 Q. And what was it before and what was it after,  
10 doctor?

11 A. I'm going to have to refresh my memory, but as I  
12 recall it was in the six range when he was  
13 admitted and it rose to around the ten range in  
14 the post-operative period.

15 Q. Okay. And once it reached that point you  
16 believed he should have been dialyzed?

17 A. I think it was appropriate at that point.

18 Q. You don't think it was appropriate at the  
19 preoperative range?

20 A. No. No.

21 Q. Did he have hyperparathyroidism in your opinion?

22 A. Absolutely.

23 Q. And was that taken care of, that condition taken  
24 care of by virtue of the operation?

25 A. Yes, that was the treatment of choice for his

1 hyperparathyroidism.

2 Q. I have read your report, I know you disagree  
3 with Dr. Gorbaty, but can you, in fact, treat  
4 medically the condition, just in the abstract,  
5 of hyperparathyroidism by dialysis, reducing the  
6 symptomatology that caused the  
7 hyperparathyroidism?

8 A. Dialysis, no. Dialysis is not a treatment for  
9 hyperparathyroidism.

10 Q. It's a treatment for uremia?

11 A. But it's not a treatment for the  
12 hyperparathyroidism that goes along with uremia.

13 Q. If you treat the uremia successfully, does that  
14 then alleviate the symptomatology due to the  
15 hyperparathyroidism?

16 A. Not dialysis alone. Dialysis in conjunction  
17 with other therapies.

18 Q. All right. Such as?

19 A. In conjunction with Vitamin D supplementation,  
20 good diet, and phosphate binders and diet, yes.

21 Q. So that there's then a medical versus a surgical  
22 treatment in the abstract for  
23 hyperparathyroidism?

24 A. For hyperparathyroidism but not to the degree  
25 that Mr. Carrick had it at the time of his

1 presentation.

2 Q. So your real disagreement, at least in terms of  
3 what we're talking about now, this particular  
4 issue with Dr. Gorbaty, is the degree of, the  
5 degree to which Mr. Carrick was suffering from  
6 his hyperparathyroidism at the time he went into  
7 the Clinic?

8 A. Yes. But that's a very essential distinction.

9 Q. I'm not suggesting it's not, but that is the  
10 difference?

11 A. Yes.

12 Q. Correct?

13 A. Yes.

14 Q. Okay. And I take it then you would agree that  
15 Mr. Carrick should have therefore been treated  
16 for this condition long before, in fact, he was  
17 in order to have allowed an alternative  
18 treatment?

19 MR. GORE: Okay. Clarification.

20 Treated for this condition.

21 Q. The hyperparathyroidism?

22 A. Yes.

23 Q. And that would be a failing on the part of  
24 Dr. Riley again?

25 A. To either treat or to refer him to someone who



1           could, yes.

2       Q.   Do you know Dr. Riley?

3       A.   No.

4       Q.   You're not a surgeon, I take it?

5       A.   That's correct.

6       Q.   All right.  So that in the event that you have  
7           patients that you believe require surgical  
8           management, you would then refer them to a  
9           surgeon?

10      A.   That's correct.

11     Q.   Do they make the decision as to whether surgery  
12           is the appropriate modality or do you make it in  
13           conjunction with them?

14     A.   We usually make it together but the fact that I  
15           have referred the patient to the surgeon usually  
16           implies that I'm requesting surgical  
17           intervention and it's ultimately up to the  
18           surgeon to agree or disagree with me.

19     Q.   And do you typically do that after trying a  
20           patient on a course of medical treatment or just  
21           depends on his --

22     A.   Depends on the problem.  If there's a ruptured  
23           appendix there's no medical treatment.

24     Q.   I'm talking about kidney failure basically, I'm  
25           not talking about --

1 A. Are you talking about hyperparathyroidism,  
2 parathyroidectomy?

3 Q. Yes, sir.

4 A. Yes, I'll usually try medical treatment first.

5 Q. At what level did Dr. Chulak tell you that  
6 azotemia -- am I pronouncing that right?

7 A. Uh-huh.

8 Q. -- would be a contraindication to a  
9 parathyroidectomy?

10 A. He didn't think that any level of azotemia alone  
11 would be a contraindication to a  
12 parathyroidectomy.

13 Q. And that was how you posed the question to him?

14 A. Uh-huh.

15 Q. When you said alone?

16 A. Well, azotemia may occur in conjunction with  
17 other metabolic disorders and it often does and  
18 any one of those metabolic disorders may be a  
19 relative or absolutely contraindication.

20 Q. Such as?

21 A. Such as hyperkalemia or severe metabolic  
22 acidosis or volume overload which sometimes  
23 occurs in patients with renal failure, but a  
24 high BUN alone is not a contraindication to  
25 surgery.

1 Q. Did Mr. Carrick have any of those other  
2 conditions?

3 A. Not at the time of his presentation.

4 Q. Well, so that I see, okay. You make the  
5 statement in your report, doctor, that  
6 Mr. Carrick was not suffering any clear  
7 complications of his renal failure prior to his  
8 parathyroidectomy that could be expected to be  
9 immediately reversed by dialysis. The sentence  
10 actually was Mr. Carrick was not suffering?

11 A. Right.

12 Q. And then you go on to say the decision not to  
13 perform dialysis preoperatively is justified?

14 A. That's correct.

15 Q. And my question, sir, is you qualify that by it  
16 being immediately reversed. I take it you're  
17 not saying that there wouldn't be a reversal of  
18 the complications of renal failure by use of  
19 dialysis, I take it the operative word is  
20 immediately?

21 A. Well, if the question was whether dialyzing him  
22 preoperatively for a day or two would have made  
23 a difference, that I consider to be more of an  
24 immediate time course than dialyzing him for six  
25 months before the surgery which would be a more

1 long-term type course.

2 Q. Well, so that you're then posing the issue as an  
3 immediate one and you're doing that by virtue of  
4 Mr. Carrick's condition?

5 A. Well, I'm doing it on the basis of the issue  
6 that I thought I was addressing, that I was  
7 supposed to address, and that was whether or not  
8 preoperative dialysis was indicated here.

9 Q. All right. The difficulty perhaps I'm having is  
10 I'm not privy to the issues you were asked to  
11 address and that's contained in Mr. Gore's  
12 letter.

13 A. Well, it's basically on the basis of  
14 Dr. Gorbaty's statement that the patient should  
15 have been dialyzed preoperatively and I'm  
16 responding to that.

17 Q. Sure. But his position was that a course of six  
18 to 12 months of dialysis would have reversed the  
19 condition?

20 A. That is totally unjustified.

21 Q. Well, I understand, and you said that?

22 A. Yes.

23 Q. But my point, and I don't want to be talking  
24 cross-purposes, I guess what I'm interested in  
25 knowing is why you chose to frame the issue as

1 an immediate reversal of the --

2 A. Because I was addressing the issue of whether or  
3 not the fact that his BUN was high would have  
4 put him at higher risk for some of the  
5 complications that Dr. Gorbaty alleged resulted  
6 from the failure to dialyze him preoperatively  
7 such as an increased tendency to bleed, or the  
8 fact that he developed an ileus and those kinds  
9 of things. Those things would not have been  
10 affected by his being dialyzed preoperatively.

11 Q. Okay. What -- well, all right. I mean you're  
12 choosing certain things that you disagree with  
13 Dr. Gorbaty about, but the basic premise, and  
14 that is that dialysis over a long period of time  
15 would have reversed the effects of the  
16 hyperparathyroidism, if that wouldn't have  
17 worked you could always do the  
18 hyperparathyroid -- the operation later on?

19 A. No, you couldn't. He needed the  
20 parathyroidectomy then.

21 Q. Because of his deteriorating condition?

22 A. Yes. He was getting worse and worse and  
23 dialysis and Vitamin D and calcium and all the  
24 things that we would normally do to treat  
25 patients who are not as severe as he was, may

1 have stabilized their condition but would not  
2 have stabilized his condition. His condition  
3 was terrible. He needed surgery.

4 Q. How did he do after surgery?

5 A. He died but that doesn't necessarily mean that  
6 the decision to do surgery was inappropriate.  
7 You don't judge the quality of a decision by the  
8 outcome, you judge the quality of the decision  
9 by the facts that were taken into account when  
10 the decision was made.

11 If I hold a basket over your head and I say  
12 there's ten balls in this basket, nine of them  
13 are red, and one of them is white, and I'm going  
14 to ask you to, before you reach in to tell me  
15 what color ball you are going to pick out,  
16 you're obviously going to say I'm going to pick  
17 out a red ball because you have a 90 percent  
18 chance of being right. And if you pick out a  
19 white ball and you were wrong does that mean  
20 your decision was wrong? No. Your decision was  
21 justified on the basis of the odds; you just had  
22 an adverse outcome. And that's what happened to  
23 Mr. Carrick, he had an adverse outcome but the  
24 decision to perform surgery was correct.

25 Q. What would have been the outcome had the

1 decision been made to treat him medically?

2 A. What would have been the outcome? I can't say.  
3 He may still have died.

4 Q. Or it may have worked?

5 A. No. His parathyroidism would have continued to  
6 ravage his bones and he probably would have died  
7 from some other complication.

8 Q. When we talk about secondary  
9 hyperparathyroidism, what mechanism resulting in  
10 renal failure causes that?

11 A. The elevated serum phosphorous.

12 Q. And does dialysis and the medical treatment that  
13 you refer to that would go along with it reduce  
14 the serum phosphorous?

15 A. It reduces it but it does not normalize it. So  
16 the phosphorous normally remains elevated and  
17 that's why we have to give them the phosphate  
18 binders and Vitamin D as well.

19 Q. But you said dialysis and the other treatment  
20 you talked about --

21 A. Uh-huh.

22 Q. -- would then reduce it, giving the phosphate  
23 binders and the other treatment as well?

24 A. Yes. But the horse was already out of the barn  
25 here. This man's bones were already falling

1           apart. Normalizing the serum phosphorous is not  
2           going to make what already happened better.

3       Q. Well, what fact does the hyperparathyroid  
4           surgery have on the serum phosphorous?

5       A. What effect does the hyperparathyroid surgery  
6           itself have on the serum phosphorous if nothing  
7           else was done?

8       Q. Yes.

9       A. It would cause the phosphorous to go up.

10      Q. And what effect would that have on his bones,  
11           any?

12      A. But you wouldn't do that in isolation. That's  
13           the point. You would do this in conjunction  
14           with medical therapy which is what they do.

15      Q. What medical therapy?

16      A. They started him on phosphate binders which was  
17           the appropriate decision.

18      Q. To reduce the serum phosphorous level?

19      A. Exactly.

20      Q. And that could be done then either with or  
21           without the surgery, correct?

22      A. You can reduce the serum phosphorous level  
23           without the surgery. What you can't do is put  
24           the patient back into the positive calcium  
25           balance which is what you need to do.



1 Q. And that's what the surgery did?

2 A. What the surgery does is immediately to remove  
3 the stimulus for the demineralization for the  
4 bone.

5 Q. And how does it do that?

6 A. By taking away the hormone that causes the  
7 calcium to come out of the bone which is the  
8 parathyroid hormone. If you treated this  
9 patient medically it would probably take months  
10 to suppress his parathyroid hormone, so during  
11 months his parathyroid would continue to ravage  
12 his bones.

