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IN THE CIRCUIT COURT OF CRAWFORD COUNTY, ARKANSAS
CIVIL DIVISION II

MARY HARTMAN, ET AL PLAINTIFF

VS. NO. 17CV-10-425 (II)

HENRY N. EDWARDS, M.D. DEFENDANT

FILED
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APPEAL TRANSCRIPT

TRIAL IN CHIEF

NOVEMBER 26, 27, 29, 30, 2012

VAN BUREN, ARKANSAS

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BEFORE THE HONORABLE MIKE MEDLOCK

CIRCUIT JUDGE

TWENTY-FIRST JUDICIAL DISTRICT - DIVISION II

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VOLUME IV OF VII

(Pages 801-1052)

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DAY TWO - NOVEMBER 27, 2012

VAN BUREN, ARKANSAS

* * * * *

BEFORE THE HONORABLE MIKE MEDLOCK

CIRCUIT JUDGE

TWENTY-FIRST JUDICIAL DISTRICT - DIVISION II

* * * * *

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DAY 2, TUESDAY, NOVEMBER 27, 2012

[9:00 A.M.]

THE COURT: Is there something else before we get the jury in?

(SIDEBAR CONFERENCE OUT OF THE HEARING OF THE JURY AS FOLLOWS:

THE COURT: Mr. Keever mentioned something yesterday and I just want to do, if we need to do, something before I get the jury out here?

MR. KEEVER: And we have -- we have three items that we want to bring to the court's attention. Uh, yesterday Mr. Cox, we believe, said things that were prohibited by the motion in limine. And we just wanted to -- Mr. Swindle has got it here and just want to put on the record orally reminding counsel of what the motion in limines were so there's no confusion. If that would be all right with you, Your Honor.

MR. COX: Your Honor, I know what the order says and I offer my apologies to the court and I don't think I need to be reminded by counsel what it says.

THE COURT: Well, I don't -- I -- unless you're -- I'm not sure I agree first of all with your statement that he violated the order. I think what

you objected to was them using the term of working or something to that effect, and before he could finish his sentence, before he could finish his sentence you objected and I -- I took it to be that his argument was going in the direction, for whatever purpose, stating that the guy was healthy and working. I don't know, but I mean that seemed the direction he was going in --

MR. KEEVER: -- well --

THE COURT: -- let me finish!

MR. KEEVER: -- I'm sorry, I apologize, Your Honor.

THE COURT: The -- the implication being I guess that he was healthy before he was admitted to the hospital and I didn't see the reference that you were making that it had something to do with an implication of something else to do with work which was prohibited by your order. And so before he could even get to that, you objected and so I don't see any reason to remind him of that. I think he understands that, and I said before unless you all open the door on that possibility of where some of this happened, then I don't think he'll inquire anymore about it. And I think everybody understands it unless there's something else and I think

everybody knows where -- where we are on that. So. What else? What else?

MR. KEEVER: The second is -- uh -- I want to object to Mr. Cox's lines of questioning that were outside of the scope of direct yesterday. I kind of thought that was gonna be his only time to examine Dr. Edwards and I didn't object at the time, but he was asking about all these other doctors and I never inquired about Dr. Silver, Dr. Rhomberg, or Dr. Neva, that's clearly outside the scope of direct and I would ask that he limit his cross examination to the scope of my direct examine.

THE COURT: Mr. Cox.

MR. COX: Your Honor, my response is that that objection has been made but not making it at the time, and Dr. Edwards was asked many questions about what the standard is and what -- and what the recommendations are and I think it's fair to say that others don't agree with Mr. Keever's belief that that was the standard of care.

THE COURT: Well, I think you probably have waived your objection since you didn't object and I

think that's probably water under the bridge as they say. But I understand part of your argument, the rest of it is I think you -- if I remember right, we admitted Exhibit 1 which is all the records, all the hospital records and I would dare say that everyone of these doctors is mentioned in all those records.

MR. KEEVER: No, sir, I -- I -- I respectfully I would say -- I would say Dr. Rhomberg is mentioned in the records. Dr. Ruff is mentioned in the records. Dr. Silva, Dr. Sue is, is it Neva or Sue?

MR. COX: Neva.

MR. KEEVER: Dr. Neva, thank you, is never mentioned in the records.

THE COURT: All right.

MR. COX: He -- he is mentioned in the records, Your Honor, as being the doctor taking care --

THE COURT: -- Well, stop! I mean I'm not taking up a late objection, it's over, let's move on to the next thing.

MR. KEEVER: Yes, sir. Thank you.

Doctor -- one brief thing, Your Honor, Dr. Frank Michota is here, he's an expert witness and experts are entitled to rely upon the testimony of others and -- and I would just ask if the court is okay with him being in the testimony for the rest of

the morning's -- or in the court room for the rest of the morning's testimony?

MR. COX: Your Honor, I object to that. He wasn't here for two and a half hours of his testimony yesterday and I don't see the benefit of another 30 minutes today. He's not going to rely upon what he hears today, and I think the Rule does apply to an expert we've invoked it and we ask that he be asked to step out.

THE COURT: Anything else?

MR. KEEVER: Well, yes, sir.

THE COURT: I'm only talking about on that, on that issue.

MR. KEEVER: Okay. And -- and -- and, Your Honor, there's another matter that I think is a little more serious. Our clients have informed us that they've seen Mrs. Edwards visiting with some of the jurors yesterday. I didn't see this but -- but that's what I was reported, and -- and I think I'd like the court to take that up. I don't know that I'm asking for a mistrial, but I -- but I'd really like for the court to clarify with Ms. Edwards, and if necessary we can my clients on the stand and they can tell the court what they saw and I suspect that -- that might lead to the court wanting to ask the

jurors if any of them knew who they were talking to, had any influence on -- on this trial.

THE COURT: Well, what specifically are you talking about that supposedly happened here?

MR. KEEVER: That the wife of the defendant had social converse -- conversations with some of the jurors out in the hallway.

THE COURT: And when did that happen?

MR. KEEVER: Yesterday during recesses.

THE COURT: Like what time?

(COUNSEL CONFERS WITH PLAINTIFFS)

PLAINTIFF ONE: Specifically the second one when we were trying to get to the rest room. All they -- they were all in the bathroom --

PLAINTIFF TWO: All the jurors went out there.

MR. KEEVER: Okay, so it would have been in the afternoon?

In the afternoon recess.

THE COURT: Do you know anything about what was said or anything other than just?

MR. KEEVER: No, sir, other than -- uh -- someone closely associated with the other side was -- was supposedly having contact with the jurors.

PLAINTIFF: We came back in here and --

MR. KEEVER: -- I'm sorry, would you like to

hear from my clients, Your Honor?

THE COURT: No.

MR. KEEVER: Okay.

THE COURT: No. I mean I -- I figure if there's a problem here, Mr. Keever, we don't need to wait 12 or 24 hours to talk about it and bring it up as an issue. Stop! If it was an issue yesterday, then that would have been the time to bring it to my attention and I could have dealt with it. You're in here the next day and saying there's some issue about it. You know, I made it real clear at the beginning to the jury not to talk to anyone about the case, have any discussions about it, or anything like that. You know somebody running into somebody in the hallway is totally different from that, and bringing it to my attention 12 hours later doesn't seem to be something that you thought at that time was serious enough to talk about. You know, we've had the bailiffs out there, I've got one outside, I've got two or three in here all the time. You know if anything is going on that seems to be inappropriate, then somebody can say something to them and they can catch it and find out what's going on. And, you know, all I can say at this time is the best thing to do if -- if you want it, is me to

make sure the jury stays in here and doesn't go out anymore and that's probably the most I can do to accommodate you. I don't think you've told me enough at this point to insinuate anything other than the fact that they were using the rest room together and if that's what you want me to stop, then I'll be glad to do that. If you know more than that, then tell me more than that?

MR. KEEVER: Well, Your Honor, I just found out about this 5 minutes ago. My clients just informed me.

THE COURT: Well, that's my point. If it was serious yesterday, that would have been the time to bring it to my attention. So let's move on.

MR. KEEVER: Yes, sir, and -- and, Your Honor, just I don't want you to restrict the jurors, I don't -- I don't think that's fair.

THE COURT: Well, I think you brought it to everyone's attention here so as far as any parties having to do with the defendants in this, then they need to avoid contact with the jurors and make sure the jurors are separate. You know, when you say the huge panel I don't even know that any of those people ended up sitting on this panel unless it's something different. So. I don't know.

MR. KEEVER: Very well, and I understand the court's reasoning and the court's decision, and I thank you for it.

THE COURT: I'm back -- I'm still. I'm back on this issue about your expert staying in the court room that's what I wanted to hear some more about?

MR. KEEVER: Your Honor, I apologize I don't have the cases with me, but I know that there is law that -- uh -- the court has the discretion to let experts stay in the court room. I had Judge Griffin denied my motion to have one expert out of the court room when his -- when the other expert was testifying -- uh -- and I didn't question that. I didn't think that was right. But I know that experts -- uh -- can be allowed to stay in the court room. I don't think there's -- can be any law cited that says they are absolutely barred -- uh -- do you have the Rules of Evidence here? While Ken can look at the annotations -- uh -- to Rule 615 or 613 -- but -- uh -- you know, it's -- it's not a huge, huge thing but I think as -- as a courtesy to the expert. Uh -- he's -- couldn't be here yesterday because he was on the road from Cleveland all day, he's here today.

THE COURT: Well, I think the issue I have and

I -- and I guess what Mr. Cox is arguing here is that he wasn't here for the beginning and so he's going to be here for the end. I -- I think I'm kind of down to this. I don't care if he stays in here, but if Mr. Cox objects to anything he says about what he hears today, I'm probably going to sustain that objection because he wasn't here from the start. So, that's my problem, if he had been here from the beginning and we were having this discussion and he had been in the court room from the beginning, then I think that might be more appropriate. But if he stays in here for the end of the defendant's testimony and then gives opinions or answers based on that, then I think it's probably inappropriate since he wasn't here the whole time. So, that's kind of where I am.

MR. KEEVER: Okay. And, Your Honor, I would just as a -- as an addendum we did have a transcript of the doctor's testimony, it was too long for the Dr. Michota to read all the way through, but certain parts of it were looked at last night, I don't know if that makes any difference.

THE COURT: It doesn't make any difference to me.

MR. KEEVER: Well then it doesn't make any

difference to this case. (LAUGHTER)

THE COURT: I think -- again, I think the issue would be that you asking him questions about testimony today and him not being here for all of it. And all that may -- may not be really significant, again, if it comes up then I'm probably not going to allow it so if you want to leave him in here, I'm going to let you do that but understand you ask him questions about what the defendant says today and Mr. Cox objects, then that's probably going to get sustained. So. Enter at your own risk I guess is what I'm saying.

MR. KEEVER: Thank you. And if I couch the question -- uh -- Dr. Michota, I'll represent to you that Dr. Edwards has testified what do you, dah dat dah, what -- what do you think of that, is that okay?

THE COURT: Well, you probably would ask that question if he hadn't heard it.

MR. KEEVER: Yes, sir, thank you very much and -- and I understand. We appreciate letting the courtesy --

THE COURT: -- Anything else, Mr. Cox?

MR. COX: No. I do agree it's discretionary with the court, Your Honor. I do believe that if it

was important for him to be here, he would have been here yesterday.

THE COURT: All right. What else?

MR. KEEVER: -- Huh -- Well, just that I could give you the case cite that says that, the trial judge did not abuse his discretion in refusing to -- uh -- well -- the court ruled. And -- and I'm okay --

THE COURT: All right. All right, just so we're clear on this other issue, let's make sure that everybody having some connection with either party avoids the jury when they go out and so we don't have that question of, you know, impropriety or whatever. And, you know, I'm not trying to be unfair to anyone but if you see something, then you have to report it when you see it so I can deal with it. And, you know, saying hello and all of that, although might seem innocuous to other people it sometimes doesn't and so the point is just try to stay away from all of them. Usually the best thing to do is if they go out, is wait until the jury goes out, takes care of their business and then any of the parties or witnesses, etcetera then they do that separately and then you don't have that question.

MR. KEEVER: Well, I mean, I -- and -- and,

Your Honor, I -- Mr. Swindle just reminded me that when I was going out and following my clients out I actually bumped into one of the jurors and I would have liked to have apologized to -- to him or her, I don't even remember if it was him or her, but I think we're -- we're very clear on the court -- on the court's --

THE COURT: -- Okay. Anything else?

MR. KEEVER: Thank you.

THE COURT: All right, I'm going to take a break and we'll get the jury out here and get started then.

END OF SIDEBAR CONFERENCE.)

BAILIFF: All rise.

(9:19 A.M. COURT RECESSES)

(9:20 A.M. OPEN COURT RESUMES)

THE COURT: All right, it looks like all of you made it back.

Are you ready to continue then with your witness, Mr. Cox?

MR. COX: Yes, Your Honor.

TESTIMONY AND EVIDENCE ON BEHALF OF THE PLAINTIFFS

HENRY EDWARDS, M.D.

having been called by and on behalf of the Plaintiff, previously duly sworn, was examined and testified as follows,

to-wit:

CROSS EXAMINATION

MR. COX:

Q. Dr. Edwards, we were going over some lab values yesterday at the close of your testimony. I want to step aside from that for the moment and I don't believe that you were asked questions about your background, your training and your experience.

First of all, tell the jury where you attended undergraduate school.

A. I was born and raised in Kansas. Went to the University of Kansas at Lawrence to receive my undergraduate degree, Bachelor of Science in pharmacy, and from there --

THE COURT: -- Do you have something, Mr. Keever?

MR. KEEVER: Could we please?

THE COURT: Sure.

(SIDEBAR CONFERENCE OUT OF THE HEARING OF THE JURY AS FOLLOWS:

MR. KEEVER: Well, Mr. Cox just said something I didn't ask him about, and I think that's pretty much outside the scope of direct.

THE COURT: Well, I agree with you just because it goes to his credentials.

MR. COX: That's all it is, Your Honor.

MR. KEEVER: And it'd come in anyway, I just wanted to make the objection.

THE COURT: We need to have an understanding here that if you're going outside direct from this point forward, you know I think [INAUDIBLE BECAUSE OF COURTROOM COUGHING]

MR. KEEVER: -- Your Honor, I just want to --

MR. COX: -- If I go outside then he can object, but I can't -- I can't know what his interpretation of going outside is.

THE COURT: I understand, but I'm going to let you do this, let's move on.

MR. KEEVER: Thank you, Your Honor.

END OF SIDEBAR CONFERENCE.]

CONTINUED CROSS EXAMINATION

MR. COX:

Q. After you received your undergraduate degree, Doctor, did you go to medical school?

A. Then I went to the University of Kansas Medical School in Kansas City for three years and graduated there in 1976, and completed my training residency in internal medicine at Wesley Medical Center principally in Wichita, Kansas.

Q. And what year did you complete that training?

A. 1979.

Q. And you mentioned yesterday that you're board certified,

is that correct?
A. That's correct. I took my certification exam in 1979 and passed it on the first.
Q. When did you begin your practice here in Crawford County?
A. The first part of August of 1979.
Q. And have you been in practice every since?
A. Every since then in Van Buren.
Q. So, you're in your thirty-fourth year, is that correct?
A. In my thirty-fourth year.
Q. Doctor, is your practice both in-patient and out-patient treatment?
A. Yes, sir. Uh, I see probably about a third of my time in the office, a third of the time in the hospital, and a third of the time in the nursing home, fairly well divided amongst all three.
Q. Doctor, we were I think finished with the laboratory reports on the kidney function or renal function that Mr. Bieler had during his admission and I want to turn now to the issue of his blood status, his blood counts during his admission to the hospital. Do you recall what his hemoglobin and hematocrit was at the time of his admission for his hip fracture surgery?
A. At the time of the first admission on January 6, I believe his hemoglobin was 14.4.
Q. Is that a normal blood count?

A. That's very normal for a male.
Q. Okay. And do recall what his hematocrit was, whether it was normal or abnormal?
A. It was normal but I don't remember the value I usually just kind of remember the hemoglobin.
Q. If the record shows that his hematocrit was 42.6 at the time of that admission would that be a normal hematocrit?
A. That would be and that would be concurrent, or congruent with the hemoglobin level.
Q. All right. Now, when he came to the emergency room on the late evening of January 13 there was some blood draws there to assess his hemoglobin and hematocrit status, correct?
A. That's correct. Walter, I don't have --

MR. COX: -- we're going to pull it up, and David, would you pull up SMC 350, please. And go to that column right there starting with the time and then go down from there, there you are.

Q. Doctor, it looks as if that blood was drawn at 23 minutes and 30 seconds that's 11:30, is it not?
A. Eleven thirty at night on the 13th of January.

MR. COX: Okay. And, David, we can't see what -- let's go down now and go across on these two values right here.

Q. Okay. The one I think we can see the one on the 13th hemoglobin was 10.6; hematocrit was 30.7, is that correct?

A. I think it's on the 13th it was 10.2 and a hematocrit of 30 --

Q. -- I'm sorry --

A. -- and on the 15th maybe, it was 10.6 and 30.7.

Q. Okay. Is that a change from his status in the hospital previously?

A. That's a drop from his admission hemoglobin. During the first hospitalization they did not obtain a follow-up blood count after surgery.

Q. So, we don't know what it was at the time of discharge, is that what you're saying?

A. That's correct, we do not know.

Q. All right. Is -- is this of any concern to you this blood count that you see on the 13th, the morning of the 14th when you saw this patient?

A. No, sir, that's not a great surprise.

Q. Okay. It's not unexpected, is that correct?

A. Not unexpected.

MR. COX: Now, it -- it looks like on the next day, David, go down to the, or just go all the way across on hemoglobin and hematocrit, and if you could give us the dates all the way across on that. There you go.

Q. It looked like it actually improved to the 15th, did it not?

A. It did go up slightly on the 15th to the 10.6 value and then later on the afternoon of the 15th up to 11.1.

Q. So, this is what you had hoped to see, correct?

A. That's correct.

MR. COX: All right. Let's then go to page SMC357, and do the same thing all the way across down to the hemoglobin and hematocrit. That's not the right page, David, 357 is what I'm. Well, I'm sorry that's not the one. My numbers are not the same obviously. I apologize. Let's do it this way.

Q. Are these the lab values for the 17th, 18th and 19th, and what is the hemoglobin count doing over that period of time, Doctor?

A. Over about the next 48 hours the hemoglobin dropped from that value of about 11.2 down to 10.0; 9.3; and then 8.7.

Q. Is that of a concern to you?

A. Very great concern.

Q. And did you have any explanation of why this was happening in this patient?

A. I presumed he was losing blood somewhere.

Q. Okay. Do -- does this drop indicate that there is a blood loss somewhere?

A. Yes, sir.

Q. Doctor, did you order some tests to determine why his blood counts were dropping to see if there was blood loss that

could be detected?
A. During this time we had done the CT scan and the colonoscopy; so those were our first two steps which not done exclusively for that purpose but certainly that was to be part of what we were looking for.
Q. Okay. Was there anything on those tests that would give an answer as to why the blood counts were dropping?
A. The blood did not manifest itself on those exams.
Q. Doctor, were there further blood tests done during that admission?
A. Yes, sir.

MR. COX: I'm going to try 352, David, see if we have the same numbers on that. Okay. Go across the top and get the dates and then drop down to cover the hemoglobin and the hematocrit.

Q. Doctor, would you tell the jury what you see there in terms of the hemoglobin and hematocrit?
A. The hemoglobin at this point has somewhat leveled off, if you remember it was down to 8.7 on the 19th and on the 20th it is 9.1, down a little bit on the 21st at 8.9; down a little bit further on the 24th at 8.7.
Q. Okay. Are those still good values, Doctor?
A. Those are not good values, those are still worrisome. We -- we think about doing transfusions when the hemoglobin gets in the 8 range, and certainly if it drops below 8.0 we almost

always will initiate a transfusion. So, in that 8 range it's hovering to where I'm starting to think about does this fellah need a transfusion.

Q. All right. Were you concerned about bleeding somewhere?

A. I'm still very much concerned about bleeding because his blood count was not recovering.

MR. COX: Go to page 353, David. And do the same thing across and we're going to look at hemoglobin and hematocrit over the next 2 days, or actually part of 3 days.

Q. Doctor, it would appear that the hemoglobin and hematocrit essentially was the same for the 25th and 26th, correct?

A. That's -- that's correct, I think I even remarked in my notes that the hemoglobin was sort of stuck on that value of 8.7 which finally prompted me to proceed with the transfusion which accounts for the rise in hemoglobin on the 27th.

Q. Now, I was going to ask you about that, Doctor. Did you order some blood to be transfused?

A. Yes, sir.

Q. How many units of blood?

A. Two units.

Q. And do you know when those were actually administered to Mr. Bieler? I can show you if you need, if you don't remember?

A. I'm going to presume on the night of 26th and 27th, I'm not sure of the exact hours.

Q. If my memory serves me correctly, one was started sometime after 5 o'clock the other started sometime after 9 o'clock that night, does that sound about right?
A. That would sound typical.
Q. And so, on -- on the next day then the hemoglobin and hematocrit show a rise do they not?
A. That's correct, which is what would be expected.
Q. And that's what you hope to see, correct?
A. Correct.
Q. Did it remain at that level, Doctor?
A. No, sir, it dropped down a little bit further the next day to about 10.6, I guess we'll have to skip to the next page.

MR. COX: We're going to get there just in a second and I'll show you. -- Pull up page 354, David, and go across.

Q. This is a blood draw on the early morning of January 28, 2009 after having had two units of blood the night of the 26th, has his hemoglobin and hematocrit remained level, or what -- what's happened to him?
A. The hemoglobin went from 8.7 before transfusion up to 11.2 after transfusion, and then 24 hours later it gets back down to 10.4 which is not expected.
Q. Pardon?
A. That is not expected, not desirable.
Q. Is that of a concern to you, Doctor?

A. That is a concern for ongoing blood loss.
Q. Doctor, did you take into account your concerns about blood loss in deciding whether or not to give blood thinners to Mr. Bieler?
A. That was the entire crux of the question was whether or not it was safe to administer anticoagulation on somebody who was bleeding. And so, I withheld the anticoagulation until there was, I think I used the term the balance tipped on the 28th and the clot was proven then at that point there was absolutely no choice that we had to proceed with anticoagulation.

MR. COX: And pull up page 157, David, and we're going to look at your progress note, page 2 of your progress note on January 28th, go down to that second paragraph.

Q. And just, Doctor, I can read your handwriting, but just read starting with I'm afraid, read that please.
A. I'm sorry, what date was that, Walter?
Q. It's -- well, can you read it from where you are, it's your progress note of January 28th, page 2 of that, second paragraph.
A. Okay. I was discussing the anemia concerns, the hemoglobin level was 11.2 yesterday; 10.4 today, this is an unexplained drop. He's not making enough blood yet either. The stool hemoccult is negative. The hemoccult test is what we

do to check chemically to see if there's blood in the stool and so there wasn't any sign that we could see chemically blood in the stool at that point. I went on to say, I hope we don't find a deep vein thrombosis or pulmonary embolism, I'm afraid he'd be at risk for complications of anticoagulation and we're having trouble enough as is maintaining his blood count. If he's losing blood I don't know where, but anticoagulation will likely make matters worse.

Q. Doctor, you then got the results of the venous doppler study which showed a deep vein thrombosis, is that correct?

A. That's correct.

Q. Now, on the morning of the 28th was there a change in his, the appearance and condition of his right lower extremity? Let's -- let's -- let's go back and just pick up on page 155, this is your progress note of 6 P.M. on January 27, 2009, do you find that?

A. Correct.

MR. COX: And highlight that paragraph right there, David.

Q. On your evening visit with Mr. Bieler in the hospital on the 27th of January, 2009, would you read for the jury what your last paragraph says?

A. I was commenting on the right hip that the surgical incision, the right hip incision looks completely sealed over without the slightest hint of swelling or erythema, erythema

meaning redness.

Q. Okay. Doctor, let me stop you right there. If there had been bleeding around the surgical site, would -- would the appearance have been the way you described it there?

A. No, sir.

Q. Go ahead. Go ahead.

A. He did not exhibit pain or unusual sensations there, meaning around the incision site. He had no swelling of the right lower extremity or signs of deep vein thrombosis.

He has a generalized color meaning the skin looked pale, but his distillary capillary filling is good, that's where I push on the toes and watch the pink fade under pressure and then see how quickly it rebounds when you take pressure off of the toes. So I commented that the circulation was good to the foot.

Q. So I want to particularly ask you about the entry no swelling of right lower extremity or sign of DVT. Were you looking to see if there was evidence --

A. -- yes, sir --

Q. -- of a blood clot in the lower extremity?

A. Yes, sir.

Q. Did you see evidence?

A. There was no sign of it at that exam.

Q. All right. Now, on the -- did he have a swollen lower extremity the next day, Doctor?

A. -- (REFERS TO FILE)
Q. If you don't recall I'll move on Doctor. But on the 27th he did not have evidence of swelling or redness or inflammation of his lower extremity, did he?
A. In reading my note from the 29th, or excuse me, the 28th in the morning, discussing concerns for deep vein thrombosis but I did not note any sign of it physically at that point.
Q. Doctor, as a result of the venous Doppler study that you ordered you apparently, according to what we were shown yesterday got the results about 2:30 in the afternoon is that correct?
A. That's correct.
Q. And came to see Mr. Bieler at approximately 5:30?
A. That's correct.
Q. And at that time ordered Lovenox at 60 milligrams?
A. Yes, sir.
Q. And to be given that evening --
A. -- yes --
Q. -- and ordered Coumadin. What is Coumadin?
A. Coumadin is a blood thinner tablet, the generic name is warfarin and jurors might also well know it as D-con rat killer, which it is.
Q. Okay. Doctor, why did you not give 120 milligrams of that drug at the time?
A. The Lovenox dosage of 60 milligram was half of the usual

standard dose because of the worsening renal failure that had shown up on the lab that morning. His renal dysfunction had markedly worsened; his creatinine level had almost doubled overnight. So, I knew he was having more trouble again with renal failure and so I reduced the dose of Lovenox accordingly.

Q. Doctor, let's talk about some of the other conditions that Mr. Bieler had in the hospital some of which were touched on briefly yesterday and I want to talk to you more about them today. There was mention made of some liver issues, jaundice and that sort of thing?

A. That's correct.

Q. What was going on with his liver?

A. Uh, honestly I don't think we ever understood that. I speculated about it at length. His bilirubin level when he came in was elevated and I think it rose up to a peak level of around 4.9, if memory serves me which is markedly elevated and certainly enough to make somebody appear grossly more yellow than my shirt. Uh, so there was something seriously going on with the liver functions that it wasn't able to -- The liver would ordinarily clear out the bilirubin out of the blood stream and you would not have it accumulating like that so there's something seriously going on with the liver to allow it the bili -- the bilirubin level to elevate like that.

Q. We saw yesterday that Dr. Silver as part of his admitting diagnosis diagnosed Mr. Bieler as having cirrhosis?

A. He did.
Q. And is that a liver disease, Doctor?
A. That is. That's a scarring of the liver.
Q. Okay. Uh, was that a concern of yours based on the liver function studies that were obtained?
A. That was at least a concern, but I don't know if I ever really used that as a working diagnosis. I was just too uncertain about his liver condition to call it that.
Q. Okay. Did his liver condition or liver function I should say, normalize during his admission?
A. As I recall, I'm sorry I don't have the lab with me. As I recall the levels got near normal, maybe not completely normal but near normal as far as what we call the enzymes which are markers of liver injury and the bilirubin also had dropped back down near normal, if not completely normal.
Q. Doctor, we -- we see in the records do we not that you gave insulin to this patient during his admission to the hospital?
A. Yes, sir.
Q. Why did you give insulin?
A. His blood sugars were elevated and that could have been in part because we were giving him such high concentrations of intravenous calories, including 25 percent sugar water, uh, and for whatever reason his body was not able to manufacture enough insulin on its own. He and I even had the discussion about he

-- well, he asked me, am I diabetic? And my answer was, I'm not sure yet. When you're in the hospital and ill like this it's not unusual to see the blood sugars go up and then when they return to a state of wellness blood sugars normalize, and you hate to put a title of diabetes on somebody like that when it's just a passing condition related to hospitalization and hospital stress or medications that we're giving them.

Q. Okay. Did you have the benefit of any prior medical records to know whether or not he was diabetic?

A. Essentially not. The initial blood sugar when he arrived in the hospital January 6 with a fracture, the blood sugar was 140 at 9:30 in the morning, that's one reading I wouldn't call that diabetes. Yes it's a slightly high blood sugar, it's certainly not anything I would ever treat. I would not make a diagnosis of, or label somebody as diabetic because of that. But if the blood sugar was elevated when he very first presented to the hospital.

Q. Which organ of the body manufactures insulin?

A. The pancreas makes the insulin.

Q. Okay. What can you say about the condition of the pancreas during this second admission to the hospital?

A. I don't recall any major malfunction with the pancreas. We often will check the -- uh, again enzyme numbers of lipase and amylase which are again markers of injury to the pancreas. And I think we did check those. I don't have those in front of

me.
Q. It's not that important, Doctor. We'll move onto something else.
A. I can tell you that we did not see any sign of pancreatitis or injury to the pancreas on the Cat scans.
Q. Doctor, physical therapy became involved in this case, and was that based upon an order by you and also Dr. Rhomberg?
A. That's correct.
MR. COX: Let's look at page SMC171, David, and I want to have you look an order at the bottom of the page.
A. Yes, sir.
Q. And, does it appear that this order is actually written by Dr. Rhomberg's physician assistant? -- Can you tell?
A. Okay. The order at 1500 on the 16th would have been written by, I think that's Patrick Walton, the -- yes, physician assistant of Dr. Rhomberg.
Q. And do you recognize Dr. Rhomberg's signature?
A. Yes, sir.
Q. And is this his signature also on that order?
A. Yes, sir, he co-signed that one.
Q. And read this order here, mobilize with, and then read the rest of that sentence.
A. Uh -- okay, it starts with physical therapy to evaluate range of motion of right lower extremity and hip, knee and

ankle in bed, mobilize with walker. TDWB means touch down weight bearing of right lower extremity when okay by Dr. Edwards, follow-up with Dr. Rhomberg one week after discharge.

Q. And then let's go to page SMC172, the very last entry. At the bottom?

A. That's my writing at 6 PM on the 16th. My comment there for physical therapy was full speed ahead on therapy and I included there to disconnect the nasalgastric tube from suction when they're doing therapy. The nasalgastric tube is the one that we had through the nose down into the stomach to keep the stomach pumped out and it's pretty hard to do much walking or therapy when they're connected up to the nose, the hose and the nose. So, it's realistic to just disconnect the tube all together temporarily from the wall suction so they can get up and get about with their therapy.

Q. Okay. Doctor, what was the purpose in your ordering full speed on therapy?

A. Well, at least three things. Uh, I was very much concerned about his intestinal motility. He'd come in with this massively distended colon for unknown cause but what we call Ogilvie Syndrome and it's just a principle of surgery generally that if the intestinal activity is not as rapid and normal as it needs to be that if you're physically active walking around that tends to normalize, enhance the intestinal movement. Uh, so that was certainly one major factor.

The next one would have been muscle activity in general is one of the prime mechanisms to prevent blood clots in the muscles, well in the lower extremities especially, if you're walking the muscles are massaging the veins, enhancing the circulation and that acts as a very effective way to keep the circulation moving and prevent blood clots in the legs.

And then just general, uh, if you don't use it you lose it. You want to keep all the muscles as active as you can to return to home.

