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UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

Case No. 1:08-MD-01928-MIDDLEBROOKS/JOHNSON

IN RE TRASYLOL PRODUCTS LIABILITY
LITIGATION – MDL-1928

This Document Relates to:

Naguib Bechara, et al., v. Bayer Corp., et al.,
Case No. 9:08-cv-80776
_____/

BAYER'S OPPOSITION TO PLAINTIFFS' MOTION TO EXCLUDE EVIDENCE OF SETTLEMENT AGREEMENT AND PLAINTIFFS' POSITION IN PRIOR ARBITRATION PROCEEDING

Defendants Bayer Corporation, Bayer HealthCare Pharmaceuticals Inc. (as successor in interest to Bayer Pharmaceutical Corp.), and Bayer Schering Pharma AG (as successor in interest to Bayer Healthcare AG) (collectively, "Bayer") oppose plaintiffs' motion *in limine* to exclude evidence of plaintiffs' prior arbitration proceedings against Kaiser Foundation Health Plan, Inc. and its doctors (collectively, "Kaiser") ("Motion") (D.E. 4378 in 1:08-md-01928; D.E. 101 in 9:08-cv-80776). In that arbitration, plaintiffs claimed that Kaiser's medical malpractice *before his heart surgery* caused Mr. Bechara's kidney failure. That alleged malpractice had nothing to do with Trasylol.

Bayer does ***not*** intend to offer evidence of plaintiffs' claims to show that Kaiser's malpractice was in fact the cause of Mr. Bechara's kidney injuries. Rather, Bayer intends to offer evidence of plaintiffs' malpractice claims because such evidence is directly relevant to plaintiffs' credibility and to Bayer's statute of limitations defense. The Federal Rules of Evidence leave it to the jury to consider plaintiffs' previous inconsistent statements and allegations in weighing plaintiffs' credibility and, if Bayer's motion for summary judgment

based on the statute of limitations is denied, in deciding when plaintiffs were on notice of their potential claim against Bayer.

In addition, evidence of the fact and amount of plaintiffs' settlement with Kaiser is necessary to determine the appropriate set-off of any award for economic damages as required by California law. Federal Rule of Evidence 408, on which plaintiffs' argument is based, does not preclude admission of evidence of the settlement for that purpose. More generally, that rule does not preclude evidence of such admission in the present circumstances.

BACKGROUND

Mr. Bechara's Quadruple Bypass Heart Surgery. On December 21, 2004, Mr. Bechara was rushed to the emergency room at Kaiser Permanente Anaheim Medical Center with chest pain. Kaiser Found. Hosp. Sunset ("KFH-Sun-MD") Med. R. (Ex. A) at 892. The attending physician diagnosed Mr. Bechara with "GI [gastrointestinal] atypical chest pain, secondary to GI cause." S. Cal. Permanente Med. Group ("SCPMG") Med. R. (Ex. B) at 391-93. After hours of repeated ventricular tachycardia, *id.* at 310-12, a cardiology examination revealed that Mr. Bechara had suffered a heart attack. *Id.* at 391-93. The cardiologist recommended a cardiac catheterization, *id.*, which showed evidence of severe heart disease. *Id.* at 396-97, 419, 788. Mr. Bechara was then transferred by ambulance to Kaiser Foundation Hospital Sunset in Los Angeles for quadruple coronary artery bypass graft ("CABG") surgery. *Id.* at 788; Kaiser Permanente Los Angeles Med. Ctr. ("KPLAMC-MD") Med. R. (Ex. C) at 31-33. Trasylol was administered during that surgery. KFH-Sun-MD Med. R. (Ex. A) at 132-33.

Mr. Bechara experienced a number of complications following his surgery, including kidney failure. He was diagnosed with acute kidney failure (following removal of a

balloon pump that had been inserted to assist his weakened heart) and was on hemodialysis for one year after surgery. *Id.* at 587; SCPMG Med. R. (Ex. B) at 241.

Plaintiffs' 2005 Medical Malpractice Claim Against Kaiser. In November 2005, plaintiffs filed a medical malpractice claim against Kaiser, alleging that Kaiser's negligence caused Mr. Bechara's kidney failure. Nov. 9, 2005 Ltr. (Ex. D); Cl. Arb. Br. (Ex. E) at 9; Bechara Dep. (Ex. F) at 24:19-21. In particular, plaintiffs alleged that Kaiser's "failure to timely diagnose and treat [Mr. Bechara's] heart attack, the negligent interpretation of electrocardiograms, and the failure to obtain a timely cardiology consultation" caused his kidney failure. Cl. Arb. Br. (Ex. E) at 9, 10. In response to interrogatories, Mr. Bechara stated that "[a]s a result of [Kaiser's] negligence, I suffered permanent heart and kidney damage." *See* Cl. N. Bechara's Resp. to Special Interrog. of Resp. (Ex. G) at 3-4. Plaintiffs retained three medical experts who opined that the failure of Mr. Bechara's physicians and hospitals to meet the standard of care proximately caused Mr. Bechara's kidney injures. *E.g.*, Oct. 12, 2006 Dep. of Peter C.D. Pelikan, M.D. (Ex. H) at 64:21-67:14, 86:12-16 ("Everywhere where care was delayed by an extra hour and a half or an extra hour allowed him to get to the point by that afternoon of significant hypotension such that he injured his kidneys and injured his lungs and had this terrible postoperative result."); Oct. 19, 2006 Dep. of Donald F. Nortman, M.D. (Ex. I) at 53:13-56:14, 87:17-90:4.

After approximately a year of discovery, plaintiffs' medical malpractice claim was settled in November 2006, with plaintiffs receiving $900,000 from Kaiser for Mr. Bechara's alleged kidney injuries. Release of All Claims (Ex. J).

Plaintiffs' Current Claims Against Bayer. On July 15, 2008, plaintiffs filed this action against Bayer, alleging that Mr. Bechara's kidney injuries were caused by Trasylol, not

the pre-operative medical malpractice on which his prior claim for the same injuries was based. *Bechara* Compl. (D.E. 1 in 9:08-cv-80776) ¶ 5. Bayer has moved for summary judgment on grounds that, *inter alia*, plaintiffs' malpractice investigation and arbitration proceedings reflect that plaintiffs discovered or should have discovered their claims in 2005 or, at the latest, in early 2006 (when the Mangano study was published in the *New England Journal of Medicine* and widely publicized in the popular press), and their claims are therefore barred by California's two-year statute of limitations. *See* Bayer Mot. for Summ. Judg. and Supporting Memo. of Law (D.E. 4019 in 1:08-md-1928; D.E. 73 in 9:08-cv-80776). This Court has not yet ruled on Bayer's motion.

Plaintiffs Conceal the Prior Arbitration Proceedings. In sworn answers to the Plaintiff Fact Sheet ("PFS") required by PTO 4 in this case, plaintiffs answered "NO" when asked whether they had ever "filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury, sickness or disease." Aug. 18, 2008 PFS (Ex. K) at p. 5, § II.N. Plaintiffs again failed to disclose the arbitration when the PFS was amended three months later. *See* Nov. 18, 2008 Ltr. Amending PFS (Ex. L).

The first cryptic reference to any previous litigation came on September 4, 2009 – more than a year after plaintiffs' complaint was filed. In response to the same question about previous claims for bodily injury, plaintiffs finally amended their answer to state: "Yes, Los Angeles Superior Court v. Kaiser Permanente; medical malpractice lawsuit not involving Trasylol." Sept. 4, 2009 Ltr. Amending PFS (Ex. M). Although the PFS also asked plaintiffs to "state the court in which such action was filed, the case name and/or names of adverse parties, and the civil action or docket number assigned to each such claim, action or suit," they failed to provide any additional information and the information given proved to be inaccurate. *Id.* Based

on these PFS responses, Bayer still had no information disclosing that the "Los Angeles Superior Court v. Kaiser Permanente" proceeding was in fact an arbitration or that it had anything to do with the 2004 surgery.

Mr. Bechara was finally forced to reveal to Bayer during his September 9, 2009 deposition that his claims against Kaiser "relat[ed] to the events that led to the [Trasylol] surgery," but still denied any recollection of the underlying facts and allegations. Bechara Dep. (Ex. F) at 23:2-29:23. At that time, plaintiffs' counsel also refused to provide more than the barest of information, citing "confidentiality concerns." *Id.*

Plaintiffs' Counsel Admits the Inconsistency of Their Causation Theory.

Immediately upon the completion of Mr. Bechara's deposition, Bayer moved to postpone Mr. Bechara's surgeon's deposition scheduled to be taken by plaintiffs the next day so Bayer could evaluate this significant change in the facts. At the hearing on that emergency motion, plaintiffs' counsel claimed they were unaware that their client had previously sued for the same injuries:

> [W]e suddenly for the first time this late in the game found out that our client had asserted a claim against [Kaiser] for ***essentially the same kinds of injuries that are involved in the instant litigation.*** So the net result of that is that the experts that were retained by the plaintiffs in that litigation against [Kaiser] were saying that *it was the fault of [Kaiser]*, ***not Trasylol***. . . . The only one that's hurt here by this revelation that at this late date we find out that ***our client has filed a separate claim for the same damages*** is the plaintiff.

9/10/09 Tr. (Ex. N) at 3-4 (emphasis added).[1] Plaintiffs conceded that defendants "get a credit for any damages that we recover on economic loss." *Id.* at 5. Contrary to their previous

[1] Counsel's purported surprise is belied by the fact that plaintiffs' causation expert, Dr. Quigg, had received records from the arbitration in plenty of time for him to review and consider them before formulating his final report, dated September 11, 2009, the day after this hearing. Quigg Rep. (Ex. O). Yet even while plaintiffs had provided the arbitration materials to their own

statements at the hearing, plaintiffs now characterize their prior allegations as "consistent" with and therefore irrelevant to their present claims as a basis for preventing the jury from hearing about and considering their prior claims.

ARGUMENT

I. PLAINTIFFS' PRIOR MEDICAL MALPRACTICE CLAIMS ARE RELEVANT TO PLAINTIFFS' CREDIBILITY AND NOTICE OF THEIR CLAIMS.

Plaintiffs claim that Trasylol caused Mr. Bechara's kidney failure. The fact that they previously brought a legal proceeding claiming that Kaiser's negligence caused the exact same injury on a different theory of causation is directly relevant to plaintiffs' credibility and the weight to be given to their testimony at trial, as well as to whether plaintiffs' claims are time-barred. Moreover, their untruthful sworn answers to PFS questions denying the existence of the claim, followed by the late, incomplete, and misleading disclosure of it, and the amnesia Mr. Bechara developed when asked about it in his deposition, all reflect a pattern of dishonesty and deception. The probative value of this evidence outweighs any slight risk of confusion or undue prejudice. *See Young v. Ill. C. Gulf R.R.*, 618 F.2d 332, 337 (11th Cir. 1980) ("Trial courts must not lose sight . . . of the liberal nature of the Federal Rules of Evidence. It must be remembered that the federal rules and practice favor the admission of evidence rather than its exclusion if it has any probative value at all.") (internal quotation omitted); *U.S. v. Dodds*, 347 F.3d 893, 897 (11th Cir. 2003) ("In reviewing issues under Rule 403, [a court must] look at the evidence in a light most favorable to its admission, maximizing its probative value and minimizing its undue prejudicial impact.").

experts, the *fact* of the arbitration (much less any of the arbitration records) still had not yet been disclosed to Bayer.

A. Plaintiffs' Prior Claims and Allegations Are Relevant to Impeach Plaintiffs' Credibility.

Courts have consistently found that a plaintiff's prior allegations may be relevant and admissible to attack a plaintiff's credibility. For example, in *Williams v. Union Carbide Corp.*, 790 F.2d 552, 553-54 (6th Cir. 1986), the plaintiff sued his former employer for injuries allegedly caused by exposure to toxic chemicals, after previously alleging in a separate lawsuit that an unrelated explosion was responsible for his injuries. The Sixth Circuit found that the previous allegations were admissible: "[T]he plaintiff's belief that the explosion caused his injuries is [ ] probative, not only to support [an] intervening cause theory ***but to impeach the plaintiff's accusation*** against [the current defendant]." *Id.* at 556 (emphasis added). The court found "no unfair prejudice in the admission of the prior allegations," noting that "[t]he hiring of an attorney and the filing of a lawsuit are generally done with considerable thought and care. Absent unauthorized conduct on the part of the attorney, ***there is nothing unfair about having to explain one's past lawsuits***." *Id.* (emphasis added).

The Tenth Circuit followed *Williams* in *Dugan v. EMS Helicopters, Inc*., 915 F.2d 1428 (10th Cir. 1990), where the plaintiffs alleged that the negligence of a helicopter owner and operator led to a crash, contrary to allegations in the plaintiffs' previous lawsuit that the helicopter manufacturer and maintenance company were responsible. The *Dugan* court held that evidence of the previous litigation should have been admitted because the plaintiffs' previous allegations were "directly contrary to the position plaintiffs [subsequently] took at trial" insomuch as "[t]he totality of the position taken in the immediate case is inconsistent with the allegations contained in the ancillary complaint." *Id.* at 1433. The court noted that plaintiffs'

prior allegations were admissible as substantive evidence and also "for [ ] impeachment value." *Id.* at 1434.[2]

Plaintiffs' argument against admission of the prior allegations is that the prior and current allegations are not completely inconsistent, and that complete inconsistency is required for admission. Motion at 13-15. But it should be up to the jury to determine the consistency – or inconsistency – of the claims in assessing plaintiffs' credibility. The sparse authority cited by plaintiffs – *Mitchell v. Fruehauf Corp.*, 568 F.2d 1139 (5th Cir. 1978) and *Spinosa v. Int'l Harvester Co.*, 621 F.2d 1154 (1st Cir. 1980), Motion at 14,15 – are not to the contrary. First, neither *Mitchell* nor *Spinosa* expressly considered the Federal Rules of Evidence, which were enacted in the mid-1970's. Second, in both cases the evidence was being offered as a substantive alternative causation theory, not for the purpose of impeachment. Third, state law in both cases made the evidence of the previous litigation irrelevant. In *Mitchell*, the decedent was killed when a meat trailer overturned onto his truck. Plaintiff first sued the trailer driver, then later sued the trailer manufacturer. Relying on Texas state law, the *Mitchell* court refused to allow admission of plaintiffs' prior claim against the driver because negligence of the driver would not exonerate the trailer manufacturer. 568 F.2d at 1146-47. Similarly, in *Spinosa*, the plaintiff sued a truck manufacturer for personal injuries and wrongful death arising out of a truck accident, having previously sued the driver of the truck. 621 F.2d at 1157. New Hampshire state law

[2] *See also Brewer v. Jones*, 222 Fed. Appx. 69, 70-71 (2d Cir. 2007) (upholding district court's admission of evidence of previous lawsuit); *Vincent v. Louis Marx & Co.*, 874 F.2d 36, 41 (1st Cir. 1989) (prior litigation where the plaintiff alleged that a bicycle accident was caused by a driver's negligence admissible when the same plaintiff later alleged a design defect against the bicycle manufacturer); *Kassel v. Gannet Co.*, 875 F.2d 935, 952 (1st Cir. 1989) (concluding that trial court "threw out the baby with the bath water" by erroneously excluding a brief filed by the plaintiff in previous litigation which "flatly contradict[ed]" plaintiff's current theory of damages); *Hancock v. Dodson*, 958 F.2d 1367, 1372 (6th Cir. 1992) (finding evidence of earlier suit alleging a different cause of injuries to be admissible).

allowed the jury to find the truck manufacturer at fault even if the driver was also negligent. *Id.* Given that these cases were relying on state law from Texas and New Hampshire to provide the standard for admission, neither are binding – or even persuasive – here.[3]

Even if there were some requirement that the prior allegations be inconsistent in order to be admissible, the facts of *Mitchell* and *Spinosa* are entirely different from the facts here. In both of those cases, the theories of causation were not at all inconsistent. In *Mitchell*, the plaintiff alleged in both cases that the decedent was killed by the overturning of the trailer; in *Spinosa*, the plaintiff alleged in both cases that her injuries were caused by the truck accident. In this case, plaintiffs previously alleged that Kaiser caused their injuries by delaying treatment; in this proceeding, they alleged that Trasylol caused the exact same injuries and deny that Kaiser's actions before the surgery were the cause. On their face, these allegations are inconsistent. It is up to the jury to decide whether and how they take this inconsistency into account when judging the credibility of the plaintiffs.