13 MR. GORE: Aneta, Chulak is, C H U  
14 L A K.

15 Q. Do you know Dr. Heyka?

16 A. Yes.

17 Q. Personally?

18 A. Yes.

19 Q. All right. And how do you know him?

20 A. I know him because we have been at conferences  
21 together, being that we are both nephrologists.

22 Q. And do you belong to the same societies?

23 A. We belong to the nephrology societies, yes.

24 Q. Have you chaired -- have you been on any  
25 committees together?

1 A. No.

2 Q. Have you chaired any studies?

3 A. No.

4 Q. Or done any studies, I should say?

5 A. No.

6 Q. When's the last time you were at a conference  
7 with him?

8 A. I'm trying to remember. It wasn't this year.  
9 It was probably sometime in 1990 because it  
10 wasn't at this year's conference.

11 Q. Do you socialize with him at all?

12 A. No.

13 Q. Is there a local nephrology group?

14 A. Not really. There's not any nephrology group  
15 that takes in the entire nephrology community.  
16 There's kind of two chasms if you will.

17 Q. What are they?

18 A. There's the Case Western Reserve-affiliated  
19 institutions that have kind of their own thing  
20 for nephrologists and the Cleveland Clinic seems  
21 to do their own thing.

22 Q. Do the two of you interrelate at all with  
23 respect to those two groups?

24 A. No.

25 Q. Share information or --

1 A. Not regularly.

2 Q. You do but then on an irregular basis?

3 A. On a national basis if we happen to be at the  
4 same national meeting we see each other.

5 Q. Okay. Doctor, of some concern is I guess you  
6 know I see it in your report and now I see it in  
7 these letters from the Cleveland Clinic doctors,  
8 is your use of adjectives as it relates to  
9 Dr. Gorbaty as opposed to just disagreeing with  
10 his opinions or setting forth yours?

11 A. I was quite outraged by Dr. Gorbaty's opinions.  
12 I thought they were totally off the wall and my  
13 adjectives reflect the way I felt.

14 Q. Well, and you're pretty certain then of the  
15 things you said in your report?

16 A. Very certain.

17 Q. Everything you said in your report is accurate  
18 then?

19 A. Everything I said in my report I strongly  
20 believe in.

21 Q. I asked you if it was accurate?

22 A. I believe it is.

23 Q. None of what you said is preposterous, right?

24 A. I don't think so.

25 Q. I take it you reviewed the record fairly

1           carefully before you made some of the statements  
2           that you did in your report?

3       A.   Yes, I did.

4       Q.   Page five of your report, sir?

5       A.   Uh-huh.

6       Q.   Paragraph four?

7       A.   Number four.

8       Q.   Sure.   Where you use one of your adjectives to  
9           describe Dr. Gorbaty?

10      A.   Right.

11      Q.   Yes.

12      A.   I didn't describe Dr. Gorbaty.   I described the  
13           statement.   I'm not using abominable arguments.

14      Q.   And what you said is Dr. Gorbaty makes the  
15           preposterous statement that Mr. Carrick's  
16           post-operative ileus was due to obstruction by,  
17           quote, "rocks," end quote, composed of phosphate  
18           binders.   There's absolutely no evidence in the  
19           medical record to support this allegation?

20      A.   Right.

21      Q.   Right?   Was he noted, was Mr. Carrick noted to  
22           have abdominal distension on April 14?

23      A.   Yes, he was.

24      Q.   Does a GI consult indicate that there was  
25           distension of the large bowel?

1 A. Yes.

2 Q. And did the note indicate that there was a large  
3 amount of solid, semisolid stool?

4 A. Semisolid, yes.

5 Q. And that they tried to suction to remove solid  
6 pieces of stool from the lumen but were unable  
7 to safely keep the lumen in view?

8 A. I don't remember that statement specifically.

9 Q. Well, that's a quote?

10 A. Okay.

11 Q. Out of the record?

12 A. Fine.

13 Q. And that colonic distension persisted and a  
14 second decompression colonoscopy procedure was  
15 undertaken on April 18, 1989. Do you recall  
16 that?

17 A. Yes, I recall that.

18 Q. All right. Do you recall that in that procedure  
19 the following note was made, The transverse  
20 colon was dilated and contained hard stool. In  
21 particular the proximal transverse colon was  
22 covered with hard stool. The ascending colon  
23 revealed long columns of rock hard stool which  
24 made it both difficult and dangerous to further  
25 advance the scope.

1 Do you recall that, doctor?

2 A. I recall that but there's nothing to say that  
3 those rocks were composed of phosphate binders  
4 which is Dr. Gorbaty's allegation.

5 Q. When did Mr. Carrick's constipation begin?

6 A. Postoperatively.

7 Q. I beg your pardon?

8 A. Postoperatively.

9 Q. Didn't it begin two weeks prior to admission and  
10 coincide with the large dosing of aluminum  
11 containing phosphate binding agents?

12 A. It may have coincided temporarily and, in fact,  
13 aluminum containing phosphate binders do tend to  
14 cause constipation, but that doesn't mean that  
15 the stool in the colon is composed of the  
16 phosphate binders.

17 Q. You said there's absolutely no evidence in the  
18 medical reports to support this allegation?

19 A. That the rocks were composed of phosphate  
20 binders, that's -- there was nothing. There was  
21 an analysis of the stool chemically that says  
22 they were containing the aluminum.

23 Q. So that his drawing an inference from these  
24 facts you find to be preposterous?

25 A. Well, it shows that he doesn't understand what

1 phosphate binders do. Phosphate binders do  
2 instead cause constipation but they do so by  
3 decreasing gastrointestinal motility, they don't  
4 do so by precipitating into rocks.

5 Q. So that the finding of rock hard stool was a  
6 coincidental thing?

7 A. The finding of rock hard stool is perfectly  
8 understandable. What I'm saying is the rock  
9 hard stool is not composed of phosphate binders.

10 Q. Well, in the absence of that that you have just  
11 indicated, how do you know? You just said that  
12 there was an absence of testing to establish  
13 that it was composed of phosphate. So how do  
14 you know that it wasn't in the absence of such a  
15 test?

16 A. Because we're talking about milligrams of  
17 phosphate binder. If you're talking about big  
18 pieces of stool, you're talking about a much  
19 larger quantity of stool that the phosphate  
20 binder itself could compose even if it were  
21 purely phosphate binder.

22 I mean the order of magnitude here is  
23 totally different. Most stool happens to be  
24 bacteria and undigested foods and it tends to  
25 solidify if there's been excessive absorption or

1 decreased motility. It doesn't solidify if it's  
2 all composed of aluminum.

3 Q. Does it say it was all composed of aluminum?

4 A. He says it was composed of phosphate binders.

5 Q. To your knowledge, doctor, are there studies  
6 that would indicate that patients given  
7 treatment, medical treatment as opposed to  
8 parathyroidectomy have remarkable improvement in  
9 their lab parameters and in their condition that  
10 would have caused them to undergo  
11 parathyroidectomy to begin with?

12 A. I am not sure I understand your question. Could  
13 you rephrase it?

14 Q. Yes. I asked if there were any studies that say  
15 that?

16 A. That medical therapy can be successful?

17 Q. Is successful?

18 A. Sure. In some cases. In most cases it's  
19 successful. There's only a small minority of  
20 patients with renal failure that require  
21 parathyroidectomies.

22 Q. Would you agree that parathyroidectomy should be  
23 regarded as a treatment of last resort?

24 A. Yes.

25 Q. Do you agree that Mr. Carrick was uremic prior



1 to surgery?

2 A. He had some of the manifestations of renal  
3 failure if that's how you're defining uremia,  
4 yes.

5 Q. You define it for me. I don't want us to be  
6 talking cross-purposes.

7 A. I just want to make sure that we're not implying  
8 he was so uremic that he needed dialysis. I  
9 have already stated that he didn't need  
10 dialysis.

11 Q. Define uremia for me?

12 A. Uremia is an alteration in body metabolism  
13 characterized by certain biochemical signs and  
14 symptoms that result from kidney failure.

15 Q. Well, I'm sorry, go ahead.

16 A. Okay. Now, there's obviously a spectrum in  
17 terms of the quality and the quantity of  
18 abnormalities that can occur. Now, he had  
19 parathyroid abnormality secondary to his renal  
20 disease. That is a manifestation of his uremia,  
21 so yes, in that respect he was uremic but he  
22 wasn't uremic in other ways.

23 He wasn't vomiting and he wasn't having  
24 high potassium levels or congestive heart  
25 failure and those kind of issues so in some ways

1 he was. If that's what you're referring to.

2 Q. And at what level does uremia require dialysis,  
3 and I may have asked this before and I  
4 apologize.

5 A. There's no empirical level. Dialysis usually is  
6 instituted on a basis of specific indication.

7 Q. All right. And would that be when kidney  
8 function drops below a certain percentage or --

9 A. No. As I said, it's not a numerical  
10 indication. It's usually the patient is either  
11 sufficiently symptomatic because they are  
12 vomiting or they are lethargic or they have  
13 volume overload or they are hyperkalemic or they  
14 are acidotic. Those kind of indications.

15 MR. KAMPINSKI: That's all I have.

16 MR. GORE: Mr. Spisak.

17 MR. SPISAK: I don't have any  
18 questions for you today.

19 MR. GORE: Thanks, doctor.

20 MR. KAMPINSKI: I assume you want  
21 him to read it?

22 MR. GORE: Yes. Sure.

23

24

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JAY B. WISH, M.D.

25

C E R T I F I C A T E

The State of Ohio, ) SS:  
County of Cuyahoga.)

I, Aneta I. Fine, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named JAY B. WISH, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this \_\_\_\_ day of \_\_\_\_\_, A.D. 19 \_\_\_\_.

\_\_\_\_\_  
Aneta I. Fine, Notary Public, State of Ohio  
1750 Midland Building, Cleveland, Ohio 44115  
My commission expires February 27, 1996

# THE CLEVELAND CLINIC FOUNDATION

One Clinic Center 9500 Euclid Avenue Cleveland, Ohio 44195-5043

A National Referral Center An International Health Resource

Thomas A. Broughan, M.D.  
General Surgery / A110  
Residency Program Director  
216/444-8462

December 13, 1990



George Gore, Esq.  
Arter & Hadden  
1100 Huntington Bldg  
Cleveland, OH 44115

Re: Estate of Michael Carrick v. Cleveland  
Clinic Foundation, et al.  
Clinic No. 1-973-492-7

Dear Mr. Gore:

In response to your November 28, 1990 letter, it is pertinent that Dr. Gorbaty is the only one of the plaintiff's three consultants who raised any criticism of the Cleveland Clinic. In the areas for which I can account, I find his claims without basis.

Mr. Carrick had very severe renal osteodystrophy. He had extensive demineralization of his bones and profuse metastatic calcifications of his soft tissues. The patient could not have tolerated a six to twelve month trial of medical therapy from a symptomatic point of view. His bone and joint pain was quite severe. Further, medical therapy and dialysis would not be expected to reverse this degree of secondary hyperparathyroidism. Dialysis and adequate medical therapy is designed to minimize renal osteodystrophy but is not capable of reversal of such severe cases.

To my knowledge, Mr. Carrick was not transfused in the perioperative period. It is true that azotemic patients have a platelet defect which theoretically raises the possibility of intraoperative hemorrhage. This is true whether or not they are receiving dialysis. It does not have a direct relationship to the BUN. From a practical point of view, the increased susceptibility to bleeding due to renal failure with or without dialysis, is not a significant clinical problem.

The dialume did not contribute to the postoperative colonic ileus. For the dialume to have caused dilatation of the colon, a fecal impaction would have needed to be present. A fecal impaction was not demonstrated. Parathyroid surgery is not associated with changes in bowel function. Bowel preps are not undertaken routinely.


I see no direct relationship between the azotemia, dialysis, and the development of Mr. Carrick's pneumonia. Azotemic patients are immunosuppressed whether or not they are receiving dialysis. Dialysis relates to fluid status and electrolyte levels, but not immune function.