Q. Mr. Bieler required intravenous feeding, did he not?

A. That's correct. Not just intravenous fluids but full formula life-support feeding.

Q. And what is the name you doctors use for that?

A. Sometimes it's called hyperalimentation, sometimes total parenteral nutrition, but it means the same thing that we're providing all life-sustaining calories and nutrition intravenous.

Q. Dr. Edwards, how complex of a patient was Mr. Bieler?

A. Very complex fellah. Multiple conditions with conflicting problems that you have to weigh on one hand this, one hand that. You have to balance a lot of the treatments against each other. There was -- we didn't even touch on -- much on the subject here about possibility of infections in the system but that was a major one in my mind. Uh, anytime somebody's in the hospital and they're receiving all the high calorie nutrition

intravenously that puts them at very high risk for infection complications as well.

Q. Did you do a number of cultures to --

A. -- we did a number of blood cultures, urine culture, chest x-rays, keeping an eye out for infections.

Q. How would you describe Mr. Bieler's condition from -- from your observation and review of the records at his first admission to when he returned to Summit Medical Center on the late night of January 13?

A. I'm sorry, could you say that again?

Q. How -- or what changes occurred in his condition? We've talked about some of them, was there a dramatic change in his condition?

A. There was a very dramatic change in his condition. The abdominal condition was probably the most striking factor, just to walk in the room and see him. He had a hugely, hugely bloated abdomen that would be most striking. And then he was just so lethargic, just laying there sick.

Q. And we've talked about the kidney function; we've talked about the liver issues; we've talked about his blood counts; did all of those contribute to the complexity, Doctor?

A. Very much so.

A. Doctor, did you take all those into account in treating Mr. Bieler?

A. Oh, yes, sir, that's just part of medicine. I sometimes

tell people that train -- train wrecks are my specialty and he was.

MR. COX: Doctor, I believe I'll pass the witness.

THE COURT: All right, Mr. Keever, any follow-up?

REDIRECT EXAMINATION

MR. KEEVER:

Q. Good morning, Dr. Edwards.

A. Mr. Keever.

Q. I will -- I'll certainly be briefer than yesterday.

A. I appreciate that.

Q. Dr. Edwards, now Mr. Cox asked you about a lot of the other doctors that -- that saw Kenneth one time or another but just to be sure, who was the attending physician?

A. I was the attending physician of record --

Q. -- who --

A. -- during the hospitalization from the 13th until he died.

Q. Thank you. And -- and who was responsible for Kenneth's treatment?

A. Numerous others were responsible but I was the captain of the ship.

Q. Were you ultimately responsible for Kenneth's treatment?

A. I was the captain of the ship, I'm ultimately responsible.

Q. Thank you, sir. Now -- now -- you -- uh -- you're a

trained internal medicine specialist?
A. Yes, sir.
Q. And internal medicine specialists are supposed to know about diagnosing and treating blood clots, is that correct, sir?
A. That's correct.
Q. Supposed to know about things like kidney failure, is that correct, sir?
A. Yes, sir.
MR. KEEVER: May I approach, Your Honor?
THE COURT: Yes.
Q. I'm going to hand you what I've marked as Plaintiff's No. 7 which is a summary, I think I've listed all of the serum creatinines, my apology for just a moment. -- And you went through pretty much most of these with Mr. Cox, and if you want to check the accuracy that's fine, but these are the serum creatinines, is that correct?
A. Yes, sir.
Q. Okay. Now, on the 15th, 4:20 AM the creatinine was 2.7?
A. Yes, sir.
Q. But it -- it didn't almost double but it went up a lot in a little less than 12 hours to 4.2?
A. That's correct.
Q. Now, when the kidneys fail does the creatinine go up rapidly just like it did here?

A. It may, it need not necessarily go up that fast.
Q. Well, if you took someone with a normal creatinine 1.0, say -- assume my creatinine is 1.0, and remove both my kidneys, uh -- would it -- would my creatinine double within 12 hours?
A. I don't know that. I doubt it but I don't want to claim to be an expert on that.
Q. Okay. And so same answer what would it do in 24 hours?
A. Same answer.
Q. Okay. Fair enough, sir. We have a creatinine of 4.2 on the afternoon of the 15th but you got it down to 2.8 on the 16th; 1.7 the 18th; got down to normal on the 22nd, how did you do that?
A. I supported the body and the body did the rest. The kidneys have a way of healing themselves if supported well. Supported well with good circulation and nutrition.
Q. And how about hydration, what is taking a lot of fluids in or maybe not getting enough fluids, how does that play into how the kidneys work?
A. That has a lot to do with it, that's part of the nutrition factor. Uh, if the body is dehydrated the creatinine number tends to go up, and with hydration that in itself tends to lower it.
Q. And in fact, uh -- uh -- hydration can kind of play on the blood count too, can't it?
A. It can.

Q. Sure. Now, you going on what you learned in your recent experience with Kenneth, and we're talking about right here where gosh, the creatinine could go up real fast over 12 hours and it could, you know, like on the 16th come down pretty fast over 12 hours -- uh -- how did you know on the 28th that his kidneys were failing and he was in shutdown and that was the reason to cut that Lovenox in half?

A. Because the night before his blood pressure had been so low that he was, I don't know if I would use the word shock, but it was at the levels that one would start considering shock, where the systolic pressure was down in the seventies and eighties that's becoming critically low and if it was to stay that way, uh, I would ordinarily put somebody in ICU and put them on medication to -- to try to bring their blood pressure back up.

Q. Did you put Ken -- you didn't put Kenneth in ICU I don't think, did you?

A. No I did not.

Q. Oh, okay.

A. If it had stayed that way.

Q. I'm sorry?

A. If it -- if it -- if the blood pressure had remained critically low that way I would have. As I recall I gave him extra salt water, saline and that in itself was enough to raise the blood pressure some and keep him out of shock.

Q. And -- uh -- you don't really know how the -- did you give him more fluids on the 28th?
A. Yes, sir.
Q. And your -- your -- your guess was that even with more fluid the creatinine was going up the afternoon of the 28th, is that fair?
A. That's correct I would not expect it to turnaround that quickly.
Q. Uh, and -- but you didn't test it to see?
A. No, sir, I did not.
Q. You guessed but you didn't test?
A. I did not repeat it on the evening of the 28th.
Q. Okay. We -- let's talk about those other doctors just a little bit, sir. Uh -- and -- I -- did -- did you say that you and your hospital it's -- it's informal and any doctor is able to write orders on another doctor's patients, did I understand that correctly?
A. That's essentially correct although we were really restricting our discussion at that point more to anticoagulation.
Q. Okay. Uh -- Well, you're the internal medicine specialist and Dr. Rhomberg was the orthopaedic surgeon who actually did see Kenneth in the -- the first hospitalization, the 6th through the 9th?
A. That's correct.

Q. And then Dr. Rhomberg didn't physically see Kenneth as far as the record shows in the second hospitalization that was his physician's assistant?
A. That's my understanding.
Q. Okay. So, Dr. Rhomberg -- well, is -- is it your position that one of the reasons you didn't use blood thinners is because Dr. Rhomberg didn't want them used?
A. That's not the principal reason that I did not use them. I did not use them because I was more concerned about the bleeding.
Q. Okay. So, it wasn't the other doctors it was -- it was your decision not the other doctors?
A. I think I mentioned when the -- Mr. Bieler came in, if he had been on anticoagulation with Coumadin, Lovenox, or one of those I would have had to either waited it out, or would have actively reversed the anticoagulation.
Q. Yes, sir, I remember that but and -- and I probably didn't ask a very heartful question. My question was really directed toward other doctors actively making a conscious decision to either withhold blood thinners or telling you to use blood thinners in the hospitalization you were responsible for. So, Dr. Rhomberg didn't enter in with any -- any affirmative shall we say, don't do blood thinners or do blood thinners, is that fair?
A. He didn't voice that one way or another as far as I know.

Q. Okay. And Dr. Ruff didn't affirmatively say, don't give blood thinners?
A. That's correct.
Q. Okay. Good. It clears that up.
Now, I believe you said that while the doctors in the Cleveland Clinic might operate on patients while they're on blood thinners that's not done in Van Buren?
A. Not as an elective procedure.
Q. Oh, okay. Okay. So, if there's -- well, we just -- we'll just wait for Dr. Michota.
Dr. Silver, going back to another doctor, Dr. Silver, he's an emergency room doctor?
A. Yes, sir.
Q. And he admitted Kenneth to your service at your direction?
A. Yes, sir.
Q. Okay. And you didn't come to the hospital that night, I think you testified --
A. -- That's correct.
Q. -- that' correct -- uh -- but you talked to Dr. Silver?
A. I'm -- I won't claim that I remember anything that I said, but I -- I'm sure I mumbled something in the middle of my sleep.
Q. Well, so, either you dictated the order, or you told Dr. Silver these are the orders I wanted or you saw those orders the next day, is that fair?

A. I saw the orders the next day.
Q. And you didn't change any of them?
A. That's correct.
Q. Okay. Bed rest?
A. I didn't change that.
Q. No blood thinners?
A. No blood thinners.
Q. Okay. Now you also talked with Mr. Cox about the diagnoses of Dr. Silver?
A. Yes, sir.
Q. And -- uh -- I don't have those to put up, but -- but two of them were SBO, a small bowel obstruction?
A. That's correct.
Q. And cirrhosis?
A. That's correct.
Q. Okay. Well -- uh -- talk about the -- uh -- those were -- those -- were they what we call presumptive diagnoses and they're subject to being tested by test and either ruled out or confirmed?
A. Presumptive or preliminary would be another good word.
Q. Good. Good. And the test ruled those out, didn't they?
A. The tests ruled out small bowel obstruction. I don't think we ever decided, at least I never decided about cirrhosis.
Q. And well, okay, let's -- let's start with small bowel

obstruction first. And in fact, you know, have you got Exhibit 1 up there, Doctor? Or do you have the x-ray reports as a separate folder?

A. I do now.

Q. Okay. I don't remember you can check the index, would you just turn to the x-ray reports there and we just kind of not going to take but a minute on this. I think -- I think in that chart and folder they go from latest, earliest. And -- uh -- and so I'll turn mine around and do that too. Have you got -- have you got the -- can you find the very earliest one supine -- supine -- supine is that lying on your back?

A. Supine radiograph of the abdomen on 1/13/09.

Q. Right. Findings could relate to an ileus node, a definite point of obstruction is not identified, right?

A. That's correct.

Q. And then if you go, I guess the next one is that CT of the abdomen that you did, and -- uh -- uh -- the -- the impression says most consistent with an ileus. Is -- is that like that Ogilvie's where the bowel just kind of stops motility? -- I'm sorry, I'll wait until you catch up with me, sir. And under impression?

A. Correct, impression number 1, the CT imaging of the abdomen and pelvis demonstrates findings most consistent with an ileus.

Q. Yeah. And -- and is that that like the Ogilvie's that you

were talking about?
A. Not the same. Ileus refers to a generalized paralysis of the small and large bowel. Ogilvie's syndrome is distinctly different from that.
Q. Okay. Uh -- but -- and up -- up above on 1, 2, 3, 4, 5, 6, 7th line from the bottom of the paragraph, no point of obstruction or other abnormalities demonstrated?
A. That's correct.
Q. So, there -- there just really wasn't ever any -- any confirmation that there was a small bowel obstruction and your diagnosis of Ogilvie's was really probably correct, is that fair?
A. That's fair.
Q. Okay. Cirrhosis -- cirrhosis is scarring of the liver?
A. Yes, sir.
Q. And do you remember Exhibit No. 5, the autopsy?
MR. KEEVER: Ms. Warren has it right down there, if you'd like to see it.
(EXHIBIT PROVIDED TO WITNESS)
Q. And you may want to turn to kind of I think it may be the last page on the microscopic, and I -- can you confirm that there's no -- uh -- microscopic diagnosis of scarring of the liver?
A. It's right in the -- I'll read it verbatim.
Q. That's kind of long, would you just, you know, whatever

you want to do.
A. Post mortem distention of sinusoids and loss of hepatocyte tinctorial affinity. No fibrosis or aggregates of inflammatory cells. No large vacuoles. The gall bladder adventitia has increased in reticular arrangement of fibroblast that appear mature. This doesn't help me one way or another about cirrhosis.
Q. Is there any -- is there any mention of scarring?
A. No, sir.
Q. Okay. And -- and did the pathologist make a dia -- make a pathologic diagnosis in his final diagnosis of cirrhosis?
A. He did not.
Q. Okay. Now I -- I'd like to talk a little bit about the blood and I promise I'm about done. Uh -- you told Mr. Cox -- I believe that having had that broken leg and the blood loss in the leg, you didn't tell him about that, but as a result a week after that broken leg that he had, that 10.2 hemoglobin would -- would not be unexpected or would be about right, is that?
A. That's correct.
Q. Okay. Now -- uh -- and then you talked about, and I think you were talking about the period --uh from admission to the 24th or maybe the 20th to the 24th that these blood counts indicated to you that there was some blood loss going on?
A. That's correct.
Q. And in fact, you said you did some tests, you were doing

tests to try to figure out where that was?
A. Some tests, yes.
Q. And you did a CT scan and that was on the 14th?
A. Correct.
Q. And then you did a colonoscopy and that was on the 15th?
A. That's correct.
Q. And then I think on the 26th you did a test to see if there was any blood in the stool, isn't that correct?
A. The hemoccult test, correct.
Q. Yeah. Uh -- what other tests were you doing -- did you do, you know, medical tests to investigate possible blood loss between the 15th and 26th, sir?
A. I don't recall that I did any specific study for bleeding.
Q. Okay. So, we -- we go -- uh -- the 15th to the 26th that you did some on the 14th, 15th, to 26th. Okay. Now, on the 25th through the 27th -- uh -- and I kind of -- I kind of loved the 24th through the 26th over there because all three days the hemoglobin was the same 8.7?
A. It was stuck on 8.7.
Q. And I've run out of space on the slide. Uh -- so -- uh -- and then you gave a transfusion on the 26th? Yes, sir?
A. That's correct.
Q. Uh -- is a transfusion a risk factor for a blood clot?
A. I don't know.
Q. Okay. Uh -- now, and after the transfusion the 27th

through the 28th, the blood count dropped 0.8 grams, is that right?

A. That's correct.

Q. So, it's about the same amount it went up during the day on the 15th? Not quite, I guess it went up .5 on the 15th?

A. Point 5.

Q. And -- and didn't she -- do you remember a note that you thought that that increase in the hemoglobin was due to hemo concentration or dehydration?

A. I don't remember the note specifically, but I would not be surprised.

Q. Okay. Okay. Fine and we'll move -- we'll move along. Now, you know, we talked about Dr. Silver's diagnoses, it didn't turnout to be correct but that's not a criticism to Dr. Silver because they were just presumptive diagnoses, is that correct?

A. That's correct.

Q. Good. The thing you called Ogilvie's Syndrome -- uh -- when was the first time you saw a patient with Ogilvie's Syndrome?

A. -- You get into questions of semantics on what is a true Ogilvie's Syndrome versus what is a colon pseudo obstruction. Uh, colon pseudo obstruction is one form, or Ogilvie's is one form of a colon pseudo obstruction. Ogilvie's Syndrome refers to the development of this condition that has the appearance of

an obstructed colon, just looking at the x-ray you see a very dilated, bloated colon but the characteristic of Ogilvie's Syndrome is that occurs acutely following, usually an injury in this country an orthopaedic injury or orthopaedic surgery event I think by far the most common place we see Ogilvie's Syndrome. Having said that, it's quite a rare syndrome, I don't know exact statistics but it's described as a rare complication, a rare syndrome.

Uh, in the nursing home population I see colon pseudo obstruction much more commonly but that's not a true Ogilvie's Syndrome although sometimes surgeons call it that. Have I thoroughly confused you?

Q. No. I -- I'm wondering if you remember what my question was --

A. -- when did I first see --

Q. -- and my question was when did you, and let me just make it more specific, when did you first diagnose in writing, write down and code a patient out as having Ogilvie's Syndrome, maybe that's easier?

A. -- I know I did in 2007.

Q. And -- and -- uh -- did you learn about treating Ogilvie's at that time?

A. Yes, sir.

Q. How did the patient turn out?

MR. COX: Your Honor, may we approach?

MR. KEEVER: -- I'll -- I'll withdraw the question.

THE COURT: All right.

MR. KEEVER: Uh, Doctor, I told you we would be briefer and I have no further questions at this time.

THE COURT: All right, Mr. Cox, anything else?

MR. COX: I have a couple of questions, Your Honor.

RECROSS EXAMINATION

MR. COX:

Q. Dr. Edwards, you were asked about x-ray studies that were done with regard to small bowel obstruction and I don't recall what your specific and precise answer was, but I think you indicated that there was no evidence of a small bowel obstruction, is that correct?

A. With hindsight, we could say there was no definite obstruction.

MR. COX: Okay. I'm going to have you look at a couple of x-ray reports and, David, would you pull up SMC194.

Q. This is an AP supine abdomen, just for the jury's benefit, what is an AP supine view of the abdomen?

A. It means the patient is laying flat on the table and the x-rays are penetrating the body from front to back.

Q. And let's look at the date on this x-ray report?
A. The one on January 17th at 12:44 AM.
Q. And what is the summary of the report by the radiologist?
A. Dr. Drolshagen interpreted this to be gaseous distention of small bowel loops. Again, highly suspicious for a small bowel obstruction.
Q. Based on that x-ray report of the 17th could you rule out a small bowel obstruction, Doctor?
A. No, sir.
Q. Let's go to SMC page 195. This is another radiology report of a -- what's called a KUB Study.
A. Are we on January 26th?
Q. January 20. And go then to the impression by a different radiologist.
A. This -- this time the interpretation was by Dr. Richard Brown, he described his impression as persistent small bowel loop distention. Again, suspicious for small bowel obstruction.
Q. Doctor, in your experience can a small bowel obstruction or possible or suspicious small bowel obstruction go to an acute emergency in a short period of time?
A. Absolutely. Very much, yes. It happens all the time.
MR. COX: Thank you, that's all.
THE COURT: All right, anything else?
MR. KEEVER: Very, very briefly, Your Honor.

And, Your Honor, may I ask to have Exhibit No. 7 admitted as a summary which is the under Rule 1006 is a summary which is a listing --

THE COURT: -- Any objection?

MR. COX: I have no objection.

THE COURT: It will be admitted.

[REPORTER'S NOTE: Plaintiff's Exhibit 7, creatinine levels is incorporated herein and may be found at page 1272 hereof.]

MR. KEEVER: Okay, thank you very much. May we publish that to the jury, Your Honor?

THE COURT: Sure.

MR. KEEVER: Your Honor, I only rose because I forgot to ask to have that admitted. I have no questions.

THE COURT: All right. You can step down.

Let's take about a, maybe about a 10 minute break, a chance to stretch your leg, get a drink if you need to or whatever. We'll be back as quick as we can, about 10 minutes if we can make it that. So, we'll be in recess for a little bit.

WITNESS: Am I done?

THE COURT: Yes.

WITNESS: Thank you.

(WITNESS DEPARTS THE WITNESS STAND)

BAILIFF: All rise.

[10:24 AM COURT RECESSES}

[10:40 AM OPEN COURT RESUMES]

THE COURT: All right, Mr. Keever, call your next witness.

MR. KEEVER: Thank you, Your Honor. The plaintiff would call Dr. Franklin Michota.

THE COURT: Just go ahead and raise your right hand right there will be fine.

(OATH BY COURT CLERK)

THE COURT: All right, come up and have a seat right here.

TESTIMONY AND EVIDENCE ON BEHALF OF THE PLAINTIFFS

DR. FRANKLIN MICHOTA, JR.

having been called by and on behalf of the Plaintiffs, and having been previously duly sworn, was examined and testified as follows, to-wit:

DIRECT EXAMINATION

MR. KEEVER:

Q. Dr. Michota, would you give Ms. Warren your full name for the record, please.

A. Yes, it's Franklin Michota.

Q. Uh, and -- uh -- well, good morning I'm supposed to say that.

A. Good morning.

Q. Dr. Michota, would you just introduce yourself to our jurors, please.

A. Sure. My name is Frank Michota, nobody calls me Franklin other than my mother. So, it's Frank Michota, I'm an internal medicine specialist like Dr. Edwards.

I'm 45 years old. I come to you from Ohio where I was born and raised and have lived my entire life. I'm married I have three children and one beautiful step-daughter, and for the last 19 going on 20 years I've worked at the Cleveland Clinic Hospital in Cleveland, Ohio.

Q. Would you tell us a little bit about your particular type of medical practice?

A. Well, as an internist -- uh -- I almost exclusively take care of patients in the hospital setting. I don't have an office where I see people with a waiting room. I take care of patients in the hospital on behalf of other physicians within the field of internal medicine.

Q. Do you see any outpatients?

A. The only outpatients I see is -- is part of request by surgeons. I do some consults to prepare patients for surgery so that would be the only out of hospital type of practice I have.

Q. And outside of your job in hospital medicine -- uh -- can you just tell us about any academic activities you have?

A. Sure. Uh, well, it is part of -- uh -- what I do at the

Cleveland Clinic. I'm a teaching physician so I do teach medical students. I also teach physicians who have graduated medical school but are not yet ready for unsupervised practice. And then I also teach physicians who can practice independently but they're not yet board certified in medicine. And so, between those activities as well as teaching other physicians who are already board certified as part of continuing medical education.

Q. And -- and we'll talk a little bit about that continuing medical education. But you know, on a day-to-day basis how much of your activities are involved in taking care of patients being in the trenches so as to speak versus the academic stuff?

A. Well, I mean almost everything that I do is in part related to patient care. So, 80 to 90 percent of my day is -- is going to visit patients, taking care of patients, but I do it with usually a medical student or another physician who is at a different level of training. So, even when I'm taking care of patients I'm -- I'm generally teaching and we're talking about the patients and their laboratory results and so forth, but I'm taking care of patients every day.

Q. Doctor, what caused the death of Kenneth Bieler?

A. Uh, a blood clot to his lung. Otherwise known as a pulmonary embolism.

Q. And how much of your academic activities now specifically I'm talking about the continuing medical education lectures and

so forth, how much of that revolves around blood clot disease?
A. The vast majority. Uh, especially if you're talking about things that I've written or published or lectures that I've given it's about, again probably 80 percent or so is focused on blood clot disease.
Q. And, Ms. Warren, would you mind handing Dr. Michota I think Exhibit No. 2 is his CV, uh, doctors call a resume a CV?
A. Yes that's correct.
Q. What's that? What's that?
A. CV stands for curriculum vitae. We're like the legal profession and we -- we make all of our language cryptic so nobody can understand it.
Q. It's latin.
A. Correct.
Q. Now, uh, is -- is that your current CV or resume? The jury's already had an opportunity to see that Dr. Michota.
A. It's a -- it's going on a little bit -- uh -- over a year old, but it essentially represents my -- my activities.
Q. And we're going to go through it just not exhaustively because I think it's like 26 pages, but you're board certified in internal medicine?
A. That's correct.
Q. And would you just explain to the jury what board certification in internal medicine really means?
A. Well, it -- it just means that -- well, you can't sit for

the board certification exam today unless you've completed a three year residency program after you've completed medical school. So, you go to medical school, you get you MD Degree and then you have to have a period where you have supervised practice under other physicians who are board certified, and once you complete that process you basically take a test and it says to everyone that you know everything you're supposed to know to competently practice within that specialty.

Q. And you get a certificate?

A. You do, a very big one.

Q. How long is it good for?

A. Uh, it's good for 10 years.

Q. And is that true for all -- yours is good for 10 years?

A. That's -- that's correct, I was re-certified -- well, I was initially certified in '96, re-certified in 2006 and I'll have to take the examination again in 2016.

Q. And are -- are all internists who are board certified do they go through that re-certification deal?

A. No. There are some physicians who are exempt.

Q. How's that work?

A. Well, the -- the requirement to re-certify, uh, was not put into place until really going on about maybe 20 years ago. So, physicians who were board certified prior to that time were not required to undergo the re-certification process.

Q. And just very briefly can you just tell us what the re-

certification process is, just you go in and take a test?
A. No. Actually it's -- it's a year long program. Uh, you have to register again with the -- the Board, the ones who grant the certificates in the first place. And you're required to take specific education modules, they're basically booklets, they're take-home tests. Uh, it takes about, oh, I don't know, maybe 50/60 hours of time through the course of the year to get through all the booklets and those have to be turned back into the board. And at the end of that process as long as you've done all the booklets then they let you take the re-certification exam and you have to pass that exam.
Q. And I promise we're not going page by page through your CV, but -- but here's a listing of some of the committees and things you're on, and I only want to ask you about one the review committee for the National Board of Medical Examiners, can you tell us a little bit about that?
A. Sure. Uh, well they're -- they're I mentioned that you go to medical school and you get your medical degree, but once you graduate from medical school you can't just put a sign out and say I'm Dr. Smith, you know, please come see me. You have to be licensed in your state to practice medicine legally. And there's a series of exams that you have to pass before you can get a state license, and it's a 3 step examination, it's 3 parts. One is taken after the second year of medical school. Another one is taken after you graduate from medical school and

then the last part, which is called the Step 3 Examine is taken at the end of your internship year, which is a year of supervised practice, and it's for all doctors. Surgeons, obstetricians, pediatricians and internal medicine specialists.

And, this exam is really designed not to test all of the knowledge that a doctor might have and so forth, but it's really to make sure that you have enough information to practice safely by yourself. So, it's a different type of test than the internal medicine board exam, and all doctors have to take it, but it's really designed to make sure that you're practicing safely.

Q. Okay. And we're going to move onto just another kind of a summary of some of the things that are in your -- your CV or resume. You know, how many, for instance continue in medical education programs have you been involved with that would be available over the internet?

A. A dozen approximately.

Q. And -- and would those type of programs be available to a doctor here in Van Buren?

A. Certainly.

Q. Any involve blood clot disease?

A. They all involve blood clot disease.

Q. Now in this case, we already, you know, we're going to talk about preventing and treating blood clot disease. What concepts are you going to be discussing here that would be

available -- are you going to discuss anything that wouldn't be available to an internal medicine doctor in Van Buren through some kind of medical, continuing medical education or reading?

A. No I'm not.

Q. Okay. Dr. Michota, tell our jurors what I asked you to do in this case?

A. Uh, you asked me to review the care and treatment of Mr. Kenneth Bieler.

Q. I sent you some records to review?

A. That's correct.

Q. And -- uh -- now in this case, you're -- you're testifying, or you're reviewing and reporting -- uh -- at the request of the plaintiff, the patient. Do you ever -- uh -- are you ever an expert for a doctor or a hospital?

A. Yes, I am.

Q. Just explain how you charge for your services when you do this kind of work?

A. Well, I charge for my time. So, I basically just keep a billing record of how much time that I'm using to review the records and so forth, and I charge $500 an hour.

Q. Why do you do this kind of expert work, Doctor?

A. Well, it's -- I don't know if it's an unfortunate fact of life but it's a fact of life that we generally learn more from our mistakes than we do from our successes; and as a teacher I'm -- I'm often times looking for examples where things could

have been done differently that I can bring to the students and to the other doctors that I teach, and certainly medical legal reviews often times, if not always, involve some sort of bad outcome that we would like not to have happened. Uh, so, it gives an opportunity to try and dig out those lessons that we can learn from everyone's mistakes instead of it being isolated necessarily to one person and one place.

Q. Do you share with your doctors at the Cleveland Clinic and medical students lessons you learn in this kind of work?

A. Absolutely. In fact, there's an ongoing kind of lecture conference within my department that's given -- well, they would like me to give it more often but it's basically once a month and I take cases I've reviewed and try to boil down the -- the -- the kind of those -- uh -- little pearls that -- that we want to make sure that physicians recognize so that the same mistakes don't happen twice.

Q. Doctor, I'm going to ask you to a little bit to compare how your practice in Cleveland compares to the practice of someone like Dr. Edwards here in Van Buren, at least in terms of the issues of this case. Now, you practice in Cleveland, Ohio at a large medical center?

A. That's correct.

Q. Would you tell us about the patients you see and where they come from?

A. Well, the Cleveland Clinic Hospital is in Cuyahoga County,

which includes the city of Cleveland, but it includes a number of communities that are very similar in fact to Van Buren or Fort Smith and they -- I could rattle off all the names in Ohio, but there are places like Solon, Ohio; Winesburg and patients come to me through our emergency room or from doctor's offices in the community and so I'm frequently treating patients back and forth if you will from the doctors in these sorts of communities, as well as, the unassigned patients, the patients who live right around the hospital who just walk into the emergency room.

Q. Now -- uh -- Summit Medical Center is around a 100 to 109 beds and Van Buren is about 19,000 -- uh -- the places you've mentioned does that give you familiarity with a similar type of medical community?

A. Certainly it does. And -- and I will go on to say that I have given presentations and -- and lectures in hospitals virtually identical to the size of Summit Medical Center, and again these -- I mean again I can rattle off names in Ohio, Tiffin, Ohio; Sandusky, Ohio; these are all very similar hospitals and I've talked with physicians, of course, who work in those hospitals and I have the familiarity with the kind of similarities and differences that you might find in that sort of setting versus where I go to work.

Q. Doctor, how would the standard of care in those kind of communities similar, which are similar to Van Buren compare

with the standard of care, and we're talking about treating, preventing and diagnosing in treating blood clot disease. How would those community standard of care vary with that you see and expect in the doctors who practice at the Cleveland Clinic?

A. They'd be no different.

Q. And I'm just, we're going to make, I'm going to try to make this fairly short, but I'm just going to go over the materials that I believe you've received and would just say yes if you've received them and we can go through that. The Summit Hospital records for the January 13th admission of Kenneth?

A. Yes.

Q. The January 6th admission, Summit?

A. Yes.

Q. The Ashton Place, the rehab admission?

A. Yes.

Q. Dr. Edwards' deposition?

A. Yes.

Q. Both of the depositions of the defense medical witness?

A. Dr. Daniels, yes.

Q. Yelp. And then the deposition of Shawn Imhof or Imhoof the director of radiology at the hospital?

A. Yes.

Q. And the deposition of Kevin Elliott the physical therapist?

A. Yes.

Q. And Kenneth's records from the Cooper Clinic?
A. Yes.
Q. Okay. Now, I'm going to ask you about something and we're going to call it the standard of care. And, uh, gosh I'm so low on this slide, but this is what Dr. Daniels, defense medical witness agreed was a reasonable definition of the standard of care. How do you feel about that definition?
A. I agree with it.
Q. Okay. Now, we met last night?
A. Yes.
Q. And we went through kind of the form of the testimony, you asked me to have certain slides ready to kind of help you explain the testimony?
A. Yes. Yes I did.
Q. Okay. Will you help me and if I get behind and don't have the slide up just -- just give me a sign.
A. Okay.
Q. Now, the first one is gonna be a time line of what happened with Kenneth, and would you just kind of go through that for us?
A. Certainly. Well, Kenneth Bieler was admitted back in January 06 of 2009 with an injury to his hip. He had a -- a hip fracture and -- uh -- basically he had his -- uh -- fractured hip repaired and he was transferred to the rehabilitation center on -- on January 9th, that's Ashton

Place. And he was in the process of rehabilitating from his hip surgery when he got readmitted to Summit Medical Center on January 14th with distention, an enlargement of his -- his abdomen. Uh, and that's what brought him to the -- to the care of Dr. Edwards and he remained under the care of Dr. Edwards until his death on January -- well, it says 28th, I believe it was just past midnight on the 29th.

Q. Okay. And -- and I'm gonna put up a slide that -- that you provided to me and I'm gonna ask if you could -- oh, use this slide and can you kind of give our jurors maybe blood clot disease 101?