Moreover, the evidence of plaintiffs' concealment of the arbitration proceedings in the PFS – a document in which Mr. Bechara swore to be truthful – and then the disclosure of those proceedings in a misleading and incomplete manner also go directly to their credibility. The jury is entitled to know not only that plaintiffs made prior inconsistent allegations, but also that they attempted to conceal those allegations and proceedings (and the resulting $900,000

[3] Plaintiffs also cite *Kassel v. Gannett*, 875 F.2d 935 (1st Cir. 1989), ostensibly in support of their argument against admission of evidence of the arbitration proceedings. Motion at 14. However, *Kassel* held that the exclusion of the plaintiff's previous allegations was erroneous. *Kassel* at 952 (concluding that the trial court "threw out the baby with the bath water" by erroneously excluding a brief filed by the plaintiff in previous litigation which "flatly contradict[ed]" plaintiff's current theory of damages).

settlement) from Bayer, when determining the weight to be given to plaintiffs' current claims and testimony.[4]

B. Plaintiffs' Prior Claims are Relevant to Whether Plaintiffs' Current Claims are Time-Barred.

Not only is evidence of plaintiffs' prior arbitration allegations probative of their credibility, it is also relevant to Bayer's statute of limitations defense. In response to Bayer's summary judgment motion, plaintiffs argued that "genuine issues of fact exists [sic] as to whether the available facts were sufficient to put Mr. Bechara on notice of his claim more than two years before it was filed" and that therefore "the statute of limitations is a matter for the jury." Pl. Resp. in Opp. to Bayer's Mot. for Summ. Judg. and Br. in Support Thereof (D.E. 4576 in 1:08-md-01928; D.E. 109 in 9:08-cv-80776) at 11. If in fact this Court finds that there are genuine issues of material fact for the jury to decide related to the timeliness of plaintiffs' claim, then the arbitration is relevant to plaintiffs' notice and investigation of their potential claim, and such evidence is admissible for that purpose.

C. Evidence of Plaintiffs' Prior Claim and Allegations Will Not Unduly Prejudice Plaintiffs.

Rule 403(b), which prohibits otherwise relevant evidence "if its probative value is substantially outweighed by the danger of unfair prejudice, confusion of the issues, or misleading the jury, or by considerations of undue delay, waste of time, or needless presentation of

[4] California courts have consistently recognized that parties taking inconsistent positions in legal proceedings have "an adverse impact on the judicial process . . . The policies underlying preclusion of inconsistent positions are general consideration[s] of the orderly administration of justice and regard for the dignity of judicial proceedings . . . It seems patently wrong to allow a person to abuse the judicial process by first [advocating] one position, and later, if it becomes beneficial, to assert the opposite." *Jackson v. County of Los Angeles*, 60 Cal. App. 4th 171, 181 (1998) (internal citations omitted). Plaintiffs filed a claim attacking the professionalism and judgment of the doctors who treated him. They made a serious claim that could have affected the defendants' livelihood. They cannot now pretend it never happened in an effort to hide their prior inconsistent allegations.

cumulative evidence," does not bar admission of this evidence. The evidence at issue here "prejudices" plaintiffs only by undermining their credibility and showing notice, which is precisely the point. *See U.S. v. Wright*, 392 F.3d 1269, 1276 (11th Cir. 2004) ("[I]f all evidence were favorable [to one party], there would be no trial."). The fact that the evidence tends to rebut certain aspects of plaintiffs' case does not mean that it should be excluded: "Virtually all evidence is prejudicial or it isn't material. The prejudice must be 'unfair' [to be excluded]." *Ballou v. Henri Studios, Inc.*, 656 F.2d 1147, 1155 (5th Cir. 1981). The Eleventh Circuit has acknowledged that "[s]imply because the evidence is damaging or prejudicial to a [party's] case does not mean . . . that the evidence should be excluded. It is only *unfair* prejudice, *substantially* outweighing probative value, which permits exclusion of relevant matter under Rule 403." *U.S. v. Terzado-Madruga*, 897 F.2d 1099, 1119 (11th Cir. 1990) (emphasis in original; internal quotations omitted).

The evidence of the arbitration is not confusing: In 2005, plaintiffs claimed that medical malpractice by Kaiser before Mr. Bechara received Trasylol caused his injuries. Now they claim something entirely different and deny that the alleged malpractice was the cause. *See Tomaino v. O'Brien*, 315 Fed. Appx. 359, 361 (2d Cir. 2009) (affirming admission of prior litigation because "the fact of these former lawsuits [was not] particularly inflammatory or potentially misleading"). This is not a case like *Specialized Transp. of Tampa Bay, Inc., v. Nestle Waters*, No. 09-12807, 2009 WL 3601606 (11th Cir. Nov. 3, 2009), the only case cited by plaintiffs in support of their unfair prejudice argument. *See* Motion at 15-16. In that case, the court affirmed exclusion of prior complaints under Rule 403 because"[t]he prior complaints had little probative value, as Nestle was able to elicit the facts of the complaints from the witnesses." *Id.* at *4. Here, Mr. Bechara could not remember details of the arbitration proceeding, leaving

the pleadings, his interrogatory responses, and the sworn depositions from the arbitration proceedings as the only evidence that can be proffered. Bechara Dep. (Ex. F) at 23:2-29:23.

D. Plaintiffs' Prior Claim and Allegations Are Not Hearsay.

Rule 801(d)(2) – which provides that party admissions are not hearsay – encompasses allegations made by a party or by his attorney in the course of previous litigation. *See Williams*, 790 F.2d at 555-56 (citing Second, Seventh, and Ninth Circuit decisions treating various attorney statements as party admissions); *Hanson v. Waller*, 888 F.2d 806, 814 (11th Cir. 1989) (letter from plaintiff's attorney to defense counsel admissible against the plaintiff under Rule 801(d)(2)(C)) (citing *Williams*). Accordingly, any statements made by plaintiffs (*e.g.*, in deposition testimony or interrogatory responses) or by their attorneys (*e.g.*, in pleadings or briefs) are not hearsay.

II. THE FACT AND AMOUNT OF PLAINTIFFS' SETTLEMENT WITH KAISER ARE ADMISSIBLE.

Most of plaintiffs' motion is devoted to arguing that the fact and amount of the settlement between plaintiffs and Kaiser are not admissible. Motion at 5-13. But plaintiffs completely ignore the California statutory set-off requirement, which allows this Court to admit evidence of the fact and amount of the settlement payment made by Kaiser, a settling tortfeasor. Federal Rule 408, which should not apply to settlements with a third-party or when settlement is offered for purposes other than to prove liability for a claim, does not change this result.

A. Evidence of the Settlement Agreement is Admissible for Set-Off Purposes Under California Law.

The fact that plaintiffs settled with Kaiser for $900,000 is admissible as relevant to the set-off required by California law.[5] California statutory law entitles a defendant to a set-

[5] The apportionment of damages is a substantive issue; therefore, this Court must apply California law. *See Stuckey v. N. Propane Gas Co.*, 874 F.2d 1563, 1571-72 (11th Cir. 1989);

off from a plaintiff's award of economic damages[6] in the amount of pre-trial settlements paid to the plaintiff by other tortfeasors:

> Where a release, dismissal with or without prejudice, or a covenant not to sue or not to enforce judgment is given in good faith before verdict or judgment to one or more of a number of tortfeasors claimed to be liable for the same tort. . . it shall reduce the claims against the others in the amount stipulated by the release, … or in the amount of the consideration paid for it whichever is the greater.

CAL. CIV. PROC. CODE § 877 (2009) (emphasis added); *see also Slaven v. BP Am., Inc.*, 958 F. Supp. 1472, 1476 (C.D. Cal. 1997) ("Under California law, after a finding of good faith, the non-settling defendants are entitled to a credit equal to the settlement amount to be applied against any judgment reached against them."); *Wade v. Shrader*, 168 Cal. App. 4th 1039, 1046 (2008) ("a good faith settlement with co-tortfeasors . . . reduces the nonsettling tortfeasors' ultimate liability to the plaintiff"). The settlement credit provided by Section 877 "encourage[s] settlement," "promotes equitable sharing of fault and prevents the plaintiff from obtaining an unfair double recovery." *Id.* *See also Reed v. Wilson*, 73 Cal. App. 4th 439, 444 (1999) (Section 877 "assures that a plaintiff will not be enriched unjustly by a double recovery, collecting part of his or her total claim from one joint tortfeasor and all of his claim from another").

A set-off does not require that the settling tortfeasor has been a defendant in the case against the non-settling defendant, but rather that the plaintiff has *claimed* that the other

McLeod v. Am. Motors Corp., 723 F.2d 830, 835 (11th Cir. 1984). Mr. Bechara's surgery took place in California, his alleged injuries occurred in California, and California substantive law will be applied to the other substantive aspects of his case. *See Estate of Miller v. Thrifty Rent-A-Car Sys., Inc.*, 609 F. Supp. 2d 1235, 1247-51 (M.D. Fla. 2009) (discussing Florida's "significant relationship" test applied to determine which state's laws govern in diversity cases); *Connell v. Riggins*, 944 So.2d 1174, 1277 (Fla. 1st DCA 2006) ("[U]nder most circumstances, the state where the injury occurred will be the decisive consideration in determining the applicable choice of law.") (internal citations omitted).

[6] "Economic damages" are defined by statute as "objectively verifiable monetary losses including medical expenses, loss of earnings, burial costs, loss of use of property, costs of repair or replacement, costs of obtaining substitute domestic services, loss of employment and loss of business or employment opportunities." CAL. CIV. CODE § 1431.2(b)(1) (2009).

tortfeasor was liable for the same injury as the defendant seeking the set-off. *See, e.g., Francies v. Kapla*, 127 Cal. App. 4th 1381 (2005). As such, Bayer is entitled to the Section 877 set-off even if Bayer does not seek to apportion fault to Kaiser. *See id.; accord McComber v. Wells*, 72 Cal. App. 4th 512, 516-17 (1999) (finding set-off appropriate "despite the jury's finding that the settling defendants had no fault for plaintiff's injuries").

In the present case, plaintiffs received $900,000 in exchange for a release of claims against Kaiser that Kaiser's negligence caused Mr. Bechara's kidney injury. This settlement was not a nuisance settlement or one based on a preliminary review. It came after nearly a year of discovery, including more than 20 depositions of fact and expert witnesses, the review of medical records, and the exchange of other documents. Both parties were represented by competent counsel. Release of All Claims (Ex. J). This case clearly fits within the purview of Section 877, and Bayer is entitled to a set-off of any economic damages awarded by the jury. Plaintiffs' counsel conceded at the Sept. 10, 2009 hearing that Bayer "get(s) a credit for any damages that [plaintiffs] recover on economic loss." 9/10/09 Tr. (Ex. N) at 5. Accordingly, defendants should be entitled to introduce evidence of the existence and amount of the settlement to the jury with instructions that the jury should deduct the amount previously paid to the plaintiffs from any recovery of economic damages allowed the plaintiff. *See, e.g., Barker v. Fleetwood Enters., Inc.*, No. A094058, 2002 WL 453931, *7-8 (Cal. App. Ct. Mar. 26, 2002) (admitting evidence of prior settlement award so that jury could calculate set-off under § 877); *Steele v. Hash*, 212 Cal. App. 2d 1, 3-4 (1963) (same). *See also* 1 Cal. Jur. 3d Accord & Satisfaction § 128 ("The general principle . . . [is] that evidence of such payments is admissible

for the purpose of reducing *pro tanto* the amount of the damages the plaintiff may be entitled to recover.").[7]

B. Rule 408 Should Not Bar Evidence of the Settlement Agreement.[8]

Finally, Rule 408 should not bar evidence of plaintiffs' prior settlement in this case. The purpose of Rule 408 is to encourage settlement offers and settlements. In this case, admitting evidence of plaintiffs' settlement with Kaiser would not hinder that purpose. The settlement here is not being offered against Kaiser, the settling defendant, which would be the typical situation where the policy behind Rule 408 would come into play. As courts have recognized, "[i]n deciding whether Rule 408 should be applied to exclude evidence, courts must consider the spirit and purpose of the rule and decide whether the need for the settlement evidence outweighs the potentially chilling effect on future settlement negotiations. ***The balance is especially likely to tip in favor of admitting evidence when the settlement communications at issue arise out of a dispute distinct from the one for which the evidence is being offered***." *Zurich Am. Ins. Co. v. Watts Indus., Inc.*, 417 F.3d 682, 689 (7th Cir. 2005) (internal citation omitted, emphasis added). *See also Broadcort Capital Corp. v. Summa Med. Corp.*, 972 F.2d 1183, 1194 (10th Cir. 1992) (finding that "Rule 408 did not bar [ ] evidence . . . related to settlement discussions that involved a different claim than the one at issue in the current trial").

[7] California courts employ a "well-established formula" in order to calculate the proper amount: "The portion of the settlement which may be set off from a judgment of economic damages is determined by the application of the percentage of the economic damages award in relation to the total award of damages." *McComber v. Wells*, 72 Cal. App. 4th 512, 517-18 (1999). *See also Hackett v. John Crane, Inc.*, 98 Cal. App. 4th 1233 (2002); *Espinoza v. Machonga*, 9 Cal. App. 4th 268, 271-277 (1992).

[8] There can be no question that Rule 408, upon which plaintiffs heavily rely in their motion, relates only to settlements and is inapplicable to evidence of plaintiffs' claims and allegations against Kaiser.

Bayer is not using the evidence regarding the settlement to argue "guilt as to Kaiser," Motion at 7, or to "show causation as it relates to Kaiser," *id.* at 11, or to impeach Kaiser. Rather, the fact of the settlement is relevant to the credibility of plaintiffs' claims because it shows not only that plaintiffs asserted these claims but that they diligently pursued them for more than a year and ultimately reached a resolution.[9]

Moreover, the spirit and purpose of Rule 408 is to encourage the resolution of disputes through settlement and offers of settlement. Rule 408 is not intended to facilitate what plaintiffs seek to do here – namely, conceal their resolution of prior inconsistent claims so that they can pursue an entirely different theory of recovery unencumbered by their prior decisions. Prohibiting evidence of plaintiffs' prior settlement in these circumstances only encourages misuse of the settlement and judicial process, and should not be permitted.

Finally, in this case, using Rule 408 to exclude evidence of plaintiffs' prior settlement with a third party could conflict with substantive state law providing for apportionment of damages among non-party tortfeasors. *See supra* at §II.A. As courts have recognized, state law regarding set-off is substantive and should trump Rule 408. *See, e.g.,*

[9] Rule 408(a) provides that "[e]vidence of the following is not admissible on behalf of any party, when offered to prove liability for, invalidity of, or amount of a claim that was disputed as to validity or amount, or to impeach through a prior inconsistent statement or contradiction: (1) furnishing or offering or promising to furnish – or accepting or offering or promising to accept – a valuable consideration in compromising or attempting to compromise *the claim* . . . ") (emphasis added). The phrase "the claim" in Rule 408(a)(1) – as opposed to "a claim" or "any related claim" – seems to refer to the same claim previously mentioned; *i.e.*, the claim which the evidence described in Rule 408(a)(1) is offered to "prove or disprove liability for." Courts have agreed. *See, e.g., Dahlgren v. First Nat'l Bank of Holdrege*, 533 F.3d 681, 699 (8th Cir. 2008) ("Rule 408 as written only applies to evidence of compromise offered to prove liability for or the amount of the claim that was compromised"). The Eleventh Circuit has not addressed "the question of whether Rule 408 bars evidence of a settlement between one of the parties and a third party when such settlement involves similar circumstances, but does not arise out of, the transaction with which the litigation is concerned." *Dallis v. Aetna Life Ins. Co.*, 768 F.2d 1303, 1307 n.2 (11th Cir. 1985).

Carota v. Johns Manville Corp., 893 F.2d 448, 451 (1st Cir. 1990) (acknowledging *Erie* implications of Rule 408 and concluding that state law prohibiting double-recovery trumps Rule 408's prohibition against evidence of prior settlements because "when a state permits the admission of out of court settlement evidence with the intent that such admission affect the damage award, then we must deem the issue substantive").

CONCLUSION

For all the foregoing reasons, Bayer respectfully requests that the Court DENY plaintiffs' Motion in Limine to Exclude Evidence of Settlement Agreement and Plaintiffs' Position in Prior Arbitration Proceeding (D.E. 4378 in 1:08-md-01928; D.E. 101 in 9:08-cv-80776).

Dated: March 8, 2010

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on March 8, 2010, I electronically filed the foregoing document with the Clerk of the Court using CM/ECF. I also certify that the foregoing document is being served this day on all counsel of record or pro se parties identified on the attached Service List in the manner specified, either via transmission of Notices of Electronic Filing generated by CM/ECF or in some other authorized manner for those counsel or parties who are not authorized to receive electronically Notices of Electronic Filing.