Mr. Carrick had significant demineralization of his bone secondary to far advanced renal osteodystrophy. This would be another reason why surgery should be undertaken sooner rather than later. Dr. Marks of our Department of Orthopedics could provide insight as to the degree of renal osteodystrophy present. Mr. Carrick did not have aluminum bone disease. This takes years to develop, and Mr. Carrick was not receiving aluminum products for that period of time. Further, aluminum bone disease does not lead to metastatic calcifications and parathyroid hormone levels greater than 3,000. These findings are characteristic of renal osteodystrophy. I see no clinical pertinence to ordering an aluminum level in this patient.

The questions that Dr. Gorbaty raises about hearing loss and antibiotic use should be directed to Dr. Longworth who managed Mr. Carrick's antibiotic therapy carefully. The antibiotic levels were rigorously monitored by our pharmacology team. Mr. Carrick could have possibly survived had he not bitten through his endotracheal tube and had a difficult reintubation.

I might suggest that all of the physicians involved get together in a strategy planning session. We should be able to mount a successful defense to these claims.

Sincerely,



Thomas A. Broughan, M.D.

TAB/jmc



# THE CLEVELAND CLINIC FOUNDATION

One Clinic Center 9500 Euclid Avenue Cleveland, Ohio 44195-5042

A National Referral Center An International Health Resource

December 17, 1990

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**RE: Estate of Michael Carrick v. Cleveland Clinic Foundation, et al.  
Clinic Patient # 1-973-492-7**

Dear Mr. Gore:

Let me answer some of the issues raised by the "expert witness", Isaac Gorbaty, M.D.

- 1) I also have never heard of Dr. Gorbaty. I have reviewed some of the references in standard textbook on Renal Osteodystrophy and also do not find his name mentioned as any of the major authors. I would look very closely at his credentials because I think some of the statements that he makes are outrageous.
- 2) Concerning the question of initiation of dialysis. This is certainly a gray area in which there are no definite answers. Dr. Gorbaty apparently thinks that dialysis should have been treated because of the high BUN. BUN is a marker of both kidney function and muscle break-down and I mentioned in Mr. Carrick's instance probably related to the effect of the prednisone which had been started several weeks earlier. We assessed Mr. Carrick's urine output and physical examination. On the basis of examination and interviewing the patient there was no indication to start dialysis acutely at that time. In addition, Mr. Carrick was adamant about not starting dialysis. We always consider the patient's wishes in the initiation of dialysis as well. As recognized at the time of the second admission, Dr. Nakamoto thought that dialysis was necessary at that time for those specific indications mentioned in the record and dialysis was started. It appears that Dr. Gorbaty's main argument for starting dialysis is based on the BUN. There is no absolute BUN at which dialysis must be started. There are some

The Department of Hypertension and Nephrology

Clinical Hypertension and Nephrology / Hypertension Drug Studies Unit / Hemodialysis and Extracorporeal Therapy / Medical Renal Transplantation /  
Pediatric Nephrology / Renal Function Laboratory / Renal Stone Clinic / Continuous Ambulatory Peritoneal Dialysis /  
Histocompatibility and Immunogenetics Laboratory / Nephro-Urologic Research Laboratory

George Gore, Esquire

December 17, 1990

-2-

**RE: Estate of Michael Carrick v. Cleveland Clinic Foundation, et al.  
Clinic Patient # 1-973-492-7**

patients who become sick with relatively low levels and some patients who are stable with much higher levels. As mentioned, the examination, urine output, and patient feelings were strong considerations in not starting dialysis at that time.

- 3) In addition, Dr. Gorbaty has confused the issue of dialysis and the patient's bone disease. These are two separate issues and dialysis would not have made any difference in the renal bone disease. Dr. Gorbaty's statement about the renal bone disease reversing with "standard medical treatment" is also ludicrous. He states that this would take a minimum of 6 to 12 months. Dr. Gorbaty obviously does not realize that Mr. Carrick had calcifications of his cardiac valves, frozen shoulders to the point where he was unable to elevate his arms above his shoulders and was mostly wheelchair bound. In addition there was severe bone pain that limited his mobility and was to the point that Mr. Carrick was weeping with the pain. To suggest that we should have waited 6 to 12 months and put up with these major problems and allowed the calcification of the heart valves to continue for another 6 to 12 months is also ludicrous. Dr. Gorbaty also contradicts himself when he states later on concerning Mr. Carrick's hip fracture that this was a result of his renal osteodystrophy. If the osteodystrophy was so bad that a spontaneous hip fracture occurred why should we have waited 6 to 12 months for the disease to reverse itself. It would have been very likely that spontaneous hip or other fractures would have also occurred over the 6 to 12 month period of standard treatment.
- 4) Concerning the issue of bleeding. There certainly is an association of chronic renal failure and increased bleeding risk. To a certain extent this was addressed because protime, PTT, and blood count were done. In addition, although Dr. Gorbaty thought that there was a high risk for bleeding. But none occurred peri-operatively. There is no mention anywhere in the record that there was need for blood transfusion or that there was any weeping from the wound. In fact, Dr. Braun stated in the chart that the wound was healing well. To me this is a non-issue since again it is a subjective interpretation and there is in fact no evidence that any damage occurred.

George Gore, Esquire  
December 17, 1990  
-3-

**RE: Estate of Michael Carrick v. Cleveland Clinic Foundation, et al.  
Clinic Patient # 1-973-492-7**

- 5) His statements concerning the Dialume are also ridiculous. He does not seem to understand that aluminum hydroxide phosphate binder is the only option until the phosphorous level is controlled. If calcium binders (which are the only other option) are used and the calcium -- phosphorous product is elevated above 70, extra-skeletal calcification will continue to occur. This is precisely the problem Mr. Carrick was having that debilitated him to the point of being in a wheelchair. To suggest that we should have used anything other than aluminum hydroxide and thus worsen the patient's symptoms in the short term is ridiculous. The goal is to control the phosphorous level with aluminum hydroxide and then to switch the patient to calcium compounds. A Standard Textbook of Dialysis states that "in patients who have been on dialysis for at least 8 years only 37% had aluminum bone disease". I have the reference on that if necessary. Since Mr. Carrick had just been started on aluminum hydroxide and had not had dialysis for even one month, to suggest that he had significant aluminum accumulation reflects a misunderstanding of the disease. Aluminum intoxication occurs slowly and in fact patients with any residual output appear to be protected from aluminum bone disease. Since we have documented that Mr. Carrick had continued urine output, he was at minimal to no risk in the short term of aluminum intoxication. In fact, as I stated earlier to use anything other than aluminum hydroxide would have been medically reckless. It is known that aluminum hydroxide can cause constipation. However, to suggest that nephrologists routinely give patients strong laxatives prior to surgical procedures is incorrect. I would push for any references suggesting that that is the proper course of treatment. We certainly do not do this on any routine basis and I also believe that there is no recommendation in the literature to follow that course of action. Once constipation does develop it is treated by routine measures. Again, the use of aluminum hydroxide was dictated by the clinical situation and there were no options. There are also multiple reasons for developing an ileus and to claim that the binders were the only reason and that they routinely cause severe constipation is totally incorrect.
- 6) The pneumonia might well have been associated in the general picture to Mr. Carrick's over all poor health. We certainly know that debilitated patients are more likely to develop pneumonia then those who are in good health. We have stated from the beginning, however, that Mr. Carrick's medical situation was so severe at that time that we had no option but to



George Gore, Esquire  
December 17, 1990  
-4-

**RE: Estate of Michael Carrick v. Cleveland Clinic Foundation, et al.  
Clinic Patient # 1-973-492-7**

proceed with the surgery.' So, Dr. Gorbaty is not stating anything that we do not already acknowledge ourselves. The question is what the options to waiting would have been. As mentioned previously, I thought the options to waiting were not acceptable and would have, in fact, introduced Mr. Carrick to more risk. It is on that basis that I decided to proceed with parathyroidectomy.

- 7) Dr. Gorbaty also states that the hip fracture occurred post operatively. I agree with his assessment as to the causes. Again this highlights the severity of the symptoms and why standard medical treatment was not indicated. In addition, as mentioned above, I do not believe the aluminum load is a factor. If it takes up to 8 years on hemodialysis with 6 to 8 capsules per day to accumulate aluminum, Mr. Carrick is nowhere in that ballpark. In addition, as mentioned earlier, to use anything other than aluminum would have raised a much higher risk of worsening his symptoms.
- 8) Dr. Gorbaty also does not understand that serum aluminum is not a good index of patient aluminum status anyway. If he had suggested a DFO infusion test or a bone biopsy either might have been reasonable suggestions in a given clinical situation. The aluminum levels are routinely notorious for reflecting recent intake and not total body burden of aluminum. So even his statement of the proper screening technique is incorrect.
- 9) Mr. Carrick probably did suffer some hearing loss related to his antibiotics. I suggest that the Infectious Disease experts would be better able to address this question. Certainly there is a risk with use of aminoglycosides. However, if a person has life threatening infection and if the drug levels are followed this is a risk worth taking rather than allowing the patient to die from his infection. I believe, this was the case with Mr. Carrick and that he was followed very closely by the Infectious Disease expert who is well aware of this potential complication.

George Gore, Esquire  
December 17, 1990  
-5-

**RE: Estate of Michael Carrick v. Cleveland Clinic Foundation, et al.  
Clinic Patient # 1-973-492-7**

- 10) I believe the only area that is gray enough to be disputable is whether hemodialysis ought to have been done pre-operatively based solely on the BUN. Some might argue that the patient might have done better with removal of waste products more vigorously. This is hindsight and as mentioned, I think, is a debatable question. Certainly there was no peri-operative bleeding as suggested by Dr. Gorbaty. The coagulation parameters were screened and that was a non-issue. Whether removal of waste product would have improved Mr. Carrick's immune status to the point where he would not have become infected is unknown. In reviewing the chart this is the only gray area which I have questioned about my medical treatment of Mr. Carrick. Again, this relates mostly to the peri-operative period and not to the time before he was admitted for surgery.

I hope this is helpful. In summary, I believe their expert witness has shown us more about his lack of information on the topic than any usable information for the plaintiff. As mentioned, from my perspective, the only debatable issue has to do with pre-operative hemodialysis and not from a bleeding perspective since none of this occurred but from a perspective of removing waste products to improve the immune function. All other issues that have been raised I think are spurious and not backed by any scientific information.

Best regards,

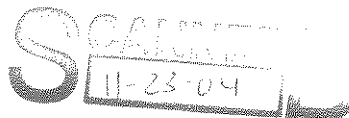


Robert J. Heyka, M.D.

RJH/ec  
cc: Michael Meehan, Esq.

1                   IN THE COURT OF COMMON PLEAS  
2                   OF CUYAHOGA COUNTY, OHIO  
3                   - - - - -

4       CHARLES TENNEY, III, etc.,  
5       et al.,



6                   Plaintiffs,

7                   vs

Case No. 448548

8       URMILA PATEL, M.D., et al.,

9                   Defendants.  
10                  - - - - -

11               DEPOSITION OF JACQUELINE WHITTINGTON, RN

12               MONDAY, APRIL 22, 2002  
13               - - - - -

14               Deposition of JACQUELINE WHITTINGTON, RN, a  
15       Witness herein, called by counsel on behalf of  
16       the Plaintiff for examination under the statute,  
17       taken before me, Vivian L. Gordon, a Registered  
18       Diplomate Reporter and Notary Public in and for  
19       the State of Ohio, pursuant to agreement of  
20       counsel, at the offices of Southwest General  
21       Health Center, Middleburg Heights, Ohio,  
22       commencing at 11:30 o'clock a.m. on the day and  
23       date above set forth.  
24  
25

1 APPEARANCES:

2 On behalf of the Plaintiff

Becker & Mishkind

3 HOWARD D. MISHKIND, ESQ.

Skylight Office Tower Suite 660

4 Cleveland, Ohio 44113

216-241-2600

5

6 On behalf of the Defendant Southwest General  
Health Center

7 Bonezzi, Switzer, Murphy & Polito

DONALD SWITZER, ESQ.