A. Sure. Uh -- well -- uh -- certainly blood is -- is a liquid and it has the ability to form a solid. This is very similar to water which is liquid but can become a solid in -- in the form of ice. And blood itself is a very complex and delicate combination of -- of chemicals and proteins and cells and it's a very important aspect this ability to go from liquid to solid because if we cut ourselves or we injure ourselves, we want the blood to clot and prevent us from bleeding to death. And there are a variety of factors that can cause the blood to tip more to the side of clotting versus perhaps not being able to clot. And we're going to talk about some of the factors that predispose to clotting.

But what you're looking at on the image is a vein in the leg and you can see the cutout, those red circles represent red

blood cells and so it's traveling through the tube in a liquid form, but in that middle section the blood has started to form a solid. It forms a clot. And that clot on a regular basis as blood goes through our body, microscopically we're constantly forming clots that form and fall apart and dissolve partly and then it clots again and then it falls apart. This is all on a microscopic level. But if in fact, factors are present you can abnormally clot inside your body and you'll be able to see it. And those clots can sometimes break loose as the picture shows on the far right and that clot then travels to wherever it ends up which is usually to the heart and eventually the lungs, that's how a pulmonary embolism or a blood clot to the lung can occur.

Q. Would you like to have a laser point?

A. I would very much like to have a laser point.

MR. KEEVER: May I, Your Honor?

THE COURT: All right.

(LASER POINT PROVIDED THE WITNESS)

A. So, I just to amplify what I was saying, I think, there we go. Here's the veins, this a cutout of the vein, these are the red blood cells. So, imagine they're bathed in a liquid and it's traveling through the vein and then here the blood cells have all stuck together in a sticky spot forming a solid, this is a clot; and if a piece of this breaks loose, this chunk it travels up towards the -- to the heart and the lungs and it

basically dead ends in a tube that's getting smaller and smaller and wherever it ends up it will block blood flow and that can cause the symptoms that patients finds in symptoms of pulmonary embolism.

Q. And depending in the smaller and smaller tubes those are in the lungs?

A. That is correct. The lung is basically a filter for the blood and so anything that's this -- anything that's big like this clot will get stuck in the filter.

Q. How about if it's a little tiny clot that goes all the way out to the -- the very periphery of the outside of the lungs?

A. Well, it you know, the -- the blood vessels eventually will become microscopic you don't see them by the naked eye, but clots do end up in the periphery of the lung and they cause symptoms -- uh -- that are generally about the same as clots that are bigger.

Q. Okay. Now -- uh -- this next slide is one that you provided to me and would you tell the jurors first where that slide came from and then maybe use it to kind of describe the scope of the problem of blood clot disease?

A. Sure. This was a slide as part of an internet based medical education presentation that I prepared basically to teach doctors about blood clot disease. And when we talk about the scope of the problem that deep -- that, you know, VTE up at the top is a lung doctor word it stands for venous

thromboembolism so for the lack of better term, it means blood clot disease.

How big of a problem is blood clot disease? Well, you can see that there's hundreds of thousands of patients each year who have blood clot disease and it kills about a hundred thousand in the US annually. And realize that that number of deaths exceeds the number who died annually from breast cancer, AIDS and highway fatalities combined. So, it's a big problem. But many patients don't, or people, US citizens don't know that much about blood clot disease. Uh, but this just talks then about the risk of developing recurrent blood clot disease and some of the complications that can come from having blood clot.

Q. And I think this next one, I just tried to translate it into people talk but I think you already did that. So, let's go onto your next slide, and -- whoops. Uh -- Doctor, I wanted to have a slide about risk factors and I can't seem to -- to find it. So, I'm going to just go to it right now. And -- and again, tell us where this slide came from, and could you use this to kind of tell us -- we've heard something about risk factors and we'd like your explanation?

A. Well this, again, this is another slide from a -- uh -- a lecture that talks about the different factors that can tip the balance in the blood from clotting versus not clotting. And highlighted in the yellow are some of the things that we would have associated with Kenneth Bieler. But certainly any type of

surgery, trauma or injury can predispose the blood to clot. The less we move around the more blood kind of sits in our legs. Blood that's not moving is more likely to clot. Similarly and unfortunately as we get older we're more likely to clot, that's not something we can necessarily modify or change, being overweight. And this one which is very important it's acute medical illness. It should go without saying that, you know, people in the hospital are sick. We don't admit not sick people to the hospital anymore. And the sicker you are, the more likely your blood is -- is tipped in the favor of clotting. It's just a natural host response to -- to stress or injury. So, just simply being sick enough to be in the hospital is a significant risk factor for blood clot.

Q. And what can be done about the problems of blood clots to cut down on that rate of death?

A. Well, there's -- there's a host of things that have been studied, and we do in fact have very effective ways now to tip that balance back so that the body is not necessarily prone to clotting so that things sort of even out. And the most effective thing we have are very low doses of medications, blood thinners, which I'm sure we'll probably talk more about. But if we give them in these little doses they can -- uh -- kind of tip the scales so that things are balanced again and patients will not form these abnormal blood clots when they're not supposed to.

Q. When using preventive doses of blood thinners how much can that cut the risk of a blood clot in a -- in a patient who has more than one or -- one risk factor in the hospital?

A. Well, the -- the studies that have been done that evaluate how effective these -- these sorts of strategies are, uh, have -- uh -- cuts -- they up the rate of blood clots as high as two-thirds, 65/66 percent effective. But the other thing to keep in mind too since we're talking about a case that involved a death from a blood clot. This is just the ability to prevent the clots from forming. But if you otherwise look at the total population in people who have risk of dying from these blood clots, I mean there are some studies where they've tested these sort of strategies and -- and the death rates were zero in the studies.

So, some clots may still occur but -- but nobody died. So, the efficacy is both compared to ability to stop the clot but also to prevent those sorts of things we care about the most, not just the clot on an x-ray, or a scan, but the ability actually to prevent people from having symptoms and -- and going on to suffer events which could be lethal.

Q. Okay. Uh -- if a patient is on blood thinners or not I guess, and develops a blood clot and say it does travel up to the heart and lungs -- uh -- what are you saying about the measures that can cut the death rate?

A. Well, I mean, patients who have blood clots that cause

symptoms, if it does not get treated, in other words the clot has developed in the leg, its traveled to the lung and it doesn't get treated with blood thinners at all, those patients die usually within one to four weeks of the original event, about 30% of the time.

So, we can cut a significant number of deaths by not only providing the preventative strategies but then if somebody is determined to have an existing clot, we give higher doses of the blood thinner and it makes death virtually, it just doesn't happen if we detect it and treat it properly.

Q. Okay. I want to be sure that we understand this. We're gonna -- we're gonna have a patient and he has his first blood clot going to his lungs and there's no treatment, what's his chances, his or her chances of dying?

A. Uh, it's -- it's -- about 30% of those patients will die within one to four weeks.

Q. And then we have the same patient but treatment is instituted when they have signs of it going to their heart and lungs, and what's the death rate then?

A. Uh, 0 to 1 percent.

Q. Okay. Doctor Michota, I think I'd like to now ask you to -- to talk about what actually happened to Kenneth, would that be okay?

A. Sure.

Q. Now, in the -- you reviewed both Dr. Daniels' deposition

and you reviewed Dr. Edwards' deposition and in their deposition both of those doctors testified that they thought the risk to Kenneth of developing a blood clot when he came in the hospital on January 13th was moderate. I think Dr. Daniels said moderate to low. Uh, how would you have rated Kenneth's risk of developing a blood clot? I mean is that a fair question?

A. Yes it is a fair question. I mean it actually forms the basis of what all physicians who take care of hospitalized patients need to do on admission is assess their risk for blood clots and apply preventative strategies to patients who are found to be at risk. In Mr. Bieler's case he actually was high to very high risk for blood clots based on the number of risk factors that he had.

Q. And I don't think that you brought your records or notes up there with you, but we could -- oh, we got right there. Could you tell us what were the -- the risk factors in Kenneth?

A. Sure. Well, first of all he was -- he was 58 years old so he was over 40 so he had age as a risk factor.

He recently had a long bone fracture, a hip fracture. Hip fractures are actually the most robust, most significant risk factor for fatal PE that we've ever uncovered so.

Q. PE is?

A. Pulmonary embolism or blood clot to the lung. So, just the fact that he has age over 40 and had a hip fracture puts

him in the high to very high risk category even if we don't look at the other risk factors that he had which included obesity, volume mass index over -- over 30. He also got readmitted on the 13th with an acute medical illness.

Uh, he also had other things. He had a central venous catheter, he had a blood transfusion, these are all things that are added that increases risk. But simply by having the hip fracture alone, you would have categorized them in the high to very high risk category. You didn't even need anything else.

Q. Well, and -- uh -- I -- and -- and I have that slide for you from the Spencer and Anderson study, in fact, if I'm lucky it came right back -- right up. Can you use this to kind of explain to us how the number of risk factors correlates with the risk of a blood clot?

A. Sure. I mean we -- we have a variety of studies that are very similar to this one that have shown us that as the risk factors go up, so does the likelihood of -- of being in a population that suffers a blood clot. And it's believed to not just be -- uh -- well, you can sort of tell by the -- the way that the curve moves up in this direction. It's not each step is of equal size. As you get a risk factor it's additive, they work together to increase the risk greater than just one single factor added to another, and that's really the point. Uh, when patients have multiple risk factors they're in very high risk groups for the development of thrombosis, or blood clots.

Q. And how foreseeable was it that Kenneth would have a blood clot in a 15 day hospitalization?
A. It's very foreseeable. In fact, if you look at the people who are identified appropriately as being at high to very high risk, their -- their risk of developing the clots are in the 40 to 80% range. In other words, it makes it the expected event, if you don't do anything to try and prevent it.
Q. Okay. Now, Dr. Michota, now I'd like to talk to you about what the standard of care that, you know, what is that degree of learning a skill expected to be possessed and used with reasonable care by a doctor like Dr. Edwards in Van Buren or a similar community, would that be okay?
A. Yes.
Q. All right. Let's -- in Dr. Daniels' depositions, in both of them, he agreed that there was a two-part standard of care and would you look at that? In fact, if you want to just read out the first one and tell me what you think of that, tell us what you think of that?
A. Well, it says the standard of care requires that a hospitalized seriously medical patient with multiple risk factors for blood clots is to be treated with blood thinners unless there's a medical reason to withhold them. And, I not only agree with it, that's -- that's what our evidence would say is, is mandatory for the standard of care. We evaluate patients for their risk of clots, and if they have risks for

clots we're to use these preventative doses of blood thinners to tip that balance so that the blood doesn't clot inside our body in an abnormal way. So, I completely agree with Dr. Daniels. This is the standard of care.

Q. Now but some people, Dr. Daniels testified that some people have medical reasons that tip the risk balance so that they can't give blood thinners and that if there's a medical reason to withhold blood thinners, in that same patient, multiple risk factors, seriously ill, the standard of care requires maximal mechanical measures to help prevent blood clots. How would you feel about that second prong?

A. Well again, that's -- that's also completely correct. Uh, and as I talked to you about the importance of blood clotting obviously if we're -- if you're actively bleeding, if you have a bloody nose or you're bleeding, I don't give you medicines that make it impossible for you to clot. Uh, so there are medical situations where if a patient can't receive a blood thinner then we do what we can, in this case the term mechanical measures refers to leg squeezing devices and -- and certain type of tight pantyhose that -- that aren't as effective as blood thinners in preventing clots but may be of benefit. We have nothing else to use so we use those. But the importance is there has to be a real reason not to use the blood thinner.

Q. And, Doctor, we have -- have shown this book to the jurors

and -- uh -- I'm gonna show you the next slide is kind of out of this book and -- and could you just explain first of all, that's got a lot of words. What does that say?

A. Well, it essentially says the same thing as your previous slide. Actually in doctor language it says exactly the same thing.

Q. And -- and this book here, can you -- would you just explain to the jurors a little bit about this book?

A. Sure. You know blood clot disease doesn't live in one specialty. Blood clots effect medicine patients, surgery patients, it actually effects children as well, there's not one specialty in medicine that owns blood clot disease. And as a result, we call it an orphan disease. It's talked a little bit at every national meeting of the specialists but nobody just focuses on blood clot disease until the chest physicians started publishing these guidelines. And essentially what they've done is they've taken all the studies that are available about blood clots in all different types of patients with all different types of treatments and so forth. And they've kind of boiled them down to recommendations for physicians so that they can apply them to their patients.

Q. So, these -- these are not published standards of care, these are published medical guidelines?

A. That's correct. They're -- they're based on the evidence for which a reasonable physician -- uh -- would apply to their

patients to get the best result.
Q. But in -- in this case we -- we've agreed that that basically is the standard of care for what we're talking about in this case?
A. That's exactly right. Uh, we apparently all agree Dr. Daniels, Dr. Edwards and myself that this is the standard of care.
Q. Okay. Now -- uh -- let's talk about what Dr. Edwards -- what you could tell from the record and the depositions what Dr. Edwards did to -- did or did do to protect Kenneth against blood clots, now we're just talking about the protection part of it? Can you tell what measures Dr. Edwards took during the first two days which -- uh -- uh -- let me just -- get -- well -- I apologize I should have had this up.

MR. KEEVER: May I put a poster up over here, Your Honor?

THE COURT: All right.

Q. And this is -- this is not just the period of hospitalization, can you -- can you see it?
A. Yeah, I can see it, yeah.
Q. But it is -- this -- now we're just talking about the 13th through the 29th. So, the first two days, and we'll say he came in about midnight on the 13th so let's just say the 14th and 15th, what steps were taken to -- uh -- prevent blood clots?

A. Well, I mean specific to the -- to the orders and documentation by Dr. Edwards in the chart nothing. We do know from the nursing records that the patient did have thromboembolic device stockings that were placed. Uh, these may have had some role but again, in terms of what was actually ordered or documented in the chart there was nothing.

Q. Okay. And we'll -- we'll -- we'll get to later on in the -- in the record and we're gonna move through this fairly rapidly. Uh, after the first two days, let's say now we're talking like the 16th through the 25th. So, now we're talking about the first 11/12 days of hospitalization. What kind of preventative measures were taken, measures were taken to prevent blood clots?

A. Well, again, I -- there's -- there's nothing in there for blood thinners. There's no specific risk assessment in the chart, there's nothing.

Q. Those stockings or those squeezing things, sequential compression devices, how about those?

A. Well, the devices on the right or the SCD or sequential compression device these are essentially devices that -- uh -- squeeze the leg to improve blood flow. There's no evidence that those were ordered or given to -- to Mr. Bieler.

The devices on the left, these are those white pantyhose of which there are many different types with many different pressures. There is documentation by the nurses on some of the

days, certainly not in the later -- in the later -- uh -- uh -- you know, in the last week or so before his death. But there's occasionally some -- something written in the early part of the hospital stay that spoke to the patient perhaps having those on or not having those on.

Q. There was -- there was an order for physical therapy. Uh, how would that relate to preventing a blood clot?

A. That would not relate at all. That's not a strategy for the prevention of blood clots.

Q. Walking around is not a -- isn't a preventative measure for blood clots?

A. It is not, and it's a very common misconception among physicians. The ability or the lack of the ability to walk around is used for the risk assessment for the development of blood clots. Patients who don't walk around very well are at greater risk of developing a blood clot. But there's no evidence that patients who are at risk have a reduction in the development of blood clots regardless of how much they walk. The best example I could give you would be cancer patients. Cancer patients are at very high risk of blood clot. You can take a patient with cancer and they can walk up and down the stairs, walk the hallways, what have you, it doesn't decrease their risk of developing the clot.

So, mobility is very important as part of the risk assessment, but it's a common misconception that -- that

patients if they just walk around it will prevent a clot when they're already at risk.

Q. And is -- what -- what's -- scientific evidence do you have to support that?

A. Well, if you simply look at the standard of care that we've already looked at as far as what would be appropriate in a patient like Kenneth Bieler, you don't see anything in there about well you just get him up and walk him around, just go ahead and order physical therapy it will protect them. It doesn't say that. It says, the standard of care is you use preventative doses of blood thinners and if you can't use those, you use maximal mechanical methods which would be a combination of the leg squeezers on the right and the pantyhose on the left; it doesn't say physical therapy. There is no evidence that walking around will prevent a clot in somebody who's at risk and that's why it doesn't say that in that book, that chest guideline and it's why it wasn't said by Dr. Daniels in his deposition either.

Q. Uh, well, Dr. Daniels in his deposition made a big point --

MR. COX: -- Your Honor, I'm going to object to Mr. Keever telling the doctor what --

THE COURT: -- sustained, rephrase your question.

CONTINUED DIRECT EXAMINATION

MR. KEEVER:

Q. What did Dr. Daniels say in his deposition, Doctor, particularly in the second deposition about Kenneth's activity, and his activity in bed and so forth?

A. Well, he -- he did say that -- uh -- he felt that he wasn't bedfast and that he was moving around and that he was -- uh -- he was getting physical therapy and he did believe that that somehow affected or would change his risk of development of blood clots.

My point though is when he was specifically asked about the standard of care as we highlighted on the slide, he basically -- uh -- uh -- put forth the exact same recommendation that that chest guidelines puts forth. And there is nothing in that chest guideline about if you start physical therapy you can decrease the risk of blood clots in someone who is at risk. And Kenneth Bieler was at risk and he needed an efficacious strategy for prevention, he just didn't get it.

Q. Efficacious means?

A. An effective.

Q. I'm sorry?

A. Effective, an effective method to reduce his risk.

Q. Okay. Well, Doctor, these mechanical measures how effective are they as compared to the preventive doses of blood thinners, can you tell us that?

A. Sure. It depends, and it depends on the risk of the patient. So, if you have a patient who is at low risk for the clots to begin with, then in fact these sort of mechanical devices may be very effective. But as the risk of the patient goes up, those sorts of mechanical approaches don't balance the -- the clotting of the blood. You need the blood thinners.

In a cancer patient these devices would do nothing to help prevent blood clots. And in fact, its been shown that they're ineffective in the intensive care units in medical patients; they're ineffective in the cancer population; they're ineffective in a variety of high-risk groups.

So, the blood thinners are deemed to be more effective across all the different risk categories than these strategies which is why the standard of care says you use blood thinners first. And only when you can't use blood thinners would you resort to these strategies. If these things were all the same, no one would ever use a blood thinner because no one is going to bleed from using pantyhose; these blood thinners all carry a small risk of bleeding which every doctor has to consider when applying these approaches, but the bottom line is these things don't work as well which is why the blood thinners are advocated when people are at risk for blood clots.

Q. And how about comparing the left side to the right side, the pantyhose to the squeezing things?

A. Well, the squeezing devices are deemed to be more

effective than the pantyhose. Uh, but I -- but I should caution that when we talk about these things, we're talking about them like they're all the same and they're not. Uh, in my hospital I have four different types of leg squeezers and they don't all work the same, and the studies have not shown even the leg squeezers among themselves to all have the same degree of efficacy or success.

The pantyhose are no different. There's thigh high pantyhose, calf high, there's the full pantyhose, there's some are at 5 millimeters of compression, some are at 20, some are at 30, so we talk about them like well they're all the same. But if in fact we're not comparing apples to apples, it's very difficult to even make any conclusions about how effective these devices as a group really are because every single one of them could be different. We have to know exactly what we're talking about. But the bottom line is that in general the blood thinners are more effective than the leg squeezers, the leg squeezers are more effective than the pantyhose; but it depends on the risk of the patient as well.

Q. In a high risk patient if blood thinners are here and here is nothing, where would the -- the pantyhose and the -- and the -- uh -- uh -- squeezers fall?

A. Down where your hand is representing almost nothing.

Q. Okay. Now, would it help us any to understand Kenneth's situation -- uh -- if you were to go through the activity

level? I mean would that add anything to our understanding about Kenneth's risk while he was in the hospital?

A. Well, it -- it would simply just add to what I hope we've -- we've established already is that Kenneth Bieler was at very high risk for the development of blood clot. And his level of mobility as charted by the nurses -- uh -- pretty much shows that from the 13th to the 28th -- uh -- he was very limited in his mobility as you would expect. Patients who walk around a lot in hospitals, walk right out the front door. We don't keep them in the hospital when they're healthy.

So, it would be expected that most patients in the hospital have limitations in their mobility and are no where near what they are normally or they wouldn't be there in the first place.

Q. Dr. Michota, what can you conclude from the -- all the things that you've reviewed, including the depositions, about the reasons that Dr. Edwards did not give preventative doses of blood thinners?

A. Well, I will say that when I first reviewed the records -- uh -- prior to reading his deposition testimony I concluded he simply just forgot about it. And there's precedent for this. The literature actually describes the most likely reason that people don't give preventative therapies is they forget. And that's simply because patients get admitted, they've got all sorts of problems, their labs are abnormal, they've got all

these signs and symptoms and sometimes physicians forget about the things that -- that are preventative because we're focusing on the -- the sickness at hand.

Uh, following his deposition testimony he testified that he did consider the risks. He did think about the prevention of blood clots in Kenneth, but that he felt that -- uh -- there were medical reasons not to use the blood thinners and that he otherwise was -- uh -- using the mobility as well as the -- the stockings and so forth the best he could under the circumstances due to Kenneth's condition.

Q. What were the medical reasons that -- that he gave in his deposition that were an excuse not to give blood thinners?

A. Well, he thought that the patient was bleeding, and in my opinion that was an unreasonable conclusion given the data he had at the hand -- at hand.

Q. And what did he -- what did he think about possible surgery on the patient?

A. Uh, well, that was another issue as well is that he thought that the patient might need surgery upon admission and that somehow needing surgery was a reason not to give these preventative doses of blood thinners which is in fact not true.

Q. When you say it's not true can you -- can you explain that to us?

A. Well, sure. If you recall the slide that listed the risk factors for -- for clotting one of the first things on the

slide is surgery. Surgery increases your risk of clotting because the inflammatory cascade of healing can tickle the blood into a clotting pre-disposition. So, we have specifically studied giving these small preventative doses of blood thinners to people having surgery. And we've shown that patients actually have a lower rate of abnormal blood clots and not an increased risk of bleeding at these small doses. Matter of fact, one of the groups that was specifically studied were patients who needed colorectal surgery, both with and without cancer. We actually give these blood thinner doses two hours before they go into the operating room as a protective strategy for blood clots around that type of surgery.

So, its been studied in large randomized clinical trials that this is in fact an appropriate way to keep patients safe when they're having surgery. So, there's no reason in this case that I can -- I can see as to why the thought of surgery would prohibit the use of the preventative doses of blood thinners.

Q. What are the -- what -- what -- what's the correlation between a patient having a colonoscopy and being on blood thinners?

A. Uh, virtually none unless you were planning to -- uh -- do some sort of biopsy or -- or remove a polyp or something of that nature, uh, it shouldn't make any difference.

Q. Well, if you just take the devil's advocate point of view

and assume that it was reasonable to withhold blood thinners for a couple of days because maybe surgery, what would have been required by the standard of care?

A. The maximal mechanical method that was outlined on the slide. It would have been compression devices, the leg squeezers with or without the pantyhose.

Q. Now you mentioned that you concluded from the record that Dr. Edwards and I think Dr. Daniels said there was an issue of possible internal bleeding that would make it more dangerous to give blood thinners. And if you'll just bear with me flipping through here, this is a summary slide and its been admitted as I believe Exhibit No. 7, is that correct, Ms. Warren?

A. Yes that's correct.

Q. And it's the blood count, so what -- what did using this and your review of the record and so forth, what can you tell us about Kenneth and a chance of internal bleeding and whether that was medical reason to withhold blood thinners?

A. Well, there's a -- there's a variety of things that as an internal medicine specialist you would look at to determine whether your patient was actively bleeding.

The first one is common sense. Do you see any blood? People bleed in places where the blood comes out of the body. They bleed from their nose, they bleed from their rear end, they bleed from a variety of places that you can see. So, the first thing you ask yourself is well do I have any evidence of

bleeding. There are in fact places where blood can hide. Uh, and you don't necessarily see it right away, and you have to consider that. But typically if somebody is continuing to bleed, you see this ongoing trend of these numbers, they start dropping and dropping and dropping and they don't stop. It's not like they level off and they have -- they have a steady course going south.

Now, most patients who are in the hospital we draw blood on them every day so there's a certain amount of loss of blood that we expect. We also have to think that Kenneth Bieler lost a fair amount of blood related to his long-bone fracture. Patients will lose anywhere between 2 and 4 pints of blood in a fracture such as that. And to be so sick to be hospitalized now on the 13th he's now suffered a medical complication of his surgery. Patients are sick, they generally don't rebound. The body doesn't make red blood cells to replace it, it could take weeks for that to happen.

So, with all those factors being considered, you look at these numbers. You understand what Kenneth Bieler's medical history is and his current situation. I'm at a loss to understand why we would think that this represents an active bleed. And then you add on top of that the fact that we had a colonoscopy, we had a couple of x-rays and the CAT scans that were done, there clearly was no active bleeding and I'm not sure why people would think that that's in fact what was going

on.

Q. Now, here's a picture of -- of the fracture, the break in Kenneth's leg. Have you some experience seeing patients like this after their surgeries in the hospital, sir?

A. Absolutely. In fact, at the -- the Cleveland Clinic the orthopedic surgeons don't admit these patients to their service. They're admitted to our service and we take care of them. We send them down to the operating room to have them fixed, but they're actually our patients.

Q. Now, and I think there's been testimony and the records will show that the actual blood loss at the time of surgery -- uh -- was less than half a pint, or around a half pint. Going back to the blood counts, how does that relate to -- uh -- uh -- I think he had a hemoglobin of 14 --

A. -- uh-huh --

Q. -- or so when he came in, how does that all tie together for you?

A. Well, you know, keep in mind that when the surgeon says how much blood loss was there when they opened up the leg, it's how much blood they visually see at the time that they're actually, you know, cementing and plating the bones together. Uh, once you have the -- excuse me, once you have the fracture blood is leaking out and it -- it leaks out and it -- it actually kind of follows through the leg -- uh -- and depending upon the size of the patient, and in Kenneth Bieler's case

trying to imagine how big his legs actually were, you can lose a lot of blood. It goes into the -- the -- uh -- the spaces between the fat and the muscle. Blood moves in there and you just don't, you can't quantify that. However, looking at a blood count after a hip fracture, I mean hemoglobin of 10 is expected. I don't -- I have very few patients in the hospital who have normal blood counts. People are sick so they're anemic. They have low blood counts. Uh, it actually is just part of being in the hospital.

Q. On the 26th there's a progress note by -- uh -- Dr. Edwards, it says his oral intake is so poor that he can't nutritionally support recovery of red blood cell production. Uh, what -- do you recall that note, sir?

A. Yes. Yes and -- and I actually thought that was very appropriate. That's part of the reason why he didn't recover that quickly, he was sick.

Uh, the blood count fell because he broke his leg. Uh, it didn't recover because he got sick. And -- uh -- it was gonna take time. It was gonna take weeks probably before he eventually came up to a normal red blood cell count.

Q. When did you review the medical records relative to when you reviewed Dr. Edwards' deposition, Doctor?

A. Well, the medical records were -- were reviewed first. I believe I reviewed them sometime in the fall of -- of 2010.

Q. And when you reviewed those, what did you -- what did you

find that -- uh -- about Dr. Edwards' thought processes that you could glean about -- about the anemia or the low blood count?

A. Well again, I -- I thought he was -- based on what he wrote in the chart that -- that he thought that what I'm saying to you I thought he thought what I'm saying to you which is he had a low blood count because he was sick, and that it was going to take some time both from a nutritional perspective and recovery from his medical illness before his red blood cell count increased. I didn't see anything in the chart except for -- uh -- perhaps on the 27th, anything related to concern over blood loss or blood problems with using blood thinners. This was after he was already starting out a test for blood clot disease.

Q. And he died late on the 28th?

A. That's correct. Just past midnight.

Q. Now, Doctor, what is your opinion as to whether or not the possibility of internal bleeding was a reasonable excuse to withhold blood thinners on any of the days, the 13th through the 29th?

A. Well, as I testified in my deposition, original deposition, the first couple of days in the hospital, the 13th, the 14th, perhaps up until the 15th I didn't quibble with the idea that maybe blood thinners at that time was not the right approach. I would have still used blood thinners. I know

plenty of doctors who would have used blood thinners.

MR. COX: I'm going to object to what he would have done.

THE COURT: Sustained.

A. There's a lot of reasonable physicians who would have used blood thinners at that time. There's reasonable physicians who would have --

MR. COX: Your Honor, I'm going to --

THE COURT: -- Sustained. You can give your opinion not others. Go ahead.

A. Okay. Uh --

Q. -- maybe I should -- I ought to rephrase the question.

A. Maybe rephrase because I -- I'm gonna get stuck with how I answer it.

Q. Yeah. Yeah. Uh -- and -- uh -- well, let's just -- what is your opinion as to whether or not the possibility of internal bleeding was a reasonable excuse to withhold blood thinners on any of the days in the hospital?

A. Well, specific to the concern over bleeding I don't think any of the days. My deposition though talks about the issue of surgery the first couple of days he was there the 13th, 14th, and 15th when I think that -- uh -- it's my opinion that you could have used either approach with respect to prevention, mechanical or blood thinners.

Q. Good. Now, what is your opinion as to whether or not Dr.

Edwards met the standard of care in what he did, or what he did not do to prevent blood clots in Kenneth?

A. It's my opinion he did not meet the standard of care.

Q. And what is your -- what was the -- what did that cause?

A. Well, by not meeting the standard of care he developed a blood clot that traveled to his lungs and killed him.

Q. And, Doctor, is that opinion based upon at least a reasonable degree of medical probability?

A. Yes it is.

Q. Can you tell the jurors what you understand a reasonable degree of medical probability to mean?

A. More likely than not. So, 51% compared to 49%.

Q. And beyond a reasonable degree of medical probability, how certain are you that Kenneth would have survived had Dr. Edwards used preventative doses of blood thinners?

A. Virtually certain.

MR. KEEVER: Okay. Doctor, I'm gonna want to talk about the last 3 days of Kenneth's life. Uh, Your Honor, I'm -- I'm gonna, the -- the next section is probably gonna be about, not quite as long as the first session, section. I just want the court's guidance to go on or to break now or what?

THE COURT: Come up for a minute.

(SIDEBAR CONFERENCE OUT OF THE HEARING OF THE JURY AS FOLLOWS:

THE COURT: Here's the issue, I'm not going to cut Mr. Cox's cross examination short because your witness has got a flight to catch, I don't care how long you go but I want you to understand that. So, you know, he's not going to be limited.

MR. KEEVER: I understand that.

THE COURT: Understand I don't mind taking a recess now and coming back say 12:40, this be our lunch hour, I'm just -- my caution to you is that I'll give you all the time you want I just want you to understand we're still going to have the jury take some reasonable lunch break.

MR. KEEVER: I wasn't pointing toward that, I understand. I just wondered whether you wanted to go. And I do understand not to cut him short.

THE COURT: All right.

END OF SIDEBAR CONFERENCE.)

THE COURT: Ladies and gentlemen, I think it's probably better we go ahead and take a little early break because we might be going a little further in the afternoon and then that kind of messes everything up. So, let's do this. Just remember what I told you initially, don't discuss this matter with anyone. Don't let anyone discuss the case with you. Be back, let's try to be back about 12:30,

that's a little short but if we can get back by then maybe that means we can get started by about I guess 12:40 or something. So, if you get back a little bit early maybe we can start back up a little early. Be in recess until then.

(11:40 A.M. COURT RECESSES FOR LUNCH)

(12:40 P.M. OPEN COURT RESUMES)

THE COURT: All right, continue with your witness.

MR. KEEVER: Thank you, Your Honor.