/s/ Barbara Bolton Litten
Barbara Bolton Litten

SERVICE LIST

In re Trasylol Products Liability Litigation – MDL-1928
Case No. 08-MD-1928-MIDDLEBROOKS/JOHNSON
Case No. 9:08-cv-80776 *Bechara v. Bayer Corp.*

United States District Court
Southern District of Florida

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Liaison Counsel for Defendants

Exhibit A

KAISER PERMANENTE
Los Angeles

PERFUSION REPORT #1
Summary Sheet

Bechara, Naguib S
10290840
Male [redacted]/1954
Age: 50

gery Date: 12/21/2004
RM #: 10
Wt.: 91 kg Allergies: ASA, SULFA
Ht: 165 cm BSA: 1.98 M^2

Perfusionist

Preop Diagnosis: EMERGENT CABG, VT, IABP, TIGHT LAD Procedure: CABGx4
Comments: ACUTE MI, 3 VESS CAD

Cannulations:
Arterial: 24 Fr TMP
Venous: 2 Stage Baxter 3646
Vent: Aortic Root
Retrograde: Edwards RMI 14 Fr

Calculated Flow: 4.8 L/min
Average Pump Flow: 4.6 L/min
Pump On: 8:15:00 PM
Pump Off: 9:27:00 PM

Surgeon: Pfeffer, T
Assistant: Hyde, M
Assistant: Carretta, M.
Anesthesiologist: Floegel, C.
Resident: None
Perfusionist: Viebahn, R
(Secondary): Liston, T
Cardiologist: Teplinsky, K
Facility: Anaheim
Pump Time: 72 min
Aortic X-clamp: 43 min
Ischemic Time: 33 min
Circ Arrest Time: min
Cerebral Perfusion: min

Tubing Pack: COBE
Tubing Pack Lot #: 0427200201
Oxygenator Lot #: xpdb17
Cell Saver Lot #: 0432100002
Hemo Lot #: 040311
Pre Pump Blood: cc
Post Pump Blood: 700 cc
Cell Saver: 750 cc
Hemoconcentrator: 3000 cc
Low Body Temp: 34 °C
High Body Temp: 37.5 °C
IABP: Yes
Balloon Size: 40cc 8 Fr
Insertion: Preop

	Pump Prime	Added Volume
Plasma-Lyte A (cc)	1100	0
Blood (cc)	0	0
Albumin 25% (cc)	300	0
Hespan (cc)	0	0
NaBicarb (cc)	50	50
Mannitol (cc)	150	0
Heparin (units)	10000	0
0.9% NaCl (cc)	0	0
Trasylol (cc)	0	200
Cell Saver (cc)	0	0
Lidocaine (mg)	0	100
Neosynephrine (mcg)	0	5
0	0	0
Plegia (cc)		1000
Prime (cc)		1610

Prime Total Vol.: 1610 cc
TOTAL: 2870 cc

Graft	Conduit	Mean Flow	Mean B/P	Flow / Patency Check	Endo Vein	Size	Severity	Target	Quality of Vein	Occl Time
LM										
RM										
LAD	LIMA			None	No	1.5	Moderate	Good	Good	
D1	SV	80	80	Perfusion Pump	No	1.5	Severe	Good	Good	
D2										
Ramus										
Cx										
OM1	SV	80	80	Perfusion Pump	No	1.5	Mild	Good	Good	
OM2										
PL Cx/OM3										
PDA	SV	90	80	Perfusion Pump	No	1.5	Mild	Good	Good	
PL RCA										
AM										

	CO	CI	SVR	Wedge	CVP	PA
PRE	4.5	2.2	988	31 PAD	19	39/31
POST	6.8	3.4	710	22 PAD	17	35/22

Total Blood Cardioplegia: 2000 cc

Blood Type: A Pos
 # Units Given: 0

Valve Manufacturer	Type	Serial No.	Model No.	Size

000135

KAISER PERMANENTE.
Kaiser Foundation Hospitals

BECHARA, NAGUIB S
00 001029-08-40 M
[redacted]/1354 ...

4.8

PERFUSION REPORT #2

Data Flow Sheet

Date 12-2101 12/21/04 Page # ____

Time	1900	2007	2023	2030	2045	2100	2115
H/R	89	1x	0	0	0	0	0
Arterial Pressure	100/53	112/60	60	80	75	73	70
Mean Arterial Pressure	77	71	60	78	71	69	70
Venous Pressure	12	13	3	9	7	8	5
Arterial Line Press			130	167	160	170	172
RPM			per	Pul	per	Pul	14
Blood Flow			4.3	4.6	4.6	4.6	5.4
Ethrane/ Halothane			1.0	1.0	1.0	1.0	1.0
Gas FIO₂			65	68	65	90	90
LPM			1.0	1.0	3.0	4.0	4.0
Temperatures: Water In			34	33	32	35	38
Arterial Blood			34	33	32	34	37
Venous Blood			34	33	33	32	37
Bladder/ Rectal			36	34	34	34	37
Esophageal			16	—	19	29	37
MYO			—	—	—	—	—
Venous Sat			58	70	72	82	70
Laboratory Analysis: pH	7.24	7.38		7.25		7.44	
pCO₂	53	37		56		34	
pO₂	118	93		100		385	
HCO₃/BE	23/-2	21/-4		24/-1		23/-1	
Spec.#	1	2	—	3	—	4	
Hct.	40	35		25		26	
K+/COP	3.7	3.7		4.7		4.0	
ACT	95	124		24		219	
COMMENTS Ca	1.15	1.03		0.81		0.90	

Act 115 619 605 538

CROSS CLAMP ON	CROSS CLAMP OFF	CARDIOPLEGIA TIME	VOL.	TEMP/TYPE
1. 2017	6900	2018	800	7 24 Ao,
2.	2100	2026	200	7 M Retr
3.		2028	400	8 14 Ao
4.		2040	300	7 J Ao
PUMP ON	**PUMP OFF**			
1. 2015	2127			
2.				
3.				
4.				
5.				

Comments

1. 360 Heparin 1558
2. 1 Amp Nitro 2017
3. 200 Protamine 2040
4. Add Heparin 2020
5. Lasix 2055
6. 100 mg Lidocaine 2040
7.
8.
9.
10.
11.
12.
13.
14.
15.
16.

HO-6068 (5-88) WHITE - Hospital Chart CANARY - O.R. PINK - Physician

000136

NBechara-KFH-Sun-MD-000133

KAISER PERMANENTE.

HEMODIALYSIS RECORD

Diagnosis: CABG X4

☐ **Pt. ID Verified**

Date: 12/27/04 Start: 1510 Stop: 1710

Mode of Transport: Bedside

☐ Ascorbic Acid: ____ gm ☑ Alarm Check

☐ Chloramine Check ☐ Residual Bleach Check

☑ Conductivity Check

Access: (L) I.J. Catheter newly inserted 12/27

Needle: Arterial gauge: ∅ position (Circle) ↑ ↓

Venous gauge: ∅ position (Circle) ↑ ↓

Condition: ☑ Clear ☐ Redness ☐ Drainage

☑ Patent ☐ Other: See Comments

Pre-Assessment

Neuro: ☐ WNL ☐ Confused ☑ Lethargic ☐ Disoriented ☐ Unresponsive ☐ Other: Medicated

Cardio: ☐ WNL ☐ Systolic Murmur ☐ Rub

Edema: ☐ None ☑ 1+ ☐ 2+ ☐ 3+ ☐ 4+ ☐ Facial ☐ Sacral ☐ Tibial ☐ Pedal ☑ General ☐ Other:

Resp: ☐ WNL ☐ Wheezes ☐ Rales ☑ Rhonchi ☑ Other: [illegible]

Pain: ☐ Yes ☐ No # ∅ (0-10)

BECHARA, N

[redacted]/1354 050

Room #: 367

IMPRINT KAISER PERMANENTE ID CARD HERE

12/21/04

Treatment #: 1

Duration: 2

QB / QD: 200

Fluid Rem: 2 - 2.5L as [illegible]

Machine #: 6161

Dialysate: # 2

K+:

Na+:

Mg:

Ca++:

Dex:

RO#: ____ (if applicable)

Dialyzer/Cartridge: NR 70

Heparin Initial Dose: ∅

Heparin Hourly: ∅

Heparin Total:

Vitals	BP	TPR	Weight	Other
Pre	118/57	36.8-101-20	—	—
Post	110/58	[illegible]	—	—

Chem	Na+/K+	Cl/CO2	BUN/Cr	Ca++	Hb	Hct
Pre						

Time	BP	Pulse	Blood Flow	Arterial Pressure	Venous	TMP	Dial. Temp	UF	Heparin	Fluid Intake	Comments
1510	118/57	101	200	-140	100	[illegible]	[illegible]	[illegible]			[illegible]
1530	111/[illegible]	102	200	-140	100	[illegible]	[illegible]	[illegible]			
1545	111/63	103	200	-140	100	[illegible]	[illegible]	[illegible]			
1600	115/55	115	200	-140	100	[illegible]	[illegible]	[illegible]			
1615	[illegible]	[illegible]	200	-140	100	[illegible]	[illegible]	[illegible]			
1630	[illegible]	101	200	[illegible]	100	[illegible]	[illegible]	[illegible]			
1710	112/70	101	200	-160	100	[illegible]	[illegible]	3000		200 ml NS	[illegible] back to [illegible]. Returned via (L) I.J. catheter. Catheter [illegible] sealed [illegible]

Post: Tx completed uneventful

☐ Needles Removed ☐ Hemostasis @ ____ minutes ☐ Heparin 5000 units/ml ☑ Arterial 1.9 ml ☑ Venous 1.9 ml

Total Intake: 200 Total Output: 3000 Net: -2800 Report Given To: [illegible] Signature/Title: [illegible]

NS-9117 (4-04) WHITE—Inpatient Chart CANARY—Dialysis Unit

000186

NBechara-KFH-Sun-MD-000587

KAISER PERMANENTE MEDICAL CENTER - PATIENT RECORD TUESDAY 12/21/04 1328

BECHARA NAGUIB S NUMBER 03950401 10290840

[redacted]ORY

TRANSCRIBED BY GENEST MARGARET P CMT ON 12/21/04 AT 0759
VERIFIED AND SIGNED BY PANTANGCO EUGENE R MD

DATE OF ADMISSION: DECEMBER 21, 2004.

DATE OF HISTORY AND PHYSICAL: DECEMBER 21, 2004, 0355 HOURS.

REASON FOR ADMISSION: CHEST PRESSURE.

HISTORY OF PRESENT ILLNESS: THIS IS A 50-YEAR-OLD PERSIAN GENTLEMAN WHO PRESENTS TO THE EMERGENCY ROOM THIS EVENING WITH CHEST PAIN AND PRESSURE STARTING FROM THE MIDDLE OF HIS CHEST RADIATING TO THE SIDES. THIS AWOKE HIM OUT OF SLEEP, AND HE HAD A COMPLAINT OF SHORTNESS OF BREATH. THIS OCCURRED APPROXIMATELY ABOUT 11:30 P.M. TO 12 O'CLOCK AND PRESENTS HERE AROUND ONE O'CLOCK IN THE MORNING. THE PATIENT HAD SOME SHORTNESS OF BREATH WITH THIS CHEST PAIN. HE DESCRIBES IT AS KIND OF LIKE A PRESSURE LIKE FEELING INHIBITING FROM BREATHING. IT RADIATES ONLY ACROSS HIS CHEST. IT DOES NOT RADIATE TO HIS BACK. HOWEVER, HE DOES HAVE SOME RADIATION TO HIS ABDOMEN. HE FEELS THAT HE NEEDS TO THROW UP AND HAS BEEN TRYING TO FORCE HIMSELF TO GAG BECAUSE HE FEELS LIKE THERE IS SOMETHING STUCK. HE HAS BEEN UNABLE TO DO SO. WHILE HERE IN THE E.R., THE PATIENT WAS FOUND TO BE IN SINUS TACHYCARDIA, BUT OTHERWISE NO ACUTE ISCHEMIC CHANGES. HIS INITIAL LABORATORIES ARE BENIGN INCLUDING A NEGATIVE TROPONIN. THE PATIENT WAS GIVEN MORPHINE 4 MG TIMES TWO, ATIVAN 1 MG. AS WELL AS STARTED ON NITROL DRIP. THE PATIENT WAS ALSO GIVEN A GI COCKTAIL IN ADDITION TO 20 MG I.V. PEPCID.

AFTER AN HOUR OR SO, THE PATIENT STILL CONTINUED TO HAVE CHEST DISCOMFORT. UPON EVALUATION BY MYSELF, THE PATIENT WAS WRITHING IN PAIN AND BEING MINIMAL COOPERATIVE. CHEST X-RAY SHOWED EVIDENCE OF ENLARGED CARDIAC SILHOUETTE, BUT OTHERWISE NO INFILTRATE OR EDEMA. I ATTEMPTED TO PLACE AN NASOGASTRIC TUBE THERE AT BEDSIDE MYSELF. HOWEVER, THE PATIENT WAS UNABLE TO TOLERATE AND GAGGED AND HE SUBSEQUENTLY VOMITED HIS FOOD CONTENTS FROM EARLY THIS EVENING WHICH WAS DESCRIBED BY HIS WIFE TO BE AN EL POLLO LOCO BURRITO. THE PATIENT WAS NOTED TO BE INSTANTLY RELIEVED WITH DECREASED COMFORT AND LESS AGITATION. THE PATIENT STATED THAT HE STILL NEEDS TO VOMIT MORE, HOWEVER, AT THE CURRENT TIME, HE IS WITHOUT GAG OR SIGNIFICANT DISCOMFORT AS COMPARED TO PRIOR.

REVIEW OF SYSTEMS: THE PATIENT DENIES ANY APPETITE CHANGE OR ANY WEIGHT LOSS. HE DENIES ANY DIARRHEA OR CONSTIPATION. THE PATIENT DENIES ANY PALPITATIONS, COUGH, FEVERS OR CHILLS. UPON FURTHER QUESTIONING, THE PATIENT DOES APPEAR TO HAVE OCCASIONAL DYSPEPSIA VERSUS G.E.R.D. THAT HE TREATS WITH MAALOX P.R.N.

CARDIOVASCULAR RISK FACTORS: THE PATIENT IS A SMOKER, BUT UNWILLING TO QUANTIFY. HE ALSO HAS A FAMILY HISTORY WITH A FATHER AT AGE 52 WHO HAD ANGINA AND DIED.

Exhibit B

KAISER PERMANENTE PROGRESS NOTE 10290840 BECHARA MAGUIS S
WEDNESDAY 08/02/06 08:57

[RE: URRA NITROGEN 12/10/05 ID: L 279 Y00582080]

ACTIONS TAKEN / INITIATED:

1) WORKUP PREVIOUSLY DONE, OR IN PROGRESS

ADDITIONAL ACTIONS / COMMENTS:

SPOKE TO PATIENT. FEELS WELL. URINATING WELL. CURRENTLY ON TWICE A WEEK HD. ADVISED TO DO ONLY ONCE A WEEK HD FOR NOW.. CHECK DAILY WEIGHT. CHECK DAILY CHEM7 FOR 5 DAYS STARTING THIS MONDAY.
PROGRESS NOTE FOR: 11/30/2005

SUBJECTIVE: MR. BACHARA FOLLOWS UP 6 MONTHS AFTER A LEFT RADIOCEPHALIC ARTERIOVENOUS FISTULA CREATION. HE HAS BEEN RECEIVING BUTTONHOLES WITHOUT DIFFICULTY. HE INITIALLY HAD VERY DISTAL BUTTONHOLES PLACED, BUT AS THE VEIN HAS CONTINUED TO MATURE, THE BUTTONHOLES HAVE BEEN NOW MOVED TO THE UPPER FOREARM.

PHYSICAL EXAMINATION

THE VEIN IS ROBUST WITH A GOOD THRILL. ULTRASOUND DEMONSTRATES NO AREAS OF FOCAL STENOSIS, AND THE VEIN IS IN EXCESS OF 6 MM THROUGHOUT. THERE IS GOOD RADIAL PULSE. HAND WITH GOOD CAP REFILL, NO SWELLING.

IMPRESSION: SATISFACTORY COURSE, LEFT FOREARM ARTERIOVENOUS FISTULA.

PLAN: ROUTINE EVALUATION IN 6 MONTHS.

MICHAEL M. FAROOQ, M.D. KA DT: 11/30/2005 13:57:00 RA JOB ID: 271065 D: 11/30/2005 16:41:40 T: 12/01/2005 08:38:58 950869

CC: SHAILESH P. PATEL, M
[RE: X-RAY 11/22/05 ID: X70001053262000]

ACTIONS TAKEN / INITIATED:

1) WORKUP PREVIOUSLY DONE, OR IN PROGRESS

000010

Kaiser Permanente
Medical Center, Anaheim

BECHARA NAGUIB S
KP # 10290840 Room 2099.9
AGE 51 SEX M
DOB [redacted]/54 Clin 355
DOPP: GEORGE SAINI S

CHAMPS # 23098686

Consultations

Transcriber: 12/21/04 1400 Tran Srv Priority 2, CMT DEVICE # 7950
Dictator: 12/21/04 1614 Bartz Stephen, MD
Intervention: [No Intervention Recorded]

DATE OF CONSULT: 12/21/2004

REFERRING PHYSICIAN: OSVALDO RODRIGUEZ, MD

REASON FOR CONSULT: CHEST PAIN, ELEVATED TROPONIN, AND VENTRICULAR TACHYCARDIA.