8 1400 Leader Building

Cleveland, Ohio 44114

9 216-875-2767

10 On behalf of the Defendant Patel

Weston, Hurd, Fallon, Paisley & Howley

11 BEVERLY HARRIS, ESQ.,

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12 Cleveland, Ohio 44113

216-687-3269

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1 JACQUELINE WHITTINGTON, RN, a witness  
2 herein, called for examination, as provided by  
3 the Ohio Rules of Civil Procedure, being by me  
4 first duly sworn, as hereinafter certified, was  
5 deposed and said as follows:

6 EXAMINATION OF JACQUELINE WHITTINGTON, RN  
7 BY MR. MISHKIND:

8 Q. Tell me your name, please.

9 A. Jacqueline Whittington.

10 Q. Where do you live, please.

11 A. Middleburg Heights, 15900 Ramona  
12 Drive, Middleburg.

13 Q. Zip code out there is?

14 A. 44130.

15 Q. We had a chance to chat for a few  
16 minutes before the deposition started, while  
17 Mr. Switzer was out of the room, although it was  
18 all unrelated to this case. I will say that on  
19 the record.

20 My name is Howard Mishkind and I  
21 represent Dawn Davis and Charlie Tenney and  
22 Charles Tenney, the father, in connection with  
23 this case. I'm going to ask you some questions  
24 and I want to learn what you know, and I want to  
25 learn perhaps what you don't know, okay?

1 A. Yes.

2 Q. Tell me whether you have ever had  
3 your deposition taken before.

4 A. No, never.

5 Q. Let me give you a couple  
6 precautionary instructions that hopefully will  
7 help you and me get through this.

8 Answer verbally, okay?

9 A. Yes.

10 Q. If you don't, I'll remind you.

11 A. Yes.

12 Q. Wait until I'm done with my question  
13 before you start answering it, for two reasons:  
14 To make the flow nice and neat, and also to make  
15 sure that you are understanding my question  
16 before you start to answer it. Okay?

17 A. Yes.

18 Q. A common reaction is to start  
19 answering something when you know what the  
20 answer is, because the question is going on and  
21 on, like my statement is now, and you are  
22 wondering when I'm going to finish. Wait until  
23 I am done before you start answering.

24 A. Okay.

25 Q. You are an RN?

1 A. Yes, an RN.

2 Q. And are you a BSN?

3 A. Diploma.

4 Q. From where?

5 A. Fairview.

6 Q. What year?

7 A. 1974.

8 Q. You are employed here at the  
9 hospital?

10 A. Yes, at Southwest.

11 Q. And how many years have you been  
12 employed here?

13 A. Twenty.

14 Q. In what department?

15 A. OB.

16 Q. Do you have any special certification  
17 in the area of obstetrical nursing?

18 A. Yes, I'm code pink certified.

19 Q. When did you become code pink  
20 certified?

21 A. They didn't have the program when I  
22 started here, so I would have to say it was  
23 within a couple years after I started. It is in  
24 connection with Metro General.

25 Q. How long of a program course is it to

1     become --

2           A.     Code pink is an ongoing program. You  
3     go down to Metro, at least we did, went down for  
4     two days, classes, practicals and now we have to  
5     be certified. Every year we have classes. We  
6     have to be certified.

7           Q.     Do you have to take an examination?

8           A.     A written one, yes, and a practical.

9           Q.     And each year you have to become  
10    recertified?

11          A.     We alternate years. One year it's a  
12    code pink certification and the opposite year  
13    it's an NRP, it's a national newborn  
14    resuscitation program through the Heart  
15    Association.

16          Q.     So each year you are taking some  
17    certification, whether it's the NRP or the code  
18    pink certification?

19          A.     Yes, every year.

20          Q.     And that's been going on since the  
21    '70s?

22          A.     I don't know exactly when code pink  
23    started. It was when Metro started their  
24    program.

25          Q.     Is it fair to say it's at least been



1     ten or more years?

2           A.     At least 15, I would say.

3           Q.     I take it you have been successful  
4     each year with your examinations?

5           A.     Yes.

6           Q.     Do you have any other certification  
7     in obstetrics or newborn management --

8           A.     No.

9           Q.     -- other than what you have told me  
10    about?

11          A.     No.

12          Q.     Do you have any family members that  
13    are in the medical profession?

14          A.     No.

15          Q.     Do you know Dr. Patel?

16          A.     Yes.

17          Q.     Have you ever had occasion to work  
18    with her outside of labor and delivery?

19          A.     As a professional --

20          Q.     Yes.

21          A.     -- arrangement? I'm a patient of  
22    hers.

23          Q.     Well, that's professional.

24          A.     Yes.

25          Q.     How long have you been a patient of

1     hers?

2           A.     I would say maybe ten years.

3           Q.     Have you ever worked in her office?

4           A.     No, I have not.

5           Q.     When is the last time that you talked  
6     with Dr. Patel about Dawn Davis?

7           A.     It would have been the day of this  
8     delivery.

9           Q.     You have not had any conversation  
10    formally or informally?

11          A.     No.

12          Q.     Even though the no may still apply,  
13    let me finish first.

14          A.     I'm sorry.

15          Q.     That's okay, not a problem. And it's  
16    so common to do what you are doing, but try to  
17    resist that urge.

18                 Formally or informally you have not  
19    had any conversation with her that's touched on  
20    any aspect of Dawn Davis' care since September  
21    13th, 2000; is that true?

22          A.     That's true.

23          Q.     I'm not going to ask you to tell me  
24    what you talked about with Mr. Switzer, and he  
25    wouldn't let me ask you anyway, but I do

1 understand that there was a meeting that was  
2 held where a number of nurses were present;  
3 true?

4 A. True.

5 Q. Have you had conversations with any  
6 of the nurses that were involved in the labor  
7 and delivery or the postpartum period that you  
8 have had privately and outside of the presence  
9 of an attorney from the hospital?

10 A. No, not about the case, no.

11 Q. Tell me what you can about Lisa  
12 Piscola, why she left the hospital.

13 A. I really didn't know her. She was an  
14 orientation, so we just worked in the delivery  
15 room. You know, I actually hadn't even  
16 remembered anything about her until we saw this  
17 chart.

18 Q. You have reviewed the chart?

19 A. Yes, I have.

20 Q. What aspects of the chart did you  
21 review?

22 A. What I have looked at is the parts  
23 that were pertinent to me. I looked at the  
24 mom's chart, but I am not a labor nurse.

25 Q. When is the last time you worked as a

1 labor nurse?

2 A. I have never been a labor nurse.

3 Q. That answers that question.

4 A. Never.

5 Q. Have you ever been involved in a  
6 delivery assisting an obstetrician in managing a  
7 shoulder dystocia?

8 A. No.

9 Q. I take it you were not involved in  
10 any aspect of the management of the shoulder  
11 dystocia that Charlie Tenney experienced?

12 A. No.

13 Q. Were you in the OR before Charlie was  
14 delivered?

15 A. It was a birthing room.

16 Q. I'm sorry. I stand corrected. And I  
17 knew that, but sometimes you just get OR in your  
18 brain.

19 A. I don't remember, but I would have  
20 been there a few minutes before he was born.

21 Q. And on what do you base that?

22 A. The routine that we have when a baby  
23 is born, when the mother reaches a point where  
24 the delivery is imminent, the labor nurse calls  
25 to the nursery and one of us goes to the

1 birthing room. We prepare our equipment and  
2 then we wait for the baby to be born, so if you  
3 want a time frame, I don't have an exact number.

4 Q. There was code pink called due to the  
5 shoulder dystocia.

6 Would you have been responding to the  
7 birthing room as a result of the code pink or  
8 for other reasons?

9 A. I would have already been in there.

10 Q. And at that time, obviously,  
11 Dr. Patel would have been there in the room with  
12 mom; true?

13 A. Yes, at the time of delivery, yes.

14 Q. From looking at the record, is it  
15 likely that Lisa Piscola was also in the room?

16 A. According to the record, yes.

17 Q. According to the record, who else  
18 likely would have been in the room by way of  
19 medical staff when you arrived?

20 A. When I arrived in the room, according  
21 to the record, it would have been Dr. Patel,  
22 Lisa Piscola and Lois Cricks.

23 Q. What is Lois Cricks' position?

24 A. She is a labor RN.

25 Q. Have you had occasion to talk with

1 Lois at all about her relationship with Lisa  
2 Piscola that existed back in September of 2000?

3 A. Only when we were with Mr. Switzer,  
4 he talked to each one of us what our role was in  
5 the room.

6 Q. Have you talked privately or outside  
7 of the presence of Mr. Switzer concerning what  
8 Lois' title or position was as it relates to  
9 Lisa?

10 A. No.

11 Q. When is the last time you talked to  
12 Lisa?

13 A. Last week when we went with  
14 Mr. Switzer. That was, I believe, Wednesday or  
15 Thursday.

16 MR. SWITZER: Thursday.

17 Q. So you believe that Lisa would have  
18 been in the room, Lois would have been in the  
19 room, Dr. Patel would have been in the room as  
20 medical care providers before you arrived; true?

21 A. I don't know. I don't remember. I'm  
22 just reading what's on here.

23 Q. And on here is the summary of the  
24 pregnancy, labor and delivery record?

25 A. Yes.

1 Q. But based upon that, do you conclude  
2 that what I just said is accurate?

3 A. That when I came into the room, it  
4 would have been Dr. Patel, Lisa, and Lois.

5 Q. Now, you were coming into the room as  
6 a routine to just assist in managing the  
7 transition of the baby from delivery to  
8 preparing the baby for the newborn period; is  
9 that why you were coming in?

10 A. Yes.

11 Q. You weren't coming in in response to  
12 any type of a crisis or a code?

13 A. No.

14 Q. Do you have any recollection of  
15 witnessing the delivery?

16 A. No, I don't remember this delivery at  
17 all.

18 Q. Do you have any recollection, vague  
19 or otherwise, of anything that was being said or  
20 done in the birthing room when you arrived?

21 A. No.

22 Q. Ever have any conversation with  
23 Dr. Patel about what she encountered at the time  
24 that the shoulder dystocia was encountered?

25 A. No.

1 Q. Do you have any knowledge as to why  
2 Charlie Tenney suffered a permanent brachial  
3 plexus injury as a result of this shoulder  
4 dystocia?

5 MS. HARRIS: Objection.

6 A. No.

7 Q. You come into the room under normal  
8 circumstances. What would be your custom and  
9 practice in terms of what you would do  
10 preparatory to the delivery?

11 A. When you come into the room, the  
12 warmer, where you place the baby after it's  
13 born, is in a corner. So we go back there, make  
14 sure the heat is on, check all our equipment,  
15 all our resuscitation equipment for every  
16 delivery, whether there is risk factors or not.  
17 We make sure the oxygen is on, the suction is  
18 on, check the anesthesia bag, make sure that's  
19 working, gather all of our -- like the  
20 measuring tape, the eye ointment, all the  
21 paperwork, concur with the labor nurse just to  
22 see what the status is, how soon it will be, if  
23 there is any risk factors.

24 Q. I have already been told that the bed  
25 in this birthing room is perpendicular to the



1 door; that the stand where the computer is would  
2 either be to the right or to the left of the  
3 head of the bed.