CONTINUED DIRECT EXAMINATION

MR. KEEVER:

Q. Doctor Michota, I think we're about finished on the subject of preventing blood clots, but one of the things that you said was that -- uh -- activity, walking around there was a common misperception that that was an effective mechanical measure to prevent blood clots. How would -- how would you expect the doctor in -- in the trenches like someone in Van Buren, an internal medicine doctor to be aware of that?

A. Well, that's precise sort of information that would be available on a recertification exam to keep up with current advances in medicine, new medicines and technologies but also to address common misunderstandings in the medical community, that's the whole point of the recertification process.

MR. KEEVER: Okay. Let me get my

screen active here. Okay.

Q. Now, Doctor, we're going to move on, we're going to go about and talk about those last three days and let's go to the 26th. Now it's a Monday, third day, third full day before Kenneth dies. Can you tell us what was going on in that day?

A. Well, at this point -- uh -- Kenneth Bieler was already starting to show improvement from what initially brought him to the hospital, the combination of the swelling of the colon and the bowel. He actually had started to take in a little bit of food by mouth, even though he was still on some nutrition through the IV.

But now the focus goes from well what brought you initially into the hospital to let's get you back to your -- your normal state, your normal healthy state. And, of course, you also have to continue to address the issue of the hip fracture which his medical illness sort of interrupted that rehabilitation process.

So, uh, he was seen -- uh -- that morning by physical therapy with the intention of -- of working on his gait training related to his hip fracture and -- and also just basically see how -- how much strength he had for kind of the routine things we do in life, which is walking, and eating and dressing and bathing and so forth.

Q. Okay, what happened on the 26th?

A. Well, when he got up to work with the physical therapist,

he got very short of breath. Uh, his respiratory rate went up, and it certainly was to the point where he had to sit down and rest because he had so much trouble -- uh -- just getting up and walking, things of course that all of us take for granted. He was too short of breath to do that. And it was also accompanied by some chest pain which he reported to the physical therapist.

Q. Okay. So we have chest pain and shortness of breath. Doctor, would you explain a little bit about a process called differential diagnosis?

A. Sure. Uh, that's a, you know again perhaps a confusing term, it's -- it's just nothing more than doctor language for creating a list of conditions which could explain the patient's sign, symptoms, laboratory studies and so forth. So, at least in this context when somebody has chest pain for example, doctors create a list of things that can cause chest pain.

Q. So, on -- on Kenneth we had the pt note and then we had Dr. Edwards' note with -- with that information available, that evidence available at that time what would you expect to be on the top of the list of that differential diagnosis, list of diagnoses?

A. Well, certainly one of the things that would be in that list and certainly at the top would be a blood clot to the lung. And chest pain is just one of those complaints that all physicians take very seriously. Uh, it doesn't matter how old

you are -- uh -- you can be a relatively young man for example, and if you go to the doctor and say I've got chest pain, there's a good bet you're going to have a couple of tests run, even though it might just be heartburn or indigestion it's -- it's one of these danger symptoms. So, we -- we think about things like blood clots to the lung. Uh, heart attacks. Uh, collapsed lungs, there's -- there's a relatively short list that we have to consider each time somebody says chest pain so that we're not missing something that could kill you.

Q. And, Doctor, what in your opinion caused the chest pain and the sudden shortness of breath?

A. Well, this without doubt was a blood clot to the lung. It was probably one of the first ones that Kenneth Bieler had.

MR. KEEVER: Your Honor, I'd like to place a poster.

THE COURT: All right.

Q. Are you able to see that from that angle?

A. Yes I can.

Q. Okay. Now, we talked a little bit earlier about small blood clots and large blood clots, can you use this artist illustration which is, first of all, have you seen -- you've seen the autopsy on Kenneth?

A. Yes I have. I've seen the autopsy report, sure.

Q. And we had an opportunity to go over this artist illustration last evening?

A. Yes.
Q. And, Doctor, what -- what would you say about the fairness and -- and degree of accuracy of this illustration in terms of the autopsy findings?
A. It's very accurate.
Q. Okay. Well, can you use this illustration and kind of explain to the jurors what in your opinion was happening on, and we'll start with the 26th?
A. Well, on the 26th the pain that Kenneth Bieler was experiencing was due to a blood clot to his lung. Now the -- the diagram shows a lot of clot and this is, hopefully this shows up here. This is his heart and these are his lungs here, these are the filters, and all of this red gunk represents clot. Now this is, you all can see that, that's big clot, that's what we would call central clot. This is the sort of clot when it's to this extent -- uh -- would and could be expected to be lethal. That's not the type of clot that Kenneth had on -- on the 26th. It was a clot that would have been almost microscopic that would have traveled all the way out here, these are all, these spaghetti things here are all blood vessels, it would have traveled out here to the -- to the outer edges and it would have blocked one of these blood vessels and -- and that's what would have caused pain, it's an irritation of the lining of the lung. Most patients with blood clots to the lung are not as big as you see -- uh -- as shown

by this graphic which represents, of course, the autopsy findings after Kenneth died.

Q. And, Doctor, what would have been required under the standard of care on the morning of the 26th when Kenneth had these findings?

A. Well, the first step is and what all physicians would be expected is to do a history and a physical exam and -- and generate this differential diagnosis a list of possibilities. But given Kenneth Bieler's risk for blood clots, the fact that he had not been on blood thinners to prevent blood clots, the signs and symptoms, which are consistent with a blood clot of the lung, the standard of care would have required testing to confirm whether a blood clot had occurred or not, and while you were doing that sort of testing, the standard of care would have required that you give the patient blood thinners so that they don't have a second clot, which could then kill them, while you're doing your tests.

So, this is a disease which is -- is lethal enough that once you suspect it you're supposed to treat for it while you're kind of confirming the diagnosis. If it turns out to be something else, you stop the blood thinner treatment. And this is no different than when you all have infections and doctors prescribe antibiotics, maybe not even sure if you've had an infection yet, and if it turns out you don't have an infection, you can stop the antibiotics. But if you have an infection

that's not treated it can cause you a lot of harm, and that's the same sort of situation with the blood thinners. Once you've been suspected, especially up here in the heart, you need to treat for it while you're testing.

MR. KEEVER: May I approach the witness, Your Honor.

THE COURT: All right.

Q. Doctor, I've got, and I hope this will fit up here for you and you're able to use this, and I've got this chart which is -- and it -- and it talks about the date, time of the treatment and whether or not with treatment it's your opinion that Kenneth would have survived the hospitalization, and -- uh -- and if you would, let's go first of all to the preventative treatment. And I can't see it from here so you'll have to -- what's the first column?

A. The first column is date and time for start of treatment, and here is January 14th through the 25th using these many preventative doses of blood thinners. What's the -- what's my conclusion on whether or not Kenneth Bieler would have survived based on a reasonable medical probability if that had been followed.

Q. And what is your conclusion?

A. Well, I assume you want me to write up here on the thing now --

Q. -- would you please, sir --

A. -- so, I'll give you a check mark, but yes it's my opinion he would have survived to a reasonable degree of medical probability.

Q. And the next column?

A. So this is now conclusion on survival based beyond reasonable medical probability. We talked that, you know, reasonable medical probability is more likely than not. Well, my opinion is it's actually, or my assertainty of this is -- is much beyond 51%. So, as you look at this what's the likelihood he would have survived the hospital stay? It would have been 99 to 100% for the hospital, and 99 to 100% one year after this date, if he would have received these preventative doses he would not have had a blood clot go to his lung. He never would have been at risk for death.

Q. Okay. Now this next slide is a summary sheet of -- of what happened on the morning of the 27th, and do you recall that from the records, can you see around all the posters?

A. Yes. Well, I -- I recall it. I mean basically -- uh -- after the 26th this episode and physical therapy there are chart notes on the 26th later in the afternoon that when he tried to get up and walk around he was similarly short of breath. It was harder for him to do things than you would have expected from a breathing perspective.

On the morning of the 27th, at least when he's at rest, he's described as otherwise being okay. But once he goes back

to physical therapy again and he starts to have to walk with the physical therapist, he gets nauseated, he also has an increase in his respiratory rate, and at least what was most alarming to the physical therapist is he changed color. He turned almost like a dusky blue color described as an ashen appearance. And he, you know, had to sit back down and his color returned after he sat down and his breathing improved.

MR. KEEVER: May we approach, Your Honor.

THE COURT: All right.

(SIDEBAR CONFERENCE OUT OF THE HEARING OF THE JURY AS FOLLOWS:

MR. KEEVER: Your Honor, may Dr. Michota step down from the stand and stand by the easel?

THE COURT: It's fine with me.

MR. KEEVER: Thank you, Your Honor.

END OF SIDEBAR CONFERENCE.)

MR. KEEVER: Doctor, if you don't mind standing for awhile so that everyone can see, would you just go on over to the easel and I think you'll be sure to speak up enough so Ms. Warren can pick up your testimony.

WITNESS: Sure.

(WITNESS STANDS IN FRONT OF EASEL)

CONTINUED DIRECT EXAMINATION

MR. KEEVER:

Q. Okay, so -- uh -- now we're talking about the 26th -- uh -- go ahead and fill in the chart on would -- would -- if -- if -- if he had been started -- if Kenneth had been started on a full dose of blood thinner on the 26th would he have survived?
A. So, just to -- uh -- emphasize again this is the 26th is when he had chest pain and was short of breath. This was, as I described, not these big clots that you can all visually see, but microscopic clots perhaps or tiny clots that go to the periphery. If he had been treated with full dose blood thinners at that particular time, again he would have survived based on a reasonable medical probability and based on his survival of the hospital stay and one year after, and it would have been 99 to 100%.

People who were diagnosed and treated with these sorts of blood clots, when the clots are this size, they don't die if they are appropriately anticoagulated.

Q. Now, how about the morning of the 27th where now he's got these symptoms --
A. -- right --
Q. -- what's going on now and can you use the illustration?
A. So, now that -- uh -- essentially we have another episode of physical therapy remember that he's -- he's fine when he's at rest, when he's not moving around his color looks good; he's not having a lot of problems breathing; he's not requiring oxygen beyond what's in the air.

Uh, he goes to physical therapy on the 27th and he -- he changes color when he gets up and moves around. This didn't happen on the 26th, this suggest and is more indicatative of a clot that's bigger. So again, it's not all of this clot but it's a bigger clot, perhaps one that you can see a little bit -- uh -- here as it's moving out to the lungs it gets stuck here, so it's a bigger clot.

However, even at the morning of the 27th his blood pressure is okay. Okay. So, in the morning if you had treated him with full dose anticoagulation, full dose blood thinners the results are -- are identical to what would have happened if you had treated him on the 26th, beyond a reasonable degree, or based on a reasonable medical probability -- uh -- he would have survived; and again, if you look at the hospital stay, and then 99 to 100% and then the percentage drops a little bit at one year because now his clots are bigger and that can affect you down the road. But as far as immediately, still as you can tell I mean it would have been uncommon, it would have been unlikely for him to -- to die from that clot even a year after.

Q. The afternoon and here's what the summary was from Dr. Edwards' note and then from the nursing note -- uh -- blood pressure down to 90s, and 70s and you can tell us what that means and -- and explain to us what's going on?

A. Right. Well, I mean now we're seeing the effect of a bigger clot, one that's bigger than when his color just

changed. And, if you look at this diagram we didn't talk about this, but there are two -- two sides to the heart, one pumps blood to the lungs which is that filter. Blood has to come through the lungs and get to this side of the heart and then the blood is ejected to the rest of the body.

Your blood pressure is based on the ability of this part of the heart to pump blood throughout your body. It -- it can only pump what it receives. So, blood has to get through the filter to this side of the heart and then it's pumped throughout the body.

So, when you clog up the filter with larger clot, less blood is getting here so less blood can get out to the body. So, once you start to see a blood pressure change in the setting of these blood clots, it suggests these clots are getting bigger. They're growing from where they are. Blood is sloshing across them and they're -- they're kind of getting bigger. And as a result, that drop in blood pressure suggest that he had another, or an involving blood clot and we would describe that as a major -- uh -- or even massive blood clot at that particular time.

However, in patients who have even massive blood clots to the lung if you fully anticoagulate them, they more likely than not survive. Uh, so based on that, yes reasonable medical probability he would have survived.

The hospital stay the percentage drops a little bit, I

can't be more precise than this because I need x-ray evidence of what was going on in his heart to give you a better number. But by and large you can see these numbers are still in the 90% range as long as he gets appropriate blood thinning medication.

Q. Okay. Thank you. And now, and -- and what is your -- what would have been required by the standard of care in the morning and the afternoon of the 27th, sir?

A. It would have been the full dose blood thinner. We've got the term Lovenox here which I suspect we might just explain in a little bit, but we're essentially saying these are blood thinner medications. Now these are not the small doses that we use to prevent the clot. Once you have the clot, we give much bigger doses that's based on your weight. So, when I'm saying full dose, I'm talking about weight base dosing of these blood thinners.

Q. And -- and in effect when you have this full dose -- uh -- what is it really doing to the clots that are there and what does it due to the potential of new clots?

A. Sure. Well, these -- these blood thinning medications -- uh -- these are not synthetically made chemicals, either in the setting of -- of Lovenox or other blood thinning medicines. This is actually, believe it or not animal products. Uh, we get this from animals because we actually have a lot of these same chemicals in our body, it's part of our natural system for eating up clots if we have to. So, we give much larger doses

of something we actually have in some fashion in our body anyway and it causes these clots to shrink slightly. It prevents additional clot from building on top and it kind of causes the clot to stick to the wall. It kind of shrinks and sticks to the wall and then the rest of this clot for the best example I can give you is it makes it greasy.

So, I want you to imagine that you've got a clot and blood is washing over it. In the absence of the blood thinner that clot is sticky so as the blood cells go by it grows. It gets bigger as everything kind of piles on. In the face of a blood thinner not only will the clots shrink but it gets greasy. The blood cells will go by it without sticking and making it get bigger, so it stabilizes the clot and it shrinks it.

Q. Now, what evidence was there in the record -- uh -- that Dr. Edwards considered -- uh -- a blood clot going to the lungs in his -- in his differential diagnosis on the 26th to the 27th?

A. Well, basically he thought something was going on but he didn't know exactly what it was and he was very concerned about getting an x-ray picture of the abdomen because he thought that this was related to infection or -- or some other process. So, it doesn't appear at that time, based on the chart documentation that it was high on his suspicion list.

Q. And, Doctor, what is your opinion, or what would your opinion be in terms of whether, if there was no consideration

of blood clots to the lungs on the 26th and the 27th? Would that have met the standard of care?

A. It would not.

Q. Okay. Let's -- let's go on to the 28th. Uh -- and -- this is -- uh -- well -- can you -- can you remember the events --

A. -- sure --

Q. -- of the 28th well enough, 11 o'clock in the morning?

A. Sure. Well, basically on the 28th in the morning he goes for the CAT scan that Dr. Edwards had ordered the previous day to kind of investigate why his blood pressure was falling and so forth.

Uh, he went to the CAT scan, it did not show any evidence of -- of bleeding or anything of that nature, but when Kenneth got back from the CAT scan -- uh -- he was very short of breath; his blood pressure was low again. And, in fact, I didn't mention it but later in the evening on the 27th, he actually started requiring oxygen, supplemental oxygen beyond the oxygen in the air, and he needed it even when he was lying in bed.

So, again, if you look at this progression he went from the 26th where he had bad symptoms when he was up walking around, but his oxygen level was fine. On the 27th he had a color change and he was short of breath, but when he sat down everything got better again. By the evening of the 27th he

required oxygen even when he was lying in the bed. By the 28th, the next day after the CAT scan now he's needing even higher levels of oxygen even though he's not moving around and he's just in the bed. And that just suggest again as you look at this picture the clots are starting to extend because he doesn't have any blood thinner on board. The clots are -- are growing in this -- this -- this gunk is clogging the filter which means that it's harder than for the heart to get blood over here, which means it's harder to get oxygen to the rest of the body.

Q. Now -- uh -- what did Dr. Edwards do at 11 in the morning?

A. Well, he -- he -- once I -- he -- he had to -- the whole picture now, and now he's -- he's thinking of DVT, based on what he wrote in the chart. He's considering a blood clot to the lung and he's ordered a scan of his leg to look for clots in his leg.

Q. And what would the standard of care require?

A. Well, if you suspect clots to the lung, it's what I said before I came down here, you start treating with blood thinners while you're doing your test because if you don't do that you run the risk of the patient having the second clot and dying before you can even confirm your diagnosis.

Q. And had Dr. Edwards started blood clots going back to the -- the small chart?

A. So, basically from this point down everything is going to

look real similar because by this point he's already had what we describe as a major blood clot to the lung. The same thing is true -- here, in the absence of standing here and having you watch me write, it's going to be the same all the way down here to the 28th at 11 o'clock in the morning, all the way down to 2:40 in the afternoon when the result of the ultrasound confirmed that Kenneth had a blood clot in his leg. It's going to continue down till 5:30 in the evening, which is now when we're essentially giving fluid boluses, we're giving IV fluids for low blood pressure, and then again, now we get down to 8 o'clock, this is about 4 to 5 hours before Kenneth dies, and again, this is right around the time, even though we've got the result of the blood clot. We don't get -- we've got an order for blood thinners to be given and right around here is when Kenneth actually received at some point a dose of blood thinner; unfortunately, it was not the right dose. It was a low does.

Q. And on the first column on 11 AM, okay, yes, yes, yes.

Now -- Okay. Dr. Michota, at 8 o'clock at night when the blood thinner was finally given he would have survived the hospitalization in your opinion?

A. If he received appropriate blood thinning medication. And this is -- this is a very important point. All of our evidence, we -- we -- we have studies that look at patients with these different size clots and we -- we know what happens

to them; its been described in our -- in our writings and our textbooks and so forth. And the one thing that determines survival in blood clots to the lung is getting appropriate dose blood thinning medication and getting it before there's any strain on your heart.

Well, up until here, he had no evidence of strain on the heart so his survival was virtually assured, this 99 to 100% it's based on that. Once we go below this, he's having low blood pressure that suggests a strain on the heart that's why these numbers drop. But even in the setting of a strain on the heart people survive the hospital stay. They're far more likely to have problems down the road because they'll end up with a condition called pulmonary hypertension. They'll have some chronic problems down the road, but they live. They live.

So, it's certainly expected that if he'd gotten appropriate blood thinners, Kenneth Bieler should be -- still be here.

Q. Doctor, I'm going to just bring you a blank, the back of a blank and ask you to just use your red marking pen because the last subject that I really want to go over is Dr. Edwards prescribed half of a therapeutic dose of that Lovenox, that heparin drug --

A. -- correct --

Q. -- and -- uh -- his note says, he was concerned about kidney disease and -- and when you weren't in the court room

the day Dr. Edwards talked about the creatinines and so forth -- uh -- and we have Exhibit No. 8 which you can look at for the -- the series of creatinines, if you need it for this explanation.

A. Uh-huh.

Q. But tell us, discuss for us, please, the giving of half of the dose of Lovenox Kenneth's kidney function and the standard of care and how all that ties together, if that's not too complex of a question?

A. Okay. Well, I'll address the last part first. The standard of care requires that you give the dose correctly. It has to be given based on understanding how the drug works in your body, how the drug is eliminated from your body and what's the right dose for the weight of the patient or other circumstances surrounding the patient. And the FDA, when they approve medications to be used in the United States they all come with a big pamphlet on the inside of the package, it's called the package insert and it tells physicians how drugs are supposed to be administered appropriately. So the standard of care requires they be administered appropriately.

The treatment of Lovenox, or the treatment with Lovenox for a pulmonary embolism is one milligram per kilogram of body weight to be given in subcutaneous shots twice a day.

Q. Can you translate that?

A. So, Kenneth Bieler was 122 kilos, or somewhere

thereabouts, okay, 260 to some pounds. That means that he should have received 120 milligrams of this drug injected into his skin twice a day.

Now by doing that -- I'm going to draw you a graph. This is concentration and this is time.

Q. Concentration in?

A. Of drug.

Q. In the?

A. Don't even go -- don't make it more complicated than that.

Q. Yes, sir.

A. Just think about this is the amount of drug in your body. I inject it into you, it's going to go up until I reach whatever the total dose is that I -- I've given you. Okay.

Then, the drug, if I don't give you any more doses it's going to slowly go away, until eventually it goes back down to zero.

Now for the treatment of blood clots there's a certain threshold dose that has to be met to prevent clots like this from growing and getting bigger. Okay. So, there's a maximum dose and then there's a dose, I'll call it a trough or a floor. Okay. So, there's a ceiling and there's a flood. We want this amount in our patient to treat the patient to prevent the clot from getting bigger. We don't want it to be higher than this because that puts the patient at risk of too much blood thinner and bleeding. We don't want it to be lower than this because

it puts you at risk for more clots. So, we want it to be right in this particular range. This dose and this dose frequency which is twice a day keeps your dose right in here.

If you give a dose that was given to Kenneth Bieler, which is a 60 milligram dose it will come up to here. Okay. But then as time goes by he falls below the floor. In other words, he's unprotected when he gets down here. Okay. So, while it's true that if you have kidney problems, and by the way Kenneth's kidney problems was not severe enough to effect the elimination of Lovenox according to the package insert. His kidneys never got bad enough for which you would have to change the standard dose. It's right out of the package insert of the drug. There was no reason to change this dose. This is the dose that he should have been on, and had he been on that dose he would have been in this therapeutic range. Because his dose was lower he fell below the therapeutic range and unfortunately this is the key determinant to survival when you suffer blood clots to the lung.

MR. KEEVER: Okay. I think that probably does it for being up there, Doctor.

(WITNESS RETURNS TO THE WITNESS STAND)

Q. What is your opinion as to whether or not the record and the testimony that you've seen by a preponderance of the evidence shows any medical reasons to have withheld blood thinners during Kenneth's hospitalization?

A. There's no evidence that blood thinners should have been withheld.

Q. And what is --

A. -- And -- and I should go on to say that they clearly were not withheld when finally Dr. Edwards considered that this must be a blood clot to the lung. Now granted he didn't use the appropriate dose, but the bottom line was he wasn't concerned at that point in using blood thinners. He still used them. So, I -- I don't understand why they weren't used in this case.

Q. And -- uh -- what is your opinion as to whether or not Dr. Edwards' failure to meet the standard of care on -- I won't go through all of them but on the occasions of which you've testified was a proximate cause of the death of Kenneth Bieler?

A. There's no doubt that the failure to use blood thinners appropriately in Kenneth Bieler for either prevention or for treatment is directly related to why Kenneth Bieler is dead.

MR. KEEVER; Thank you, Doctor.

Your Honor, I would ask that the three posters be marked as exhibits and offered into evidence?

THE COURT: Any objection?

MR. COX: I think they're demonstrative only, Your Honor, and I object on that basis.

THE COURT: Come up a minute.

(SIDEBAR CONFERENCE OUT OF THE HEARING OF THE JURY AS FOLLOWS:

MR. COX: They're demonstrative only.

THE COURT: I'm not going to admit it, it is demonstrative.

MR. KEEVER: The illustration?

END OF SIDEBAR CONFERENCE.)

MR. KEEVER: Ms. Warren, are we up to Number 9?

COURT REPORTER: Eight.

MR. KEEVER: Oh, we're up to Number 8 on Plaintiff's.

Thank you, Your Honor.

MR. KEEVER: Dr. Michota, thank you very, very much and I will pass the witness at this time.

THE COURT: All right. Mr. Cox.

MR. COX: May I take the exhibits down, Your Honor.

THE COURT: Sure.

MR. KEEVER: Oh, certainly.

CROSS EXAMINATION

MR. COX:

Q. Good afternoon, Doctor.

A. Good afternoon.

Q. You and I have met on two different occasions in Cleveland, Ohio, have we not?

A. That's true, yes we have.

Q. In two different cases, one -- this being one of those two

cases?
A. That is correct.
Q. In about 2010 you were an expert witness against a doctor of internal medicine in Bentonville/Rogers, Arkansas, correct?
A. That is correct.
Q. That case did not involve any blood clot disease, did it?
A. Not that I recall.
Q. It involved a colon issue where the colon twisted on itself, did it not?
A. That's correct.
Q. And it was your opinion there that that internist had violated standard of care in not recognizing or appreciating the kink in the colon, correct?
A. Well, if I recall correctly it was more because he didn't do appropriate testing which would have revealed the kink. The kink itself actually is a very uncommon thing that I wouldn't have expected a physician to know necessarily up front, but if appropriate steps had been taken with appropriate testing it would have become apparent.

MR. KEEVER: May we approach, Your Honor?

THE COURT: Sure.

(SIDEBAR CONFERENCE OUT OF THE HEARING OF THE JURY AS FOLLOWS:

MR. KEEVER: I have no objection to this line of questioning it doesn't go to the facts

[INAUDIBLE]

MR. COX: Your Honor, I'm not going to touch that.

THE COURT: All right.

MR. KEEVER: Yes, sir.

END OF SIDEBAR CONFERENCE.)

CONTINUED CROSS EXAMINATION

MR. COX:

Q. That case and this case are two cases here from Arkansas that you have reviewed and given expert testimony in, correct?

A. That's correct.

Q. Have you looked at any other cases from Arkansas?

A. Uh -- there -- there have been a couple of cases, at least one or two that I've talked to Mr. Keever about, but I don't recall any others off the top of my head no.

Q. And I'm not entitled to know the names of those cases, but there are two other cases that Mr. Keever's asked you to look at and you've agreed to do so, correct?

A. Uh, actually I think it was -- it hasn't even raised to a level of looking -- its been a conversation really. But I'd be happy to do so, if he wanted to sign me the cases.

Q. All right. He's asked you to and you're willing to do so, correct?

A. If -- if he's asked me I'd be happy to do so.

Q. And, Doctor, you do -- uh -- provide expert witness

testimony on a fairly regular basis, do you not?
A. That's correct.
Q. When I took your deposition in this case back on October 7, 2011 you gave me an exhibit which we attached to your deposition in which you listed 42 cases in which you had either given a deposition or had given trial testimony, correct?
A. That's correct.
Q. And I'm going to put this on the Elmo in a moment, but this list, 42 cases show that 35 of them were cases in which you gave testimony on behalf of a patient suing a doctor, correct?
A. That's correct.
Q. And 7 of those were cases in which you provided testimony on behalf of a physician or hospital?
A. That's correct.
Q. And of those 42 cases you put an asterisk by 4 of them and you indicated that those were pulmonary embolus cases, correct?
A. Yes I believe I did that for your benefit.
Q. Would you take a look at this and agree that this is Exhibit 1 to your deposition which was a listing of your cases through some point in 2010?
A. Yes that's correct.
MR. COX: I want to put this on the Elmo so we can talk about it in a little more detail, Doctor.
Q. Now, the 4 cases that have an asterisk are cases which you

designated as pulmonary embolus cases, correct?
A. That's correct.
Q. And in the first 2 you testified on behalf of a plaintiff, and where were those cases, would you scroll over to the side there?
A. Uh -- Greenville, Pennsylvania, and somewhere around Washington, DC, Virginia Commonwealth.
Q. Somewhere in Virginia, correct?
A. Correct.
Q. And go down to the other two here. And the first was again on behalf of a plaintiff and that case was in Chicago, correct?
A. That's correct.
Q. And then the fourth and last case was on behalf of a defendant and that was in Canton, Ohio your home state, is that correct?
A. That's correct.
Q. Since 2010, Doctor, how many cases would you add to that list of 42 cases?
A. I don't know the number exactly, it's probably somewhere on the order of 15 to 20 perhaps.
Q. Okay. So, if we added 42 and 15 that's 57 cases, correct? Total?
A. If your math is correct yes.
Q. My math is terrible but I think that's correct.

A. I -- I think that's about right. I mean I -- obviously I don't have the -- I actually have an ongoing list that I could have brought but I think that's about right.
Q. Okay. How many additional of those cases are pulmonary embolus cases? Do you know of any?
A. I honestly, I -- I don't know off the top of my head. There may be one or two I'm not sure.
Q. And in those cases did you testify on behalf of a plaintiff or a doctor?
A. Again, if they're on that list I actually don't recall.
Q. All right.
A. There haven't been any -- there haven't been any -- uh -- blood clot trials. I generally remember them if they've gone to the trial stage, but I can't remember deposition -- if that was part of it.
Q. Doctor, I guess my point of this is that you not only testify as an expert witness in pulmonary embolus cases but also in a broad variety of other cases involving internal medicine, do you not?
A. That's correct I do.
MR. COX: And you told -- you can take that down, David. Thank you.
Q. You told Mr. Keever that you charge $500.00 an hour, is that correct?
A. That's correct.

Q. How much time would you estimate that you have spent all together on this case?
A. Over -- since 2010?
Q. Yes, sir, from the beginning?
A. -- Uh, probably leading up until the actual time I left Cleveland to travel here its probably been 12 to -- 12 to 14 hours perhaps.
Q. Some seven thousand dollars plus before you left Cleveland?
A. That's correct.
Q. And what -- what are your charges for coming to Van Buren, Arkansas and testifying in this court room?
A. It -- it's the same hourly charge, it just caps at an 8 hour day. So, it's -- it's a $4,000.00.
Q. Okay. So, have you charged for two days coming down and then all day here today and going back this evening I assume?
A. It will be two days if I leave here in time to catch my flight home today; otherwise, it will be tomorrow as well.
Q. All right. With another day's charge I assume?
A. That's correct.
Q. And, Doctor, I assume that your charges that you charge for reviewing cases and testifying depending upon the complexity of the case that's -- this is kind of an average case for you, isn't it? Terms of hours spent?
A. No I wouldn't agree with that. I mean most of the cases

don't go to trial. Many cases I review don't even go to a deposition stage. We review the records and either things are settled or there's not, there's actually not, you know, I'll tell the attorneys that I don't see anything here that I can, you know, help you with and so on and so forth. So, I would actually say that's not -- that's not average.

Q. Doctor, how much of your professional time do you spend in serving as a reviewer and then testifying in medical malpractice cases?

A. Well, if you add the testifying part it's going to be less than probably 10% of my time.

Q. Let's lump it all together, testifying, review, talking to attorneys, how much of your professional time is spent in doing that sort of activity?

A. Well, again, it's still gonna probably be less than 15% of the time, it depends, again, it depends on how you define the professional day. I mean most of my day I'm spent seeing patients but -- uh -- if you count everything I do as a physician it could stand 15 or 16 hours a day.

Q. Dr. Michota, is this your first trip to Arkansas?

A. Yes it is.

Q. Have you done any sort of investigation or inquiry as to the practices among doctors in internal medicine anywhere in the State of Arkansas?

A. You mean outside of the Van -- this area?

Q. Yeah, outside of this case here?
A. Uh -- I may have as it related to the other matter you mentioned, the Drews case.
Q. Okay. All right. And that other case did not involve deep vein thromboses or pulmonary emboli, did it?
A. No I don't -- I don't believe it did.
Q. And I guess I should have been more precise in my question. Have you made any inquiry among the doctors in internal medicine here in the State of Arkansas as to their practice patterns with regard to the diagnosis and treatment of deep vein thrombosis or pulmonary embolisms?
A. I -- I have not specifically spoken to physicians from this area about that issue no.
Q. Now, you base your opinions in large part upon the 2008 chest article about the prevention of -- of venous embolic diseases, correct?
A. Well, I base it on the evidence for which the chest guidelines were created for both prevention and treatment.
Q. But it's what is in that article in terms of recommendations that you base the substance of your opinions on, correct?
A. Again, I -- I would say that I'm basing my opinions based on the evidence which created the recommendations and the guidelines. It's not the -- the words of the guidelines is not what I'm basing my opinions are. It's the evidence behind the

recommendations that I'm basing my opinions on.
Q. I don't want to quibble with you and parse words with you, Doctor, but the guidelines are the guidelines that recommend to a doctor what to do, correct?
A. Yes, based on the evidence that forms the basis for how reasonable physicians practice. Yes.
Q. And it's your belief and opinion that because Dr. Edwards did not follow those guidelines he violated standard of care?
A. He didn't follow the evidence surrounding the issue of blood clots that's why he deviated from the standard of care as outlined by both Dr. Daniels as well.
Q. Doctor, he did not follow the guidelines, did he, in your opinion?
A. Well, he didn't. No he did not follow the guidelines and as such he didn't follow the evidence for which the guidelines were created. We're saying the same thing I think.
Q. Well, I think we are too, but I -- I don't know that you're willing to admit that it's the guidelines themselves and the evidence supporting those guidelines that you believe sets the standard of care?
A. In this particular case, the evidence as applied to Kenneth Bieler as an individual patient the standard of care was not met. The guidelines are not the end all be all and I've never testified or represented that they were. It's the issue that he didn't follow the evidence for which the

guidelines were created. He didn't follow the evidence and apply it to Kenneth Bieler in a reasonable fashion, that's why he didn't follow the standard of care. It doesn't have anything to do with the guidelines per se.