HISTORY OF PRESENT ILLNESS: THE PATIENT IS A 50-YEAR-OLD MAN WITH NO HISTORY OF ISCHEMIC, RHEUMATIC, OR CONGENITAL HEART DISEASE.

HE PRESENTED TO THE EMERGENCY DEPARTMENT DECEMBER 21, 2004, IN THE MIDDLE OF THE NIGHT WITH CHEST DISCOMFORT THAT HAD AWAKENED HIM FROM SLEEP. THIS HISTORY IS LARGELY OBTAINED FROM THE PATIENT'S WIFE AND FROM THE MEDICAL RECORD. THE PATIENT HAS BEEN GIVEN A SIZABLE DOSE OF [illegible] BENZODIAZEPINE AND ANALYTIC A[illegible] FALLING ASLEEP DURING THE INTERVIEW. HOWEVER, IT APPEARS THAT HE [illegible] CHEST PAIN AND SHORTNESS OF BREATH AT ABOUT MIDNIGHT LAST NIGHT. IT WAS DESCRIBED TO THE ON-CALL INTERNIST AS A PRESSURE-LIKE F[illegible]NG THAT CAUSED SHORTNESS OF BREATH. IT WAS RADIATING ACROSS THE CHEST AND INTO HIS ABDOMEN. HE FELT THE NEED TO VOMIT. HE TRIED TO FORCE HIMSELF TO GAG. HE PRESENTED TO TH[illegible] EMERGENCY DEPARTMENT, AND AN NG TUBE WAS PASSED AFTER SOME DIFFICULTY. THIS ASPIRATED A RELATIVELY LARGE MEAL WITH PROMPT RELIEF OF THE DISCOMFORT. AN INITIAL TROPONIN WAS 0. A 12-LEAD ELECTROCARDIOGRAM WAS UNREMARKABLE. AND HE WAS ADMITTED FOR OBSERVATION.

OVER THE NIGHTTIME HOURS HE HAD REPEATED RUNS OF NONSUSTAINED VENTRICULAR TACHYCARDIA. AS I WAS MAKING ROUNDS IN THE INTENSIVE CARE UNIT THIS MORNING, THE ICU NURSE BROUGHT THESE RUNS OF NONSUSTAINED VENTRICULAR TACHYCARDIA TO MY ATTENTION. I DISCUSSED THE CASE BRIEFLY WITH DR. RODRIGUEZ AND PROCEEDED WITH CARDIOVASCULAR EVALUATION.

HE HAS NO HISTORY OF HEART DISEASE. A RECENT LIPID EVALUATION DEMONSTRATES A TOTAL CHOLESTEROL OF 273, TRIGLYCERIDES 374, HDL 36, AND LDL 168. HIS FATHER DIED AT 60 OF MYOCARDIAL INFARCTION AFTER EXPERIENCING HIS FIRST MI IN HIS 40'S. HE IS A CIGARETTE SMOKER. HE IS OVERWEIGHT. HE DOES NOT HAVE DIABETES, AND HYPERTENSION IS NOT KNOWN TO BE PRESENT.

PAST MEDICAL HISTORY:

1. ASTHMATIC BRONCHITIS.

2. TENSION HEADACHES.

3. HYPERPLASTIC COLONIC POLYPS.

4. ALLERGY TO ASPIRIN WHICH INCLUDES AIRWAY OBSTRUCTION.

CURRENT OUTPATIENT MEDICATIONS: NONE.

Kaiser Permanente
Medical Center, Anaheim

BECHARA NAGUIB S
KP # 10290840 Room 2099.9
AGE 51 SEX M
DOB [redacted]/54 Clin 355
DOPP: GEORGE SAJNI S

CHAMPS # 23098586

Consultations

Transcriber: 12/21/04 1400 Tran Srv Priority 2, CMT DEVICE # 7950
Dictator: 12/21/04 1614 Bartz Stephen, MD
Intervention: (No Intervention Recorded)

ALLERGIES: SULFA MEDICATIONS AND ASPIRIN.

FAMILY AND SOCIAL HISTORY: HE IS A SMOKER. HE DOES NOT USE ALCOHOL. THERE ARE SIBLINGS APPROXIMATELY HIS AGE WHO DO NOT HAVE HEART DISEASE.

REVIEW OF SYSTEMS: UNOBTAINABLE.

PHYSICAL EXAMINATION

GENERAL APPEARANCE: THIS IS AN OBESE MAN RESTING COMFORTABLY IN A HOSPITAL BED.

VITAL SIGNS: BLOOD PRESSURE IS 110/70. PULSE IS 110 AND REGULAR. RESPIRATIONS ARE 12.

HEENT/NECK: HEAD AND NECK UNREMARKABLE. JUGULAR VENOUS PULSATIONS ARE AT 7. CAROTIDS QUIET.

CHEST: CLEAR.

HEART: HEART TONES READILY HEARD. RHYTHM IS REGULAR AND RAPID. THERE IS AN S4.

ABDOMEN: BENIGN. BOWEL SOUNDS PRESENT.

EXTREMITIES: PULSES ARE SATISFACTORY. THERE IS NO DEPENDENT EDEMA.

SKIN: NO SKIN RASHES NOTED.

NEUROLOGICAL: EXAM IS NONFOCAL.

LABORATORY/DIAGNOSTIC DATA: 12-LEAD ELECTROCARDIOGRAM REPEATED THIS MORNING DEMONSTRATED SINUS RHYTHM WITH ONLY NONSPECIFIC MINOR ST AND T WAVE ABNORMALITIES. THE RATE IS 120. INITIAL TROPONIN I DONE LAST NIGHT AT 0200 IS 0. TROPONIN I DONE AT 0830 IS 10.2. CHEMISTRY PANEL SHOWS BUN AND CREATININE OF 25 AND 1.0. COMPLETE BLOOD COUNT SHOWS HEMOGLOBIN 14.3 AND PLATELETS 249,000.

IMPRESSION:

1. NON-Q WAVE MYOCARDIAL INFARCTION. I SUSPECT THAT THE EPISODE OF DISCOMFORT LAST NIGHT WAS THE EVENT, AND THE TROPONIN IS NOW JUST BEGINNING TO RISE AT A TIME APPROPRIATE TO THE EVENT LAST NIGHT AT AROUND MIDNIGHT. HE WILL REQUIRE CARDIAC CATHETERIZATION.

2. VENTRICULAR TACHYCARDIA. THE COMBINATION OF THE VENTRICULAR TACHYCARDIA

Kaiser Permanente
Medical Center, Anaheim

[redacted] NAGUIB S
MP # 10290840 Room 2099.9
AGE 51 SEX M
DOB [redacted]/54 Clin 355
DOPP: GEORGE SAJINI S

CHAMPS # 23098686

Consultations

Transcriber: 12/21/04 1400 Tran Srv Priority 2, CMT DEVICE # 7950
Dictator: 12/21/04 1614 Bartz Stephen, MD
Intervention: (No Intervention Recorded)

AND THE SINUS TACHYCARDIA IS VERY WORRISOME FOR MULTIVESSEL OR LEFT MAIN CORONARY DISEASE.

3. ASPIRIN ALLERGY.

RECOMMENDATIONS:

1. BEGIN ANTIPLATELET THERAPY WITH A 2B-3A PLATELET INHIBITOR.

2. BEGIN HEPARIN.

3. BEGIN AMIODARONE.

4. CARDIAC CATHETERIZATION.

I DISCUSSED MY RECOMMENDATIONS IN DETAIL TODAY WITH THE PATIENT'S WIFE. SHE APPARENTLY IS AN EMPLOYEE HERE AND WORKS AS A PHLEBOTOMIST. SHE HAS SOME UNDERSTANDING OF HEART ISSUES BUT CLEARLY RELATIVELY LIMITED UNDERSTANDING. SHE IS EXTREMELY ANXIOUS AND IS QUESTIONING EVERY DETAIL OF THE MANAGEMENT. HOWEVER, I REVIEWED THE PATHOPHYSIOLOGY WITH HER IN DETAIL. I OUTLINED THE NEED FOR CARDIAC CATHETERIZATION AND POSSIBLE SUBSEQUENT INTERVENTIONS INCLUDING ANGIOPLASTY, BYPASS GRAFTING SURGERY, AND MEDICAL THERAPY. I ALSO REVIEWED

POSSIBLE RISKS INCLUDING DEATH, STROKE, MYOCARDIAL INFARCTION, AND NEED FOR EMERGENCY HEART SURGERY. DR. RODRIGUEZ'S REPORT IS THAT HE DISCUSSED THESE SAME ISSUES WITH THE PATIENT PRIOR TO HIS RECEIVING THE BENZODIAZEPINES.

I ALSO DISCUSSED THESE ISSUES WITH THE WIFE'S BROTHER WHO ADVERTISES HIMSELF AS A FORMER PHYSICIAN WHO NOW WORKS AS AN R.N. HE DID NOT SEEM UNDERSTANDING OF THE PATHOPHYSIOLOGY, THE NEED FOR ANGIOGRAPHY, AND THE RATIONALE FOR THE THERAPY.

WE WILL SCHEDULE A CARDIAC CATHETERIZATION FOR THIS MORNING.

STEPHEN BARTZ, MD D: 12/21/2004 T: 12/21/2004 1658

[redacted]

000025

DATE OF ADMISSION: DECEMBER 21, 2004.

DATE OF HISTORY AND PHYSICAL: DECEMBER 21, 2004, 0355 HOURS.

REASON FOR ADMISSION: CHEST PRESSURE.

HISTORY OF PRESENT ILLNESS: THIS IS A 50-YEAR-OLD PERSIAN GENTLEMAN WHO PRESENTS TO THE EMERGENCY ROOM THIS EVENING WITH CHEST PAIN AND PRESSURE STARTING FROM THE MIDDLE OF HIS CHEST RADIATING TO THE SIDES. THIS AWOKE HIM OUT OF SLEEP,
AND HE HAD A COMPLAINT OF SHORTNESS OF BREATH. THIS OCCURRED APPROXIMATELY ABOUT 11:30 P.M. TO 12 O'CLOCK AND PRESENTS HERE AROUND ONE O'CLOCK IN THE MORNING. THE PATIENT HAD SOME SHORTNESS OF BREATH WITH THIS CHEST PAIN. HE DESCRIBES IT AS KIND OF LIKE A PRESSURE LIKE FEELING INHIBITING FROM BREATHING. IT RADIATES ONLY ACROSS HIS CHEST. IT DOES NOT RADIATE TO HIS BACK. HOWEVER, HE DOES HAVE SOME RADIATION TO HIS ABDOMEN. HE FEELS THAT HE NEEDS TO THROW UP AND HAS BEEN TRYING TO FORCE HIMSELF TO GAG BECAUSE HE FEELS LIKE THERE IS SOMETHING STUCK. HE HAS BEEN UNABLE TO DO SO. WHILE HERE IN THE E.R., THE PATIENT WAS FOUND TO BE IN SINUS TACHYCARDIA, BUT OTHERWISE NO ACUTE ISCHEMIC CHANGES. HIS INITIAL LABORATORIES ARE BENIGN INCLUDING A NEGATIVE TROPONIN. THE PATIENT WAS GIVEN MORPHINE 4 MG TIMES TWO, ATTIVAN 1 MG, AS WELL AS STARTED ON NITROL DRIP. THE PATIENT WAS ALSO GIVEN A GI COCKTAIL IN ADDITION TO 20 MG I.V. PEPCID.

AFTER AN HOUR OR SO, THE PATIENT STILL CONTINUED TO HAVE CHEST DISCOMFORT. UPON EVALUATION BY MYSELF, THE PATIENT WAS WRITHING IN PAIN AND BEING MINIMAL COOPERATIVE. CHEST X-RAY SHOWED EVIDENCE OF ENLARGED CARDIAC SILHOUETTE, BUT OTHERWISE NO INFILTRATE OR EDEMA. I ATTEMPTED TO PLACE AN NASOGASTRIC TUBE THERE AT BEDSIDE MYSELF. HOWEVER, THE PATIENT WAS UNABLE TO TOLERATE AND GAGGED AND HE SUBSEQUENTLY VOMITED HIS FOOD CONTENTS FROM EARLY THIS EVENING WHICH WAS DESCRIBED BY HIS WIFE TO BE AN EL POLLO LOCO BURRITO. THE PATIENT WAS NOTED TO BE IMMEDIATELY RELIEVED WITH DECREASED DISCOMFORT AND LESS AGITATION. THE PATIENT STATED THAT HE STILL NEEDS TO VOMIT MORE, HOWEVER, AT THE CURRENT TIME, HE IS WITHOUT GAG OR SIGNIFICANT DISCOMFORT AS COMPARED TO PRIOR.

REVIEW OF SYSTEMS: THE PATIENT DENIES ANY APPETITE CHANGE OR ANY WEIGHT LOSS. HE DENIES ANY DIARRHEA OR CONSTIPATION. THE PATIENT DENIES ANY PALPITATIONS, COUGH, FEVERS OR CHILLS. UPON FURTHER QUESTIONING, THE PATIENT DOES APPEAR TO HAVE OCCASIONAL DYSPEPSIA VERSUS G.E.R.D. THAT HE TREATS WITH MAALOX P.R.N.

CARDIOVASCULAR RISK FACTORS: THE PATIENT IS A SMOKER, BUT UNWILLING TO QUANTIFY. HE ALSO HAS A FAMILY HISTORY WITH A FATHER AT AGE 52 WHO HAD ANGINA AND DIED.

PAST MEDICAL HISTORY:

1. WRIST GANGLION.

2. ASTHMATIC BRONCHITIS.

3. TENSION HEADACHES.

4. HYPERPLASTIC COLONIC POLYPS IN NOVEMBER 2004.

ALLERGIES: SULFA AND ASPIRIN.

CURRENT MEDICATIONS: NONE AS REPORTED BY THE PATIENT.

SOCIAL HISTORY: THE PATIENT IS MARRIED. OCCASIONAL SMOKING HISTORY UNCLEAR. DENIES ANY CHRONIC ALCOHOL USE OR I.V. DRUG USE.

FAMILY HISTORY: SIGNIFICANT FOR FATHER WITH ANGINA AND CHEST PAIN THAT DIED AT AGE 52. SIBLING HISTORY IS OTHERWISE UNREMARKABLE.

PHYSICAL EXAMINATION

VITAL SIGNS: TEMPERATURE 97.3, BLOOD PRESSURE 128/74, RESPIRATORY RATE 20 SATURATING GREATER THAN 98% ON 2 LITERS NASAL CANNULA.

GENERAL APPEARANCE: THE PATIENT IS AN OBESE MALE, WRITHING IN PAIN, MINIMALLY COOPERATIVE. HE APPEARS WITH SOME SHORTNESS OF BREATH.

HEAD/EYES/EARS/NOSE/THROAT: EXTRAOCULAR MOVEMENTS ARE INTACT. SCLERAE ARE CLEAR. ORAL MUCOSA IS MOIST. NO EXUDATE OR ERYTHEMA.

NECK: THERE IS NO JUGULAR VENOUS DISTENTION.

CARDIAC: S1 AND S2, TACHYCARDIC, BUT OTHERWISE NO MURMURS, RUBS, OR GALLOPS. THERE IS NO REPRODUCIBLE CHEST PAIN UPON PALPATION OF HIS MIDSTERNUM.

CHEST/LUNGS: LUNG SOUNDS ARE CLEAR. BREATH SOUNDS BILATERALLY AND THROUGHOUT. THERE IS NO EVIDENCE OF RALES OR CRACKLES.

ABDOMEN: DISTENDED WITH QUIET BOWEL SOUNDS. THERE IS NO HEPATOSPLENOMEGALY APPRECIATED. OTHERWISE ABDOMEN IS SOFT.

EXTREMITIES: THERE IS NO LOWER EXTREMITY EDEMA.

NEUROLOGIC: CRANIAL NERVES II THROUGH XII ARE GROSSLY INTACT.

RECTAL: MINIMAL STOOL WHICH IS GUAIAC NEGATIVE.

DIAGNOSTIC DATA: CHEST X-RAY, PORTABLE, SHOWS ENLARGED CARDIAC SILHOUETTE BUT OTHERWISE NO EVIDENCE OF INFILTRATE OR EDEMA. THERE APPEARS TO BE NO OBVIOUS AIR SEEN, AT LEAST ON THE CHEST X-RAY SINCE IT DOES NOT VISUALIZE INTO THE ABDOMEN.