4 A. Yes.

5 Q. With mom laying her head furthest  
6 from the door, her feet closest to the door,  
7 would the computer be to mom's right or to mom's  
8 left?

9 A. It would depend on what room she was  
10 in. I don't remember the room.

11 Q. 316.

12 A. Because sometimes the bed is here and  
13 sometimes the bed is on this side of the door.

14 Q. Do you know back in September whether  
15 the computer would have been to mom's left or to  
16 mom's right?

17 A. I don't know. I would have to go up  
18 and look at that room and see what the setup of  
19 the beds is. The computer is at the head of  
20 bed, but depending on if the bed is on this wall  
21 or this wall is what side the computer is on.

22 Q. Did you make any entries in the  
23 computer?

24 A. No, I have no access to that  
25 computer.

1           Q.     The warmer that the baby would  
2     ultimately be placed in after delivery, where in  
3     relationship to the head of the bed would that  
4     be?

5           A.     The bed would be here, the computer  
6     would be here, and then the warmer would be  
7     here.

8           Q.     So the warmer would be furthest from  
9     the door behind the computer?

10          A.     Closest to the door.

11          Q.     Would you mind drawing? I have not  
12     asked anybody else to do it, but I want to try  
13     to get an idea of the total layout.

14                 MR. SWITZER: She may not remember  
15     this particular room.

16          A.     The rooms are set up, but I couldn't  
17     tell you the direction.

18          Q.     But in terms of the relationship of  
19     the computer and the warmer, they all pretty  
20     much follow the same pattern, do they not?

21          A.     Yes.

22          Q.     So that while it may be to the right  
23     or the left of the birthing bed, you can give me  
24     a general layout of where the door is and where  
25     the --

1           A.     Yes.

2           Q.     I'm going to have you draw this for  
3     me, but do it silently. We will go off the  
4     record, because if you start saying here and  
5     there or this, the court reporter has to take  
6     everything down. So draw it silently off the  
7     record and then we will go back on the record  
8     and have you identify what you have drawn, okay?

9           A.     Okay.

10                  (Pause.)

11                         - - - - -

12                         (Thereupon, Plaintiff's Deposition  
13                         Exhibit 1 was marked for  
14                         purposes of identification.)

15                         - - - - -

16           Q.     At least to get a framework for what  
17     we are talking about, Plaintiff's Exhibit 1 with  
18     your name on it for this deposition is a sketch  
19     that you have made of a birthing room. Whether  
20     it is identical to what birthing room 316 looked  
21     like back in September of 2000, you are unclear  
22     about, but this at least shows the relationship  
23     of the birthing bed, the computer, the warmer,  
24     and the armoire in relationship to the entry to  
25     the room; true?

1 A. True.

2 Q. The armoire, is that just with  
3 supplies and things of that nature?

4 A. Yes.

5 Q. And then the window looks out over  
6 the parking lot?

7 A. It looks out over the courtyard.

8 Q. So you would have come into the room  
9 in anticipation of the delivery of Charlie  
10 Tenney; true?

11 A. True.

12 Q. And that would have been because Lisa  
13 would have let you know that the delivery was  
14 imminent?

15 A. It may not have been Lisa  
16 particularly, it may have been someone else who  
17 called.

18 Q. Where would you have been stationed  
19 prior to getting notified that the delivery was  
20 imminent?

21 A. In the newborn nursery.

22 Q. And as I understand it, the newborn  
23 nursery was basically across the hall from room  
24 316?

25 A. Yes.

1 Q. Does that sound right?

2 A. It is across from the birthing rooms.

3 Q. So you would have come in, gotten  
4 equipment prepared, and would have then waited  
5 for the delivery to take place?

6 A. Yes.

7 Q. You would not have participated in  
8 the delivery of the baby?

9 A. No.

10 Q. Do you have any recollection of the  
11 position of any of the nurses that were in the  
12 room during the management of the shoulder  
13 dystocia?

14 A. No.

15 Q. Do you have any knowledge or  
16 recollection as to how many nurses were in the  
17 room at the time that the shoulder dystocia was  
18 being managed?

19 A. No.

20 Q. Do you recall Dr. Patel calling out  
21 that the head was stuck?

22 A. No.

23 Q. That doesn't ring a bell at all?

24 A. Not at all.

25 Q. Are you able to help me at all in

1 terms of the number of family members that were  
2 in the room at the time that the baby's head was  
3 delivered?

4 A. No.

5 Q. Or how many family members were in  
6 the room and their position from the time the  
7 baby's head was delivered until the time the  
8 baby was delivered?

9 A. No.

10 Q. Do your notes reflect any of that  
11 information?

12 A. My particular notes?

13 Q. Yes.

14 A. No.

15 Q. And do you see as you are looking at  
16 the notes any reflection as to how many family  
17 members were present in the delivery, in the  
18 birthing room immediately prior to the shoulder  
19 dystocia being encountered, as well as up  
20 through the time that the baby's body was  
21 delivered?

22 A. On the delivery summary it says  
23 support person present in delivery room and it  
24 says Charles.

25 Q. And whose note is that; do you know?

1           A.     No, I don't know. But it's on the  
2     summary.

3           Q.     Got it. So if the parents of Dawn  
4     Davis were also in the room during the delivery,  
5     would you have any explanation for why their  
6     name would not be reflected on this summary of  
7     pregnancy, labor and delivery?

8           A.     I'm not the labor nurse. I don't  
9     fill this out, so no, I don't have any  
10    explanation.

11          Q.     Who is Dr. McKnight?

12          A.     Dr. McKnight is a pediatrician who is  
13    from University Rainbow. He is what we call  
14    them here at Southwest our hospitalist. They  
15    work in the hospital. There is a group of four  
16    of them.

17          Q.     Dr. Patel's note reflects that  
18    respiratory and house physicians came into the  
19    birthing room. Do you have any recollection of  
20    Dr. McKnight coming into the birthing room?

21          A.     No, I don't remember.

22          Q.     The record reflects that Dr. McKnight  
23    did come in.

24          A.     Yes.

25          Q.     Correct?

1           A.     Yes, the record says that.

2           Q.     Now, tell me what was Charlie's  
3     condition when you received him?

4           A.     I don't remember the delivery. But  
5     according to the notes, at one minute of age he  
6     had an apgar of seven.

7           Q.     Are you referring to the newborn  
8     resuscitation record?

9           A.     Yes, I am.

10          Q.     This newborn resuscitation record  
11     would have been created in the birthing room;  
12     true?

13          A.     Yes, it is.

14          Q.     The comment section at the very  
15     bottom, would that also have reflected events  
16     that occurred in the birthing room?

17          A.     Yes, in the birthing room.

18          Q.     Do you know why Charlie's breathing  
19     became labored with audible grunting shortly  
20     after delivery?

21          A.     No, I don't know why.

22          Q.     Did anyone explain to you why that  
23     was?

24          A.     No.

25          Q.     Do you know why Charlie developed



1     bilateral pneumothoraces?

2           A.     No, I don't know why.

3           Q.     Has anyone explained that to you?

4           A.     No.

5           Q.     Do you know why Charlie had a  
6     cephalohematoma at birth?

7           A.     From my experience, that's a common  
8     thing for a baby to have swelling of the head,  
9     but as to what anyone explained to me about him,  
10    no.

11          Q.     Any place on this newborn  
12    resuscitation record for you to record  
13    abnormalities as it relates to the brachial  
14    plexus or any type of trauma to the shoulder or  
15    to the neck that you see when you are handed the  
16    baby?

17          A.     On this particular paper?

18          Q.     Yes.

19          A.     No, there is not.

20          Q.     What did you do as part of the  
21    newborn resuscitation? You were the one that  
22    recorded the apgars?

23          A.     I am the recorder. The doctor  
24    assigned the number.

25          Q.     Got it. And at one minute of life,

1 the baby's apgar was seven?

2 A. Correct.

3 Q. At five, it was eight, and at ten, it  
4 was eight?

5 A. Correct.

6 Q. The apgars do not reflect anything as  
7 it relates to a shoulder or a brachial plexus  
8 type of injury as a factor in evaluating the  
9 apgars; true?

10 A. No.

11 Q. What else was part of your  
12 responsibility, ma'am, during this newborn  
13 period over the first ten minutes in the  
14 birthing room? What else would you be doing?

15 A. As I said before, in this case, I  
16 don't remember, but as our usual routine, we  
17 receive the baby in a warm blanket, take it over  
18 to the warmer. The doctor is there. He looks  
19 at the baby, we dry the baby off. If he has  
20 anything he wants us to do as far as any  
21 interventions, we follow his order.

22 Q. Dr. McKnight's deposition was taken  
23 and he testified that he transferred the baby to  
24 -- is it the special care nursery?

25 A. That's what we call it.

1 Q. SCN?

2 A. It's just a room off the nursery with  
3 resuscitation equipment and isolettes.

4 Q. Any recollection of him doing that?

5 A. No.

6 Q. Has anyone ever explained to you --  
7 Dr. McKnight, Dr. Shaw, or anyone -- why Charlie  
8 had to be resuscitated, why he had to be  
9 intubated shortly after birth in light of  
10 relatively good apgar scores during the first  
11 ten minutes of life?

12 A. I'm not sure I understand the  
13 question.

14 Q. Do you know what transpired after the  
15 first ten minutes of life to cause his  
16 respiratory condition and his overall  
17 hemodynamic status to deteriorate?

18 A. As I said before, I don't remember,  
19 but in reading the notes, it says when the baby  
20 came to the nursery, he became dusky.

21 Q. Is it your responsibility in  
22 assessing the newborn to look for signs or  
23 symptoms that would suggest an impending  
24 respiratory failure or respiratory distress?

25 A. I'm not sure I understand that.

1           Q.     When you assess the baby and do the  
2     apgars, you are looking for any abnormalities;  
3     true?

4           A.     When I'm working with a physician,  
5     the physician gives the apgars.

6           Q.     Would the apgars have been given by  
7     Dr. McKnight or Dr. Patel?

8           A.     Dr. McKnight.

9           Q.     Once Charlie was transferred to the  
10    special care nursery, the room next to the  
11    nursery, for further attention, were you  
12    involved in any aspect of that?

13          A.     As I said before, I don't remember.

14          Q.     According to the record, were you?

15          A.     According to the record, the baby was  
16    brought to the nursery and Darlene Vacca was  
17    taking care of the baby.

18          Q.     According to the record, when was  
19    your last involvement during the newborn period?

20          A.     Do you mean during the --

21          Q.     The immediate newborn period.

22          A.     In the birthing room, and then I took  
23    the baby from the nursery to her. She started  
24    taking care of the baby and then down the road I  
25    came in to help her.

1           Q.     Tell me, looking at your notes, what  
2     was the baby's condition when you came in to  
3     help her?

4           A.     According to the record, the next  
5     time that I had hands on contact with the baby  
6     was at 1325 I hung an IV.

7           Q.     What was the baby's condition at that  
8     time?

9           A.     According to the notes, he had a UAC  
10    catheter, which is a uterine artery catheter.  
11    He was intubated, receiving oxygen, and he had  
12    two chest tubes in.

13          Q.     I take it that he was being treated  
14    for the bilateral pneumothoraces?

15          A.     According to the record, yes.

16          Q.     And again, no one has explained to  
17    you why this baby experienced bilateral  
18    pneumothoraces?

19          A.     No.

20          Q.     Have you ever encountered bilateral  
21    pneumothoraces in a newborn baby?

22          A.     Yes.

23          Q.     Have any of those situations where  
24    you have encountered bilateral pneumothoraces  
25    been secondary to trauma at the time of birth?