Q. All right. Okay. And there are no exceptions in your mind in this case that would have allowed Dr. Edwards to refrain from using blood thinners in Mr. Bieler's case?

A. No I don't believe there was.

Q. Now, Dr. Edwards was in the trenches taking care of this patient whereas you have the benefit of hindsight, you know the outcome and you can look back in retrospect and say what should have been done, correct?

A. That's -- that's one possibility but I think -- uh -- all of us who review these sorts of cases do our best to put ourselves in the moment and try to evaluate the reasonableness of care based on what was available to the physician who was in the trenches at the time. Obviously I'm not there and -- and -- what's known as confirmation bias there -- there's a risk of that, but obviously we -- we try to say well what would -- what would in fact be the right thing if we had only known what the physicians knew at the time.

Q. And you would agree would you not, Doctor, that your having the benefit of knowing what happened in this case from start to finish helps you assess this case and form your opinions?

A. Well, it certainly helps form the basis of causation because we have an autopsy and I can piece together the chart exactly what happened, but its got nothing to do with whether or not at the moment in real time whether it was appropriate to skip the prevention of DVT in a patient like Kenneth Bieler. Whether it was appropriate given the signs and symptoms of a blood clot to the lung to not give appropriate dosing of blood thinners. That has nothing to do with what I know happened at the end. If Kenneth Bieler was alive today and someone said, Dr. Michota could you evaluate this chart and tell me what you think about the standard of care that was followed. I would say well Kenneth Bieler got lucky because he survived. So, that has nothing to do with knowing what happens at the end. You evaluate how things proceed based on the knowledge you had at the time and Kenneth Bieler was a high risk patient. He should have had blood thinners to prevent his blood clots.

Q. All right. But let's -- let's talk about Mr. Bieler for a moment. You agree that he was a very complex medical patient?

A. I think that he was certainly. Most patients we admit to the hospital today require the alerted physician to take care of them, everybody's complex.

Q. Well, Mr. Bieler had more than his fair share of complex medical issues, did he not?

A. I don't know what you mean by fair share. I agree he's a

complex patient.
Q. And you told me in your deposition, I assume you still agree, that Dr. Edwards did many things right in this case?
A. Yes he did.
Q, And he, I think you told me the only thing that he failed to do was to assess for the risk of DVT and to start preventative treatment with the use of blood thinners?
A. I -- well no I went beyond that. I don't think that I remember saying it was the only thing that he did wrong. But I think what I testified to was that unfortunately one of the things that he failed to do was what killed Kenneth Bieler. So, it's great that he did so many things right and he -- he -- uh -- obviously he had a complex patient and -- and took care of him in a way that I would expect an internal medicine specialist to do. But unfortunately he forgot to give preventative doses of blood thinner. He failed to treat Kenneth Bieler when he had signs and symptoms of the blood clot to the lung and he had delayed inappropriate doses of blood thinner then and that's what caused his death. So, everything he did right really doesn't factor into the equation when in fact the thing that he did wrong is in fact the reason that Kenneth Bieler is not here.
Q. Doctor, I understand that and I don't believe that was my question. Dr. Edwards was -- gave a lot of attention to this patient, did he not? He saw him on a regular basis. He was

there every day, correct?
A. Correct. I -- I -- I have no -- uh -- criticisms of -- of Dr. Edwards -- att -- attentiveness to the patient.
Q. And he was dealing with a number of medical issues, anemia. He was dealing with what could have been a very serious abdominal condition, correct? You'd agree with that?
A. Well, I - I think his -- his colonic dilatation and his bowel dilatation was a serious abdominal condition, absolutely.
Q. And -- and potential --
A. -- He was very sick when he was admitted.
Q. Yeah, and his abdominal condition potentially -- uh -- could have caused him to undergo surgery?
A. It's -- it's possible. Again, I -- I don't think that that was a big issue as it relates to the blood thinners as I've already testified. Yes I agree he was complex and there were a lot of issues that -- uh -- that Dr. Edwards had to attend to in addition to try and prevent blood clot.
Q. And, you would agree that his renal status went up and down in this case?
A. It did.
Q. And he -- he had some -- some significant issues with his kidney function, did he not during that admission to the hospital?
A. Yes absolutely he did.
Q. He had liver issues too also didn't he?

A. Yes he did.
Q. He -- he had elevated glucose levels that had to be treated?
A. He had uncontrolled blood sugar as well, yes.
Q. And, can you say whether he did or did not have diabetes?
A. Well, he had hyperglycemia in the hospital. I don't recall from his Cooper records whether he carried the diagnosis of diabetes, but it's not uncommon in hospitalized patients to have hyperglycemia. We don't typically call that diabetes unless it reaches a certain threshold or persists for a certain period of time.
Q. But it was sufficient to require the use of insulin, correct?
A. No that is true.
Q. There was a central line placed to give him parenteral feedings?
A. Yes.
Q. That's -- that's a major step, major treatment isn't it?
A. I'm not sure I know what you mean by major. It's appropriate.
Q. Well, let's not -- that's not done lightly is it, Doctor, in patients?
A. I -- I don't think there's anything we do to patients in the hospital that's done lightly. There has to be a benefit over the risks as I already testified the mere fact he had a

central line actually increased his risk for blood clots. But I still think it was appropriate that it was placed, and that total parenteral nutrition was given, given the fact that he wasn't able to eat a worley because of the abdominal condition. None of that makes -- uh -- none of that lessens the requirement under the standard of care to address the prevention and treatment of blood clot.

Q. Doctor, do you subscribe to the Annals Of Internal Medicine?

A. I don't receive any paper journals to my house, everything is available to me on-line at the computer at my hospital.

Q. Do you read that publication periodically?

A. Yes I do.

Q. And it's published by the American College of Physicians, correct?

A. That is correct.

Q. Of which you're a member?

A. And a fellow, yes.

Q. And, I assume you're aware that in September of 2008 the Annals of Internal Medicine published an abbreviated version of the recommendations in the chest study that was published, I believe in June of 2008?

A. Correct.

Q. And do you recall on the very first page of that article that it said, "the information contained herein should never be

used as a substitute for clinical judgment"?
A. That's correct, I'm familiar with that phrase certainly.
Q. And do you -- do you dispute that clinical judgment -- uh-- trumps the information in this case?
A. I don't know what you mean by trumps the information, I --
Q. -- Well, do you agree with the statement that the information contained herein should never be used as a substitute for clinical judgment?
A. I think I said almost the exact same thing when I said the guidelines are not to be followed blindly. That you have to take the evidence for which the guidelines are created and apply it to your individual patient. And that's what that statement means to me. We don't want physicians to -- uh -- read a recommendation and a guideline and apply it blindly without any judgment.
Q. Doctor, is it your belief and opinion that any doctor in this country who does not follow the evidence based recommendations of the American College of Chest Physicians is practicing beneath standard of care as it relates to venous embolic diseases?
A. Well, the -- the evidence that forms the basis for the American College of Chest Physician guidelines is not owned by the American College of Chest Physicians. The truth is the truth. The evidence is the evidence. The ACCP simply took that evidence and boiled it down into small digested little

bites of recommendations that have to be applied to the individual patient.

It is my opinion that if physicians don't follow our lines of evidence, as we would expect reasonable physicians to do, they are in fact in breach of the standard of care as a general rule. But we have to talk about individual patients and individual circumstances if we're really going to have a useful discussion about whether or not standard of care was met or not.

Q. All right. But it's the recommendations, and I don't want to misquote you, it's the recommendations of that study that you believe -- excuse me, the evidence in that study that you believe a physician is obliged to accept and follow in treating a patient who is, that you're trying to prevent a venous embolic disease?

A. I'm sorry, I might have lost what you said in the words. Uh, I -- I don't know why using the word obliged and so forth, I think I've said --

Q. -- mandated, you used the word mandated, can we use that word?

A. I'm sorry?

Q. Can we use the word mandated, you used that word earlier?

A. Well, the individual circumstance and the application of the evidence is what mandates -- uh -- so again, it's not -- it's not the guideline, it's not -- it's not the words on the

paper, it's the evidence behind it. It's the -- it's what we've learned in multiple clinical trials, multiple studies. We -- we didn't talk about it with the jury but there's grades of evidence --

MR. COX: -- Your Honor, this is not responsive to my question. I would ask that --

THE COURT: -- All right, wait until he asks you a question.

Q. Doctor, let me see if I can ask it so that you'll agree with me. It is your opinion, is it not, that any physician who is treating a patient at risk for developing venous embolic disease is mandated to follow the evidence based recommendations that you have talked about here today?

A. They're mandated to follow the evidence for which the -- the guidelines have been created, and it has to apply to your individual patient. So, in patients who are at risk for venous thrombo embolism it's mandatory that physicians consider the risks. It's mandatory that physicians then apply the evidence and pick a strategy that's commensurate to the risk of the patient, and it matches the evidence behind what works and what doesn't work. Yes, that is mandatory in my opinion.

Q. All right. And, Doctor, tell me the results of your review as to the percentage of patients who should receive prophylaxis for venous thrombic disease, who actually receive those recommended treatments?

A. Well, that -- that's been a basis for -- uh -- much of my work within the coalition to prevent DVT is that there's a gap between where our evidence is and people actually getting the treatments that we know over 20 years or longer actually work. And it -- and it's part of the reason why we've worked within the Joint Commission and other regulatory bodies to --

MR. COX: -- Your Honor, my question was what percentage, that's what I asked him, what percentage based on his study actually receives the recommended treatment.

A. My answer to that is I don't know what study you're referring to then.

Q. Well, what have you written, Doctor, in terms of who or what percentage of patients who should receive prophylaxis who actually do receive prophylaxis?

A. Again, I -- I've not performed an individual study myself. I've written plenty of articles that summarize existing evidence and then I too make recommendations in my articles as far as what the appropriate treatment plan is or so forth. So, you're referring to an individual study of mine, I don't know what you're talking about.

Q. Doctor, I'm not referring to any study I'm referring to a writing or a publication that you have -- have presented, did you give an oral presentation and have you written as late as October, 2009, 7 or 8 months after Mr. Bieler's death, that the

study begs the question of why the percentage of patients at risk for a VTE who were given prophylaxis was still so low (34%) demonstrating how much progress in improving practice remains to be achieved. Do you remember writing that?

A. Again, you're -- you just pulled out a paragraph out of I don't know, why don't you just show me the article and I'll be able to answer your question?

MR. COX: We'll let's do that, 546.

Q. Doctor, is there a medical journal published by the Cleveland Clinic called the "Cleveland Clinic Journal of Medicine?"

A. Yes there is.

Q. And do you from time to time contribute to that journal?

A. Yes I do.

Q. And in November of 2009 was there published in your clinic's journal an article written by you entitled, "Prevention of Venous Thrombo Embolism After Surgery?"

A. Yes, that was based on a -- a live presentation at a national conference. But yes.

Q. Well, I know it was based on a conference but it was taken -- it was printed, or a manuscript was made from the transcript of that conference, was it not?

A. That is correct.

Q. And you had a chance to edit it, correct anything in it before it was published, correct?

A. Yes. I believe what's in there is accurate, I just don't remember the individual passage you're referring to. I didn't understand what it is -- if you'll just show me what it is I'll be happy to address it --

Q. -- I -- I -- Doctor, I'm -- I'm getting there. I had to ask you first all if you had said that. And let's go down and just to be clear on what the date is, it's down at the bottom. Doctor, let's -- let's go to 547. And let's go down, start with this paragraph because it continues over on the next page. You are discussing strategies to promote the best practices for the use of these drugs to prevent DVTs and pulmonary emboli, correct?

A. Well, this -- this talks about different strategies to help physicians to not forget to give preventative -- uh -- methods for blood clot.

Q. Well, and that's what I said, strategies to promote best practices?

A. Well, right, but it's not about what you use, it's how you remind the physician on what to use.

Q. Doctor, I understand that --

A. -- oh, okay.

Q. -- and I'm not suggesting otherwise. But if you'll look, go to the paragraph here. In the first full paragraph you're talking about an alert system which some hospitals have put into place, correct?

A. That is correct.
Q. And there -- there's a long paragraph about that and then let's focus on that last paragraph, that's the one I read just a little bit ago.
A. Now, I'd be happy to explain that now if you give me the latitude to describe what the study was about.
Q. Doctor, I'm just asking you, did you say in that article that the percentage of patients at risks for developing a venous thrombotic embolism -- uh -- who were given prophylaxis was still so low (34%) demonstrating how much progress and improving practice remains to be achieved?
A. You -- you are so misconstrued you don't even know what -- up -- sorry.
Q. Doctor, I probably don't, but I -- I know what I'm reading.
A. No. And I'd be happy to explain it if you'll let me because if you're just asking me, do I agree that that's what that says. Yes. I'd be happy to explain what it means because this was a study at Brighman & Women's Hospital where they over a two year period of time collected records based on patients who did not receive prophylaxis. It took them two years to collect an adequate number of records because at Brighman & Women's 99% of the patients received preventative strategies.
So, over two years they identified patients who did not receive prophylaxis and then those records were randomized to

getting a computer alert to remind physicians, hey, your patient is not on prophylaxis versus usual care which is no reminder. The reminder system dramatically improved the rate of prophylaxis in this very small group that didn't receive prophylaxis in the first place. And my comment was, how unfortunate that even in the 2% that didn't get prophylaxis you remind the physician by a computer system and why is it that that reminder didn't drive that number to a 100%.

But the context is at Brighman & Women's 99% of the people got preventative strategies. This was the 1% where the doctors apparently forgot. The computer system apparently didn't fix that problem. It was a problem with the docs, not with the fact that they forgot.

Q. All right. Doctor, let's -- let's talk about your view about other folks involved in this case. Uh, you know the orthopedic surgeon prescribed an aspirin and Tedhose after surgery?

A. That's correct.

Q. And you take issue with that, do you not?

A. I don't believe that's the evidence based approach, no.

Q. Do you agree that in 2009 when Dr. Rhomberg gave that order or provided that treatment that that was the guideline of the American Academy of Orthopedic Surgeons?

A. Yes I'm aware of that.

Q. And do you know when and if that changed?

A. No it did not change.
Q. It did not. That's still their practice today?
A. Correct.
Q. So, they're operating in your opinion outside of the standard of care in their method of approaching prevention of a VTE?
A. I don't agree with that. I don't know if I would say that it's outside of the standard of care because I'm not orthopedic surgeon.
Q. But it's inappropriate or inadequate treatment in your opinion?
A. I would never refer a patient to a surgeon who provided that type of prophylaxis and I'm thankful to say that I have colleagues in Cleveland who otherwise use what I consider to be, and they consider to be, the appropriate evidence based approach in that regard.
Q. But, you're willing to concede that the governing body, the American Academy of Orthopedic Surgeons disagrees with your opinion about how these things should be managed?
A. I think what I'd say to that is the American Academy of Orthopedic Surgeons offered up their opinions on appropriate DVT prophylaxis in their patients. It's not necessarily under the same strength of evidence for which the chest guidelines were created. We differ on the strength of evidence. In this case as an orthopedic surgeon they're certainly entitled to

offer up whatever they think is appropriate.

Q. But you simply take issue with that?

A. I don't think it matches the lines of evidence, no.

Q. And, you also, did you not, tell me in your deposition that the family practice physician who took care of Mr. Bieler in the first admission to Summit Medical Center failed to follow those recommendations as well?

A. Well, he was -- he -- he was under Doctor, I think Neva is the name. He was under Dr. Neva's service or he was co-managing the patient with Dr. Rhomberg. So, again, the criticism would go across both.

Q. You would -- you would take issue with Dr. Neva's agreement with Dr. Rhomberg on how that patient should be managed?

A. No I didn't take issue with his agreement; in fact, that happens quite frequently. The surgeon is the one doing the surgery so they're the ones who are gonna decide whether blood thinners are given or not or how they're given.

Uh, I was just critical with, again, the fact that it doesn't actually match the evidence and it's why the chest physicians -- the evidence behind the chest physician recommendations is I know that you are aware actually recommend against the use of aspirin because there are most effective anticoagulants or blood thinners and they don't create as much bleeding. So, you know, again it's -- in that sense it's a

risk benefit equation and we differ on the -- on the answer.
Q. As a matter of fact you've written about that about the kind of disagreement between the American Academy of Orthopedic Surgeons and -- and -- and the -- the -- study that we're talking about here today and the evidence based information in that study, you've written about that and you take issue with, or disagree with the orthopedic surgeons and say they're wrong, don't you?
A. I don't disagree with the orthopedic surgeons I work with in Cleveland. I disagree with the American Academy of Orthopedic Surgeon practice guideline on the prevention of DVT. Or prevention of PE, excuse me.
Q. The recommendations in the chest article do recommend the use of blood thinners in a patient such as Mr. Bieler who had the same fracture and surgery that he had, correct?
A. Correct.
Q. The orthopedist just disagree with that, don't they?
A. The American Academy of Orthopedic Surgeons and I guess what I represent the AOS has a certain group -- uh -- it certainly by no means considered -- uh -- uh -- what's the right word. It's not generalizable to the orthopedic community at large. There were orthopedic surgeons, particularly Dr. Cliff Coldwell who participated in the chest guideline who actually at the time in 2009 was wholly supportive of using blood thinners, not aspirin, for the prevention of DVT in hip

fractures. So, it's certainly not all orthopedic surgeons.
Q. And I've asked you only about the Academy not individual doctors within that Academy, you understand?
A. Oh, well, Cliff Coldwell is in the Academy of Orthopedic Surgeons. So, as a group there were several physicians as part of that Academy who wrote that position paper representing the entire Academy when in fact that wasn't the agreement of the entire Academy.
Q. Doctor, have you written that doctors who are treating a patient with renal insufficiency should use caution when administering blood thinners, such as Lovenox?
A. Yes.
Q. It's not a drug to be given lightly in a patient who has renal insufficiency, would you agree?
A. I would agree. Although, we should probably define what we mean by renal insufficiency.
Q. Well, renal insufficiency is that not described by an elevated creatinine level?
A. Well, there's certain levels. When you say renal insufficiency in the article that I think that you're referring to that I wrote with Gene O. Merli it relates to certain degrees of renal dysfunction. So, not all bumps in creatinine reflect the renal insufficiency definition that you're suggesting that was in that article. It's a creatinine clearance that's approaching 30 cc's per minute or less.

Q. Doctor, were any of the studies upon which the recommendations of the American College of Chest Physicians based upon any group of patients whose creatinine level was 2. and higher?

A. I'm sorry, are you asking me if out of any of the 750 references in that chapter did some of them involve creatinine that were --

Q. -- do you know if --

A. -- yes.

Q. Does your clinic also have a pharmacy publication that comes out periodically?

A. I suspect they do, yes.

Q. Okay. Do you know whether or not it has commented that none of these studies involve patients whose creatinine levels were greater than 2?

A. Again, I -- I think you're -- you're mixing information again because if you ask me are there any clinical studies involving the use of lomo equate heparins in patients with abnormal kidney function, particularly that are represented in the chest guidelines the answer is yes. Has there been direct clinical randomized trials taking a sub set of patients who have renal failure, or have creatinines greater than 2, has that been specifically studied the answer is no. So, you're mixing apples and oranges as far as what evidence is out there. There's plenty of evidence on how to use lomo equate heparins

in renal insufficiency. But its never been the purpose of an individual study which is what the pharmacy guideline is speaking to.

Q. Doctor, have you written -- have you made the statement that optimal dosing of lomo equate heparin therapy has not been established for patients with morbid obesity or renal insufficiency?

A. Correct.

Q. I take it, it is your position that Mr. Bieler did not have renal insufficiency?

A. He didn't based on that's -- there's a certain degree of renal impairment that has to exists for that term renal insufficiency to apply the way you're using it. So, it has to be a certain level of -- of kidney dysfunction, any amount of dysfunction past normal could be called in a layman's term renal impairment or renal insufficiency. But you have to get to the point where the kidneys filter so poorly that the word implies what you're -- the -- the -- the articles that I've written are speaking to. And in this particular case, Kenneth Bieler's creatinine wasn't high enough, his kidneys worked well enough there was no reason he couldn't use the standard recommended doses that was in the package insert for the drug.

Q. All right. What is the medical definition of renal insufficiency?

A. Well, it's kind of an in precise term. I mean we use --

we use now we use terms called acute kidney injury and chronic kidney disease and we stage it by certain levels of -- of kidney dysfunction. So, renal insufficiency is a very kind of broad and needs to be clarified in terms of what you mean.

Q. In this case you agree that Mr. Bieler could not receive contrast, a contrast medium because of his, what was perceived to be renal insufficiency?

A. I agree with that. At -- at -- at certain points of his hospital stay. I mean his creatinine was essentially normal at some points but when he was initially admitted his creatinine peaked, I think at 4.2 and any creatinine greater than 2 generally we don't give contrast, intravenous contrast because of the risk of further kidney damage.

Q. So at least from that standpoint he was considered to have renal insufficiency when it was 2. or better, correct?

A. Again, you're -- you're mixing the terms together. They mean totally different things. Yes, he had renal insufficiency.

Q. All right. Doctor, let's talk about the Tedhose if we might. Uh, it's your belief and opinion they provide no benefit, isn't that correct?

A. I don't believe they provide any benefit to a patient who's at high to very high risk.

Q. So it in your opinion made no difference whether Mr. Bieler had Tedhose on or not during his admission for that

second admission to the hospital?
A. That is correct.
Q. Now, don't you also agree that there are no studies which show that intermittent pressure cuffs are any better than Tedhose in preventing DVTs?
A. Uh, well, no it depends on the patients you're talking about. If you're talking about Kenneth Bieler there's no studies in medical patients that have shown conclusively that the mechanical device is actually working acutely on medical patients.
Q. Doctor, you are a sponsor or at least a participant in an annual seminar symposium that is held each year in either January or February or March, correct?
A. Correct. Are you talking about the perioperative summit? Yes.
Q. Yes. Yes. And you invite people to come and you're always on the program, are you not?
A. I'm one of the symposium directors, yes.
Q. Yes. And you invite people to come from time to time and participate and give presentations?
A. I do.
Q. And is a Dr. James Duketis from Hamilton, Canada one of the participants?
A. Yelp, he came last year.
Q. He was there in 2011 wasn't he?

A. Correct.
Q. And if one would go on the internet and find the website for that seminar symposium you'd be able to pull up some of the presentation slides and poster boards, couldn't you?
A. Yes.
Q. Do you remember last year Dr. Duketis had a presentation in which he discussed the relative benefit of IPC devices as compared to Tedhose?
A. Yes in surgery patients, yes.
Q. Do you remember what Dr. Duketis reported to the doctors who were in attendance?
A. I don't re -- I don't remember if he used any specific numbers no.
Q. Do you remember him saying that based upon a study of which mechanical method IPC versus graduated compression stockings that the result was you cannot conclude that one method is superior, do you remember that?
A. Correct. He was implying that actually both of them didn't work that well. He wasn't implying that graduated compression stockings were as good as the sequential compression devices. He was basically saying that sequential compression devices may be no better than graduated compression stocking.
Q. Doctor, that -- he doesn't say that, does he? What he says is, one cannot conclude that one method is superior to the

other?
A. No, but I was there, I'm telling you that what he's -- he was not suggesting that the graduated compression stockings were as good as mechanical leg squeezers. He was basically saying with the study that he talked about that the leg squeezers may be no better than graduated compression stockings which are not that effective.
Q. And that's your belief, neither is very effective, is it?
A. It depends on the risk of the patient. If you have a low risk patient those devices actually have been found to be very effective. In certain surgery population, such as knee replacement, the leg squeezers are actually very effective. But in a medical patient like Kenneth Bieler and a patient who is at very high risk, those devices are actually not known to even work. We use them as a default when we can't use what we know works which are the preventative doses of blood thinners.
Q. And, Doctor, I should have been precise. I was referring to a patient such as Kenneth Bieler and whether he had the Tedhose on or IPC cuffs made no difference, did it, in his case?
A. In terms -- in terms of the outcome it would be hard to know what benefit he would have received from those, that's true.
Q. -- Doctor, I notice in the various articles that you have published that you at the end give a disclosure and you say

that you have relevant financial relationships with the following commercial interest: advisory board for, is it Sanofi Adventis?

A. It was at that time, yes. Sanofi Adventis, correct.

Q. That's a drug company, correct?

A. Correct.

Q. Cios or Sios?

A. Correct.

Q. Is that a drug company?

A. Well, it's defunct now but it was.

Q. Okay. Uh, Johnson and Johnson, that's a drug company?

A. Yes.

Q. Genentech?

A. Genentech, yes.

Q. And you were on the speakers bureau of Sanofi Adventis and Genentech, correct?

A. Genentech, at that time yes.

Q. Doctor, do any of those drug companies sponsor the symposium that you have each year?

A. Oh, they -- we do receive unrestricted monies for the perioperative summit, yeah.

Q. Does the drug companies of which you have a financial interest now or in the past, have they supported you financially in -- in the studies you have done?

A. Yes. I've been a consultant with most companies that make

blood thinners and I am today.
Q. Okay. And which of the companies are you associated or affiliated with today that manufacture blood thinners?
A. Well, Janssen Pharmaceutical -- uh -- Boehringer Ingelheim; Daiichi Sankyo and -- uh -- well, Gillott and Otsuka are different, those would be the three that make blood -- newer blood thinners today.
Q. Some of these newer blood thinners have been on the market a relatively short period of time, haven't they?
A. That's correct. The -- yes, that's correct.
Q. Okay. And some of them are quite expensive, aren't they?
A. I couldn't even, I don't. Almost all new -- new medicines cost more than generic medicines. I couldn't even tell you what they cost.
Q. Do you know what the full dose of Lovenox cost in a hospital setting?
A. Well, it depends on the hospital and their -- their contract. I mean I am involved with the pharmacy and therapeutics committee at my hospital so we receive generic exnoaparin which is Lovenox for a little less than $30.00 for a 40 milligram dose. But what you pay out at a Wal-mart or what you would get charged for an insurance company could be a totally different amount.
Q. Do you know what it cost in this case for a 60 milligram dose of Lovenox for Mr. Bieler?

A. I -- I don't know what Summit Medical Center would have paid for it, but if it was, again, a full cost at a pharmacy it's usually a dollar per milligram.

Q. Doctor, it's in -- I understand your -- your -- your motives for -- for wanting to prevent folks from developing blood clots and pulmonary emboli, but the drug companies have a significant financial interest in seeing that that is done, would you agree?

A. They are for profit companies so I'm sure they do.

Q. And they make a lot of money off blood thinners, don't they?

A. Well, I -- Mr. Cox, I honestly don't know how much the blood -- the drug companies make on their jobs.

Q. Doctor, are you -- well, I'm not going to ask you. You receive significant sums of money from these various drug companies, do you not? For your work?

A. I -- I do have a portion of my income that comes from consulting and research, yes. Yes I do. I don't know what you mean by significant but yes I do.

Q. Well, only you -- you would know that and I'm not going to ask you how much that is, but it is substantial isn't it?

A. Again, I don't know what you mean by substantial but it's -- it -- I do make money from consulting. Yes I do.

Q. Okay. And that's paid for by the drug companies, correct?

A. In part, as well as by hospitals who invite me to speak.

MR. COX: That's all.

THE COURT: Mr. Keever.

MR. KEEVER: Yes, sir, and I'll be very brief I hope.

Ms. Warren, could Dr. Michota have that exhibit on the creatinine. And, Dr. Michota, I'm not going to ask you about that. I just want to ask you a few questions.

REDIRECT EXAMINATION

MR. KEEVER:

Q. The liver failure, did -- did Kenneth have some abnormal liver function studies, is that correct?

A. Yes. Yes he did.

Q. Okay. And Dr. Edwards has testified and I think Dr. Daniels has testified that they really didn't know what caused the liver abnormalities, do you recall that in the deposition testimony?

A. Yes.

Q. What's your opinion, what do you think caused the liver abnormalities?

A. Well, he had -- he had some enzymes that the liver will leak if it's inflamed and he had some additional chemicals that are detected in the blood when there's evidence of -- uh -- lack of movement from the gall bladder or bile salts through the gall bladder duct. This is all consistent actually with

Ogilvie Syndrome. Ogilvie's technically is just colonic pseudo obstruction, but we have seen cases where the dilatation spreads up into the small bowel, so it's the colon and small bowel and then it affects the biliary tree where the gall bladder and the bowel duct live which cause what's known as colon stasis, an absence of movement of bile salts and this inflames the liver and it causes an elevation in liver enzymes. So, it's my opinion that when he was admitted on the 13th he had evidence of colon static hepatitis, very mild, but it was related to an Ogilvie type syndrome.

Q. Okay. Now, Mr. Cox talked to you about that -- the strategies that -- that are being implemented and you've been advocating to have doctors be more active and more proactive and more aware, uh, could you tell from what you reviewed whether Dr. Edwards was aware of those strategies?

A. Well, I mean in his deposition he described himself as the chief of medicine at Summit, and that he was actually participatory on a committee that was looking to develop a guideline that would go in the chart of all admissions to Summit Medical Center where it would be required to assess for the risk of DVT, and you'd have to affirmatively document either a protective strategy with the reasons why you weren't giving a protective strategy.

Q. What is your opinion as to whether or not Dr. Edwards used with reasonable care that learning about prevention of blood

clot?
A. That he didn't --
MR. COX: -- its been asked and answered multiple times.
THE COURT: I'm going to allow him to answer.
A. He didn't use it.
Q. Okay. Now -- uh, Doctor, Mr. Cox had asked you about these guidelines and whether or not they represented the standard of care, in this particular case as applied to Kenneth Bieler, what was the opinion of yourself and Dr. Daniels in terms of whether those guidelines that we showed actually did represent the standard of care in this case?
A. They represented the standard of care.
MR. KEEVER: Thank you, Doctor, I appreciate it.
THE COURT: Anything else?
MR. COX: I have no further, Your Honor.
THE COURT: All right, you can step down.
Can this witness be excused?
MR. KEEVER: Thank you, Your Honor, we appreciate it, yes.
THE COURT: All right, you're free to go.
(WITNESS DEPARTS THE WITNESS STAND)
THE COURT: Counsel approach for a second.
(SIDEBAR CONFERENCE OUT OF THE HEARING OF THE

JURY AS FOLLOWS:

THE COURT: Here's kind of where we are in time. Tomorrow I have a full day of other court so there's no way we can continue this tomorrow. Thursday I have part of the day and my inclination is to start Thursday at one o'clock. I'm telling you before I tell the jury because apparently some of them will have to work tomorrow because we're not having court. So, I'm going to tell them and then I think we're going to take a break and they'll probably call in or whatever, but that's kind of where we are schedule wise.

How many more witnesses do you have today?

MR. KEEVER: I'm going to have two depositions to read.