EKG HERE IN E.R. WHICH SHOWED EVIDENCE OF SINUS RHYTHM, HEART RATE 78, OTHERWISE NO ACUTE ISCHEMIC CHANGES. THERE IS MINIMAL BORDERLINE LEFT VENTRICULAR HYPERTROPHY NOTED. SERIAL EKG'S SHOW SLIGHT ST ELEVATION IN THE PRECORDIAL LEADS, V2 AND V3, HOWEVER, THEY SEEM TO RESOLVE ON THEIR OWN.

WHITE BLOOD CELL COUNT 10.1, HEMOGLOBIN 15.3, HEMATOCRIT 44.7, PLATELETS 320, MCV 85, RDW 13, TROPONIN 0.0, SODIUM 137, POTASSIUM 3.4, CHLORIDE 102, BICARBONATE 28, BUN 25, CREATININE 1.2, GLUCOSE 137, AMYLASE 64, ALT 28, ALKALINE PHOSPHATASE 64, TOTAL BILIRUBIN 0.6.

IMPRESSION: THIS IS A 50-YEAR-OLD GENTLEMAN WHO PRESENTS WITH CHEST PAIN, AT LEAST INITIAL EVALUATION SHOWS NEGATIVE, SEEMS TO BE LESS LIKELY CARDIAC WITH NEGATIVE TROPONIN, NEGATIVE EKG. THE PATIENT IS SYMPTOMATICALLY IS IMPROVED AFTER HAVING REGURGITATED HIS STOMACH CONTENTS WITH SOLID FOOD. THIS APPEARS MOST LIKELY A GI ATYPICAL CHEST PAIN SECONDARY TO GI CAUSE. MOST LIKELY DIFFERENTIAL INCLUDES POSSIBLE LONG TERM EROSIVE ESOPHAGITIS WITH POSSIBLE STRICTURING. WILL, HOWEVER, ADMIT THE PATIENT ON CHEST PAIN PROTOCOL FOR CONTINUED CARDIAC EVALUATION, SINCE THIS SEEMS TO BE NECESSARY IN THE SETTING OF THE PATIENT WITH CARDIAC RISK FACTORS, SUCH AS FAMILY HISTORY, SMOKING, OBESITY, AND POSSIBLY HYPERCHOLESTEROLEMIA.

PLAN:

1. CHEST PAIN: WILL ADMIT TO THE CHEST PAIN UNIT. CHECK ANOTHER TROPONIN IN THE MORNING, AS WELL AS EKG. THE PATIENT IS ALLERGIC TO ASPIRIN, HOWEVER, SINCE HIS CURRENT EVENTS APPEAR TO BE MORE GI IN NATURE, WILL HOLD OFF ON ANY FURTHER ANTIPLATELET THERAPY. WILL START THE PATIENT ON CHEST PAIN PROTOCOL WITH LOPRESSOR AND ALSO NITROL PASTE AS TOLERATED. WILL CONTINUE WITH I.V. FLUIDS. IF TROPONINS AND EKG'S REMAIN UNREMARKABLE IN THE MORNING, WILL SCHEDULE FOR A TREADMILL TEST TOMORROW.

2. GI: WILL CONTINUE THE PATIENT ON I.V. PPI TIMES ONE DOSE HERE IN THE EMERGENCY ROOM AND START THE PATIENT ON ORAL DOSE OF PRILOSEC 20 MG P.O. B.I.D. WILL RECOMMEND GI EVALUATION FOR POSSIBLE ENDOSCOPY IN THE FUTURE. HAVE ALSO ADVISED THE PATIENT OF ANTIREFLUX PRECAUTIONS AS WELL AS HAVING NUTRITION EVALUATE FOR ANTIREFLUX DIET. WOULD RECOMMEND HAVING THE PATIENT AT LEAST 30 TO 45 DEGREES WHILE HERE IN THE HOSPITAL FOR ANTIREFLUX PRECAUTIONS.

3. DISPOSITION: THE PATIENT IS OTHERWISE A FULL CODE. RESULTS OF TEST AND ALSO PLAN AND MANAGEMENT WERE DISCUSSED WITH THE PATIENT AND FAMILY AND THEY ARE IN TOTAL AGREEMENT.

EUGENE PANTANGCO, M.D.
DEPARTMENT OF INTERNAL MEDICINE.

D..12/21/04 T..12/21/04 MPG 0412 HOURS WORKTYPE 13

KAISER PERM[illegible]TE DISCHARGE SUMMARY 10258940 RECTAL HEALTH S
FRIDAY 11/18/05 15:09

DATE OF ADMISSION: DECEMBER 20, 2004.

DATE OF TRANSFER: DECEMBER 21, 2004.

TRANSFER DIAGNOSES:

(1) CORONARY ARTERY DISEASE WITH THREE VESSEL DISEASE. PROXIMAL LAD, PROXIMAL CIRCUMFLEX AND RCA.

(2) ACUTE MYOCARDIAL INFARCTION.

(3) HYPERLIPIDEMIA.

(4) NONSUSTAINED VENTRICULAR TACHYCARDIA.

ON PRESENTATION THE PATIENT COMPLAINED OF CHEST PAIN.

HISTORY OF PRESENT ILLNESS: THE PATIENT IS A 50-YEAR-OLD GENTLEMAN WITH A POSITIVE FAMILY HISTORY OF MYOCARDIAL INFARCTION WHO PRESENTED WITH SYMPTOMS OF CHEST PAIN AND MILD SHORTNESS OF BREATH AND DYSPNEA ON EXERTION WITH DIAPHORESIS AND RADIATION TO HIS LEFT CHEST.

THE PATIENT'S INITIAL EKG AND TROPONINS WERE NORMAL AND WAS KEPT IN THE HOSPITAL OVERNIGHT FOR RULE OUT MYOCARDIAL INFARCTION.

THE NEXT MORNING THE PATIENT DEVELOPED BOUNDS OF NONSUSTAINED VENTRICULAR TACHYCARDIA AND TROPONIN INCREASED TO 10.1.

THE PATIENT WAS STARTED ON AMIODARONE, HEPARIN AND INTEGRILIN. NO ASPIRIN WAS INITIATED AS HE HAS A TRUE ASPIRIN ALLERGY DEVELOPING CHEST TIGHTNESS AND SHORTNESS OF BREATH WITH USE OF ASPIRIN.

THE PATIENT WAS QUICKLY TAKEN TO THE CATH LABORATORY WHERE DOCTOR BARTZ PERFORMED A CARDIAC CATHETERIZATION WHICH SHOWS LESIONS IN ALL THREE VESSELS.

PLEASE SEE DOCTOR BARTZ'S DICTATION FOR DETAILS.

THE PATIENT HAD AN INTRA-ARTERIAL AORTIC BALLOON PUMP INSERTED FOR STABILIZATION OF HIS BLOOD PRESSURE.

AT THE TIME OF TRANSFER THE PATIENT IS CLINICALLY STABLE MAINTAINING A STABLE BLOOD PRESSURE OF 106/64, HEART RATE OF 89, SATURATION OF 96% ON TWO LITER NASAL CANNULA. THE PATIENT IS STILL HAVING TELEMETRY RUNS OF VENTRICULAR TACHYCARDIA THAT ARE NONSUSTAINED.

THE PATIENT'S TRANSFER MEDICATIONS INCLUDE HEPARIN 1,100 UNITS PER HOUR, AMIODARONE 1 MG PER MINUTE, METOPROLOL 50 MG PO BID, MORPHINE SULFATE 1 MG IV PRN FOR CHEST PAIN.

NITRATES HAVE BEEN HELD BECAUSE OF THE DECREASE IN THE BLOOD PRESSURE. ASPIRIN HAS BEEN HELD BECAUSE OF

KAISER PERMANENTE DISCHARGE SUMMARY 10290840 BECHARA, NAGUIB S
FRIDAY 11/19/04 15:09

THE ALLERGIC REACTION. ..... HAS BEEN GIVEN IN ANTICIPATION OF CARDIOTHORACIC SURGERY LATER TODAY.

DISPOSITION: KAISER SUNSET CARDIOTHORACIC ICU.

ACCEPTING PHYSICIAN: DR. PFEIFFER.

THE PATIENT IS A FULL CODE AS DISCUSSED WITH HIM AND HIS FAMILY PRIOR TO CARDIAC CATHETERIZATION.

OSVALDO RODRIGUEZ, M.D.
DEPARTMENT OF INTERNAL MEDICINE

D:...12/21/04 T:...12/21/04 JN

KAISER [redacted] PROCEDURE 10294868 BECHARA [redacted] S
FRIDAY 11/18/05 15:09

CARDIAC CATHETERIZATION

DATE OF PROCEDURE: DECEMBER 21, 2004

PROCEDURES PERFORMED:

1. CORONARY ANGIOGRAPHY.

2. INTRA-AORTIC BALLOON PUMP INSERTION.

PRE-PROCEDURE DIAGNOSES:

1. UNSTABLE ANGINA.

POST PROCEDURE DIAGNOSES:

1. HIGH GRADE CRITICAL MULTIVESSEL EPICARDIAL CORONARY DISEASE.

2. SUCCESSFUL PLACEMENT OF INTRA-AORTIC BALLOON PUMP.

DESCRIPTION OF PROCEDURE: AFTER INFORMED CONSENT WAS OBTAINED, MR BECHARA WAS BROUGHT TO THE CARDIAC CATHETERIZATION LABORATORY IN A FASTING STATE. THE RIGHT GROIN WAS PREPPED, DRAPED, AND ANESTHESIZED IN THE USUAL STERILE FASHION.

A #6 FRENCH SIDE-PORT ANGIOSHEATH WAS PLACED INTO THE RIGHT FEMORAL ARTERY USING A MODIFIED SELDINGER TECHNIQUE. THE CATHETER WAS ASPIRATED AND FLUSHED WITH SALINE. A #6 FRENCH JL-4 CATHETER WAS USED TO PERFORM A LEFT CORONARY CINEANGIOGRAPHY AND A JR-4 USED TO PERFORMED RIGHT CORONARY CINEANGIOGRAPHY. THE SHEATH WAS EXCHANGED FOR THE SHEATH AND THE INTRA-AORTIC BALLOON PUMP PACKAGE, AND AN INTRA-AORTIC BALLOON PUMP WAS POSITIONED. THE PUMP WAS SUTURED IN POSITION AND THE PATIENT REMAINED IN THE CARDIAC CATHETERIZATION LABORATORY AWAITING TRANSFER TO SUNSET HOSPITAL FOR URGENT BYPASS GRAFTING SURGERY.

D: 12/21/04 T: 12/22/04 ALK

Kaiser Permanente
Medical Center, Anaheim

BECHARA NAGUIB S
KP # 10290840 Room 2099.9
AGE 51 SEX M
DOB [redacted]/54 Clin 355
DOPP: GEORGE SAJINI S

CHAMPS # 23098686 Cardio Pulmonary Reports

Transcriber: 12/22/04 0832 Kerns Allison L DEVICE # 0
Dictator: 12/22/04 0832 Bartz Stephen, MD
Intervention: (No Intervention Recorded)

C00087 CARDIAC CATHETERIZATION

DATE OF TEST : 12/21/04 HT: WT: REQ. BY: 32944 BARTZ STEPHEN MD
DIAGNOSIS : CHEST PAIN
TEST PERFORMED BY : 32944 BARTZ STEPHEN
PARAMETERS/HEMODYNAMICS/IMPRESSION:

CARDIAC FLUOROSCOPY: NORMAL.
HEMODYNAMICS: THE SYSTOLIC BLOOD PRESSURE THROUGHOUT THE PROCEDURE WAS APPROXIMATELY 100. THE CARDIAC RHYTHM WAS SINUS TACHYCARDIA WITH RUNS OF NON-SUSTAINED VENTRICULAR TACHYCARDIA.
LEFT VENTRICULOGRAM: NOT DONE.
SELECTIVE CORONARY ARTERIOGRAPHY:
1. *LEFT MAIN* CORONARY ARTERY: THE LEFT MAIN CORONARY ARTERY IS A LARGE VESSEL THAT BIFURCATES INTO ANTERIOR DESCENDING AND CIRCUMFLEX CORONARY ARTERY. THE LEFT MAIN TAPERS SLIGHTLY AND IS NARROWED BY ABOUT 20%.
2. LEFT ANTERIOR DESCENDING CORONARY ARTERY: THE LEFT ANTERIOR DESCENDING CORONARY ARTERY IS A TRANSAPICAL VESSEL. THERE IS A 99% STENOSIS JUST PROXIMAL TO A VERY LARGE DIAGONAL. THERE IS TIMI GRADE I FLOW DISTAL TO THE STENOSIS IN BOTH THE DIAGONAL AND THE ANTERIOR DESCENDING.
3. CIRCUMFLEX CORONARY ARTERY: THE CIRCUMFLEX CORONARY ARTERY HAS SEQUENTIAL 95% LESIONS IN THE A-V GROOVE. MODERATE SIZED OBTUSE MARGINAL IS DIMINISHED PROXIMALLY BY 80%.
4. RIGHT CORONARY ARTERY: THE RIGHT CORONARY ARTERY HAS SEQUENTIAL LESIONS IN THE PROXIMAL PORTION OF ABOUT 80%.
FINAL IMPRESSION:
1. HIGH GRADE MULTIVESSEL EPICARDIAL CORONARY DISEASE.
2. SUCCESSFUL PLACEMENT OF INTRA-AORTIC BALLOON PUMP.
RECOMMENDATIONS: AT THIS TIME, A TRANSFER TO SUNSET HOSPITAL IS BEING ARRANGED. DR. PFEFFER HAS ACCEPTED THE PATIENT ONTO HIS SERVICE.
IMPRESSION BY : BARTZ STEPHEN

000151

Exhibit C

KAISER PERMANENTE

PATIENT: BECHARA , NAGUIB S
MR#: 0000000010290840
DATE OF OPERATION: 12/21/2004
DICTATING PHYSICIAN: Thomas A Pfeffer, MD

SURGEON(S):
Thomas A Pfeffer, MD

ATTENDING SURGEON:
Thomas A Pfeffer, MD

PREOPERATIVE DIAGNOSIS(ES):
Coronary artery disease, ventricular tachycardia.

POSTOPERATIVE DIAGNOSIS(ES):
Coronary artery disease, ventricular tachycardia.

OPERATION:
Emergent coronary artery bypass x4 with left internal mammary artery to left anterior descending artery, reversed saphenous vein from aorta to diagonal, reversed saphenous vein from aorta to obtuse marginal, reversed saphenous vein from aorta to posterior descending artery.

INDICATIONS FOR OPERATION:
This is a 50-year-old male with coronary artery disease who underwent cardiac catheterization with findings of 3-vessel significant coronary artery disease including a tight left anterior descending stenosis. The procedure was complicated by ventricular tachycardia requiring intraaortic balloon pump placement and the patient was referred emergently for surgical intervention.

FINDINGS:
The LAD is 1.5 mm with moderate disease. The diagonal is 1.5 mm with severe disease. The obtuse marginal is 1.5 mm with mild disease. The posterior descending is 1.5 mm with mild disease. The greater saphenous vein using open technique was of good quality. The mammary artery had good flow.

DESCRIPTION OF OPERATION:
The patient was taken emergently to the operating room and placed in the supine position and after induction of general endotracheal anesthesia, the chest and leg were prepped with Betadine and sterilely draped in the usual manner. A midline sternotomy skin incision was made and the sternum divided with a Sarus saw. The left pleural space was widely opened and the left internal mammary artery dissected from the anterior chest wall using electrocautery. The branches were ligated with clips.

Concurrently, Maurice Carretta, PA, harvested the greater saphenous vein using open technique and the branches were ligated with 4-0 silk ties and surgical clips. The leg incision was closed in layers with running Vicryl. The pericardium was incised. Heparin administered and cannulation performed with a 24-French TMP aortic cannula. A two-stage venous cannula placed in the right atrial appendage.

Bypass was commenced with systemic cooling to 34 degrees Centigrade performed. The aorta was crossclamped and cold blood potassium cardioplegia delivered in an antegrade and subsequently in a retrograde manner. All

J: 1651422

OPERATIVE REPORT

Los Angeles Medical Center, 4867 Sunset Boulevard, Los Angeles, CA 90027

Clinic Records

000041

KAISER PERMANENTE

PATIENT: BECHARA , NAGUIB S
MR#: 0000000010290840
DATE OF OPERATION: 12/21/2004
DICTATING PHYSICIAN: Thomas A Pfeffer, MD

anastomoses were performed under the same aortic crossclamp with running 7-0 Prolene suture for distal anastomoses. A 4-mm aortic punch and running 5-0 Prolene suture for the proximal anastomosis to the ascending aorta. Additional cardioplegia was delivered on completion of each anastomosis. The aortic crossclamp was then removed with return to a normal sinus rhythm.