1           A.     I can't recall. I have had several  
2     babies. I know one in particular that was a  
3     preterm baby and the other one I can't recall  
4     why. It is a common occurrence, a pneumothorax.

5           Q.     And do you know whether there is any  
6     association between trauma at birth and  
7     pneumothoraces?

8           A.     No.

9           Q.     No, there isn't, or no, you don't  
10    know?

11          A.     No, I don't know.

12          Q.     Fair enough. Did you help with the  
13    transfer team, getting the baby ready to go to  
14    RB&C?

15          A.     Our role once the transfer team  
16    arrives, we step back and they take over the  
17    care and they assume care of the baby and we are  
18    done.

19          Q.     Did you have any contact with anyone  
20    over at UH at RB&C once the baby was transferred  
21    to get a sense of what the baby's condition was?

22          A.     No. For patient confidentiality,  
23    they don't talk to us at all.

24          Q.     Did you have any interaction, after  
25    the baby was transferred, with mom, with Dawn?

1           A.     I don't recall talking to her.

2           Q.     Would that be your normal practice  
3     that you would see the mom after her baby has  
4     been transferred?

5           A.     Yes, we usually go out and talk to  
6     them. The transfer team also takes the baby out  
7     to the room.

8           Q.     There is a description of the baby  
9     being in critical condition at the time of  
10    transfer. Is that consistent with what your  
11    understanding is, as well?

12          A.     Any baby that has to be transferred  
13    is considered to be critical. As far as this  
14    baby, the record says that, yes.

15          Q.     After the transfer team arrived and  
16    you stepped aside, other than perhaps some  
17    casual conversation with mom, just trying to  
18    comfort mom and assist in the process of  
19    maintaining calmness, if you will, did you have  
20    any other involvement in any care of mom or any  
21    other aspect of the baby's care?

22          A.     As I said before, I don't remember  
23    talking to the mother, but no, I never took care  
24    of her as a nurse/patient relationship, no.

25                 MR. MISHKIND: That's it. Nothing

1 further.

2 MS. HARRIS: No questions.

3 - - - - -

4 (Deposition concluded at 12:15 p.m.)

5 (Signature not waived.)

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1 AFFIDAVIT

2 I have read the foregoing transcript from  
3 page 1 through 30 and note the following  
4 corrections:

5 PAGE LINE REQUESTED CHANGE

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18 JACQUELINE WHITTINGTON, RN

19

20 Subscribed and sworn to before me this  
21 day of , 2002.

22

23 Notary Public

24

25 My commission expires .

CERTIFICATE

State of Ohio,

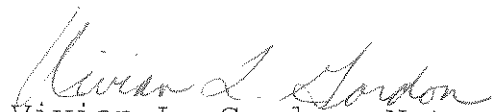
SS:

County of Cuyahoga.

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named JACQUELINE WHITTINGTON, RN was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action. I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28 (D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 29th day of April, 2002.

  
Vivian L. Gordon, Notary Public  
Within and for the State of Ohio

My commission expires June 8, 2004.

<p><b>A</b></p> <p>able 19:25</p> <p>abnormalities 23:13 26:2</p> <p>about 7:10 8:6,24 9:10,11,16 12:1 13:23 17:17,22 23:9</p> <p>above 1:22 32:11</p> <p>access 15:24</p> <p>according 11:16,17 11:20 22:5 26:14 26:15,18 27:4,9 27:15</p> <p>accurate 13:2</p> <p>across 18:23 19:2</p> <p>action 32:16</p> <p>actually 9:15</p> <p>adjournment 32:14</p> <p>AFFIDAVIT 31:1</p> <p>affiliated 32:16</p> <p>affixed 32:18</p> <p>aforesaid 32:11</p> <p>after 5:23 14:12 16:2 22:20 25:9 25:14 28:24 29:3 29:15</p> <p>afterwards 32:11</p> <p>again 27:16</p> <p>age 22:5</p> <p>agreement 1:18</p> <p>al 1:4,7</p> <p>already 11:9 14:24</p> <p>alternate 6:11</p> <p>although 3:17</p> <p>anesthesia 14:18</p> <p>answer 4:8,16,20</p> <p>answering 4:13,19 4:23</p> <p>answers 10:3</p> <p>anticipation 18:9</p> <p>anybody 16:12</p> <p>anyone 22:22 23:3 23:9 25:6,7 28:19</p> <p>anything 9:16 13:19 24:6,20</p> <p>anyway 8:25</p> <p>apgar 22:6 24:1 25:10</p> <p>apgars 23:22 24:6,9 26:2,5,6</p> <p>APPEARANCES 2:1</p>	<p>apply 8:12</p> <p>April 1:11 32:19</p> <p>area 5:17</p> <p>armoire 17:24 18:2</p> <p>arrangement 7:21</p> <p>arrived 11:19,20 12:20 13:20 29:15</p> <p>arrives 28:16</p> <p>artery 27:10</p> <p>aside 29:16</p> <p>asked 16:12</p> <p>aspect 8:20 10:10 26:12 29:21</p> <p>aspects 9:20</p> <p>assess 26:1</p> <p>assessing 25:22</p> <p>assigned 23:24</p> <p>assist 13:6 29:18</p> <p>assisting 10:6</p> <p>association 6:15 28:6</p> <p>assume 28:17</p> <p>attention 26:11</p> <p>attorney 9:9 32:15</p> <p>audible 22:19</p> <p>a.m 1:21</p> <p><b>B</b></p> <p>babies 28:2</p> <p>baby 10:22 11:2 13:7,8 14:12 16:1 19:8 20:8 23:8,16 24:17,19,19,23 25:19 26:1,15,17 26:23,24 27:5,17 27:21 28:3,13,17 28:20,25 29:3,6,8 29:12,14</p> <p>baby's 20:2,7,20 24:1 27:2,7 28:21 29:21</p> <p>back 12:2 14:13 15:14 17:7,21 28:16</p> <p>bag 14:18</p> <p>base 10:21</p> <p>based 13:1</p> <p>basically 18:23</p> <p>became 22:19 25:20</p> <p>Becker 2:2</p> <p>become 5:19 6:1,9</p> <p>bed 14:24 15:3,12</p>	<p>15:13,20,20 16:3 16:5,23 17:23</p> <p>beds 15:19</p> <p>before 1:16 3:16 4:3,13,16,23 10:13,20 12:20 24:15 25:18 26:13 29:22 31:20</p> <p>behalf 1:14 2:2,6,10</p> <p>behind 16:9</p> <p>being 3:3 13:19 19:18 20:19 27:13 29:9</p> <p>believe 12:14,17</p> <p>bell 19:23</p> <p>between 28:6</p> <p>BEVERLY 2:11</p> <p>bilateral 23:1 27:14 27:17,20,24</p> <p>birth 23:6 25:9 27:25 28:6</p> <p>birthing 10:15 11:1 11:7 13:20 14:25 16:23 17:19,20,23 19:2 20:18 21:19 21:20 22:11,16,17 24:14 26:22</p> <p>blanket 24:17</p> <p>body 20:20</p> <p>Bonezzi 2:7</p> <p>born 10:20,23 11:2 14:13</p> <p>bottom 22:15</p> <p>brachial 14:2 23:13 24:7</p> <p>brain 10:18</p> <p>breathing 22:18</p> <p>brought 26:16</p> <p>BSN 5:2</p> <p>Building 2:8</p> <p><b>C</b></p> <p>call 21:13 24:25</p> <p>called 1:14 3:2 11:4 18:17</p> <p>calling 19:20</p> <p>calls 10:24</p> <p>calmness 29:19</p> <p>came 13:3 21:18 25:20 26:25 27:2</p> <p>care 8:20 12:20 24:24 26:10,17,24 28:17,17 29:20,21</p>	<p>29:23</p> <p>case 1:6 3:18,23 9:10 24:15</p> <p>casual 29:17</p> <p>catheter 27:10,10</p> <p>cause 25:15 32:10</p> <p>Center 1:20 2:6</p> <p>cephalohematoma 23:6</p> <p>CERTIFICATE 32:1</p> <p>certification 5:16 6:12,17,18 7:6</p> <p>certified 3:4 5:18 5:20 6:5,6</p> <p>certify 32:9,13</p> <p>chance 3:15</p> <p>CHANGE 31:5</p> <p>Charles 1:4 3:22 20:24</p> <p>Charlie 3:21 10:11 10:13 14:2 18:9 22:25 23:5 25:7 26:9</p> <p>Charlie's 22:2,18</p> <p>chart 9:17,18,20,24</p> <p>chat 3:15</p> <p>check 14:14,18</p> <p>chest 27:12</p> <p>circumstances 14:8</p> <p>Civil 3:3 32:17</p> <p>classes 6:4,5</p> <p>Cleveland 2:4,8,12 32:18</p> <p>closest 15:6 16:10</p> <p>code 3:13 5:18,19 6:2,12,17,22 11:4 11:7 13:12</p> <p>come 14:7,11 18:8 19:3 21:23</p> <p>comfort 29:18</p> <p>coming 13:5,9,11 21:20</p> <p>commencing 1:21</p> <p>comment 22:14</p> <p>commission 31:25 32:24</p> <p>commissioned 32:8</p> <p>common 1:1 4:18 8:16 23:7 28:4</p> <p>completed 32:14</p> <p>computer 15:1,7,15 15:19,21,23,25 16:5,9,19 17:23</p>	<p>concerning 12:7</p> <p>conclude 13:1</p> <p>concluded 30:4</p> <p>concur 14:21</p> <p>condition 22:3 25:16 27:2,7 28:21 29:9</p> <p>confidentiality 28:22</p> <p>connection 3:22 5:24</p> <p>considered 29:13</p> <p>consistent 29:10</p> <p>contact 27:5 28:19</p> <p>contract 32:17</p> <p>conversation 8:9,19 13:22 29:17</p> <p>conversations 9:5</p> <p>corner 14:13</p> <p>correct 21:25 24:2 24:5 32:12</p> <p>corrected 10:16</p> <p>corrections 31:4</p> <p>counsel 1:14,19</p> <p>County 1:2 32:5</p> <p>couple 4:5 5:23</p> <p>course 5:25</p> <p>court 1:1 17:5 32:16</p> <p>courtyard 18:7</p> <p>created 22:11</p> <p>Cricks 11:22,23</p> <p>crisis 13:12</p> <p>critical 29:9,13</p> <p>custom 14:8</p> <p>Cuyahoga 1:2 32:5</p> <p><b>D</b></p> <p>D 2:3 32:17</p> <p>Darlene 26:16</p> <p>date 1:22</p> <p>Davis 3:21 8:6,20 21:4</p> <p>Dawn 3:21 8:6,20 21:3 28:25</p> <p>day 1:21 8:7 31:21 32:19</p> <p>days 6:4</p> <p>Defendant 2:6,10</p> <p>Defendants 1:8</p> <p>defined 32:17</p> <p>delivered 10:14 20:3,7,8,21</p>
---	--	--	--	--