THE COURT: How long are they?

MR. KEEVER: Well, they're only about thirty minutes a piece and then I figured I'd go in and start with my last witness, one -- at least one of my -- uh -- uh -- plaintiffs.

THE COURT: Okay.

MR. KEEVER: So, I figured I'd have to get into it.

THE COURT: So, you got two depositions and then one or both of them or?

MR. KEEVER: Probably just one I want to -- to hold the other one.

THE COURT: Okay.

MR. KEEVER: So, we won't be running too late tonight I don't think on that. Is that acceptable?

THE COURT: So?

MR. KEEVER: Then I'm going to end up with -- I have one, two, three, four fact witnesses. One is like a 38 minute deposition that's on video. Uh, one will be probably 15 minutes, the other two will probably be 30 minutes and then my last plaintiff, so hopefully we could do the rest of it in a half of day.

THE COURT: What do you have left? How long is your doctor deposition?

MR. COX: Well, my part is an hour and then Jim's part is two and a half hours.

THE COURT: So that video is about 3 hours?

MR. COX: Your Honor, just going by what he told me, David told me.

THE COURT: So, it's about 3 hours. And then what have you got after that? You're putting Dr. Edwards back on?

MR. COX: I'll put him back on for just briefly, it won't be 30 minutes, less than 30 minutes.

MR. KEEVER: If he won't be more than 30 minutes, I'm sure not going to be over 30 minutes.

THE COURT: So, sometime Friday we could finish probably, testimony.

MR. KEEVER: I think --

MR. COX: It would get our part, it depends on how much time he takes.

MR. KEEVER: My co-counsel thinks that I'm too optimistic and that I might not finish on Thursday.

THE COURT: Well, I'm just trying --

MR. KEEVER: -- it's going to be tight but --

THE COURT: -- I'm already anticipating we might even go until Monday so I'm just trying to add the time up to see. So, just want to let you all know that might be out there.

MR. KEEVER: You got to do what you got to do and we understand it, Your Honor.

THE COURT: Okay. All right.

END OF SIDEBAR CONFERENCE.)

THE COURT: All right, ladies and gentlemen, this is probably a good time for us to take a little recess. I'm going to give you a little more time, probably about 15 minutes.

I know there was some question, or maybe there was a question about where we're going to be for the

rest of the week and the trial and that's kind of what I'm trying to learn from the lawyers.

Tomorrow we are going to be recessed from this trial. I have some other things I have to take care and so for those of you that that might make a difference to that probably might mean working tomorrow at your other job.

Thursday we will be back in session on this trial at 1 PM Thursday afternoon. I have some other things I have to do Thursday morning so that kind of give you an idea where were are schedule wise. We're optimistic that we might finish Friday, but I would not -- I wouldn't take that to the bank right now. We'll just kind of see how it goes. But I wanted to go ahead and tell you all where we were at least for the next couple of days. So, if that has something to do with your plan or whatever, that doesn't mean you can leave right now because we're not finishing for today. That's just to give you an idea where we are maybe the rest of the week.

So, we'll be in recess for about 15 minutes.

BAILIFF: All rise.

(2:15 P.M. COURT RECESSES)

(2:37 P.M. OPEN COURT RESUMES)

THE COURT: Call your next witness, Mr. Keever.

MR. KEEVER: Your Honor, we will call Shawn Imhoof and we will ask to place his testimony in the record by reading his oral deposition and Mr. Swindle will come up and be Shawn Imhoof.

THE COURT: All right.

MR. KEEVER: We'll start on page 3. I have not done a deposition in the record like this, Your Honor, shall I read that he's been sworn and so forth?

THE COURT: How about we do it this way, how about I just tell the jury that it's the same as if he were here and testifying in person.

MR. KEEVER: Thank you, sir.

THE COURT: All right, go ahead.

MR. KEEVER: Are you ready, Mr. Swindle?

MR. Swindle: Ready.

ORAL DEPOSITION OF SHAWN IMHOOF

DIRECT EXAMINATION

MR. KEEVER:

Q. Would you give your full name for the record, please.

A. Shawn Ca — Shawn Carl Imhoof.

Q. Mr. Imhoof, I'm Jim Keever, and we were just introduced a moment ago. We have, I believe, had one brief telephone conversation in the past, is that correct?

A. That is correct.

Q. And would you just summarize that for us on the record, what you remember?
A. What I remember is I was off work one day and I got a phone call saying that there was a physician looking for some information about a patient, and essentially they said that it sounded like he was getting pretty upset so they wanted to transfer him to me. And I gave them my phone number, and I got his phone number and made the call, and reached you. And once I talked to you, you know, anything pertaining to that, I think I remember something about that. However, anything that needs to go through Mary Jo Brinkman.
Q. Okay, and I'm sorry if I let anyone think I was upset. That's -- but I appreciate that summary. Mr. Imhoof, have you ever given a deposition before?
A. Yes.
Q. And I won't go through all of the rules, but please make your answers audible, instead of uh-huh, unh-unh, or shaking your head.
A. Yes, sir.
Q. And if my question is not clear to you, would you let me know so I could rephrase it?
A. Yes, sir, I will.
Q. Good. I'll do my best not to have that happen. Now, would you give, tell us about your job description?
A. I am the director of radiology at Summit Medical Center.

I oversee the functioning of the department.
Q. How long have you done that, Mr. Imhoof?
A. About fourteen and a half years.
Q. Now, are you aware that originally the hospital was a named defendant in a lawsuit filed by the Estate of Kenneth Bieler?
A. Yes, sir.
Q. And are you aware that the hospital has since been dismissed from that lawsuit?
A. Yes, sir.
Q. And I'm going to show you a document which we'll mark as Exhibit Number 1. And these are the Answers of the hospital to what we call Requests for Admission. Have you seen this document before, Mr. Imhoof?
A. Yes, sir.
Q. Okay. And were you the one who provided the information for the answers in this document?
A. Yes, sir.
Q. All right. Now I'm just going to ask you some questions that are really going to track this. What documentation did you find that Dr. Edwards had contacted the radiology department on June 26th, 2009 regarding the possibility of performing a duplex venous ultrasound on Mr. Bieler?
A. I believe that's January 26th.
Q. I'm sorry. What documentation did you find that Dr. Edwards had contacted the radiology department on January 26th,

2009 regarding the possibility of performing a duplex venous ultrasound on Mr. Bieler?

A. I cannot find any documentation.

Q. Would there be any employee of the hospital or member of your department better qualified than you regarding the possibility of finding that documentation?

A. No, sir.

Q. Very good. Did your department have the equipment and staffing available on January 26th, 2009 to perform a duplex venous ultrasound on Kenneth Bieler?

A. Yes, sir.

Q. How about on January 27th? Was the equipment and staffing available?

A. Yes, sir.

Q. And I meant the 27th, 2009, of course. Were you personally on duty on, it says 6th, but meant 26th?

MR. KEEVER: Mr. Cogbill, I think you've got the date wrong.

A. January.

Q. January 26th?

A. You said the 6th?

MR. KEEVER: Mr. Cogbill, the 6th.

Q. I'm sorry, January 26th. Thank you.

A. I believe I was. I'm not positive, but I believe I was there.

Q. Well, if you weren't there -- were not there on January 26th, 2009, who would have been the senior technician or the senior supervisor of the department that would have been present?

A. Generally, I have an office manager who is not a technologist, but she's the one who grounds all phone calls and questions and they generally pass those off to me. Obviously, just like when I was off and took your phone call.

Q. Okay. Do you know whether you were personally on duty on January 27th, 2009?

A. I believe, yes, sir, I was.

Q. Are you qualified to do a duplex venous ultrasound?

A. Yes, sir.

Q. And who else in the department would have been qualified to do a duplex venous ultrasound on January 26th, 2009?

A. Can you rephrase that question, or repeat the question?

Q. Other -- other than yourself, who else in the department would have been qualified to do a venous duplex ultrasound on January 6th, 2009?

MR. KEEVER: Mr. Cogbill, 26th.

A. I'm -- I'm not for sure.

Q. Did -- am I still saying 6th?

MR. KEEVER: Mr. Cogbill, yeah.

Q. 26th, thank you.

A. I'm not sure who else was in the building on the 26th.

Q. How many members of your department were qualified to do a duplex venous ultrasound on January 26th, 2009?
A. January 26th, including myself, I believe there were three of us.
Q. Okay. And the same number on January 27th, 2009?
A. Yes, sir.
Q. Mr. Imhoof, do you recall being served a subpoena to testify at the trial in this case when it was scheduled for trial?
A. In January of 2012? Yes, sir.
Q. And did you receive notice that the trial had been continued?
A. Yes, sir.
Q. And do you understand that subpoena is still operative for the new trial date, which is the week of November 26th, 2012?
A. Yes, sir.

MR. KEEVER: I have no further questions. Thank you. You've been a great witness.

WITNESS: All right, thank you.

MR. COX: I have a few questions.

WITNESS: Yes, sir.

CROSS EXAMINATION

MR. COX:

Q. With regard to the Responses to Requests for Admissions back when you were asked to admit or deny that Dr. Edwards

contacted a member of the radiology department on January 26, 2009, regarding the possibility of performing a duplex venous ultrasound on Mr. Bieler, in order to respond to that, what investigation did you conduct?

A. In order to respond to that, with like anything, there's not any documentation ever of a verbal conversation held with another staff member. So, unless there is a written note saying so-and-so needs you or a call is transferred to me, there would be no, you know, way for me to get those, get a record of that.

Q. So, in other words, if Dr. Henry Edwards, whom I represent, had asked someone in the department, "Is there anyone here who can do a venous duplex today?" and was told no, there would be no record of that, would there?

A. There would be no record of that.

Q. And what if he had picked up the phone and just called the department of radiology and asked that same question? Would there have been a record made of that?

A. There would not be.

Q. Under what circumstances would there be a record made of that?

A. Under the circumstances, the staff would make a note if there were an issue or someone was asking for something that they didn't have the capability of doing. They would have made a note or, or transferred the call to me to try and make that,

you know, communication available so I would know what was going on and try to fix the situation.

Q. But if Dr. Edwards had simply asked someone verbally or picked up the phone and said, "Hey, is it possible to get a duplex venous ultrasound today?" and if somebody had told him no, there would be no record of that, would there?

A. No there would not be.

Q. And the same would be true if that same type of contact had been made on either January the 26th or January the 27th, correct?

A. Yes, sir.

Q. Now, do you recall there being a pretty severe ice storm in January of 2009?

A. Yes, sir.

Q. Did the hospital have some difficulty getting some personnel to work in the hospital?

A. Some personnel, just in general?

Q. In general, yes.

A. Always. Any time there's an ice storm, yes.

Q. Have you been able to go back and check the records at Summit to know whether or not the radiology techs and other personnel in the department were all there, present during that ice storm each day?

A. Yes, sir.

Q. They were there all day, each day?

A. I don't know that they were there all day, each day. You're talking about "they," meaning everybody?
Q. Yes.
A. I don't know that everybody was there all day, every day.
Q. Dr. Edwards has testified under oath that he was informed or knew that the tech who ordinarily did ultrasounds was not at work that day and could not do the test. Would there be a record kept of that sort of conversation if that had taken place?
A. No.
Q. Now, there's also some testimony from Dr. Edwards that he wanted to do a nuclear study on Mr. Bieler during that ice storm, but that the radioactive media was not available because of the ice storm and it had to come from St. Louis and could not get there. Do you remember anything of that nature happening?
A. I do not remember that specific instance, no.
Q. Is that radioactive material ordinarily brought to the hospital on an as-needed basis?
A. Yes.
Q. It is not kept at the hospital, is it?
A. No, sir, it is not.
Q. And if there is difficulty, or difficulties in transporting the radioactive material to the hospital because of weather, there would be no record kept of that either, would

there?

A. Not at my facility.

MR. COX: That's all I have, sir. Thank you.

MR. KEEVER: Just one or two brief follow-ups, Mr. Imhoof.

REDIRECT EXAMINATION

MR. KEEVER:

Q. Was there any record of a lung scan using, requiring radioactive materials ordered on Henry Bieler on the 26th or 27th of January?

A. I do not know the answer to that.

MR. KEEVER: Fair answer, thank you.

WITNESS: Uh-huh (yes).

MR. KEEVER: I have nothing further.

THE COURT: All right, you can step down.

(MR. SWINDLE DEPARTS THE WITNESS STAND)

MR. KEEVER: May we approach for a moment, Your Honor?

THE COURT: Sure.

(SIDEBAR CONFERENCE OUT OF THE HEARING OF THE JURY AS FOLLOWS:

MR. KEEVER: I have an audio deposition to play that needs some redactions and I am trying to get a hold of the videographer, if I could have a couple of minutes to see if he can get it over here in time to

play it this afternoon because the next -- the next deposition is not that long either. And I apologize.

THE COURT: So, what are you asking me? You want to go out and try to call him or what?

MR. KEEVER: Yes, sir.

THE COURT: How long is that going to take?

MR. KEEVER: Well, I tell you what, if you will give me a minute, I'll see if my wife can go get in touch with him and then we'll do the other one and if --

THE COURT: -- Okay. Well, let's go ahead and do that.

MR. KEEVER: Thank you.

END OF SIDEBAR CONFERENCE.)

THE COURT: All right.

MR. KEEVER: For our next witness, Your Honor, we would call Kevin Elliott also by reading his oral deposition.

THE COURT: All right.

ORAL DEPOSITION OF KEVIN CHRISTOPHER ELLIOTT

DIRECT EXAMINATION

MR. KEEVER:

Q. Would you give your full name for the record, please.

A. Kevin Christopher Elliott.

Q. Mr. Elliott, I'm Jim Keever and we were just introduced,

I'm trying to think whether we had a brief conversation almost a year ago or not. Do you remember if we ever talked over the telephone?

A. No I don't, I don't recall.

Q. Okay. Have you ever been deposed before?

A. No, sir.

Q. Well, I'll go over some of the rules.

A. Okay.

Q. And I'm going to ask you questions and we'll ask that you answer with audible answers instead of a shaking head or nodding head.

A. Correct.

Q. Because the court reporter needs to take down every word.

A. Yes.

Q. And if one of my questions is not clear, would you please let me know so I can rephrase it?

A. Yes, sir.

Q. And that's really about it, you're under oath just like you were in a court room.

A. Correct.

Q. Would you please tell us your job description at Summit?

A. I'm a physical therapist assistant.

Q. And what was your job description in January of 2009?

A. As a physical therapy assistant.

Q. And I'm going to hand you what we've marked as Exhibit No.

1 to your deposition, and you'll notice at the bottom there are some numbers that say 1.1409 batch 3, and then 54, 53 going back to 49. As we talk about these records, if you would, would you try to refer to the page number so we can be sure we're on the same page so as to speak?

A. Yes, sir.

Q. Okay. Great. Now would you identify what these pages represent in Exhibit 1?

A. Page 54 and 53 are the evaluation, physical therapy evaluation. Pages 52, 51, 50 and 49 are daily therapy progress notes.

Q. And who made the entries on pages 53 and 54 of the evaluation?

A. Leann Karnes.

Q. Can you tell us who Leann Karnes is?

A. She's a physical therapist and the current record of physical therapy department at Summit Medical Center.

Q. Okay. Let's go onto page 52, who made the entries on page 52?

A. Leann Karnes made the entry on 1/17/09 and I made -- I, Kevin Elliott made the entries on the 19th and 20th.

Q. Okay. And then that would be the same both above and then the comment section would be the same, is that correct? Leann on the 17th, you on the 19th and 20th?

A. Yes, sir.

Q. Would you describe Kenneth's activities in terms of being up and ambulatory for the dates noted on page 52?

A. Referring to my notes on the 17th it says, that he was supine in bed, agreeable to treatment. He took 3 or 4 steps with a rolling walker using moderate assistance with the therapist. On the 19th he with his transfers from, to a chair from his bed was at moderate assistance with me. He ambulated four feet times two using a standard walker at a moderate assist level.

On the 19th, on the second treatment we did exercises only. No transferring.

On the 20th his transfer from bed to chair was at minimal assistance. He ambulated a distance of 7 feet. The assistive device was used -- used was a rolling walker with maximum assistance of me.

Q. How was Kenneth's activities on those notated times and days, how would that compare to a normal ambulatory patient?

A. No way to determine.

Q. No --

A. -- each -- each patient is an individual. There's no -- I take each patient as an individual. There's no way to group them all together in my -- in my view.

Q. And so -- so what you can say is what he was able to do and that's reported and that stands for itself?

A. Yes, sir, it stands alone for itself.

Q. Okay. Now when you're seeing patients do you rely on the nursing notes to get an idea what their activities have been during the periods you're not with them?
A. No I do not refer to -- to the nursing notes.
Q. Okay. Well, let's go to page 51, why don't you go through the same discussion of his -- his activities levels and confirm who made the notes on each one of those for notations.
A. On the 20th in the, it looks like number 2 would be in the afternoon, at 4:05 in the afternoon that notation was made by myself. The morning treatment on the 21st was made by myself. The afternoon treatment of the 21st was made by Andy Messenger. And the morning treatment on the 22nd was made by myself.
Q. Can -- can you tell us who Andy Messenger is?
A. Andy Messenger is the former director of the physical therapy department at Summit, and he's currently just a PRN staff therapist.
Q. For the court reporter would you mind spelling his last name?
A. M-E-S-S-E-N-G-E-R.
Q. Thank you. Now I think we got who was making notations, could you tell us about the activities of Kenneth on those four notations?
A. The treatment on the 20th in the afternoon, his bed mobility, his ability to set up at minimal assistance from myself, his sitting tolerance was 45 minutes. His distance in

ambulation was 20 feet. The assisted device used was a standard walker with minimal assistance of me.

On the 21st in the morning, his sitting tolerance was 2 hours. There was no ambulation on that morning. The afternoon of the 21st Andy has written, go ahead and --

MR. KEEVER: Mr. Cogbill, yes, you can go ahead and read what Andy wrote.

A. Two feet that he ambulated with a standard walker with it looks like minimal assistance of the therapist. And on the 22nd the morning of treatment, he ambulated 2 feet with a standard walker.

Q. Do you -- can you tell us why you ambulated 20 feet on the 20th but didn't ambulate at all on the 21st?

A. No, sir, not from my notes. It just says that, let's see, the 21st, in my notes, on the 21st it says, that he had complained of dizziness. And so if he complained of dizziness, I would not have gotten him up on his feet for safety reasons.

Q. Okay. And now how about the only ambulating 2 feet on the 21st and the 22nd, can you tell us why he was only able to ambulate 2 feet on those two days, or those two sessions?

A. Mr. Messenger has written on the 21st, patient was tired and ready for bed. So that would -- that was his explanation for his treatment.

I wrote on the 22nd that he complained of nausea and being tired. He was transferred to the chair and was able to perform

easy exercises from the chair.

Q. Okay. Let's go on to page 50 now. And first the same way, go ahead and tell us who made these notes?

A. The treatment on the 22nd was made by myself. The treatments on the 23rd, both treatments and the 24th were made by Mr. Messenger.

Q. Okay. And -- and for the record, tell us what his exercise tolerance was on those days or on those treatments actually, thank you.

A. On the 22nd he did not ambulate that day. His -- he was maximal assist for his transfers from chair to bed. And we did simple bed exercise.

And the 23rd and the 24th I did not see the patient. I have no way to determine what that -- what his tolerance would have been.

Q. Well, but from the record, can you tell us what his exercise tolerance was?

A. I can read what Mr. Messenger has written.

Q. Please do.

A. He ambulated 10 feet times 2 with a standard walker using touchdown bearing -- weight bearing.

On the morning treatment of the 23rd, on the 23rd afternoon treatment it was a single distance of 10 feet again with a standard walker. Minimal assistance.

And then on the 24th he ambulated 50 feet with a standard

walker at a contact -- contact guard assistance.
Q. Okay. Let's go on to page 49, and if you would, Mr. Elliott, go ahead and we'll do the same drill in terms of tell us who made the notes first of all?
A. The 26th both treatments, on the 27th both treatments, those notes were made by me.
Q. Okay. And how much did he ambulate on the morning treatment of the 26th?
A. Twelve feet total.
Q. And would you go to your narrative comment and just read that for us?
A. Patient agreeable to therapy. Improved transferring today. No complaint of shortness of breath. Patient transferred to bedside commode. And then ambulated a total of 12 feet. Patient complained of sharp pain under left breast. Patient returned to room and sat up in chair. He has improved gait because of my loopy E I'm unable to determine what I've written there, but has very poor endurance.
Q. Okay. Did you discuss that -- the -- that treatment session with Dr. Edwards?
A. No way to determine. I mean I didn't -- I didn't note that that I spoke with anybody during that or after that treatment session.
Q. And what would your usual practice have been when you have a patient who responded to the treatment like you just

described in your narrative note?
A. Rephrase the, referring to what part of my note?
Q. Well, referring to -- well -- well, and you're right. That wasn't a very good question. Let me try that again. What would your usual practice have been in terms of notifying the attending patient when the patient -- attending physician when a patient had a response to a treatment like you just described?
A. Again, what part of the treatment are we talking about? The 12 feet?
Q. Okay. How about when a patient has walked for 12 feet and complains of a sharp pain under the left breast?
A. When a patient because he's -- because patients have varying complaints of -- of discomfort, if I had seen where the patient was in distress, then I would refer to the nurses. I -- I don't get on the phone and speak with the doctors after every treatment. And if the -- if the doctor happens to be at the nurses' station, and I've noted something that would be what I felt out of the norm or something that required immediate attention from the physician to know or the nurses to know, then I would speak to them. But as far as when he -- when I had written he complained of sharp pain under his left breast, that was just a verbal complaint that he made to me and I noted it in my note. But I did not, from reading my note, I didn't see -- I didn't write anything as he didn't have any

shortness of breath there was nothing associated with that. And it could have been just the way he was. He was tired that day. And he made the complaint and I try to put, if the patient says something specific I try to enter it into my notes.

Q. I'm going to -- do you remember Kenneth Bieler by the way?

A. Not in the -- not at all.

Q. Kenneth was an American Indian, he was about 6 foot 4 and weighed close to 280 pounds, does that refresh it any?

A. No, sir.

Q. Okay. I'm going to show you what I've marked Exhibit No. 2 and this is out of the progress notes. You'll notice on the bottom it says, Summit 1.14.009 batch 1, page 39 and then page 38 on the second page.

A. Okay.

Q. Did I get it, did I make it?

A. Yes.

Q. All right. On the second page, this is Dr. Edwards' progress note, on the second page it says, when he walked with therapist today he went only a few steps before he, "ran out of gas." Exhausted and puffing, had to sit down immediate. He's still too weak and steady to get -- unsteady to get out of bed by himself. Does that refresh your memory in terms of what you observed in Kenneth that morning?

A. No, sir, because I don't -- I don't remember the patient

at all.
Q. Okay. Let's go on and read your afternoon note which is at 1420 or 2:20 P.M. 1/26/09.
A. My note says that patient still very weak but willing to do exercises. See above for the listed exercises. All unassisted exercises, 15 to 20 reps. Assisted exercises were 10 to 15 reps, secondary to complex movements. Patient tolerated exercises well.
Q. And what was his ambulation during that session?
A. We did not ambulate.
Q. What was Kenneth's overall condition on the morning of the 27th?
A. My note states, treated deferred secondary to nausea and dizziness and shortness of breath. Patient condition reported to MD, no treatment.
Q. And on the afternoon?
A. On the afternoon of the 27th patient very agreeable and just wanted to do exercises. See above listing for exercises, all exercises times 15 reps each.
Q. And what was Kenneth's ambulation on that afternoon session?
A. On the 27th was nothing.
Q. And then you have an additional notation below that?
A. That notation was made by Andy Messenger.
Q. Okay.

A. It says, Dr. Edwards asked PT to hold until further notice.

Q. Can you tell when that noted was made?

A. No on the 28th but --

Q. -- Okay.

A. -- Oh, I thought you meant time, yeah.

Q. Yeah.

A. It was on 1/28/09.

Q. When was the last time you saw Kenneth?

A. From the notes that you provided me, the last time I saw Kenneth was on the 27th at 1400.

Q. And what was his status in terms of shortness of breath?

A. Other than what I've written on the 27th that he's complained of dizziness and shortness of breath that's -- that's all -- that's all I have here.

Q. And again, any -- any independent recollection as we sit here today about his condition on the 27th?

A. No, sir.

Q. Mr. Elliott, do you recall getting a subpoena to testify in January when this case was first set for trial?

A. Yes, sir.

Q. Are you aware that initially the hospital was a defendant in this case?

A. The defendant is?

Q. Oh, the Bieler estate was suing the hospital initially,

were you aware of that?
A. Yes. Yes I was. Yes.
Q. Are you aware that since that time the estate has dropped the suit against the hospital and they're no longer a party to the -- in the lawsuit?
A. No I did not know that.
Q. Okay. Did you understand that the subpoena that you got or -- or when did you learn that the case had been continued and wouldn't be going to trial in January, 2012?
A. I don't recall the date.
Q. But you do recall being notified?
A. Yes.
Q. And are you aware that the subpoena for the original trial date actually cares over to the new trial date the week of November 26th, 2012?
A. I did not realize that.

MR. KEEVER: Okay, I think I'll pass the witness.

Thank you very much, Mr. Elliott.

WITNESS: Thank you very much.

MR. COX: I have no questions.

THE COURT: All right. Call your next.

MR. KEEVER: Your Honor, for our next witness we would call Donna Dewey.

THE COURT: All right.

TESTIMONY AND EVIDENCE ON BEHALF OF THE PLAINTIFFS

DONNA DEWEY

having been called by and on behalf of the Plaintiffs, and having been previously duly sworn, was examined and testified as follows, to-wit:

DIRECT EXAMINATION

MR. KEEVER:

Q. Donna, you've already been sworn in, is that right?

A. Yes.

Q. Donna, how are you feeling?

A. Okay.

Q. Are you nervous?

A. Not really nervous, just.

Q. Would you give your full name for the court reporter, please?

A. Donna D. Dewey.

Q. And, Donna, could you lean a little forward to the microphone or speak up so that we're sure that everyone can hear you, please.

A. Better?

Q. Better. And I'm coughing too.

Uh, Donna, would you introduce yourself to our jurors?

A. Hi. My name is Donna Dewey. I am the sister -- was the sister of Kenneth Bieler and I am the sister of Mary Hartman. And I live in Preston, Kansas. I have three grown children and

seven grandchildren.
Q. Got any great grandchildren?
A. No not yet. Give him time, he's only 10.
Q. Donna, where did you and Mary and Kenneth grow up, can you tell us that?
A. We grew up in Ellis, Kansas. It's kind of in the middle of Kansas, on I-70, probably more closer to Colorado.
Q. How far now -- just -- I should have brought a map, but how far north is it to Nebraska?
A. Probably the same distance as it is to Oklahoma, so about two and a half hours.
Q. And how far west is it to Colorado?
A. Two and a half hours.
Q. And how far east is it to Missouri?
A. Five hours.
Q. Okay. Now, uh -- Kenneth was adopted?
A. Yes.
Q. And -- and you and Mary were adopted?
A. Mary and I were adopted. We are birth sisters.
Q. What's your first memory of your brother Kenneth?
A. Oh, yeah, I'm not supposed to lie, but it's too funny. Uh, I was 4 almost 5, and -- uh -- Mary and I had been moved to Topeka, Kansas to a foster home. Uh, and we went to the Kansas Childrens' Service one morning to meet these perspective parents and their son. And Mary and I were both a little

anxious, so we made a pack that before that we were both going to go or neither one of us were going to go. And but we had to be interviewed one at a time.

So, Mary went first and she came back, she goes, it's okay, it's okay. Don't be nervous. So, I went. And when I walked through the door all I saw was this little boy sitting there just -- looking at me, and I turned and I ran out of the room because he scared me to death.

Q. Why did he scare you to death?

A. He just looked mean. But -- so, the lady made me go back in and mom, or the people, the parents left us and we played and we talked and from that minute forward he was my best friend.

Q. Tell us -- tell us about that, that first interview and meeting, do you remember what the room looked like that you were meeting your new family in?

A. Kind of like this but about half this size, kind of like a court room.

Q. Kind of like a court room?

A. Kind of like a court room.

Q. Who all was there?

A. The lady -- the -- uh -- I guess now you'd call her a social worker. Uh, our foster parents weren't there. Uh -- dad and mom and Kenneth, well, they weren't my mom and dad and Kenneth then, and me and Mary.

Q. I'm sorry, were your foster parents there with you?
A. No.
Q. Okay. It must have been a little scary?
A. It was, but I had Mary.
Q. Where had you and Mary, you were in a foster home in Topeka, where were you and Mary before the foster home in Topeka?
A. We were taken to an orphanage in Omaha, Nebraska -- uh -- when I was about a year old.
Q. And Mary was how much older --
A. Mary is eleven months older than I am. So, because Nebraska -- it was people wanted babies and Kansas was -- uh -- better at finding families for older children, not that we were old but we weren't newborn babies.
Q. And I'm going a little backwards in time --
A. -- yes we are --
Q. -- and then we'll move forward. But -- uh -- you and Mary were related, explain exactly how you and Mary were related?
A. Well, until we were 15 we thought we were full-blooded sisters. And we were put up for adoption together and we were adopted together. And -- uh -- we were adopted together because when my parents came to adopt us, they only came to adopt one of us because they had Kenneth and they wanted a girl. But when mom and dad asked Kenneth which one, because it was gonna be his choice, he said, "I'll take 'em both." So, we

got adopted together.

So, when we were about -- I think I was 15, and -- uh -- we were having a discussion and mom told us that -- uh --

MR. COX: -- Your Honor, I'm going to object as being hearsay.

THE COURT: Sustained. Move on.

Q. Okay. Now, Mary -- uh -- you told us about your first contact with Kenneth, how about your -- how far was Topeka from Ellis, Kansas?

A. It's about -- well, back then it was about a four and a half hour drive.

Q. And same day you met your new parents you went home with them?

A. As far as I can remember.

Q. What do you remember about that trip and what do you remember about Kenneth?

A. It was long and tiring and cold.

Q. Long, tired and cold?

A. It was long and tiring and cold and I was tired. I fell asleep.

Q. Now, you're driving up to your new home in Ellis, what -- what -- what time is it when you and Mary and Kenneth and your parents get to Ellis?

A. I don't know I was sleeping. And my dad carried me in the house and put me in a bed.

Q. What was Kenneth doing while you were going in?
A. He was jumping up and down. Because I woke up when we were going into the house, and he was trying to show us where our room was and show us toys and all I wanted to do was go to bed.
Q. And what did you do?
A. Go to bed. I was four.
Q. So, you and Kenneth and Mary grow up in Ellis, Kansas. Tell us -- tell us about Ellis, Kansas so we can get a sense of that part of your life with Kenneth?
A. Ellis is a small town I think of about, at that time maybe 5,000 people. It has a school and it has 6 churches, but it's a very small rural town.
Q. And what's the -- what's the population like in Ellis?
A. About 5,000/6,000.
Q. Okay. But what kind of people in terms of, you know, what do they do, what do they look like --
A. -- well, most of the people were farmers, and a lot of them were retired class people that -- and my dad was a police officer and my mom eventually went to work in the grocery store. But we were just middle -- a lower class people I guess. We weren't high society but we weren't -- uh -- poor, you know. I didn't think so anyway but.
But we -- we were different because we were adopted. And, you know, back then, you know when you were adopted people

looked at you a little stranger. You know. And we were, more Kenneth and Mary than me, you know, American Indians, you know, we -- our mom, you know, she was pretty -- uh -- how do I want to say it. German. She was a German -- uh -- mix so she was kind of -- even though she had kind of brown hair she looks more like me. Uh -- but -- we -- we did okay. We fought our own battles.