After completion of systemic rewarming, bypass was weaned and discontinued. Protamine was administered and the venous and aortic cannulae were removed. An angled 36-French chest tube was placed in the left pleural space. A straight 36-French chest tube placed subcostally. Temporary right ventricular and ground pacing wires were placed. After verifying satisfactory hemostasis, the sternum was then closed with #6 stainless steel wire. The rectus abdominis fascia was closed with figure-of-eight #1 Vicryl, sternal fascia with running 0-Vicryl, the subcutaneous layer closed with running 2-0 Vicryl, and the skin closed with subcuticular 3-0 Vicryl. A 4x4 was applied as dressing and the patient was transported to CSU.

TOTAL BYPASS TIME:
72 minutes.

AORTIC CROSSCLAMP TIME:
43 minutes.

ISCHEMIC TIME:
33 minutes.

TOTAL BLOOD CARDIOPLEGIA:
2 liters.

GRAFT FLOWS DURING CARDIOPLEGIA ADMINISTRATION:
Diagonal 80, obtuse marginal 80, posterior descending artery 90 with a perfusion pressure of 80.

CARDIAC INDEX:
Preoperatively 2.2, PA wedge 31, PA pressure 38/31.
Postoperative cardiac index 3.4, PA wedge 22, PA pressure 35/22.

COUNTS:
Final sponge and needle counts were correct.

COMPLICATIONS:
There were no perioperative complications.

J: 1651422

KAISER PERMANENTE

PATIENT:	**BECHARA , NAGUIB S**
MR#:	**0000000010290840**
DATE OF OPERATION:	**12/21/2004**
DICTATING PHYSICIAN:	**Thomas A Pfeffer, MD**

TRANSFUSIONS:
No blood products were transfused during the procedure.

Thomas A Pfeffer, MD
TAP:Sphinx17574 DOCUMENT: 20050804190903200
D:08/04/2005 @13:36 T:08/06/2005@05:24 c:08/06/2005@05:24

J: 1651422

OPERATIVE REPORT

Los Angeles Medical Center, 4867 Sunset Boulevard, Los Angeles, CA 90027

Clinic Records

Exhibit D

GARY M. SCHNEIDER
ATTORNEY AT LAW
SUITE 1100
12100 WILSHIRE BOULEVARD
LOS ANGELES, CALIFORNIA 90025
TELEPHONE (310) 820-5544
FAX (310) 820-6024

November 9, 2005

CERTIFIED MAIL--RETURN
RECEIPT REQUESTED___

Kaiser Foundation Health Plan, Inc.
Legal Department
393 East Walnut Street
Pasadena, California 91188

RE: NAGUIB BECHARA & NABILA SAAD vs. KAISER FOUNDATION HEALTH PLAN, et al.;
PATIENT: NAGUIB BECHARA;
PATIENT NO.: 10290840;
PATIENT DATE OF BIRTH: [redacted], 1954

TO: KAISER FOUNDATION HEALTH PLAN, INC.;
KAISER FOUNDATION HOSPITALS (KFH);
SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP (SCPMG);
AND ALL INVOLVED PHYSICIANS, NURSES AND PERSONNEL OF KFH AND OF SCPMG
(ALL JOINTLY HEREINAFTER REFERRED TO AS "RESPONDENTS")

This office has been retained to represent Mr. Naguib Bechara and his wife, Nabila Saad, in a medical malpractice claim against Respondents. This letter is a DEMAND FOR ARBITRATION of said claim. Enclosed herewith you will find a check in the sum of $150.00, issued to the order of "Arbitration Account", in payment of the required filing fee.

Claimants contend that Respondents negligently and carelessly examined, diagnosed, monitored, treated, cared for, and attended to Naguib Bechara, at each facility where he was seen. Claimants further contend that as a result of said negligence Naguib Bechara suffered severe permanent injuries and damages on December 20, 2004, and thereafter. As a result of said injuries and damages Naguib Bechara is now permanently disabled. Nabila Saad is claiming damages for loss of consortium.

GARY M. SCHNEIDER
ATTORNEY AT LAW

Claimants hereby name Phillip W. Neiman, Esq., as their party arbitrator. Mr. Neiman's address is 605 Hanley Way, Los Angeles, California 90049.

Very truly yours,

GARY M . SCHNEIDER

\GMS\alt
\Bechara\corres03\Kaiser\demand
\Enclosure
cc: Mr. Naguib Bechara
Ms. Nabila Saad

Exhibit E

GARY M. SCHNEIDER
Attorney at Law
12100 Wilshire Boulevard, Suite 1100
Los Angeles, California 90025-7111
Telephone: (310) 820-5544
Fax: (310) 820-6024
STATE BAR NO.: 72553

Attorney for Claimants

IN THE MATTER OF THE ARBITRATION BETWEEN

NAGUIB BECHARA and NABILA SAAD, Claimants, vs. KAISER FOUNDATION HEALTH PLAN, INC.; KAISER FOUNDATION HOSPITALS; SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP; et al., Respondents.	CLAIMANTS' ARBITRATION BRIEF Neutral Arbitrator: Honorable Sam Cianchetti, Ret. Arbitration Dates: October 30, 31 & November 1, 2, 2006

1. INTRODUCTION.

This is a catastrophic damage medical malpractice case which, pursuant to the provisions of the Kaiser Health Plan, is being submitted to binding arbitration. The Claimants are Naguib Bechara ("Mr. Bechara"), the patient in question, and his wife Nabila Saad ("Ms. Saad"), who is claiming damages for loss of consortium. The Respondents are Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Hospitals; and the Southern California Permanente Medical Group.

///

2. FACTUAL SUMMARY.

A. DECEMBER 21, 2004: KAISER ANAHEIM.

(1) 12:45 A.M. ONSET OF CHEST PAIN AND SUMMONSING OF PARAMEDICS.

On December 21, 2004, at approximately 12:45 a.m., Mr. Bechara, who was then 50 years old, was awakened from sleep by severe chest pain that was radiating to his jaw. He also had shortness of breath. Paramedics were called and arrived at his home at 1:08 a.m. The paramedics then attended to Mr Bechara and transported him to Kaiser Anaheim, arriving there are 1:29 a.m. In their report the paramedics noted that Mr. Bechara was overwhelmed with pain and unable to communicate, and also that he was overcome with anguish.

(2) 1:34-4:15 A.M.: MR. BECHARA'S STAY IN THE KAISER ANAHEIM EMERGENCY ROOM.

Mr. Bechara arrived in the emergency room at 1:34 a.m. and was initially seen by nursing personnel and emergency room physician Emio Bond, M.D. ("Dr. Bond"). Later he was also seen in the emergency room by internist Eugene Pantagco, M.D. ("Dr. Pantagco").

At 1:34 a.m. Mr. Bechara was assessed by a triage nurse who noted a complaint of chest pain of 10 of 10 that radiated to his jaw. The nurse also noted that ten days earlier Mr. Bechara had had chest tightness that resolved. In addition to chest pain Mr. Bechara was noted to have shortness of breath, diaphoresis (profuse sweating), and anxiety, and had been nauseous and vomiting. In addition to the signs and symptoms of a heart attack that Mr. Bechara presented with, he also had risk factors for heart disease of his father having died at age 52 of a heart attack, and of being a smoker and overweight. In addition to the initial notation of chest pain of 10 of 10 at 1:34 a.m., Mr. Bechara had chest pain of 9/10 at 1:50 a.m., 10/10 at 2:00 a.m., 10/10 at 2:20 a.m., and 10/10 at 3:00 a.m.

At 1:34 a.m. the nurse wrote that Mr. Bechara was moaning aloud. At 1:40 a.m. the nurse wrote that Mr. Bechara continued to moan and be anxious while Dr. Bond

was at his bedside. However, Dr. Bond, while noting the complaint of chest tightness, wrote in his note that Mr. Bechara was in no acute distress.

Initial EKGs of 1:43 and 1:46 showed no evidence of ischemic chest pain. An EKG of 2:12 a.m. showed significant changes that caused Dr. Bond to conclude that Mr. Bechara was in fact having acute ischemic cardiac chest pain. While it is not documented in the chart, Dr. Bond testified at deposition that within three minutes from the 2:12 EKG he called internist Dr. Pantagco to request a consultation. Dr. Bond further testified that any request for a consultation from the emergency room is to be a "stat request," meaning that what is being requested is to be done right away.

Immediately after seeing the 2:12 EKG, Dr. Bond ordered that Mr. Bechara be given a nitroglycerin drip, which was started at 2:15 a.m. However, Dr. Bond failed to order beta blockers, anti-platelet medication, and heparin, all of which are standard medications to be given to a patient who presents with acute ischemic cardiac chest pain.

After the EKG of 2:12 Mr. Bechara had EKGs at 2:31 and 2:46. The 2:31 EKG continued to show that Mr. Bechara was having acute ischemic chest pain. The EKG of 2:46 was interpreted as appearing more like the initial EKG of 1:43. In addition to EKGs, Mr. Bechara's Troponin I (a biomarker for heart damage) was checked at 2:00 a.m., at which time it had not yet elevated.

While Dr. Bond testified that he called Dr. Pantagco at 2:15 a.m. requesting a stat consultation, the record indicates that Dr. Pantagco did not see Mr. Bechara until 3:10 a.m. In his deposition Dr. Pantagco testified that he has no recollection of being called by Dr. Bond and that he was in the emergency room seeing another patient when someone informed him that he needed to see Mr. Bechara.

When Dr. Pantagco examined him, Mr. Bechara was described by Dr. Pantagco as "writhing in pain." With regard to Mr. Bechara's stay in the emergency room prior to Dr. Pantagco examining him, contrary to the conclusion of Dr. Bond that Mr. Bechara had acute ischemic changes on EKG, Dr. Pantagco wrote in this report that Mr. Bechara had "no acute ischemic changes." Dr. Pantagco also interpreted the EKGs to be negative, and

concluded, after Mr. Bechara threw up when Dr. Pantagco tried to insert a nasogastric tube and expressed some relief, that Mr. Bechara most likely had a gastrointestinal atypical chest pain secondary to gastrointestinal cause and less likely a cardiac chest pain. Dr. Pantagco did not request a cardiology consultation, instead arranging for Mr. Bechara's admission to the chest pain unit with what he referred to as a chest pain protocol. However, Dr. Pantagco did not order any anti-platelet therapy or heparin, and his order for Lopressor which is a beta blocker, was for giving at 8:00 a.m., more than four hours after Dr. Pantagco saw Mr. Bechara.

The last documented complaint of chest pain was Dr. Pantagco's reference to Mr. Bechara's writhing in pain. There are no further documented complaints of chest pain, although Mr. Bechara was heavily sedated.

(3) 4:15 A.M. TO 5:20 P.M.: ADMISSION TO AND STAY IN KAISER ANAHEIM HOSPITAL.

At 4:15 a.m., pursuant to Dr. Pantagco's orders, Mr. Bechara was transferred from the emergency room to the Kaiser Hospital. At 4:30 a.m. a nurse did an initial assessment of Mr. Bechara where she wrote that the history of present illness was "persistent chest pain at home." The nurse also indicated that Mr. Bechara was lethargic from sedation in the emergency room, but arousable. While there is no further assessment or evaluation of Mr. Bechara during that night after the initial nursing assessment, there is a 4:49 cardiac rhythm strip in the chart that shows what is known as sinus rhythm. At 7:42 rhythm strips in the chart show that Mr. Bechara was having runs of ventricular tachycardia, which is a potentially fatal arrhythmia. There is no evidence that anybody at Kaiser noticed these runs of ventricular tachycardia, for other than the rhythm strips in the chart they were not documented and not brought to the attention of any doctor until 9:30 a.m. when a nurse brought them to the attention of Dr. Bartz, a Kaiser cardiologist who was making rounds unrelated to Mr. Bechara at the time. At that time Dr. Bartz was also informed that an 8:30 a.m. check of Mr. Bechara's Troponin I level was 10.2, a clear indication that Mr. Bechara had in fact suffered a heart attack. This is how a cardiologist first became involved in Mr.

Bechara's care eight hours after Mr. Bechara had been brought to the emergency room with classic signs and symptoms of a heart attack and more than seven hours after EKG changes made it absolutely clear that Mr. Bechara was suffering from acute ischemic cardiac chest pain.

Upon Mr. Bechara being brought to the attention of Dr. Bartz, Dr. Bartz ordered that Mr. Bechara be started on IV heparin, IV integrelin (anti-platelet) and IV Amiodarone drip (an anti-arrhythmic medication which can also have a beta blocking effect). The beta blocker that Dr. Pantagco ordered be given at 8:00 a.m. had been held and not given by the nurse with an indication that Mr. Bechara was sleepy.

In his consultation report Dr. Bartz indicated that Mr. Bechara was referred to him by a Dr. Rodriguez (the next "rounder" to whose care Mr. Bechara had been admitted pursuant to Dr. Pantagco's order). However, prior to Dr. Bartz' involvement Dr. Rodriguez had not even seen Mr. Bechara.

In his consultation report Dr. Bartz noted that he was obtaining Mr. Bechara's history mainly from his wife and the medical record because Mr. Bechara had "been given a sizable dose of a benzodiazepine anxiolytic and is falling asleep during the interview." Dr. Bartz also mentioned that over the night time hours Mr. Bechara had had repeated runs of non-sustained ventricular tachycardia and that as he was making rounds in the intensive care unit that morning the ICU nurse brought those runs to his attention. Dr. Bartz' impression was myocardial infarction the night before and thus made his orders for the above medications and for Mr. Bechara to undergo an angiogram.

At 12:20 p.m. Mr. Bechara was taken to the catheterization laboratory where Dr. Bartz performed the angiogram and diagnosed multi-vessel coronary artery disease. During the procedure Dr. Bartz placed an intra-aortic balloon pump and recommended a transfer to Kaiser Sunset for further management. During the catheterization Mr. Bechara's aortic pressure was found to be 85/64, and recorded blood pressures during the procedure included hypotensive systolic measurements of 96 at 1:20 p.m., 83 at 1:35 p.m., 79 at 1:45 p.m., and 71 at 2:15 p.m., 98 at 3:45 p.m., and 96 at 4:15 p.m. The

catheterization progress notes indicate that when Mr. Bechara was received in the cath lab he was drowsy but arousable and that the consent to the procedure had been signed by his wife. At 3:40 p.m. note in the cath lab indicates that Mr. Bechara's systolic blood pressure had dropped to 62 and that Dr. Bartz had been made aware of that and after the A-line was rebalanced the pressure increased to the 80's systolic.

At 3:50 p.m. an ambulance was dispatched to pick up Mr. Bechara to transfer him to Kaiser Sunset. That ambulance arrived at Mr. Bechara's side at 4:20 p.m. and Mr. Bechara was taken from Kaiser Anaheim to Kaiser Sunset at 5:20 p.m. Dr. Rodriguez dictated a discharge summary wherein he stated that an intra-aortic balloon pump had been inserted in Mr. Bechara for stabilization of his blood pressure and that at the time of transfer Mr. Bechara was clinically stable.

(4) 5:20-6:26 P.M.: THE TRANSPORT OF MR. BECHARA FROM KAISER ANAHEIM TO KAISER SUNSET.

The ambulance departed Kaiser Anaheim at 5:20 p.m. During the transport he had hypotensive systolic blood pressure readings of 86 at 5:13 p.m., 88 at 6:00 p.m., 82 augmented at 6:00 p.m., 91 augmented at 6:00 p.m., and 91 augmented at 6:18 p.m. The ambulance nursing notes indicate that at 5:56 p.m. Mr. Bechara had an augmented pressure of 90 and that at 6:15 p.m. the ambulance personnel were instructed to take Mr. Bechara directly to the operating room. A note at 6:30 p.m. indicates that the ambulance had arrived at Kaiser Sunset and that Mr. Bechara had been taken directly to the operating room.

B. DECEMBER 21, 2004, TO JANUARY 18, 2005, HOSPITALIZATION AT KAISER SUNSET: CARDIAC SURGERY, PROLONGED LIFE SUPPORT AND ACUTE RENAL FAILURE AND DIALYSIS.

Mr. Bechara underwent emergency bypass surgery immediately upon his arrival at Kaiser Sunset. Following the surgery Mr. Bechara was intubated and on life support for approximately twenty days. Most significantly, while Mr. Bechara had healthy kidneys when he was first brought to Kaiser Anaheim, following his heart surgery he suffered acute renal failure for which he had to be placed on dialysis during and after his Kaiser Sunset

hospitalization.