<b>delivery</b> 7:18 8:8 9:7,14 10:6,24 11:13 12:24 13:7 13:15,16 14:10,16 16:2 18:9,13,19 19:5,8 20:17,22 20:23 21:4,7 22:4 22:20 <b>department</b> 5:14 <b>depend</b> 15:9 <b>depending</b> 15:20 <b>deposed</b> 3:5 <b>deposition</b> 1:10,13 3:16 4:3 17:12,18 24:22 30:4 32:13 <b>description</b> 29:8 <b>deteriorate</b> 25:17 <b>developed</b> 22:25 <b>Diploma</b> 5:3 <b>Diplomate</b> 1:17 <b>direction</b> 16:17 <b>distress</b> 25:24 <b>doctor</b> 23:23 24:18 <b>doing</b> 8:16 24:14 25:4 <b>DONALD</b> 2:7 <b>done</b> 4:12,23 13:20 28:18 <b>door</b> 15:1,6,6,13 16:9,10,24 <b>down</b> 6:3,3 17:6 26:24 <b>Dr</b> 7:15 8:6 11:11 11:21 12:19 13:4 13:23 19:20 21:11 21:12,17,20,22 24:22 25:7,7 26:7 26:7,8 <b>draw</b> 17:2,6 <b>drawing</b> 16:11 <b>drawn</b> 17:8 <b>Drive</b> 3:12 <b>dry</b> 24:19 <b>due</b> 11:4 <b>duly</b> 3:4 32:8,10 <b>during</b> 19:12 21:4 24:12 25:10 26:19 26:20 <b>dusky</b> 25:20 <b>dystocia</b> 10:7,11 11:5 13:24 14:4 19:13,17 20:19	<b>E</b> <b>each</b> 6:9,16 7:4 12:4 <b>eight</b> 24:3,4 <b>either</b> 15:2 32:15 <b>employed</b> 5:8,12 <b>encountered</b> 13:23 13:24 20:19 27:20 27:24 <b>enough</b> 28:12 <b>entries</b> 15:22 <b>entry</b> 17:24 <b>equipment</b> 11:1 14:14,15 19:4 25:3 <b>ESQ</b> 2:3,7,11 <b>et</b> 1:4,7 <b>etc</b> 1:4 <b>evaluating</b> 24:8 <b>even</b> 8:12 9:15 <b>event</b> 32:15 <b>events</b> 22:15 <b>ever</b> 4:2 7:17 8:3 10:5 13:22 25:6 27:20 <b>every</b> 6:5,19 14:15 <b>everything</b> 17:6 <b>exact</b> 11:3 <b>exactly</b> 6:22 <b>examination</b> 1:15 3:2,6 6:7 <b>examinations</b> 7:4 <b>Exhibit</b> 17:13,17 <b>existed</b> 12:2 <b>experience</b> 23:7 <b>experienced</b> 10:11 27:17 <b>expires</b> 31:25 32:24 <b>explain</b> 22:22 <b>explained</b> 23:3,9 25:6 27:16 <b>explanation</b> 21:5 21:10 <b>eye</b> 14:20	20:16 <b>far</b> 24:20 29:13 <b>father</b> 3:22 <b>feet</b> 15:6 <b>few</b> 3:15 10:20 <b>fill</b> 21:9 <b>finish</b> 4:22 8:13 <b>firm</b> 32:16 <b>first</b> 3:4 8:13 24:13 25:10,15 32:9 <b>five</b> 24:3 <b>flow</b> 4:14 <b>follow</b> 16:20 24:21 <b>following</b> 31:3 <b>follows</b> 3:5 <b>foregoing</b> 31:2 32:12 <b>formally</b> 8:10,18 <b>forth</b> 1:22 32:11 <b>four</b> 21:15 <b>frame</b> 11:3 <b>framework</b> 17:16 <b>from</b> 5:4 9:9 11:14 13:7 15:6 16:8 18:23 19:2 20:6 21:13 23:7 26:23 31:2 <b>further</b> 26:11 30:1 32:13 <b>furthest</b> 15:5 16:8	<b>hand</b> 32:18 <b>handed</b> 23:15 <b>hands</b> 27:5 <b>HARRIS</b> 2:11 14:5 30:2 <b>head</b> 15:3,5,19 16:3 19:21 20:2,7 23:8 <b>Health</b> 1:20 2:6 <b>Heart</b> 6:14 <b>heat</b> 14:14 <b>Heights</b> 1:20 3:11 <b>held</b> 9:2 <b>help</b> 4:7 19:25 26:25 27:3 28:12 <b>hemodynamic</b> 25:17 <b>her</b> 7:18 8:3,19 9:13,16 12:1 15:5 15:6 26:23,25 27:3 29:1,3,24 <b>hereinafter</b> 3:4 <b>hereunto</b> 32:18 <b>him</b> 22:3 23:9 25:4 <b>hopefully</b> 4:6 <b>hospital</b> 5:9 9:9,12 21:15 <b>hospitalist</b> 21:14 <b>house</b> 21:18 <b>Howard</b> 2:3 3:20 <b>Howley</b> 2:10 <b>hung</b> 27:6 <b>Hurd</b> 2:10	<b>involved</b> 9:6 10:5,9 26:12 <b>involvement</b> 26:19 29:20 <b>isolettes</b> 25:3 <b>IV</b> 27:6
				<b>J</b> <b>Jacqueline</b> 1:10,13 3:1,6,9 31:17 32:9 <b>June</b> 32:24 <b>just</b> 9:14 10:17 12:22 13:2,6 14:21 18:2 25:2 29:17
				<b>K</b> <b>knew</b> 10:17 <b>know</b> 3:24,25 4:19 6:22 7:15 9:13,15 12:21 15:14,17 18:13 20:25 21:1 22:18,21,25 23:2 23:5 25:14 28:2,5 28:10,11 <b>knowledge</b> 14:1 19:15
				<b>L</b> <b>L</b> 1:16 32:8,22 <b>labor</b> 7:18 9:6,24 10:1,2,24 11:24 12:24 14:21 21:7 21:8 <b>labored</b> 22:19 <b>last</b> 8:5 9:25 12:11 12:13 26:19 <b>laying</b> 15:5 <b>layout</b> 16:13,24 <b>Leader</b> 2:8 <b>learn</b> 3:24,25 <b>least</b> 6:3,25 7:2 17:16,22 <b>left</b> 9:12 15:2,8,15 16:23 <b>let</b> 4:5 8:13,25 18:13 <b>life</b> 23:25 25:11,15 <b>light</b> 25:9 <b>like</b> 4:21 14:19 17:21 <b>likely</b> 11:15,18
	<b>F</b> <b>factor</b> 24:8 <b>factors</b> 14:16,23 <b>failure</b> 25:24 <b>fair</b> 6:25 28:12 <b>Fairview</b> 5:5 <b>Fallon</b> 2:10 <b>family</b> 7:12 20:1,5	<b>G</b> <b>gather</b> 14:19 <b>general</b> 1:19 2:6 5:24 16:24 <b>getting</b> 18:19 28:13 <b>give</b> 4:5 16:23 <b>given</b> 26:6 <b>gives</b> 26:5 <b>go</b> 6:3 14:13 15:17 17:3,7 28:13 29:5 <b>goes</b> 10:25 <b>going</b> 3:23 4:20,22 6:20 8:23 17:2 <b>good</b> 25:10 <b>Gordon</b> 1:16 32:8 32:22 <b>gotten</b> 19:3 <b>group</b> 21:15 <b>grunting</b> 22:19	<b>H</b> <b>hall</b> 18:23	

<p><b>LINE</b> 31:5  <b>Lisa</b> 9:11 11:15,22  12:1,9,12,17 13:4  18:12,15  <b>live</b> 3:10  <b>Lois</b> 11:22,23 12:1  12:8,18 13:4  <b>long</b> 5:25 7:25  <b>look</b> 15:18 25:22  <b>looked</b> 9:22,23  17:20  <b>looking</b> 11:14 20:15  26:2 27:1  <b>looks</b> 18:5,7 24:18  <b>lot</b> 18:6</p> <hr/> <p><b>M</b></p> <p><b>made</b> 17:19  <b>maintaining</b> 29:19  <b>make</b> 4:14,14 14:13  14:17,18 15:22  <b>managed</b> 19:18  <b>management</b> 7:7  10:10 19:12  <b>managing</b> 10:6  13:6  <b>many</b> 5:11 19:16  20:5,16  <b>marked</b> 17:13  <b>may</b> 8:12 16:14,22  18:15,16  <b>maybe</b> 8:2  <b>ma'am</b> 24:12  <b>McKnight</b> 21:11,12  21:20,22 25:7  26:7,8  <b>McKnight's</b> 24:22  <b>mean</b> 26:20  <b>measuring</b> 14:20  <b>medical</b> 7:13 11:19  12:20  <b>meeting</b> 9:1  <b>members</b> 7:12 20:1  20:5,17  <b>Metro</b> 5:24 6:3,23  <b>Middleburg</b> 1:20  3:11,12  <b>mind</b> 16:11  <b>minute</b> 22:5 23:25  <b>minutes</b> 3:16 10:20  24:13 25:11,15  <b>Mishkind</b> 2:2,3 3:7  3:20 29:25</p>	<p><b>mom</b> 11:12 15:5  28:25 29:3,17,18  29:20  <b>mom's</b> 9:24 15:7,7  15:15,16  <b>MONDAY</b> 1:11  <b>more</b> 7:1  <b>mother</b> 10:23 29:23  <b>much</b> 16:20  <b>Murphy</b> 2:7  <b>M.D</b> 1:7</p> <hr/> <p><b>N</b></p> <p><b>name</b> 3:8,20 17:18  21:6  <b>named</b> 32:9  <b>national</b> 6:13  <b>nature</b> 18:3  <b>neat</b> 4:14  <b>neck</b> 23:15  <b>never</b> 4:4 10:2,4  29:23  <b>newborn</b> 6:13 7:7  13:8 18:21,22  22:7,10 23:11,21  24:12 25:22 26:19  26:21 27:21  <b>next</b> 26:10 27:4  <b>nice</b> 4:14  <b>normal</b> 14:7 29:2  <b>Notary</b> 1:17 31:23  32:8,22  <b>note</b> 20:25 21:17  31:3  <b>notes</b> 20:10,12,16  22:5 25:19 27:1,9  <b>nothing</b> 29:25  32:10  <b>notified</b> 18:19  <b>NRP</b> 6:13,17  <b>number</b> 9:2 11:3  20:1 23:24  <b>nurse</b> 9:24 10:1,2  10:24 14:21 21:8  <b>nursery</b> 10:25  18:21,23 24:24  25:2,20 26:10,11  26:16,23  <b>nurses</b> 9:2,6 19:11  19:16  <b>nurse/patient</b> 29:24  <b>nursing</b> 5:17</p>	<p><b>O</b></p> <p><b>OB</b> 5:15  <b>Objection</b> 14:5  <b>obstetrical</b> 5:17  <b>obstetrician</b> 10:6  <b>obstetrics</b> 7:7  <b>obviously</b> 11:10  <b>occasion</b> 7:17 11:25  <b>occurred</b> 22:16  <b>occurrence</b> 28:4  <b>off</b> 17:3,6 24:19  25:2  <b>office</b> 2:3 8:3 32:18  <b>offices</b> 1:19  <b>Ohio</b> 1:2,18,20 2:4  2:8,12 3:3 32:3,8  32:19,23  <b>ointment</b> 14:20  <b>okay</b> 3:25 4:8,16,24  8:15 17:8,9  <b>once</b> 26:9 28:15,20  <b>one</b> 6:8,11 10:25  12:4 22:5 23:21  23:25 27:16 28:2  28:3  <b>ongoing</b> 6:2  <b>Only</b> 12:3  <b>opposite</b> 6:12  <b>order</b> 24:21  <b>orientation</b> 9:14  <b>other</b> 7:6,9 11:8  28:3 29:16,20,21  <b>otherwise</b> 13:19  32:15  <b>out</b> 3:13,17 18:5,7  19:20 21:9 29:5,6  <b>outside</b> 7:18 9:8  12:6  <b>over</b> 18:5,7 24:13  24:17 28:16,20  <b>overall</b> 25:16  <b>oxygen</b> 14:17 27:11  <b>o'clock</b> 1:21</p> <hr/> <p><b>P</b></p> <p><b>page</b> 31:3,5  <b>Paisley</b> 2:10  <b>paper</b> 23:17  <b>paperwork</b> 14:21  <b>parents</b> 21:3  <b>parking</b> 18:6  <b>part</b> 23:20 24:11  <b>participated</b> 19:7</p>	<p><b>particular</b> 16:15  20:12 23:17 28:2  <b>particularly</b> 18:16  <b>parts</b> 9:22  <b>party</b> 32:15  <b>Patel</b> 1:7 2:10 7:15  8:6 11:11,21  12:19 13:4,23  19:20 26:7  <b>Patel's</b> 21:17  <b>patient</b> 7:21,25  28:22  <b>pattern</b> 16:20  <b>Pause</b> 17:10  <b>pediatrician</b> 21:12  <b>perhaps</b> 3:25 29:16  <b>period</b> 9:7 13:8  24:13 26:19,21  <b>permanent</b> 14:2  <b>perpendicular</b>  14:25  <b>person</b> 20:23  <b>pertinent</b> 9:23  <b>physician</b> 26:4,5  <b>physicians</b> 21:18  <b>pink</b> 5:18,19 6:2,12  6:18,22 11:4,7  <b>Piscola</b> 9:12 11:15  11:22 12:2  <b>place</b> 14:12 19:5  23:11 32:14  <b>placed</b> 16:2  <b>Plaintiff</b> 1:15 2:2  <b>Plaintiffs</b> 1:5  <b>Plaintiff's</b> 17:12,17  <b>PLEAS</b> 1:1  <b>please</b> 3:8,10  <b>plexus</b> 14:3 23:14  24:7  <b>pneumothoraces</b>  23:1 27:14,18,21  27:24 28:7  <b>pneumothorax</b>  28:4  <b>point</b> 10:23  <b>Polito</b> 2:7  <b>position</b> 11:23 12:8  19:11 20:6  <b>postpartum</b> 9:7  <b>practical</b> 6:8  <b>practicals</b> 6:4  <b>practice</b> 14:9 29:2  <b>precautionary</b> 4:6</p>	<p><b>pregnancy</b> 12:24  21:7  <b>preparatory</b> 14:10  <b>prepare</b> 11:1  <b>prepared</b> 19:4  <b>preparing</b> 13:8  <b>presence</b> 9:8 12:7  <b>present</b> 9:2 20:17  20:23  <b>preterm</b> 28:3  <b>pretty</b> 16:19  <b>prior</b> 18:19 20:18  <b>privately</b> 9:8 12:6  <b>problem</b> 8:15  <b>Procedure</b> 3:3  <b>process</b> 29:18  <b>profession</b> 7:13  <b>professional</b> 7:19  7:23  <b>program</b> 5:21,25  6:2,14,24  <b>provided</b> 3:2  <b>providers</b> 12:20  <b>Public</b> 1:17 31:23  32:8,22  <b>purposes</b> 17:14  <b>pursuant</b> 1:18  <b>p.m</b> 30:4</p> <hr/> <p><b>Q</b></p> <p><b>qualified</b> 32:9  <b>question</b> 4:12,15,20  10:3 25:13  <b>questions</b> 3:23 30:2</p> <hr/> <p><b>R</b></p> <p><b>Rainbow</b> 21:13  <b>Ramona</b> 3:11  <b>RB&amp;C</b> 28:14,20  <b>reaches</b> 10:23  <b>reaction</b> 4:18  <b>read</b> 31:2  <b>reading</b> 12:22  25:19  <b>ready</b> 28:13  <b>really</b> 9:13  <b>reasons</b> 4:13 11:8  <b>recall</b> 19:20 28:1,3  29:1  <b>receive</b> 24:17  <b>received</b> 22:3  <b>receiving</b> 27:11  <b>recertified</b> 6:10</p>
---	--	---	--	--