Q. Well, tell me, maybe it would be helpful for juries -- jurors to -- to get a sense of how it was with you and Kenneth and Mary growing up. Is there a particular story, a segment that you can tell us that might give us a feel for that?

A. Well, we were very, very close growing up. And we always took punishments together. We never would tell on each other who did what. We all got punished at the same time.

Kenneth and me and Mary one day were -- we had lived in a three-story house because my parents rented out to railroaders because Ellis is a railroad town, it's also called the Ellis Railroaders. And -- uh -- on our back porch we had a flat type roof. And from the third floor if you climbed up the side of the house, you could shoot walnuts down a pipe drain. And so, we wanted to be like the squirrels and we were throwing walnuts at the neighbor lady through the pipe drain, and -- uh -- until one hit her. But it was fun to watch the lady, you know, look around, look around and see where the walnuts were coming from. And -- uh -- so anyway, that's what we were doing until we got

caught.

And then when I was ten, nine, nine and a half -- uh -- I got burned really bad. Uh, I was drying my hair in front of our wall heater and my housecoat caught on fire and my brother actually saved my life because he threw me to the ground, you know, stop, drop and roll. And -- uh -- my dad walked in and -- from the police department and ripped my clothes off and put me in the back of our station wagon and drove me 30 miles to Hays during an ice storm. Uh -- to the hospital because he didn't want to wait for an ambulance.

Q. Was Kenneth -- where was Kenneth during that time?

A. Panicking, screaming. Uh, Kenneth and Mary had to stay home because -- uh -- they -- uh -- had to go to school 'cause we were gett'n ready for school.

Q. How -- how long were you in the hospital?

A. Two months.

Q. And what was your contact with Kenneth during that time?

A. Well, he came after school with mom and dad on some of the nights. And they came every night, after -- probably after dinner, in the evening. And Mary and Kenneth back then, you had to be a certain age to visit and Kenneth was right at the age to visit.

Q. Now how old were you when that happened, Donna?

A. I was nine/ten. I believe I turned ten in the hospital.

Q. And so, Kenneth would have been how old?

A. Thirteen.
Q. How about -- how about high school as -- as Kenneth is three years older than you, when he was in high school I guess you would have been in middle school --
A. -- I was in eighth grade --
Q. -- or junior high.
A. Well, when Kenneth was a senior in high school I was a freshman. So, when he was a freshman I was about in the seventh grade/sixth grade, somewhere around there. And my dad bought my brother a motorcycle and -- uh -- huh -- we -- he wasn't allowed to give us rides because mom was afraid that somebody would get hurt. But, you know, we were children and I loved my brother and I -- where he went I went. So, he promised to take me for a ride. So, I had to walk 3 blocks from the house to -- for him to pick me up, you know. And -- uh -- at that time our cemetery in Ellis is on the south hill, and it's -- they were putt'n in a -- uh -- like a goldfish pond. So, they had all the dirt piled up, you know, nice little ramp for a motorcycle. So, my brother decided he was gonna jump it. Well, I fell off the back, he fell off. The motorcycle made it across the pond. He landed in the pond and I -- he was so worried that I was hurt. We didn't care about the motorcycle. But we -- uh -- it was funny at the time. You know, we just -- he -- he took me fishing and I always had to say he caught all the fish or he wouldn't go with me, you know,

because my mom wouldn't let me walk to the creek by myself. He just was there. He -- he --

Q. Well, let's -- let's move forward and tell us, what year did Kenneth graduate from high school?

A. 1969.

Q. 19?

A. 69.

Q. '69?

A. Uh-huh.

Q. And what's Kenneth doing after he graduates from high school?

A. Kenneth went to Goodland Vo-Tech. It is almost on the Colorado border on I-70. Uh, him and a high school buddy and one of our cousins all went to school there for about a -- nine months I think Kenneth went there. And then him and his buddy decided to move to California.

Q. Well, Donna, before we move forward could you give us a sense of your parents' personalities as you and Kenneth and Mary were growing up in your family? I mean how about your father, he was a career police officer?

A. He was a police -- well, actually his career job was heating and sheet metal. So, if you didn't have any money and you needed your furnace lite, it didn't matter if it was two/three in the morning dad would get out and go light your furnace. Or he would -- uh -- then he took a part-time job,

which turned into a full-time job. He was a police officer at night in Ellis. But mostly he did heating and sheet metal, putting in air conditioners, refrigeration work and on people's refrigerators.

My dad many times brought stray animals and people home because like I said, we had a 14 bedroom house that -- uh -- my grandfather had bought, my mother's father had bought for my parents when they were -- for a wedding present. And -- uh -- they rented the two upper floors out for rooms, like a bed and breakfast but without the breakfast, you know, back then it was like a boarding house.

Q. And what --

A. -- and -- uh --

Q. I'm sorry. I didn't mean to -- to step over you.

A. My dad was the most generous, honest man I had ever met in my life. And he instilled that in, you know. He tried to instill that in everybody but he was just a very good man. And I keep saying he was because he died in 2001 of leukemia.

Q. Your father?

A. Uh-huh.

Q. Now, how much did you see Kenneth after he graduated from high school?

A. When -- after -- after he graduated from high school or after he moved to California?

Q. Well, after he went to California, that's a better time

period?

A. When Kenneth went to California we did not see Kenneth until I got married in 1977. And when I got married in 1977 it was the first time my family had been together for a Christmas or anything. So, it was a wonderful wedding, it was a wonderful visit, and -- uh -- after that, about 3 months later. Well, at the time I was living in -- when I got married I was living in Virginia and we came back to get married.

So, we moved -- went back to Virginia and three months later my grandfather died. And so Kenneth came from the east [sic] coast, I came from the west [sic] coast to my grandfather's funeral.

Q. In Ellis?

A. In Ellis.

Q. Where was Mary?

A. She lived in Hays which is 15 miles west -- east of Ellis.

Q. And I'm sorry, what year was that again, Donna?

A. My grandfather died in 19 -- February of 1978.

Q. Now what kind of contact did you and Mary and Kenneth, including contact between you and Mary have, oh, during the next 10 years or so?

A. Well, like I say, Kenneth came home for my wedding. He came home each -- uh -- he came home when each of my children were born. Uh -- I have three. And his was -- is -- was -- their godfather. Uh, so he was there for all their baptisms.

Uh, like I said, I also lived on the east coast. So, trips home were far and few between.

Uh, my husband and I moved back to Ellis right before my daughter Danielle was born. So, we lived there. And then, like I said, my children were born, Kenneth had been home three times between '79 and '82.

Then my husband and I moved to Oklahoma and he worked on a triple drilling rig, and he had a really bad accident. I won't go into that. But I called Kenneth who was in California, and he came and stayed with me for about a week to make, you know, until I kind of got myself back together. And helped me with my kids. And the -- uh -- I ended up moving back to Ellis, or WaKeeney which is two miles the other side of Ellis.

Uh, and then I didn't see Kenneth for awhile 'cause like I said, he was in California. And then in 1984 -- uh -- he came home and he brought a girl with him, she was pregnant. And -- uh -- they stayed with my sister Mary in Preston, which is two and a half miles south of Ellis, east of Ellis. And -- uh -- for about four months and then he moved in with me for about six months while he worked at the grain elevator and Debbie was pregnant with Crystal and we were looking for a house for them because I was a single parent, of course, then with three little kids. And -- uh -- and so he and Debbie moved into a little one bedroom apartment and I got remarried

in '85. Crystal was born in '84? '85? Oh, I don't know its been so long ago.

But anyway, when Crystal was about six months old I got remarried and me and my husband moved to Ransom, here we go again with the geography, which is 20 miles south of WaKeeney. And then Kenneth when it became winter time and the grain elevators weren't needing extra help, he went to work at IBP, it's a meat-packing plant in Garden City, Kansas, which is --

Q. -- and we have geography now. We've traveled through western Kansas, where is Garden City?

A. It is kind of in the southwestern corner, not quite to Dorothy Land but almost. And -- uh -- Kenneth was there for a couple of years and I saw Kenneth quite a few times when we lived -- well, of course, when he lived me I seen him every day. And then when we lived in WaKeeney I saw him every day. When I moved to Ransom I saw him about once a week. And then when they moved to Garden City I probably saw them twice a month at least, if not more.

Q. How far is Garden City from Ransom?

A. It was about an hour, hour and ten minute drive maybe. Yeah, you know, its been a lot of years ago, I don't remember. It's --

Q. -- Now, Debbie and Crystal, Crystal is Kenneth's daughter?

A. Right.

Q. And Kenneth move to Garden City and you're living up in

Ransom with your new husband and -- uh -- your three children?
A. Yes.
Q. And -- uh -- kind of keep the story of you, and where's Mary during this time by the way?
A. Pardon me?
Q. Where's Mary?
A. Where's Mary? Mary is living in Preston, Kansas where she's lived now for the last 30 years. She is the only non-roamer in the family. She started out a roamer because she went to Virginia first with her first husband. But when Mary moved back to Kansas then she met Jim and they have lived in Preston for 30 years.
Q. Okay. And -- and just a short answer. Where do you live now?
A. Well, right now I live in Preston.
Q. Okay. Now, we're back in about -- I guess this must be about '87/'88 something like that?
A. '89.
Q. And you're in -- uh --
A. Ransom.
Q. Yeah, you're in Ransom --
A. -- Kenneth's in Garden City --
Q. -- Kenneth's in Garden City with Debbie and Crystal. What happens with Kenneth?
A. Well, when Crystal was born -- uh -- Kenneth -- or Debbie

did not put Kenneth's name on the birth certificate for, I'm sure, reasons that, you know, is not none of my business. But anyway -- uh -- Debbie took off and nobody knows the circumstances as to why Debbie took off and left Crystal with Kenneth.

And so, Kenneth went to court and got -- had his name put on Crystal's birth certificate and -- uh -- sole custody of Crystal. And he lived in Garden City with Crystal for about two years by himself while off and on with different girlfriends, you know, single man. And, Christmas -- '89? Maybe. Uh -- Kenneth called me and -- and I had been to Garden City a couple of times to see him and bring Crystal home on the weekends with me and -- and kind of help him out. And he asked me if -- uh -- I would watch Crystal -- uh -- through Christmas break because he wanted to come to Arkansas to meet his biological mother and some of his sisters and brothers. So I said yes.

Well, then he called me and he said --

MR. COX: Your Honor, I'm going to object to any conversation.

THE COURT: All right, just tell us what happened.

A. Oh, okay, I gotcha. Uh -- Kenneth decided to stay in Arkansas and I kept Crystal for the next three -- three and a half years, almost four years.

And Kenneth -- and I don't know how to word this now. Uh -- when Kenneth asked me to keep Crystal and he was gonna stay in Arkansas, I told him that was fine and that he could come get Crystal whenever he wanted but not to come if he wasn't going to take her back home with him. Because I didn't want to confuse her. I had three small children that I was raising and wanted to -- Crystal, I made Crystal part of my family. But the agreement was there that if Kenneth ever got married, or Kenneth ever decided he could take her and raise her that he could come get her. And that he did.

Q. Well, where -- where -- uh --

A. -- we were living in Missouri.

Q. Okay.

A. We had moved to Missouri because my husband was an over the road truck driver and that's where his job took us.

So, Kenneth and his new wife, Carol, came to Missouri and got Crystal. And then they moved -- took her back to Arkansas. And like I had asked my brother to do, I did likewise, I did not call and interfere because I knew if I called Crystal would want to come back, it would give her an option not to have to mind. It would give her an option not to have to try to get along with a new stepmother. So, I stayed out. Away.

My feelings were hurt. I was -- I wasn't angry I was hurt, that you know, he came and took her. And then -- I'll keep going to make it short.

Uh -- a couple of years later the, maybe four years later -- uh -- I was -- my mom and dad told me that Kenneth had put Crystal up for adoption, or that Crystal had been adopted. That Kenneth and Crystal [sic] got a divorce and Crystal is now living with Geneva Haynes.

Q. Kenneth and his wife Carol had gotten a divorce?

A. As far as I know. That's what I was told, that is hearsay I know. And -- uh -- and in the meantime, of course, I was making several trips back to Kansas because my dad was ill in 2000. And -- uh -- my sister and I would meet at the hospital and I would come back every weekend, and then I came back for a week at a time, and then I would go back to work for a couple of weeks and then I would come back for a week at a time.

Uh -- and I had called Mrs. Haynes -- uh -- dad was getting really bad and I asked her --

MR. COX: -- Your Honor, I'm going to object to any conversations with Mrs. Haynes.

THE COURT: Sustained.

Q. Uh -- what -- when was the -- let's see. Kind of set the time scene a little bit. It's what year now?

A. It's 2001 in November.

Q. And when -- and when did your father pass away?

A. Day before Thanksgiving.

Q. And -- uh -- what contact did you have with Crystal and her new family?

A. I asked that Crystal be allowed to come to see dad before he died.
Q. And did that happen?
A. Yes.
Q. And when -- when did that -- when did that visit take place?
A. Probably the week before Thanksgiving because I had moved back to Missouri and I could not be back in time to see Crystal while she visited dad. I got there the next day and they had left that morning.
Q. Now, Donna, what other contacts, did you have any other contacts with Crystal during that period of time from when Kenneth and Carol came and brought her back to their family and --
A. -- no --
Q. -- your dad's death?
A. No.
Q. What contacts did you have with your brother during that period of time?
A. A few phone calls but I was a little upset with him. You know, I -- I -- it took me awhile to get over it, or to accept it and to understand it. And I guess I really didn't understand it until my dad died and Kenneth had came home. And him and I took off one morning to have a nice little chat. And then he told me -- explained to me why he didn't call me to

come get Crystal. And why he didn't -- and why he gave her to Mrs. Haynes.

Q. And what was your understanding of the reason?

MR. COX: Your Honor, I'm going to object based on hearsay.

MR. KEEVER: Well, Your Honor, I -- I --

THE COURT: Come up. Come up.

MR. KEEVER: May we approach?

(SIDEBAR CONFERENCE OUT OF THE HEARING OF THE JURY AS FOLLOWS:

MR. KEEVER: Your Honor, this goes to the present state of mind of the decedent who obviously can't be here to -- to testify for himself. And I think that it's an exception to hearsay for that reason alone. And it is -- it is what Ms. Dewey's understanding is, she heard the words and so it's her understanding I think. And -- and really I just think in the interest of justice since this is going to be an issue of the relationship between this brother and sister and daughter. In the interest of justice that it be allowed.

THE COURT: Go ahead, Mr. Cox.

MR. COX: Your Honor, it's nothing but hearsay. This is not an issue of present state of mind of somebody that -- that -- of events leading up to the

death of this man.

THE COURT: It's way before that.

MR. COX: It was years and years before.

MR. KEEVER: But it has to do with the element of the mental anguish damages of Donna Dewey and Crystal Bieler, and -- and it's the only -- it's the only evidence of that relationship at that time which would have impacted this lady's one mental anguish -- mental anguish grief and the damages. So, again I think it goes to the presence absent impression. I think that it goes to what Mrs. Dewey's understanding was regardless of the truth of the matter asserted. She heard what her brother said and it gave her an understanding of why he did what he did which would certainly impact her grief and mental anguish.

And again, there is simply no other way to present this evidence which we really think is important to damages because Kenneth can't be here.

MR. COX: Well, she is -- she is here as a claimant only for mental anguish on her part. And she -- she's trying to bolster someone else's mental anguish by testifying.

THE COURT: I'm not going to allow it. I think the problem here is I just don't see a connection between this incident you're talking about and this

witness's damages, if any, I don't see any relevance here, connection to it based on what I've heard so far so I'm not going to allow it.

Again, I think it goes to whatever relationship there is with this other claimant who is going to testify, so she can bring up her separate issues but I don't think it's relevant.

MR. KEEVER: I understand.

END OF SIDEBAR CONFERENCE.)

CONTINUED DIRECT EXAMINATION

MR. KEEVER:

Q. Well, Donna -- uh -- going on -- uh -- you saw Kenneth in Hays --

A. -- Ellis --

Q. -- or Ellis I guess, and that was in 2001, am I okay on the dates?

A. Yes.

Q. And then -- uh -- as far as you know he returned to the Van Buren area?

A. Yes.

Q. Where was Kenneth working at that time?

A. Midsouth Rollers.

Q. Here in -- here in -- uh --

A. -- Van Buren --

Q. -- Van Buren?

A. Fort Smith.
Q. I'm sorry?
A. Is it Van Buren or Fort Smith?
Q. It's Midsouth Roller anyway?
A. Right.
Q. Yeah. And -- and, Donna, over the course of the next 8 years which would have been until Kenneth died, what kind of contacts did you and Kenneth have?
A. I saw him once, I came to Arkansas. But I talked to him on the phone several times and as I told Mr. Cox before, I can't tell you how many times I talked to him. I -- I -- I just -- I -- I don't know. My means of communication with Kenneth was over the phone. My means to visit my mother was more important to me at the time because I expected my brother to always be here, my mother was older and I would spend my money and my time off to go see my mother.
Q. When was the -- when was the -- uh -- now your mother is Doris Bieler?
A. Yes.
Q. And where is -- where is Mrs. Bieler now?
A. She is in the Hilltop Manor in a nursing home in Cunningham, Kansas, which is about a 20 minute drive from Preston.
Q. Now, you were living up in Missouri. Uh -- and then you -- when did you move to Preston?

A. In December of 2010.

Q. And -- uh --

A. -- why did I move there?

Q. What -- what can you tell us about Doris's condition during the period of time, oh, say a couple of years before Kenneth died? It would be like 2007/2009? You're up in Missouri at that time?

A. Right, but I came home quite a few times in between there to visit mom, especially after dad died because I would call her and she'd tell me how lonely she was before she told me how she went and played bingo and went shopping. But she was doing good. She was driving. She lived by herself. She was working. Uh, she was doing really well.

And -- uh -- she had a few, probably in 2007/2008 she's getting a little forgetful, you know, and I'd just chock that up to old age, not that she's old, but you know. Uh, and -- uh -- but she would get to where sometimes when I would call her on the phone she'd be like. I'd say -- I'd tell her, she wouldn't know who I was, you know, she'd say, who, who, you know. She'd think I was my daughter. And I would tell her no and I would talk to her and -- and -- uh -- but she was gett'n a little forgetful. You know.

Q. And how did -- how did Doris take Kenneth's death?

A. Well, initially I don't know because she's the one that got the phone call and she was home by herself.

I know that when I got there with my sister, mom was -- uh -- kind of quiet. But we all made funeral plans together and -- and that was kind -- really tough, you know, because mom would call pallbearers and then not remember she called 'em and get upset with us because we told her she'd already done something. And she said, no she hadn't done it yet. So, it was -- uh -- uh -- a pretty -- uh -- tense time besides the fact that we were planning a funeral.

And then after we -- uh -- after the funeral -- uh -- we went back to the house and mom told us to leave.

Q. Told you to leave?

A. Told me and Mary to leave that she was done, she didn't have any children. She didn't know who we were. She said it was time for all the guests to go. And we told her no, you know, we were going to stay another night and she said, no you're not.

Q. And where did you guys stay?

A. No we left. My mother when she said -- when she told you to do something, you did it. You know, but she did let my cousin stay who she -- uh -- 'cause at that time mom all she had was her nieces and nephews. My mom had 10 brothers and 9 sisters, and trust me she had lots of nieces and nephews. And that's pretty much for the next year that's really all she remembered was her nieces and nephews, not her children.

Q. And where did your mom -- how long did your mom stay in

Ellis?

A. I think until the Christmas of 2009. I believe when she went to Mary's house for Christmas then she ended up staying with Mary because she just really couldn't take care of herself anymore.

Q. And when did you go to Preston again?

A. I came -- well, off and on from July to -- but I moved permanently in December.

Q. December?

A. But I would come -- 2010. But I would come out for -- a -- a couple of weeks at a time and help Mary and then I would go back to Missouri because at the time I was on unemployment so -- uh -- funds were limited, but I still had the time to come out, and we looked for a house until my sister and I -- uh -- we bought a house together in Preston so that I could be there to go take care of mom while she was at work, and also take care of my sister's mother-in-law at the time who was living with my sister.

Q. And take care of whom?

A. My sister's mother-in-law who was also in my sister's house.

Q. Okay. Donna, how can you -- can you tell us how you miss your brother Kenneth?

A. Umh, I can't cry right? Uh -- Kenneth was, like I said, he was my best friend. I may not have saw him every day, I may

not have talked to him every day, but I knew if I called him he would come. And he knew, if he called I would come, and the same with Mary. We, you know, we are -- we are and were very close, you know, and a lot of people don't understand that, but my sister and I and my brother were closer than most biological kids.

My sister and I started out by ourselves when we were children. And now that's where we are again, her and me. Because on the day we buried my brother, I lost my mother too, and I'm sorry that's how I feel.

Now I'll never get my brother back. If I could have my brother back today, I would not be sitting here. I would be the happiest person in the world. I'll never get to know his granddaughter. My children loved him. He took care of them and me when we were sick and I couldn't take care of my kids, he was the one that came and helped me with my children.

So, the lost of my brother is, I, you know, losing my dad was hard but I knew he was going because I watched him, you know, every day dwindle down from this big man to nothing. My brother the last time I saw him was at my -- the year after my dad's funeral and he was here in Van Buren. And the day I saw him in his casket didn't even (WITNESS CRYING) he didn't look the same.

MR. KEEVER: Thank you, Donna.

I think I'll pass the witness, Your Honor.

THE COURT: All right. Mr. Cox, any questions?

CROSS EXAMINATION

MR. COX:

Q. Ms. Dewey, I had a hard time keeping up with some of your answers. I could not see your face and that probably is part of the reason.

A. I'm kind of short.

Q. And I'm hard of hearing and that makes it doubly difficult. I'm trying to get a feel for these various moves you had, and I want to focus primarily upon the time that your brother was in California. And that was a period of what, about 17 years that he was away from home?

A. Yelp.

Q. And how many times do you think you saw him in that 17 year period?

A. I saw him when I got married. I saw him at my grandfather's funeral. I saw him for each one of my -- probably about 12 times.

Q. Twelve times in 17 years?

A. Uh-huh.

Q. Is that correct?

A. Would you like to know how many times my parents saw him in that time?

Q. Well, I'm asking about you and your relationship with -- with your brother?

A. Well, I couldn't afford to go to California.
Q. And could he afford to come see you?
A. Once a year, or once every year and a half.
Q. All right. Now, I believe you told me that -- if I get my dates right, from approximately 1970 to 1977 you did not see Kenneth at all, is that correct?
A. That's correct. That doesn't mean I didn't love him.
Q. I'm -- I'm just asking --
A. -- I know --
Q. -- when you saw him and when -- when he saw you, ma'am.
And then I believe you said that you moved back to Ellis, Kansas in 1979. So, from '77 until '79 did you see Kenneth at all?
A. In '78.
Q. And saw him one time --
A. -- yes --
Q. -- correct? So, from 1970 until 1979, nine year period you saw him one time, is that correct?
A. No. From 1970 until 1979 I'd saw him about 14 times.
Q. Fourteen times?
A. Yes.
Q. All right. But from '70 until '77 you didn't see him at all, correct?
A. That is correct.
Q. All right. Now, I believe you said that you moved to St.

Louis and tell us again when that was, ma'am?

A. In 1992.

Q. 1992?

A. Yes.

Q. All right. When was it, what year was it that your brother Kenneth brought Crystal to your home?

A. In Ransom? Uh, I believe in '89, --

Q. -- okay --

A. -- '89 or '90.

Q. And how long did you live there in Ransom with Crystal living with you?

A. Until 1992.

Q. 1992. And then from 1992, how long did you have Crystal living with you?

A. Until May of 1993.

Q. All right. So, about a year you were in Missouri?

A. About 7 months, yeah.

Q. Okay.

A. I'm sorry, we moved to Missouri in December of 1992.

Q. 19 what?

A. '92.

Q. Okay.

A. In December.

Q. And I believe you told me in your deposition that you saw your brother one time when you were living in Missouri, or near

St. Louis?
A. I saw my brother twice. Once he came to St. Louis and once I went to Arkansas, but you're right. I saw him once in Missouri.
Q. Okay. He came one time during the several -- he saw you how many times during that 19 year period?
A. Well once, but nine of those years he was dead.
Q. I understand.
A. Or four of those years, I'm sorry, four.
Q. All right. So, how many years was he alive and you lived in --
A. -- wait, wait, wait. You're -- now you're confusing me.
Q. -- Well, I apologize --
A. -- How many times --
Q. -- I'm confused also.
A. You asked me how many times Kenneth saw me in Missouri?
Q. Yes, ma'am.
A. He saw me once in Missouri.
Q. All right. And how many years was -- were you in Missouri when he was alive?
A. Fifteen.
Q. Fifteen. So, you saw him one time in 15 years?
A. No. I saw him at my dad's funeral.
Q. Okay. And that was in 2001?
A. That's right.

Q. Any other times?
A. And you're right, Mr. Cox, no I did not see him alive.
Q. All right.
A. I saw him at my dad's funeral. I saw him in Arkansas. And he came to see me in Missouri.
Q. And you came to Arkansas and saw him?
A. In 2002.
Q. 2002?
A. Yes.
Q. And you did not see him again but prior to his death, did you?
A. No I did not.
Q. So, how long was it that you actually had physical custody or possession of Crystal?
A. Oh -- well, it probably seems longer to me because I just -- I would say probably between 3 and 4 years Crystal lived with us. I didn't really keep track of it because to me she was my daughter, or she was one of my family. She wasn't my daughter. I wouldn't let her call me mommy because I told her one day she would go back with her dad.
Q. Did Kenneth support her those 3 or 4 years that she lived with you?
A. I never asked my brother for a dime. I never asked. I asked him to stay away until he was ready to take her home with him.

Q. So, he did not support her during that period of time?
A. No.
Q. How old do you recall Crystal was when she was placed in the home of Geneva Haynes?
A. To be honest, all I know is that when Crystal was 16 she was adopted. I do not know anything -- anything I could tell you would be hearsay. -- I just know my brother didn't call me.
Q. All right. Your mother unfortunately has developed Alzheimer's, is that correct?
A. Yes.
Q. And I'm sorry that's a terrible disease, my father had that and I know what it's like.
A. Yes she does.
Q. Did you tell me that you started seeing signs of that about two years after your father passed away?
A. Yes. Yes I did.
Q. Okay. And, it got worse over time, did it not?
A. It got majorly worse when my brother died. My mother still knew who I was when I came home. She knew who my children were. The day I walked in after, or when I got back home for Kenneth's funeral, she didn't have a clue who I was. She thought I was a neighbor lady.
Q. You mean after -- the day of the funeral when you got home she did not recognize you?

A. Not then. And the day after the night that I got there, when I came from Missouri, before Kenneth -- she didn't know Kenneth when we went to the funeral home.

Q. I'm sorry?

A. She didn't know Kenneth. She didn't know my brother in his casket.

Q. Okay.

A. She didn't want to -- I didn't know that she didn't know him, she didn't want to admit it was him.

Q. But I took your deposition back in December of --

A. -- last year --

Q. -- last year, and you had, I think you told me moved to be near your mother?

A. Yes.

Q. About a year to the day before your deposition, correct?

A. That's right.

Q. Which would have been December of 2010, correct?

A. That's correct.

Q. And it is true, is it not, that at that -- at the time of your deposition your mother was in a nursing home?

A. Yeah.

Q. She'd been there for about six months --

A. -- that's exactly right --

Q. -- at that time, hadn't she?

And, I think you told me that you, or you confirmed that

she does not recognize you or your sister, correct?

A. That's correct.

MR. COX: That's all I have, thank you, ma'am.

THE COURT: Anything else?

MR. KEEVER: No, Your Honor.

THE COURT: All right, you can step down.

(WITNESS DEPARTS THE WITNESS STAND)

MR. KEEVER: May we approach?

THE COURT: Sure.

(SIDEBAR CONFERENCE OUT OF THE HEARING OF THE JURY AS FOLLOWS:

MR. KEEVER: I have the unredacted video of Ms. Haynes but I struck out on getting the redacted one. And I would really prefer that Mary Hartman be my last fact witness. I wondered if the court would let us end it now --

THE COURT: -- How long is the deposition, or this video you're talking about?

MR. KEEVER: It's about 30 minutes, it's not a big one.

THE COURT: But they haven't got it redacted yet?

MR. KEEVER: No. I'm supposed to pick it up tonight. I should have tried to push them to get it to me this morning.

THE COURT: So, who have you got left?

MR. KEEVER: Well, we've got -- uh -- Mary, Bob Rogers who is very, very quick fact witness. We've got Dale McKinney who is not going to be a long fact witness. -- I just drew a blank. We have Crystal.

THE COURT: Well, I guess my question is why do you not have some of those people here besides Mary?

MR. KEEVER: I -- I -- I really thought that they would be tomorrow. My -- my apologies, my experience -- uh --

THE COURT: -- Are they not, I mean they're not in town or?

MR. KEEVER: Two of them are working. Crystal works -- worked last night. I could put Mary on, her testimony will take about as long as Donna's. And again, I wanted to have her -- basically have her at the end. I had no -- I have no, there's no excuse but I thought I'd have this video deposition. I kind of thought that I would take longer with my expert but I miscalculated.

THE COURT: Well, I mean my problem is trying to get this completed.

MR. KEEVER: Yes, sir.

THE COURT: Ideally by Friday, and you know, not having to go really, really late tomorrow, or

Thursday to make up for today and that's kind of what I'm trying to estimate here is that.

MR. KEEVER: I guess I could put Mary on. And again, I would rather not. We could start with Mr. Cox's video deposition, start his case in chief.

MR. COX: Your Honor, I don't want to start my testimony.

THE COURT: Well, I don't want to start anything out of way that we don't have to. Well, I think my preference is that you call her and make the best use of the time that we have, unless you want to round up. I mean I'll give you a couple of minutes if you can get somebody else here.

MR. KEEVER: Let me make some phone calls and maybe I can get another witness.

THE COURT: If you can get another witness, we'll do that. We'll just take a break.

END OF SIDEBAR CONFERENCE.)

THE COURT: All right, we're going to take a real short recess, and probably try to make it about 10 minutes, we'll kind of see where we are. Be in recess.

(4:00 P.M. COURT RECESSES)

(4:13 P.M. OPEN COURT RESUMES)

THE COURT: Call your next witness, Mr. Keever.

MR. KEEVER: Yes, sir, we will call Mary Hartman.

TESTIMONY AND EVIDENCE ON BEHALF OF THE PLAINTIFFS

MARY HARTMAN

having been called by and on behalf of the Plaintiffs, and having been previously duly sworn, was examined and testified as follows, to-wit:

DIRECT EXAMINATION

MR. KEEVER:

Q. Mary, you were already sworn in earlier in the trial, do you remember that?

A. Yes, sir.

Q. Well, I asked Donna this, how do you feel?

A. Nervous.

Q. Well, go ahead and introduce yourself, Mary, please, to the jury.

A. Hello. My name is Mary Hartman, I'm Donna Dewey's sister and the deceased Kenneth Bieler's sister. Uh, I live in Preston, Kansas. I have two grown sons and eight grandchildren. And I live on a farm.

Q. How long have you lived in Preston, Mary?

A. Since 1982.

Q. So, Donna told us a little bit about you and Kenneth and Donna growing up in Kansas, tell us about your first memory of Kenneth?

A. When we went into the room, it was a little smaller than this one -- uh -- we walked into the room and Kenneth was sitting there and he had the biggest hands I've ever seen in my life. He was a very tall boy, very dark complexed, he had curly black hair.