C. POST KAISER SUNSET HOSPITALIZATION.

Following his hospitalization Mr. Bechara's kidneys did not recover and he was eventually diagnosed with end stage renal disease. Inexplicably in February of 2005 Mr. Bechara was given an IV contrast load with a CT pulmonary angiogram which further damaged his kidneys. Mr. Bechara remained on dialysis until December of 2005, and although he has been off dialysis since then his current treating nephrologist at Kaiser and both sides' expert nephrologists agree that he will have to go back on dialysis in the future and eventually require a kidney transplant.

3. LIABILITY OF KAISER FOR FOR MEDICAL MALPRACTICE IN THE CARE OF MR. BECHARA.

A. THE ELEMENTS OF A MEDICAL MALPRACTICE CASE.

The elements of this medical malpractice case against Kaiser are set forth in CACI 400/500 as follows:

1. That Kaiser was negligent.

2. That Mr. Bechara was harmed; and

3. That Kaiser's negligence was a substantial factor in causing Mr. Bechara harm.

In order to prevail a Plaintiff or Claimant must prove that it is more likely true than not true that all these elements exist. CACI 200. With regard to the first element, CACI 501 provides that a medical provider such as Kaiser is negligent if it "fails to use the level of skill, knowledge, and care in diagnosis and treatment that other reasonable medical providers would use in the same or similar circumstances."

As stated in CACI 501 the level of skill, knowledge and care required is sometimes referred to as the standard of care. With regard to specialists such as an emergency room physician, internist or cardiologist, the standard of care is to use the level of skill, knowledge and care in the diagnosis and treatment of a patient that other reasonably

careful emergency room physicians, internists or cardiologists would use in similar circumstances. CACI 502.

The second element of harm is not in dispute, for all experts agree that Mr. Bechara has suffered devastating harm. With respect to the third element, causation, contrary to Kaiser's argument that the "but for" rule of causation applies, under CACI 400 what is required is that Kaiser's negligence be a substantial factor in causing Mr. Bechara's harm. CACI 430 defines substantial factor as follows:

> "A substantial factor in causing harm is a factor that a reasonable person would consider to have contributed to the harm. It must be more than a remote or trivial factor. It does not have to be the only cause of the harm."

BAJI has also discarded the "but for" language and adopted the substantial factor test as stated in BAJI 3.76:

> "The law defines cause in its own particular way. A cause of [injury] [damage] [loss] [or] [harm] is something that is a substantial factor in bringing about an [injury] [damage] [loss] [or] [harm]."

Kaiser's reliance on *Viner vs. Sweet* (2003) 30 Cal.4th 1232, is misplaced, as is clear from the CACI 430 use note which, citing *Viner,* states that "as phrased, this [CACI 430] definition of 'substantial factor' subsumes the 'but for' test of causation." As further stated in said use note, the first sentence of CACI 430 accounts for the 'but for' concept. *Viner* was a legal malpractice case, not a medical malpractice case. The concept of using 'but for' in a legal malpractice case does not allow for the use of that language or test in a personal injury case, be it medical malpractice, asbestos exposure, or otherwise. This is clear from *Jones vs. John Crane, Inc.* (2005) 132 Cal.App.4th 990, 998. In medical malpractice cases the element of causation is satisfied when the Plaintiff produces sufficient evidence to allow the trier of fact "'to infer that in the absence of the defendant's negligence, there was a reasonable medical probability the plaintiff would have obtained a better result.' (Citation)" *Espinosa vs. Little Company of Mary Hospital* (1995) 31 Cal.App.4th 1304, 1314-1315.

Simply stated, all that Claimants need prove with regard to causation is that

Kaiser's negligence, to a reasonable medical probability (more likely true than not true) caused Mr. Bechara's harm.

B. KAISER'S NEGLIGENCE CAUSED HARM TO MR. BECHARA, INCLUDING ACUTE RENAL FAILURE RESULTING IN END STAGE RENAL DISEASE.

At arbitration Claimants will present substantial expert testimony that the Kaiser staff committed numerous violations of the standard of care, including the failure to timely diagnose and treat Mr. Bechara's heart attack, the negligent interpretation of electrocardiograms, and the failure to obtain a timely cardiology consultation. Claimants' experts will further testify that as a result of said negligence Mr. Bechara suffered catastrophic injury including acute renal failure which resulted in end stage renal disease.

4. DAMAGES.

A. MR. BECHARA.

1. PAIN AND SUFFERING.

As a result of Kaiser's negligence Mr. Bechara was forced to endure a hospitalization at Kaiser Sunset where he was on life support for close to three weeks, suffered kidney failure which has forced him to have dialysis and will eventually require more dialysis and a kidney transplant. Mr. Bechara is therefore entitled to compensation for past and future physical pain, mental suffering, loss of enjoyment of life, physical impairment, inconvenience, grief, anxiety, humiliation and emotional distress that he has suffered as a result of Kaiser's negligence. CACI 3905A. Mr. Bechara is now permanently disabled and on Social Security and Kaiser's own physicians have certified that he will not be able to return to work. It is therefore obvious that Mr. Bechara's non-economic damages by far exceed the maximum allowable amount of $250,000.00.

2. ECONOMIC DAMAGES.

At arbitration Claimants will offer expert testimony of a certified nurse life care planner and a certified public accountant. Said testimony will include the calculation of Mr. Bechara's economic damages for past loss of earnings, future loss of earnings, and

future medical needs. In that expert nephrologists for both sides are in agreement that Mr. Bechara has a life expectancy of 20 years, for that period Claimants' economist will testify that the present value of Mr. Bechara's economic damages for past loss of earnings, future loss of earning capacity and future medical needs (based on the life care plan of Claimants' life care planner) is a sum ranging from $2,935,123.00 to $3,224,461.00. Kaiser's economist will testify that for the same period, assuming that Mr. Bechara never returns to work, Mr. Bechara's economic damages based on the life care plan of Claimants' life care planner have a present value of $2,320,949.00. Of course, should Kaiser opt for periodic payments, then Mr. Bechara's damages should not be reduced to present value.

B. MS. SAAD'S CLAIM FOR LOSS OF CONSORTIUM.

At arbitration the evidence will show that Kaiser's negligence and the harm caused thereby to Mr. Bechara has had a devastating effect on Mr. Bechara and Ms. Saad's marriage. Therefore, Ms. Saad is claiming noneconomic damages for loss of consortium in the maximum amount allowed by law of $250,000.00. The $250,000.00 Micra limitation on noneconomic damages applies separately to a spouse's claim for loss of consortium, meaning that each spouse can recover up to $250,000.00 for his or her separate noneconomic damages. *Atkins v. Strayhorn* (1990) 223 Cal. App. 3rd 1380.

5. CONCLUSION.

The evidence will show that Kaiser was negligent in the care and treatment of Mr. Bechara, and that said negligence caused substantial permanent harm to Mr. Bechara, including end stage rental disease. Therefore, Claimants respectfully submit that Kaiser should be held fully liable for all the damages suffered by Mr. Bechara and Ms. Saad.

Dated: October 27, 2006

GARY M. SCHNEIDER
Attorney for Claimants

\Bechara\trial01\arbitration brief

PROOF OF SERVICE–§1013a CODE OF CIVIL PROCEDURE

STATE OF CALIFORNIA)
) ss.
COUNTY OF LOS ANGELES)

I am employed in the County of Los Angeles, State of California. I am over the age of eighteen (18) and not a party to the within action; my business address is 12100 Wilshire Boulevard, Suite 1100, Los Angeles, California 90025.

On October 27, 2006, I served the foregoing document described as CLAIMANTS' ARBITRATION BRIEF, on the interested parties in this action by placing a true copy thereof enclosed in a sealed envelope address as follows:

Christopher Cannon, Esq.
Michael Reid, Esq.
LaFollette, Johnson, DeHaas, Fesler & Ames
2677 N. Main Street, Suite 901
Santa Ana, California 92705
Fax No. (714) 972-0379

Hon. Sam Cianchetti, ret.
IVAMS Arbitration & Mediation Services
300 S. Park Avenue, Suite 780
Pomona, California 91730
Fax No. (909) 629-1607

___ **Via First Class Mail:** I caused such envelope to be deposited in the mail at Los Angeles, California. The envelope was mailed with postage thereon fully prepaid.

___ **Via Overnight Delivery:** I caused such envelope to be sent via overnight delivery service. The envelope was deposited in or with a facility regularly maintained by the express service carrier with delivery fees paid or provided for.

___ **Via Personal Service/Hand Delivery:** I delivered such envelope by hand to the offices of the addressee(s) aforenamed.

X **Via Fax Only:** I caused a true copy of such document to be sent via facsimile to the addressee(s) aforenamed.

___ **Via Fax and First Class Mail:** I caused a true copy of such document to be sent via facsimile to the addressee(s) aforenamed. An additional copy was also sent by first class mail enclosed in a sealed envelope with postage thereon fully prepaid in the United States mail at Los Angeles, California to the parties above-indicated.

Executed on October 27, 2006, at Los Angeles, California. I declare under penalty of perjury under the laws of the State of California that the above is true and correct.

ALICE LOPEZ TAKAMIYASHIRO

\Bechara\trial01\arbitration brief

Exhibit F

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF FLORIDA

Case No. 1:08-MD-01928-MIDDLEBROOKS/JOHNSON

IN RE TRASYLOL PRODUCTS LIABILITY LITIGATION - MDL-1928	)
This Document Relates to: NAGUIB BECHARA, ET AL., v. BAYER CORP., ET AL. Case No. 9:08-cv-80776-DMM	) Pages 1-286

DEPOSITION OF:

NAGUIB BECHARA

WEDNESDAY, SEPTEMBER 9, 2009

9:08 A.M.

Reported by: LINDA NICKERSON

CSR No. 8746

NEWPORT BEACH, CALIFORNIA

WEDNESDAY, SEPTEMBER 9, 2009; 9:08 A.M.

NAGUIB BECHARA,

having been first duly sworn, was

examined and testified as follows:

EXAMINATION

BY MS. LOWRY:

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

A First name is N-a-g-u-i-b, Naguib, middle name is S-o-b-h-y, last name Bechara, B-e-c-h-a-r-a.

Q Thank you, sir. My name is Gerry Lowry, and I represent Bayer in the lawsuit that you've filed against them.

You understand that?

A Yes.

Q All right. And do you understand that we're here today to take your testimony in the lawsuit that you and your wife have filed against Bayer?

A Yes.

Q All right. I want to go over just some basic rules for the deposition before we get into it just so that you and I are on the same page, okay.

A No.
Q Mr. Bechara, have you ever given a deposition before? How many times?
A Once.
Q And you're talking about like this with a court reporter where the court reporter is taking down your sworn testimony?
A Yes.
Q And what case was that in?
A That was the case against Kaiser Permanente.
Q It's a case against Kaiser?
A Yes.
Q Are you the plaintiff in that case?
A Yes.
Q Is your wife also a plaintiff?
A Yes.
Q Is it against anybody other than Kaiser?
A I'm not sure. All I know is that it was against Kaiser. You have to examine the paper to find out.
Q What was that lawsuit about?
A It was a malpractice lawsuit.
Q Related to what events?
A Related to the events on December 21, 2004.
Q So it's a malpractice lawsuit related to your surgery where you're alleging that you received Trasylol?

A It's relating to the events that led to the surgery.

Q Okay. Tell me what you mean by that, please.

A I'm not sure. You're going to have to check the medical records and the lawsuit, and I'm not sure exactly how I can answer this question.

Q Well, what I want to know is in your own words what were you alleging was done wrong.

A I don't know. You're going to have to ask -- again, you're going to have to examine the medical records and the lawsuit.

Q Well, I don't have those. Do you have those?

A No, I don't.

Q Okay. Do you have a copy of the complaint that you brought in that case?

A No, I don't have it.

Q You don't have that anywhere at home?

A No.

Q When was this lawsuit brought?

A This lawsuit was brought in 2005, I believe. I'm not sure the exact date.

Q And you say that it was malpractice. What is the malpractice that you contend occurred?

A I'm not sure about the details, Ms. Lowry, but it's -- it's relating to what happened to me after the

surgery.

Q Okay. So --

A The -- the condition that I was in after the surgery. I have seen friends and relatives going into bypass surgery and coming out, and then a week later, they are living their normal life.

They didn't have any kidney issues. They didn't have any other issues that -- that was connected with the surgery. So that's -- that's why I needed to know what happened and why and why I was in a coma or life support for 18 days after the surgery.

Q So if I can try to understand what you've told me then in your own words in your understanding, the lawsuit was brought because you have seen many people have bypass surgery and be just fine after that with no complications, and in your case, there were complications and you did not understand why that happened and wanted to understand why that happened?

A Yes.

Q Did you sue any physicians or just the hospital?

A Just the hospital.

Q Where is that lawsuit filed?

A It was not a lawsuit. There is no lawsuits under California law. I can't sue the health care provider. We can only go to arbitration.

Q So you're saying there was not ever a lawsuit at all?

A Again, you have to -- you have to ask my lawyer. I don't -- I don't know the terminology of it.

If we are going into arbitration, is it the same thing as we're going to a lawsuit? Is the court involved?

I didn't think so, but, again, don't hold me on it. You can ask my lawyer.

Q Who was your lawyer for that?

A My lawyer is Mr. Goss.

MR. GOSS: She asked you who was your lawyer in the arbitration.

THE WITNESS: The lawyer for the first case?

BY MS. LOWRY:

Q For the case against Kaiser, yes.

A Gary Snyder.

Q Where is Mr. Snyder?

A Los Angeles.

Q What is your understanding of the status of that lawsuit or complaint or whatever it is?

MR. GOSS: I'm going to interject here. It's our understanding that the resolution of that lawsuit has a confidentiality agreement.

So I'll represent on the record that that

lawsuit was resolved. We're trying at this moment to figure out what we can, without breaching the confidentiality order, disclose regarding the resolution of that lawsuit.

That's going to entail getting with Mr. Snyder to determine the scope of the confidentiality provision and seeing what can be done to provide Bayer with the information it needs regarding that lawsuit and its resolution, but I can't let this witness testify about the resolution knowing that there is a confidentiality agreement out there.

MS. LOWRY: I take it that means you've seen it?

MR. GOSS: I have not -- I know it was resolved. I've been told there's a confidentiality agreement. Knowing there's a confidentiality agreement, I intentionally have not asked him to let me look at it.

MS. LOWRY: Okay.

MR. GOSS: Which is why we want Mr. Snyder to look at it and advise us as to whether he can show it to us and what we can tell you about it.

MS. LOWRY: All right. Let me just state on the record, I think this is something obviously we'd be entitled to see.

I understand you're investigating that. So we'll reserve the right to ask any additional questions

related to that at the time a determination is made on that issue.

MR. GOSS: Sure.

MS. LOWRY: Let me ask a couple other questions, though, if I might.

Q Mr. Bechara, did you go to arbitration in that case?

A No.

Q When did you give your deposition?

A I'm not exactly sure about the date, but it was early 2006, maybe January, February. I remember it was winter.

Q Who took your deposition?

A Kaiser, Kaiser Permanente.

Q Their lawyers?

A Their lawyers.

Q Do you know the names of any of those lawyers?

A No.

Q Do you know if anyone else has been deposed in that case?

A I believe I do, yes.

Q Who else has been deposed?

A Doctors involved in the case.

Q Which doctors?

A The surgeon, the emergency room doctors.

Q So the surgeon, Dr. Pfeffer, was deposed in that case?

A Yes.

Q Have you seen the testimony he gave in that deposition at any time?

A No.

Q Do you have a copy of his deposition?

A No.

Q Do you have a copy of the deposition that you gave in that case?

A No.

Q Did you ever see your own deposition in that case?

A No.

Q Never reviewed it for errors or to make sure that it had been taken correctly at any time?

A I don't remember.

Q All right. Well, tell me as best you can, if you recall, have you ever had a copy of your own deposition in that case against Kaiser in your possession at any time?

MR. GOSS: I'm going to advise you not to speculate.

THE WITNESS: I don't remember. I'm sorry.

BY MS. LOWRY:

Q Do you know if you currently have a copy of that

Exhibit G

GARY M. SCHNEIDER
Attorney at Law
12100 Wilshire Boulevard, Suite 1100
Los Angeles, California 90025-7111
Telephone: (310) 820-5544
Fax: (310) 820-6024
STATE BAR NO.: 72553

Attorney for Claimants

IN THE MATTER OF THE ARBITRATION BETWEEN

NAGUIB BECHARA and NABILA SAAD,

Claimants,

vs.

KAISER FOUNDATION HEALTH PLAN, INC.; KAISER FOUNDATION HOSPITALS; SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP; et al.,

Respondents.