<p>recollection 13:14 13:18 19:10,16 21:19 25:4 record 3:19 11:14 11:16,17,21 12:24 17:4,7,7 21:22 22:1,8,10 23:12 23:12 26:14,15,18 27:4,15 29:14 recorded 23:22 recorder 23:23 reduced 32:11 referring 22:7 reflect 20:10 24:6 reflected 21:6 22:15 reflection 20:16 reflects 21:17,22 Registered 1:16 relates 12:8 23:13 24:7 relationship 12:1 16:3,18 17:22,24 29:24 relative 32:15 relatively 25:10 remember 10:19 12:21 13:16 15:10 16:14 21:21 22:4 24:16 25:18 26:13 29:22 remembered 9:16 remind 4:10 reporter 1:17 17:5 reporting 32:16 represent 3:21 REQUESTED 31:5 resist 8:17 respiratory 21:18 25:16,24,24 responding 11:6 response 13:11 responsibility 24:12 25:21 result 11:7 14:3 resuscitated 25:8 resuscitation 6:14 14:15 22:8,10 23:12,21 25:3 review 9:21 reviewed 9:18 right 15:2,7,16 16:22 19:1</p>	<p>ring 19:23 risk 14:16,23 RN 1:10,13 3:1,6 4:25 5:1 11:24 31:17 32:9 road 26:24 role 12:4 28:15 room 3:17 9:15 10:15 11:1,7,11 11:15,18,20 12:5 12:18,19,19 13:3 13:5,20 14:7,11 14:25 15:9,10,18 16:15 17:19,20,25 18:8,23 19:12,17 20:2,6,18,23 21:4 21:19,20 22:11,16 22:17 24:14 25:2 26:10,22 29:7 rooms 16:16 19:2 routine 10:22 13:6 24:16 Rule 32:17 Rules 3:3</p> <p style="text-align: center;"><b>S</b></p> <p>same 16:20 saw 9:16 saying 17:4 says 20:22,24 22:1 25:19 29:14 SCN 25:1 scores 25:10 seal 32:18 secondary 27:25 section 22:14 see 14:22 15:18 20:15 23:15 29:3 sense 28:21 September 8:20 12:2 15:14 17:21 set 1:22 16:16 32:11 32:18 setup 15:18 seven 22:6 24:1 several 28:1 Shaw 25:7 shortly 22:19 25:9 shoulder 10:7,10 11:5 13:24 14:3 19:12,17 20:18 23:14 24:7 shows 17:22</p>	<p>side 15:13,21 Signature 30:5 signs 25:22 silently 17:3,6 since 6:20 8:20 situations 27:23 sketch 17:18 Skylight 2:3 some 3:23 6:16 29:16 someone 18:16 something 4:19 sometimes 10:17 15:12,13 soon 14:22 sorry 8:14 10:16 sound 19:1 Southwest 1:19 2:6 5:10 21:14 special 5:16 24:24 26:10 specified 32:14 SS 32:4 staff 11:19 stand 10:16 15:1 start 4:13,16,18,23 17:4 started 3:16 5:22 5:23 6:23,23 26:23 State 1:18 32:3,8,23 statement 4:21 stationed 18:18 status 14:22 25:17 statute 1:15 stenotypy 32:11 step 28:16 stepped 29:16 still 8:12 stuck 19:21 Subscribed 31:20 successful 7:3 suction 14:17 suffered 14:2 suggest 25:23 Suite 2:3 summary 12:23 20:22 21:2,6 supplies 18:3 support 20:23 sure 4:15 14:14,17 14:18 25:12,25 swelling 23:8</p>	<p>Switzer 2:7,7 3:17 8:24 12:3,7,14,16 16:14 sworn 3:4 31:20 32:10 symptoms 25:23</p> <p style="text-align: center;"><b>T</b></p> <p>take 6:7 7:3 10:9 17:5 19:5 24:17 27:13 28:16 taken 1:16 4:3 24:22 32:14 takes 29:6 taking 6:16 26:17 26:24 talk 11:25 28:23 29:5 talked 8:5,24 12:4,6 12:11 talking 17:17 29:1 29:23 tape 14:20 team 28:13,15 29:6 29:15 tell 3:8 4:2 8:23 9:11 16:17 22:2 27:1 ten 7:1 8:2 24:3,13 25:11,15 Tenney 1:4 3:21,22 10:11 14:2 18:10 Terminal 2:11 terms 14:9 16:18 20:1 testified 24:23 testify 32:10 testimony 32:11,12 their 6:23 20:6 21:5 thing 23:8 things 18:3 though 8:12 through 4:7 6:14 20:20 31:3 Thursday 12:15,16 time 8:5 9:25 11:3 11:10,13 12:11 13:23 19:17 20:2 20:6,7,20 27:5,8 27:25 29:9 32:14 title 12:8 told 7:9 14:24 total 16:13</p>	<p>touched 8:19 Tower 2:3,11 transcribed 32:12 transcript 31:2 transcription 32:12 transfer 28:13,15 29:6,10,15 transferred 24:23 26:9 28:20,25 29:4,12 transition 13:7 transpired 25:14 trauma 23:14 27:25 28:6 treated 27:13 true 8:21,22 9:3,4 11:12 12:20 17:25 18:1,10,11 22:12 24:9 26:3 32:12 truth 32:10,10,10 try 8:16 16:12 trying 29:17 tubes 27:12 Twenty 5:13 two 4:13 6:4 27:12 type 13:12 23:14 24:8</p> <p style="text-align: center;"><b>U</b></p> <p>UAC 27:9 UH 28:20 ultimately 16:2 unclear 17:21 under 1:15 14:7 32:16 understand 9:1 18:22 25:12,25 understanding 4:15 29:11 University 21:13 unrelated 3:18 until 4:12,22 9:16 20:7 urge 8:17 URMILA 1:7 usual 24:16 usually 29:5 uterine 27:10</p> <p style="text-align: center;"><b>V</b></p> <p>Vacca 26:16 vague 13:18 verbally 4:8</p>
---	--	---	---	---

very 22:14	Zip 3:13			
Vivian 1:16 32:8,22				
vs 1:6	1			
W	1 17:13,17 31:3			
wait 4:12,22 11:2	11:30 1:21			
waited 19:4	12:15 30:4			
waived 30:5	13th 8:21			
wall 15:20,21	1325 27:6			
want 3:24,24 11:3	1400 2:8			
16:12	15 7:2			
wants 24:20	15900 3:11			
warm 24:17	1974 5:7			
warmer 14:12 16:1	2			
16:6,8,19 17:23	2000 8:21 12:2			
24:18	17:21			
way 11:18	2002 1:11 31:21			
Wednesday 12:14	32:19			
week 12:13	2004 32:24			
well 7:23 20:19	216-241-2600 2:4			
29:11	216-687-3269 2:12			
went 6:3 12:13	216-875-2767 2:9			
were 9:2,6,23 10:9	22 1:11			
10:13 12:3 13:5,9	2500 2:11			
19:11,16 20:1,5	28 32:17			
20:17 21:4 23:21	29th 32:19			
26:11,14	3			
weren't 13:11	30 31:3			
Weston 2:10	316 15:11 17:20			
WHEREOF 32:18	18:24			
while 3:16 16:22	4			
Whittington 1:10	44113 2:4,12			
1:13 3:1,6,9	44114 2:8			
31:17 32:9	44130 3:14			
whole 32:10	448548 1:6			
window 18:5	6			
witness 1:14 3:1	660 2:3			
32:18	7			
witnessing 13:15	70s 6:21			
wondering 4:22	8			
work 7:17 21:15	8 32:24			
worked 8:3 9:14,25				
working 14:19 26:4				
wouldn't 8:25				
written 6:8				
Y				
year 5:6 6:5,9,11,12				
6:16,19 7:4				
years 5:11,23 6:11				
7:1 8:2				
Z				