Q. And -- uh -- what -- what did he say to you?

A. You know, Mr. Keever, I -- I really don't recall, all I know is he was just the cutest little guy and Donna was scared of him. I wasn't scared of anything. I never was scared of anything, that always got me into trouble, either that or my mouth did, one of the two. (LAUGHS)

Q. Well, now -- and -- and -- and instead of going forward and backing up, I'll try to be a little better with you. Uh -- tell us -- uh -- about you and Donna before you got to the foster home in Topeka, was it?

A. Yes. Donna and I were placed in a -- a -- an adoption orphanage and back then I guess, you know, since I was there I guess I experienced it, but there were potties all along the wall in the hallways where we pottied every certain hours, and there was a big place where there were high chairs all over, and we had to eat in high chairs even at 3 and 4 years old.

And then in -- in the bedrooms there were cribs where the cribs were lined down the walls where each child's crib was kind of touching each other, but there were rows where the ladies could go up and down the rows and take care of the

children.

Well, the first night Donna and I were in the orphanage or thereafter, she was screaming in the crib and they had separated us and put her on one side of the room and me on the other and we were screaming. So I was jumping across the cribs all the way to the other side where I got my sister and I laid down with her, I went to sleep. Of course, you know, that's how it went in the orphanage while we were together because it was one for all and all for one. Donna and I were inseparable, that was our pack, whether or not we ever got adopted didn't matter to us as long as we were together. We were all we had. And that's until Kenneth and mom and dad came along.

And I -- I have to say I was the one who was wanting my mother and my father more than Donna because I was out there politicking so to speak, you know. You knew you -- you make yourself look really good for the parent. You're like a commodity on the market.

Q. And tell us again where the orphanage was?

A. The orphanage was in Nebraska. And the foster home was in Topeka.

Q. Have you been back since?

A. Well, we went back to get the paperwork and talk to the Christian Service League about our adoption, and it was not the same place but it was the same place, if you know what I mean. Not the same building but the same place.

Q. When -- when you and Donna meet Mr. and Mrs. Bieler -- uh -- this is -- this is what time of the year?
A. Huh! Don't ask me.
Q. What season, do you remember? The season?
A. I think it was just before my sister's birthday. I -- I don't recall too much about it, Mr. Keever. I -- I -- all I -- all I could recall was the ride home and the excitement that we had that we had a new brother, a new mom and dad, it was very exciting for me.
Q. Donna was -- was asleep when you got to Hays -- or Ellis?
A. Yes she was.
Q. What do you remember about that trip out to the car and your new home?
A. Well, as you walk up the drive there was a great big porch, and it had the old time fret work. And it had a beautiful front screen door and a huge wood door and with a beautiful oval window. And we ran up the stairs, and as the door opened you walk into the living room and it had a chandelier and it had all the wood. It was the most beautiful place I'd ever seen in my life. It was wonderful. I was so excited. And Kenneth showed us to our room and showed us around the house. And the dog came plunking out and it was just like we were home.
Q. Had you guys ever had a dog before?
A. No. Not that I'm aware of.

Q. Did you always have dogs while you were growing up with --
A. -- always had dogs. Always had dogs and even in my own life we've had dogs, cats, kids, and cows and pigs and chickens and turkeys.
Q. Uh -- how about when you were growing up in Ellis, Kansas. I mean we heard the walnut story, and we heard the motorcycle story -- uh -- what can you tell us kind of in the grade school thereabout years that would kind of give us a sense of you and Kenneth and Donna growing up together?
A. Kenneth was the oldest, and of course, he'd been in Ellis a year before us. So, the children knew one that we were adopted, and two that we were dark-haired children and a little bit different, and three that we weren't from Ellis, you know, our heritage wasn't there. And it was kind of like we had three strikes before we really got started.
Q. Three?
A. Three. Three strikes and you're out, you know, But we -- we all three fought our way through it. Uh, Kenneth was the oldest like I said, and then when he became a freshman in high school, he was there for two years more -- two years before I got there. And on the first day that I went to high school some of the younger kids, my classmates made fun of me, and my brother's friends and he came walking up and they said, you guys are in high school now grow up. And they did. So, he protected me.

Q. Did you all -- did you all ever get in trouble, all three together as kids?
A. Yes we did, all the time.
Q. Can you give us -- can -- can you give us the three Indian children's story?
A. Well, here we were all standing in a row and we were in trouble by mom and dad. And they wanted to know exactly, exactly what we did. Nope, we're not going to tell. Kenneth was tallest, Donna was smallest, and I was in the middle. And so, we were kind of like a stair step if you could imagine that. But dad was sitting there and mom said, now who did it? Kenneth, who did it? No not me. Donna, who did it? Not me. Mary Jo, who did it? Not me. Well, you're all three going to get it if -- if none of you tell. And, of course, you know, brothers and sisters they never tell right. So, we didn't tell. So we all got it. We all got spanked. And I can't really remember what that was all about, sir. I -- I do know, remember all of us got spanked.
Q. It was the other brother and not me that did it?
A. Well, it was the fourth brother and we didn't have him. It was the dog that did it.
Q. Well, Mary, you and Donna and Kenneth were all adopted, you and Donna were birth sisters, or I guess you said half-sisters. How did that -- how did that work with you guys in terms of how you felt about each other growing up?

A. We never realized any of it. The moment -- the moment we saw Kenneth and the moment Kenneth said, I'll take both of them, we were family, we were brothers, we were sisters. There was -- there was never any -- any thought of what adoption was. I don't really even think we understood the concept. I thought everybody was adopted. I'm sorry.

Q. When -- uh -- I want to kind of fill in some of the -- some of the -- the -- the area after Donna and Mary and Kenneth -- uh -- kind of left the nest so as to speak. Now you were two years behind Kenneth and Donna was three years behind and we heard about Kenneth going to vo-tech school and then going to California for, you know, 14 or 17 years. Fill in the little bit of the details about your life during the period of time after you graduated from high school and -- and how you kept in touch, or did not, with Kenneth and Donna, what your contacts were over the, say the next ten years?

A. Kenneth left for California when I was getting married in '72. Uh, I first -- well, I went -- I went to Colby Judco in Colby, Kansas on a scholarship. And met my husband and got married. Kenneth in the meantime was in California.

My husband went into the service and he took me to Illinois and I became pregnant, and then we went to Fort Eustis, Virginia. He became an Army Spec 4 and we had two children together and I was on the east coast in Virginia when things went bad. He and I didn't get along anymore so I left

him and then in the meantime Kenneth was on the east [sic] coast we never -- we -- we talked to each other. We sent letters to each other, on the phone, and I sent him a Christmas gift a couple of times and he reciprocated that he received it. But that's just about all there was to it. I mean we were way too many miles apart and living our own lives, and I had two babies and a husband, and then I got divorced and moved to Kansas.

Q. And -- and contacts with Kenneth after you came back -- what did you do when you got back to Kansas?

A. I went to college for 4 years.

Q. At?

A. At working. I went to college Fort Hays State University, graduated with a bachelor's degree and worked my way through with loans and grants.

Q. And how long were you up in Hays? And we've had our geography lesson --

A. -- right, right --

Q. -- Hays is -- is how far from Ellis in what direction?

A. It's only 15 miles. Hays is only 15 miles from Ellis. So, I was fairly close to mom and dad all the time.

Q. And after college?

A. Uh, after college I went to teach one year at Lincoln, Kansas, and that's up by Salina, Kansas and that's straight up from Hays, Kansas. And then we moved to the farm and that was

the end of that.

Q. And you moved to the farm because?

A. Oh, I married my husband.

Q. Jim?

A. I met and fell in love and married my husband. He took my two children in. He loved them and they love him like the only dad they ever had. And sometimes we have to be reminded of that, unfortunately.

Of course, my first husband passed. He had some health issues and passed on. But my boys believe that their dad Jim is their dad.

Q. Down in Preston. Where are your sons at now, Mary?

A. They're home. They live around the hub, 50 miles from me.

Q. Are they in -- are they in farming also?

A. No they're not, one is an electrician and the other works on oil rigs.

Q. What kind of contacts were you having with Kenneth during this period of time -- we've heard Donna's contact. Let's kind of backup, when Kenneth came home from California and then Crystal was born and then Kenneth and Crystal moved to Garden City?

A. Kenneth came home from California with a girlfriend who was pregnant with his baby. He stayed at my house for a couple of months and worked, and then he went to WaKeeney. He then -- had -- they had the baby and they were in WaKeeney and I was in

Preston, Kansas. I had two sons that were growing up. I had to help on the farm, as well as, do an outside job. I didn't have a lot of time to go visiting people. I was busy with my life and so was Kenneth. And from all aspects of it when I would have called mom and dad and talked to Kenneth also or Donna, he was doing fine, Crystal was fine, Debbie was fine, everything was good, and that's how we kept in touch, through mom and dad.

Of course, we'd go there for Thanksgiving or Christmas, everybody would meet there and kind of have a family get together and then we'd all go back our different directions. We had three different directions to go. And so that's how that went. Mom and dad were the central hub and then it was us and we kind of shot back and forth.

Q. Donna talked to us a little bit about the period of time when she had Crystal in her family and she moved from Ransom to Missouri -- uh -- what were your contacts with Donna and Crystal and Kenneth during that period of time?

A. I visited Donna numerous times in Ransom. Saw Crystal, the kids. We talked about Kenneth and Crystal, and what was going on and -- and it seemed okay. Everything was going okay so we didn't rock the boat. We just left it as it was. And Kenneth would have come home sooner or later.

Q. Did you -- what kind of contacts did you actually have with Kenneth during that period of time?

A. At that period of time I really didn't have much contact with him. I knew where he was but I really didn't have any contact with him. When daddy got sick, Kenneth -- we got a hold of Kenneth and he came home.

Q. Now Donna talked about -- you know Donna's wedding in '78 and grandpa Bieler's death or '77, and then grandpa Bieler's death in '78, which of course was a long time before that. Uh, what do you remember about get togethers with Kenneth on those occasions?

A. Well, he and I were -- uh -- best man, maid of honor or whatever, together at Donna's wedding. And I was into -- I don't think I was there for the children's baptismal because I don't think I was around. I don't recall whether I was somewhere over here or over there. I really don't know where I was.

Q. -- Virginia --

A. -- Okay. But I didn't go to those but I did come and go to mom and dad -- or grandpa's funeral. And I was there for holidays.

Q. Mary, we're talking -- you know the three of you were adopted and you told us as children, thought everyone's adopted, but as you became an adult can you share with the jurors what adoption feels like as an adult? Is that a fair question for you?

A. Sure. No matter how happy you are or perhaps sad you are

with your own family, my mom, my dad, or with your own birth -- biological parents, we -- we -- the adoption for me there was a little void, right here, and it wasn't in the heart. There was something missing, there was a piece of information that I didn't have. And so, I thought I really needed to find out that piece of information.

One was, where were my roots. And where -- what happened that I was placed up for adoption. I didn't know and I needed to know. So that little void needed to be filled. When adoption became open in the State of Kansas, they -- they contacted my mother, my birth mother, and she called me on the phone.

MR. COX: Your Honor, I'm going to object.

THE COURT: Don't tell us what somebody else said.

MR. COX: And I want to object to the relevancy of it. Her claim is for mental anguish.

THE COURT: I understand. Let's move on.

MR. KEEVER: Okay.

CONTINUED DIRECT EXAMINATION

MR. KEEVER:

Q. Mary, we'll -- let's move onto another question.

A. Okay.

Q. Uh -- when -- uh -- when you were -- when you guys were growing up and then -- uh -- later, what were your parents,

what -- what did you understand from your parents about your heritage or what help did you have, if any, from your parents in finding your heritage?

A. My parents -- mom and dad did not help Donna and I because we had each other. They helped Kenneth but they didn't help us because they figured that we would -- we would find out on our own.

MR. KEEVER: Could I have just a moment?

THE COURT: Sure.

(COUNSEL CONSULTS WITH HIS FILE)

MR. KEEVER: I apologize for that little delay.

CONTINUED DIRECT EXAMINATION

MR. KEEVER:

Q. What -- Mary, what efforts did -- did Kenneth go to, of which you were aware to find his heritage?

A. Kenneth found his birth -- biological mother, his biological father was dead, and he was able to meet both, or meet her, his sister and I do believe a brother, but I'm not real sure about that, because he told me about his brother. But anyway, his sister Diane and his mother.

Q. And have you had an opportunity to meet Diane?

A. Yes I have. I've met Diane several times.

Q. And did you have an opportunity to meet Kenneth's biologic mother?

A. No I did not.

Q. Okay.
A. He wanted me to but I -- when I was down here in Arkansas. I came down in Arkansas several times seeing Kenneth.
Q. And when was that, Mary, that you came down --
A. -- between 2001 and 2009, the year before Kenneth died. I'm not real sure on the dates or. I -- you -- you do -- you -- you take a vacation or you go somewhere for 3 days you don't write it down, you're not sure what you do.
Q. Sure. Uh -- when you were coming into Arkansas to see Kenneth -- uh -- was -- was Crystal with him?
A. No he had told me that --

MR. COX: -- Your Honor, I'm going to object --

WITNESS: -- oh, I'm so sorry.

THE COURT: Don't tell us what somebody else said. Just listen to what he's asking you, that's not what he asked you. He just asked you was she with him so listen to his question. Go ahead.

A. No she was not.
Q. Well, Mary -- uh --
A. He did give me a graduation picture, does that count?
Q. He -- Kenneth gave you a graduation picture?
A. Of Crystal yes.
Q. From high school?
A. Yes. He was so excited.
Q. What did it look like?

A. She's beautiful. I told him, I said, she looks just like you unfortunately but she's beautiful. (LAUGHS) As tall as he is, very pretty lady.

Q. Mary, when -- when was the last time that you saw your brother? Can you date it for us?

A. Boy I can do that. Uh, memorial day the year before he dies. The -- well -- yeah -- within the six months.

Q. And what was the occasion?

A. We have a family reunion every memorial day weekend and he came home.

Q. And that would have been in Ellis?

A. Yes.

Q. When was the last time you talked to your brother?

A. Probably about two weeks before he died. No I take that back, two weeks before his accident, that's when I talked to him.

Q. Before he broke -- or his leg was broken?

A. Yes. Yes. I had asked him to -- to -- uh -- uh -- what we were going to do with mom. We had conversations a lot about what was going on with mom. And -- uh -- I wanted him to come home and he said, he would. And -- uh -- uh -- we -- he -- he asked me if I was planning on building on and that did I need any help.

MR. COX: Your Honor, I'm going to object to conversations they had.

THE COURT: All right, just stay on what you know about it and not what he told you.

Q. Okay. Well, during your contacts with Kenneth, and we heard about how your mom had developed Alzheimer's and so forth --

A. -- right she had -- she was living with me.

Q. And what kind of -- what kind of contacts or -- or help -- or -- or was Kenneth involved in, maybe a better way is what was Kenneth's involvement in her care and the decisions about her care, Mary?

A. We discussed things of what was going on with her. Uh -- uh -- what was happening to her. I did not want to take all the respons -- I was the child that was at home and I didn't want to take all the responsibility in putting her in a nursing home or taking her away from her home, or making the decision that she was -- bad enough to go to a nursing home. And that's what I was trying to do.

Q. And what did Kenneth do in terms of helping you?

A. He told me that he --

Q. -- all right -- what -- what did he actually do?

A. He did not do anything except talk to me on the phone! How's that? Because I didn't ask for anything! I'm not an ask for anything kind of girl!

Q. Sure. Was Kenneth able to come home and see his mother during that last couple of years of his life? Well, I guess he

did --

A. -- yes he did, he came home memorial --

Q. -- yes, memorial day --

A. -- day weekend. We had -- we had a picture taken, it was nice.

Q. How was -- how was your mom's mental status at that memorial day weekend?

A. She knew who I was. She knew who Kenneth was. We stood outside. We had a nice picture of all three of us together. He stayed at the house with mom for two days, two and a half three days.

Q. And -- how did you -- what contact -- did you have any contacts with Kenneth after he was admitted the first time to the hospital with the broken leg?

A. Yes I did. Kenneth called me -- called me and said he was in the hospital --

Q. -- and he called you. Was -- was -- uh -- were you making any plans to come to Arkansas to see him?

A. Yes I was. I told him, I want to come to Arkansas to see you.

Q. And -- uh -- what were your plans going to be, Mary?

A. I was coming up with my mother and my sister to see him.

Q. When were you guys going to do that?

A. We were going to do it immediately. He said no, wait three weeks.

Q. So, what was the new expected date that you guys were going to come visit Kenneth?
A. Sunday.
Q. I'm sorry?
A. The Sunday after he died. It was that Sunday I was getting ready to leave.
Q. How did you learn about Kenneth's death?
A. My mom.
Q. And when was that?
A. After I got home from work.
Q. Was it the day after Kenneth died?
A. No. It was the day he died. He died midnight and she called me and I said, mom, we're getting ready to go. You know, I'm -- I'm going to come get you. Uh, Kenneth's dead. My whole world just blew apart right there. It was not something I expected. And there was my mom 150 miles away from me and I couldn't go to her. And my sister 500 miles away and I couldn't go to her.
Q. When did you --
A. -- I went ballistic I do believe, I would call that ballistic.
Q. When did you -- when did you guys get together and -- and actually come to Arkansas?
A. Mom and I finally came to Arkansas four months later to pick up Kenneth's -- uh -- not his remains, but his --

Q. -- effects?

A. Yes.

Q. Mary -- uh -- Kenneth had a funeral in Ellis?

A. Yes.

Q. And where's Kenneth -- where is Kenneth buried?

A. Kenneth is buried by dad.

Q. And that's in Ellis?

A. Ellis.

Q. And how did your mom do right after Kenneth's death?

A. Well, I wasn't at the house when she told me he was dead. Uh -- when I got there with Donna -- uh -- mom wasn't doing very well. Uh -- she just wasn't doing very well. Kind of like me right now, my mind is kind of gone but. Uh -- her's totally left her when Kenneth -- we had to wait -- uh -- 7 days to receive his body. And in that 7 days we planned the funeral. And did all these other things, trying to keep mom calm. We had her call the people for the pallbearers and, of course, the pallbearers said yes, they were his classmates. And they said yes they would. And mom hung up the phone and then she barely hung up the phone and said, well it's time to go call those pall -- pallbearers again. And we said, what are you doing, mom, you already did that. She could not recall that.

And then we went up to the -- uh -- funeral home and saw Kenneth for the first time, and he'd lost about 25 -- I'd say

25 to 30 pounds since May, or more, because he was a big ole brawny guy, you know, with the kind of pot belly and he didn't have that anymore, he was very skinny. And -- uh -- he was yellow. And his hair had started really graying bad and mom said, that's not Kenneth, turned around and walked away.

Q. How long, Mary, after that before you and -- and Donna decided your mom needed to be in a -- be in a nursing home?

A. We really didn't decide. It happened because of what mom was doing. Mom was living with me and she just didn't see me as her daughter anymore. I was the nice lady who took care of her, who brought her places and did things with her. And one night she came to our bedroom and had her bra over her head and her purse and nothing else on. And that night I said, mom, you need to go to bed and she became very violent with me and very angry.

And then she told me she was leaving and instead of taking her to a hospital I tried to make it through the night. I laid a mattress on the floor, at the door and let her sleep in a recliner. I put covers over her and slept in the recliner so she wouldn't leave the house and that's why I put her in a nurse -- Oh, I didn't put her in the nursing home first. I took her to the hospital because I felt like she was taking some drugs. She was taking benadryl, which is not good for old people. It kind of messes up their memory. And I thought maybe that was what was affecting and maybe we could get

something that would make her better. And she was taking them and also some Aricept, doing all those things.

Anyway, but I took her to the -- to the hospital and 6 weeks later they said I could no longer care for her in my home I had to put her in the nursing home and I did.

Q. How much -- how much do you -- can you tell us how you miss your brother Kenneth?

A. -- We once -- we once had a family and now we're down to two. Mom doesn't recognize us, she passed several years back but her body is not dead and that is hard. Her soul is still there but it's her -- her mind is gone, she's gone. We are the friends, the friends of her.

Knowing Kenneth is gone is one -- is worse than my father dying My father died because he was ill. He suffered a year and then he died. I was grateful for his death. I was glad he passed because he was in so much pain. My brother, however, broke a leg and died. Where's the justice in that?

MR. COX: I'm going to object to that and ask it be stricken.

THE COURT: Sustained.

Q. Mary, how much do you think about Kenneth now and how much --

A. -- every day, every day.

Q. -- and how much do you miss Kenneth now?

A. The same as it was the very first day I learned he died.

Every single day. Every single day I think of my dad too. Every single day I think of anybody that I love, but I miss him because he's my brother. I'm never going to have another brother, never, ever.

MR. KEEVER: Thank you, Mary.

I'll pass the witness, Your Honor.

THE COURT: All right. Mr. Cox, any questions

MR. COX: I have no questions, Your Honor.

THE COURT: All right, you can step down.

(WITNESS DEPARTS THE WITNESS STAND)

MR. KEEVER: Your Honor, I have two other witnesses if we wish to go ahead.

THE COURT: Have you got one that will be pretty short, or do you know?

MR. KEEVER: I got one that will be real short.

THE COURT: Okay.

MR. KEEVER: Okay?

THE COURT: Yes.

MR. KEEVER: We'll call Bob Rogers, please.

TESTIMONY AND EVIDENCE ON BEHALF OF THE PLAINTIFFS

ROBERT LUTHER ROGERS

having been called by and on behalf of the Plaintiffs, and having been previously duly sworn, was examined and testified as follows, to-wit:

DIRECT EXAMINATION

MR. KEEVER:

Q. Would you give your full name for the court reporter, please, sir.

A. Robert Luther Rogers, better known as Bob Rogers.

Q. Okay. Mr. Rogers, would you introduce yourself to our jurors, please?

A. I'm Bob Rogers and I live -- I live in Fort Smith with my wife Susie, been married almost 40 years, got 2 kids. I've been with Midsouth Control and Supply now for about six and a half years.

Q. And what do you do?

A. I'm in outside sales. I travel around several states in outside sales with control and supply.

Q. Maybe you could tell us just in a very short -- uh -- paragraph or so, what's Midsouth Boiler, we've heard this name?

A. Okay. Midsouth Steam Boiler is the biggest part, it's the big part of the company. I work on the parts side which is Midsouth Control and Supply. Midsouth Steam Boiler I'm not for sure how many people they have, 70/80 people or something over there. We work on steam boilers, pressure vessels, things of that nature and I just -- I'm the outside sales person on the parts side.

Q. And -- and where is your operation located?

A. It's at 30 -- 3803 East Pointer Trail here in Van Buren.

Q. Now, Mr. Rogers, would you -- would you tell us how you

came to know Ken Bieler?

A. Ken Bieler was working for Midsouth Control and Supply when I went to work there. And for about the first week and a half or so that I was there, Ken rode around with me showing me where different customers were and different places of business was, kind of introduced me to quite a few different people and everything then. Uh, Ken was a -- Ken was a great guy to be with.

Q. What was your understanding as to why Ken was kind of assigned the -- I'm going to take let the customers meet Bob Rogers?

A. Ken -- Ken was very well liked. Uh, Ken worked on -- he was -- one of his big responsibilities he was the pump man. And Ken knew most all the maintenance managers and the maintenance people because he worked on the pumps and everybody -- everybody really liked Ken. He knew what he was doing and he was a very valuable asset to the company. And, therefore, I had the privilege of riding with him, it was very helpful to me.

Q. And how much contact would you have with Ken, you've been -- you were with him for six and a half years so probably three and a half years while Ken was alive and with Midsouth?

A. Yes. Uh, I didn't see -- I would see Ken in the mornings when I came to work. I would see Ken sometimes in the afternoon if he was working a little bit late. Uh, Ken got off

a half hour earlier than I did, but I'm only in the office for a very few minutes in the morning and I'm gone the rest of the day. I come in somewhere between 4 and 4:15 usually, we'd go home at 4:30 on the days that I'm in town, or in the area.

Q. Were you contacts sufficient for you to get a feel of -- of Ken's -- oh, shall we say his qualities as an employee for Midsouth during that time?

A. Ken was very well respected. There are, I can think of one customer in particular that when we lost Ken we lost their pump business. Ken was just -- he was very good at what he did and people respected him. He had a lot of experience in the Navy with -- with boilers and being around boilers. And -- uh -- people really liked Ken. He was very good at what he did.

Q. Now, what can you tell -- were you involved with any of Ken's activities other than strictly at work?

A. Ken was very big into air shows and promoting air shows. Uh, there was a couple of times when -- I remember one time when he was riding with me, when I first started, he went by the air museum up in Fayetteville. And he introduced me to a few people and we picked up some brochures for an air show. And there were several different times when I would -- Ken would ask me to pick up brochures for an air show either there or some place in Russellville. Several different airports that I went to picking up stuff and dropping off information related to air shows.

Uh, the air show here in Fort Smith -- uh -- I met Ken out there one day. I was out there with my family and some of my son's friends, and we ran into Ken at the air show, hung around with him for several hours out there. Ken was just really big into air shows. He really -- really did like -- really liked them and did a lot to promote them.

Q. Now, Mr. Rogers, what can you tell us about Ken's hospitalization at Summit. He -- we know that he was admitted with a broken leg on January 6, 2009, and he went to the Ashton Place for rehab on January 9, 2009, and he was readmitted to Summit on January 13, 2009 until his death. So, what -- what do you know about that period of time, what were your contacts with Ken?

A. Uhm, I would go and visit Ken a lot of times when I got off work in the evenings. And a lot of times, Dale McKinney who is my boss, Dale and I would alternate. I would go one night, me miss a night and then one of us would go the next time around. Uh, and we -- we went pretty regularly when I got off work to go by and see Ken and see how he was doing. And the big thing that you notice is that Ken was going down. And -- uh -- you know, and I saw him, I guess it would be -- Dale saw him the night before he passed away, I saw him the night before that. And Ken's breathing was very labored. He was having difficulty breathing and having difficulty communicating because he was so short of breath.

Q. Now did you -- and I want to get back to that -- that last visit of yours in a moment, Mr. Rogers, but in the period, you know, like from the first 10 days or so when he was in the hospital when you would go in and see him, how active was Ken?
A. Ken was really from what I could tell was not acting. He was in the bed the whole time I was, ever wanted to see him. I never saw him out of the bed.
Q. When he was in the bed was he in a moving around or --?
A. Uh, he was always covered up. He always had the blankets on him. Uh, there was not a lot of movement around him, he made some hand gestures and everything like somebody does when they talk, but it was not a lot of activity or anything that way.
Q. Now we know that Ken died around midnight on the 28th, and do we understand that the 28th day Dale McKinney was there and you would have been there the 27th?
A. Yes.
Q. How did -- how did Ken's breathing look to you on the 27th as compared to the -- the -- the last one, the visit a couple of days before?
A. It was much worse on the 27th. He was having -- talking was difficult for him. He was just very labored with his breathing.
Q. Uh -- what were your concerns? I mean were you concerned?
A. I was very concerned. I came back and told Dale, I said,

he's not --

MR. COX: I'm going to object, hearsay.

THE COURT: Sustained. Don't tell us what somebody, or what you told somebody else or that conversation.

WITNESS: Okay.

THE COURT: Rephrase your question.

MR. KEEVER: Okay.

Q. When you saw Ken on the 27th, what plans did you make in terms of following up or having another visit with Ken?

A. Well, I was going to go back and see him as soon as I could. Uh -- he was just -- he was just not doing well at all. He was struggling to breathe.

Q. And, when was the next time you went by the hospital?

A. The next time I went by the hospital would be the morning of the 29th then, and it was probably 7:30 to 8 o'clock in that vicinity when I went by the hospital and they told me that Ken had passed away.

Q. What -- uh -- what -- what was the attitude of the Midsouth employees, how did they react, appear to you to react to Ken's passing?

A. I mean we were all very hurt. We were very lost. We hated to lose Ken. Ken was a good guy to be around. He was a good employee, and he was a lost to the company.

Q. How about personally to Bob Rogers?

A. He was a -- I mean I considered Ken a friend. I really liked Ken Bieler. He was very easy to talk to, very friendly, and you know, we were both veterans and -- uh -- he was very personable. I liked Ken.

MR. KEEVER: Thank you, Mr. Rogers.

I think I'll pass the witness, Your Honor.

THE COURT: Mr. Cox, do you have anything?

MR. COX: I have just a few.

CROSS EXAMINATION

MR. COX:

Q. Mr. Rogers, during the time that you would be riding around with Mr. Bieler to these various places, you all had a lot of time to talk I assume?

A. Yes.

Q. Ken was a talker?

A. Ken liked to talk and he mostly talked about Navy, what -- what life was like in the Navy.

Q. Okay. At anytime did he ever talk about his family?

A. Very little.

Q. Okay. And remember I asked you in your deposition what knowledge or information you gained that Mr. Bieler might have had, and did you tell me I really knew almost nothing about his family? Did you tell me that?

A. Other than I knew he had a mother in Kansas -- uh -- and I really knew -- I knew he had a -- a sister or something here

in Fort Smith but that's about all I knew. We really didn't talk much about them.

Q. Okay. And you never heard Mr. Bieler mention that he had a daughter, I take it?

A. I do not remember that.

Q. Okay. And did you ever see anyone who purported to be his daughter to come by the place of business?

A. No. I was never there. I had heard that she'd come by, but I never saw her.

Q. Did you ever see any other family member come by the place of business to see Mr. Bieler?

A. I do not recall that, no.

Q. Okay. But Mr. Bieler never said a word to you about his having a child, did he?

A. Not that I can remember.

Q. Did he ever tell you that he had a grandchild that he had not seen?

A. I did not know anything about it.

MR. COX: All right, thank you, sir.

THE COURT: Anything else?

MR. KEEVER: No. I want to thank Mr. Rogers and may he be excused?

THE COURT: All right, you're free to go.

(WITNESS DEPARTS THE WITNESS STAND)

THE COURT: Have you got another short witness

or are you going to have another?

MR. KEEVER: It -- it will probably be 30 minutes anyway, Your Honor, and he can come back.

THE COURT: All right. Ladies and gentlemen, as I told you earlier tomorrow we're going to have to recess and I have some other business to take care. I'm sorry about that but this is kind of the way it works, there's just a lot of things going on here all the time. So, what we're going to do is plan on coming back Thursday at 1 P.M. I have a little business Thursday morning and I promise you, you wouldn't want to be here for that because it's mostly juvenile court. So.

Let me read you an instruction just to remind you of some things here.

COURT'S INSTRUCTION TO JURY

THE COURT: Do not communicate about this case and the places and persons involved by any means whatsoever with anyone at all, or look for or receive any information whatsoever about this case other than the evidence in this court room and the law as I've instructed you until your jury duty is complete and I have discharged you.

Also, remember that the parties have entrusted their case to you, all of us are depending on you to

follow these rules so that you will fairly and justly decide the case based solely on the evidence presented in court before the parties and the law as instructed by me and not on any other sources of information. If you become aware of any violation of any of these rules at all, notify the bailiffs or court personnel.

If you want to leave your notebooks and stickers in your seat, again you can do that, I'll make sure the bailiff doesn't allow anybody to mess with any of that even though there will be some other court that's probably a better way to do it. If you want to take your notebook, you're free to do that. I'd hate for you to come back and have forgotten it at home, but if you feel better doing that certainly you can do that. And I don't object to you taking the juror badge, just whatever you're comfortable with that will be fine to do that either way, if you want to leave them fine, we'll leave them right where they are they'll be here when you come back, if you want to take them I'm not sure they'll get you any discounts anywhere by wearing them but certainly you're free to do that if you want to do that.

Any questions or anything? Did everybody get a work note if they need one, everybody get those?

Okay. All right, then I'll see you back Thursday at 1 P.M. and that's all of you.

You're free to go.

(4:30 P.M. COURT RECESSES)