CLAIMANT NAGUIB BECHARA'S RESPONSE TO SPECIAL INTERROGATORIES OF RESPONDENT

RESPONDING PARTY: CLAIMANT, NAGUIB BECHARA;

PROPOUNDING PARTY: RESPONDENTS, KAISER FOUNDATION HEALTH PLAN, INC.; KAISER FOUNDATION HOSPITALS; SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP;

SET NO.: ONE

Claimant, NAGUIB BECHARA, hereby responds to the Special Interrogatories, Set No. One, propounded by Respondents, KAISER FOUNDATION HEALTH PLAN, INC.; KAISER

FOUNDATION HOSPITALS; and SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP as follows:

Investigation and discovery by Claimant are continuing and are not complete. As discovery proceeds, witnesses, facts and evidence may be discovered which are not set forth herein, but which may have been responsive to an interrogatory. Facts and evidence now known may be imperfectly understood or the relevance or consequences of such facts and evidence may be imperfectly understood, and, accordingly, such facts and evidence may, in good faith, not be included in these responses.

Claimant reserves the right to refer to, conduct discovery with reference to, or offer into evidence at trial any and all such witnesses, facts and evidence, notwithstanding the absence of reference to such witnesses, facts and evidence in these responses. In addition, Claimant assumes no obligation to voluntarily supplement or amend these responses to reflect witnesses, facts and evidence discovered following the filing of these responses.

1. This interrogatory is objected to on the grounds that it calls for expert testimony in violation of the provisions of Code of Civil Procedure Section 2034. Further objection is made to this interrogatory on the grounds that it violates the attorney-client and work product privileges. However, without waiving said objections, and subject to further discovery, investigation and expert review and consultation, and subject to the testimony of Claimants' experts to be given at deposition and arbitration, I respond as follows: Respondents were negligent in their examination, diagnosis and treatment of my condition when I presented to Kaiser Anaheim on December 21, 2004. Respondents were negligent in failing to diagnose an acute myocardial infarction which should have been apparent from abnormal EKGs which showed ST elevation and in view of my clinical presentation of extreme chest pain as well as sweating and moaning. Respondents were negligent in their interpretation of said EKGs. Respondents were negligent in their continued failure to diagnose my acute myocardial infarction even though I was writhing in pain for hours. Respondents were negligent in failing to obtain a timely cardiology consultation, and in timely sending me to the catheterization

laboratory for an angiogram. Respondents were negligent in failing to obtain immediate treatment for my acute MI. Respondents were negligent in failing to do a prompt and timely angioplasty, or to treat me in a timely and prompt manner with TPA or another thrombolytic agent, or promptly treat me with a balloon and then transfer me for a coronary artery bypass graft. As a result of Respondents' negligence, I suffered permanent heart and kidney damage, and my spleen is enlarged. Additionally, by the time I was operated upon at Kaiser Sunset, as a result of Respondents' negligence, my myocardial infarction had been allowed to evolve to completion. Please see Kaiser records for further details. Discovery, investigation and expert review are continuing.

2. This interrogatory is objected to on the grounds that it calls for expert testimony in violation of the provisions of Code of Civil Procedure Section 2034. Further objection is made to this interrogatory on the grounds that it violates the attorney-client and work product privileges. However, without waiving said objections, and subject to further discovery, investigation and expert review and consultation, and subject to the testimony of Claimants' experts to be given at deposition and arbitration, I respond as follows: Respondents were negligent in their examination, diagnosis and treatment of my condition when I presented to Kaiser Anaheim on December 21, 2004. Respondents were negligent in failing to diagnose an acute myocardial infarction which should have been apparent from abnormal EKGs which showed ST elevation and in view of my clinical presentation of extreme chest pain as well as sweating and moaning. Respondents were negligent in their interpretation of said EKGs. Respondents were negligent in their continued failure to diagnose my acute myocardial infarction even though I was writhing in pain for hours. Respondents were negligent in failing to obtain a timely cardiology consultation, and in timely sending me to the catheterization laboratory for an angiogram. Respondents were negligent in failing to obtain immediate treatment for my acute MI. Respondents were negligent in failing to do a prompt and timely angioplasty, or to treat me in a timely and prompt manner with TPA or another thrombolytic agent, or promptly treat me with a balloon and then transfer me for a coronary artery bypass graft. As a result of Respondents' negligence, I suffered permanent heart and kidney

damage, and my spleen is enlarged. Additionally, by the time I was operated upon at Kaiser Sunset, as a result of Respondents' negligence, my myocardial infarction had been allowed to evolve to completion. Please see Kaiser records for further details. Discovery, investigation and expert review are continuing.

3. No.

4. Not applicable.

5. Yes.

6. Please see my response to Form Interrogatories Nos. 8.1 through 8.8.

7. December 20, 2004.

8. Please see my response to Form Interrogatories Nos. 8.1 through 8.8.

9. I am disabled and have not returned to work.

10. Please see my response to Form Interrogatories Nos. 8.1 through 8.8.

11. Please see my response to Form Interrogatories Nos. 8.1 through 8.8.

12. Please see my response to Form Interrogatories Nos. 8.1 through 8.8.

13. - 14. I have incurred out of pocket co-pays. I will try to locate records of this and produce them.

15. Not applicable.

16. This interrogatory is objected to on the grounds that it violates the attorney-client and work-product privileges, and on the further grounds that it seeks expert witness information in violation of the provisions of CCP Section 2034.

17. All of my medical care since approximately 1990 or 1991 has been from Kaiser.

Dated: January 10, 2006

GARY M. SCHNEIDER
Attorney for Claimants

\Bechara\disc02\resp\Bechara\spec.interrogs

Exhibit H

CERTIFIED COPY

IN THE MATTER OF THE ARBITRATION BETWEEN

NAGUIB BECHARA AND NABILA SAAD,)
)
CLAIMANTS,)
)
VS.)
)
KAISER FOUNDATION HEALTH PLAN,)
INC.; ET AL.,)
)
RESPONDENTS.)
)

DEPOSITION OF: PETER C. D. PELIKAN, M.D.

DATE TAKEN: OCTOBER 12, 2006

REPORTER: LELIA C. HASUIKE
CSR NO. 11082

SANTA MONICA, CALIFORNIA OCTOBER 12, 2006

1:40 P.M.

-O-

PETER C. D. PELIKAN, M.D.,

AFTER SOLEMNLY STATING, UNDER PENALTY OF PERJURY, THAT THE EVIDENCE GIVEN IN THIS ISSUE OR MATTER SHALL BE THE TRUTH, THE WHOLE TRUTH, AND NOTHING BUT THE TRUTH, WAS EXAMINED AND TESTIFIED AS FOLLOWS:

EXAMINATION

BY MR. CANNON:

Q DR. PELIKAN, MY NAME IS CHRIS CANNON. I REPRESENT KAISER. I'M HERE TODAY TO TAKE YOUR DEPOSITION. YOU'VE BEEN NAMED AS AN EXPERT ON BEHALF OF THE CLAIMANT IN THIS CASE. YOU'RE AWARE OF THAT?

A YES.

Q ANY NEED FOR ME TO GO OVER THE ADMONITIONS YOU'VE HEARD BEFORE --

A NO.

Q -- WITH RESPECT TO THE RULES OF A DEPOSITION?

A NO.

Q YOU PROVIDED TO ME BEFORE WE GOT STARTED A COPY OF YOUR C.V. THAT'S 22 PAGES. IS IT CURRENT AND ACCURATE?

INTERVENTIONAL CAPABILITY? ISN'T THAT SORT OF OBVIOUS FROM THE QUESTION?

A WELL, YOU CAN DO IT IN ANY LAB. YOU HAVE TO HAVE THE EQUIPMENT THERE, AND YOU HAVE TO HAVE THE PROTOCOLS IN PLACE, IF THEY'RE THERE.

Q NOW, IS IT YOUR UNDERSTANDING THAT THE CATH LAB AT KAISER LAKEVIEW HAD INTERVENTIONAL CAPABILITY?

A KAISER ANAHEIM.

Q KAISER ANAHEIM. I CALL IT LAKEVIEW BECAUSE THAT'S THE COMMON NAME. BUT IT'S KAISER, SAME OUTFIT.

A I BELIEVE IT DOES NOT, BASED ON WHAT I READ IN THIS CHART. I DON'T KNOW ANYTHING ABOUT IT OTHER THAN IN THIS CHART.

Q SO IN OTHER WORDS, IF HE WERE IN A CATH LAB IN THE EARLY MORNING HOURS OF THE 21ST, EARLIER, AND THE CLINICIAN HAD DECIDED THAT WHAT HE WANTED TO DO WAS TO STENT THE PATIENT OR TO OPEN THE VESSEL, THAT PATIENT WOULD HAVE TO BE TRANSFERRED TO ANOTHER CATH LAB SUCH AS U.C.I. OR SOME OTHER HOSPITAL THAT HAD THAT CAPABILITY?

A IN THAT PARTICULAR SITUATION, YES.

Q NOW, I BELIEVE YOU HAVE BEEN TRYING TO TELL ME THAT IN YOUR OPINION THE CARE THAT MR. BECHARA RECEIVED AT KAISER ANAHEIM ON THE 21ST, SPECIFICALLY THE DEVIATIONS FROM THE STANDARD OF CARE AS YOU'VE DESCRIBED THEM, WERE A CAUSE OF HIS RENAL FAILURE. IS THAT YOUR OPINION?

A YES.

Q WHAT -- FIRST OF ALL, WHAT, IN YOUR OPINION, WAS THE CAUSE OF MR. BECHARA'S RENAL FAILURE?

A OKAY. I BELIEVE THAT HE HAD AN ANTERIOR MYOCARDIAL INFARCTION WHICH WAS EITHER STUTTERING IN COURSE OR OCCURRED OVER SEVERAL EVENTS OF VESSEL THROMBOSIS, SPONTANEOUS DISSOLUTION OF THAT CLOT, WHICH CAUSED SIGNIFICANT DYSFUNCTION OF THE ANTERIOR WALL OF HIS HEART, OTHERWISE KNOWN AS "STUNNING." I MAKE THE POINT "STUNNING" BECAUSE HE HAD A LARGE AMOUNT OF WALL FILLED BY THE L.A.D. AND THE L.A.D. DIAGONAL BRANCH, BOTH OF WHICH WERE LARGE VESSELS, AND BOTH OF WHICH HAD VERY SLOW FLOW IN THEM AT THE TIME OF HIS ANGIOGRAM. YET WHEN HE HAS AN ECHO A YEAR AND A HALF LATER, HE HAS A SMALL TO MODERATE-SIZED HEART ATTACK. NOT A HUGE HEART ATTACK. SO I THINK THAT THE AMOUNT OF PERMANENT DAMAGE, THE AMOUNT OF COMPLETED INFARCTION, WAS ACTUALLY LESS THAN THE AMOUNT OF MUSCLE DYSFUNCTION ON THAT DAY.

WHEN THE MUSCLE BECOMES DYSFUNCTIONAL, THE OTHER PARTS OF THE HEART TRY TO BECOME HYPERFUNCTIONAL TO COMPENSATE FOR THE FACT THAT THE ANTERIOR AND ANTEROLATERAL WALLS ARE NOT WORKING ANYMORE. AND HIS PARTICULAR SITUATION -- AND I COULD REFER TO MY ANGIOGRAM DIAGRAM FOR YOU. BUT BASICALLY HE HAS HIGH-GRADE STENOSES IN ALL OF THE OTHER ARTERIES SUCH THAT WHEN THE CIRCUMFLEX TERRITORY

AND THE RIGHT CORONARY ARTERY TERRITORY TRY TO BECOME HYPERDYNAMIC, HYPERFUNCTIONAL, TO COMPENSATE FOR THE ANTERIOR WALL DYSFUNCTION, THEY BECOME ISCHEMIC. AND THEY ARE UNABLE TO BECOME HYPERDYNAMIC ENOUGH TO COMPENSATE FOR THE FACT THAT THE FRONT OF THE HEART IS NOT WORKING. YOU END THEN WITH A PATIENT WHO IS HYPOTENSIVE IN THE CATH LAB AND THEN GETS BYPASS SURGERY AND THUS IN A PERIOD OF TIME FROM HIS ARRIVAL TO THE HOSPITAL TO HIS FINISHING BYPASS SURGERY HAS HAD A SERIES OF INSULTS TO HIS KIDNEYS, ALL OF THEM ESSENTIALLY LOW BLOOD FLOW TO THE KIDNEYS, RESULTING FROM -- I'M SORRY. I TAKE IT BACK -- ONE OF THEM LOW BLOOD FLOW TO THE KIDNEYS FROM HIS HYPOTENSION FROM THE MECHANISM I JUST DESCRIBED WITH THE ISCHEMIA. NUMBER TWO, HE'S IN THAT SETTING WITH KIDNEYS THAT HAVE ALREADY BEEN DINGED BECAUSE OF THAT ISCHEMIC HYPOTENSIVE LOW PROFUSION SPELL. HE RECEIVES X-RAY CONTRAST MEDIA, AND THEN --

Q IS THAT IN CONNECTION WITH THE ANGIOGRAM --

A WITH THE ANGIOGRAM.

Q -- BY DR. BARTZ?

A YES. WHICH HAD TO BE GIVEN. BUT THEN HE GETS MORE HYPOTENSION IN THE AMBULANCE BECAUSE WE'RE, AGAIN, IN THIS DELAYING MODALITY, ALMOST NONE OF WHICH MAY HAVE HAPPENED OR PROBABLY WOULDN'T HAVE HAPPENED HAD THIS ALL BEEN DONE EARLIER. BUT THEN HE GETS BYPASS SURGERY, WHICH IS ANOTHER FORM OF HYPOPROFUSION, LOW BLOOD FLOW TO THE

KIDNEYS. SO HE HAS ALL OF THESE DIFFERENT SPELLS OCCURRING, BUT HE BASICALLY GOES INTO BYPASS SURGERY HAVING HAD SIGNIFICANT HYPOTENSION BEFORE HE'S IN THERE, AND THEN HE DEVELOPS RENAL FAILURE ON THE WAY OUT, NOT TO MENTION RESPIRATORY FAILURE, INTUBATION, ET CETERA.

THE SAME MECHANISMS THAT ACCOUNT FOR HIS ISCHEMIC KIDNEY INJURY PROBABLY ACCOUNT FOR HIS ISCHEMIC PULMONARY INJURY. ISCHEMIA, HYPOTENSION CAN CAUSE WHAT USED TO BE CALLED "POST-TRAUMATIC PULMONARY INSUFFICIENCY." NOW IT'S CALLED "ADULT RESPIRATORY DISTRESS SYNDROME." AND WHEN YOU GO TO SURGERY HYPOTENSIVE, HAVING BEEN THROUGH ALL OF THAT, THERE'S A MUCH HIGHER LIKELIHOOD YOU'RE GOING TO COME OUT ON THE VENT LATER AND NOT DO WELL, WHICH IS WHAT HAPPENED TO HIM.

Q SO LET ME SEE IF I UNDERSTAND THIS. IN THE RIDE OVER FROM KAISER ANAHEIM TO KAISER SUNSET YOU BELIEVE THE PATIENT SUFFERED HYPOTENSION?

A WELL, I KNOW HE SUFFERED HYPOTENSION FROM THE AMBULANCE BLOOD PRESSURES. IF YOU LOOK ON THE C.C.T. INTERFACILITY TRANSFER SUMMARY --

Q . I UNDERSTAND YOU HAVE THAT, AND I WAS LEADING UP TO THE QUESTION. THAT WAS REALLY JUST A FOUNDATIONAL QUESTION. BUT I WAS READING THAT -- NO, KEEP IT OUT. YOU'VE GOT THE RECORD OF THE AMBULANCE TRANSFER BETWEEN ANAHEIM AND SUNSET; CORRECT?

A RIGHT.

Q AND WITH RESPECT TO -- LET'S JUST ASSUME FOR PURPOSES OF MY QUESTION THAT THE FIRST RUN OF "V" TACH WAS AT 7:42 AS YOU'VE DESCRIBED IT. ASSUME THAT -- WELL, THE FAILURE OF THE NURSE AT THAT TIME TO PUT IN A CALL TO CARDIOLOGY BECAUSE OF THAT TO A REASONABLE MEDICAL PROBABILITY, DO YOU BELIEVE THAT THAT FAILURE CAUSED MR. BECHARA INJURY?

A YES, I DO.

Q WHAT INJURY?

A IT'S BASICALLY THE SAME ANSWER TO ALL THE SAME TYPE OF QUESTIONS. EVERYWHERE WHERE CARE WAS DELAYED BY AN EXTRA HOUR AND A HALF OR AN EXTRA HOUR ALLOWED HIM TO GET TO THE POINT BY THAT AFTERNOON OF SIGNIFICANT HYPOTENSION SUCH THAT HE INJURED HIS KIDNEYS AND INJURED HIS LUNGS AND HAD THIS TERRIBLE POSTOPERATIVE RESULT.

Q SO YOU'RE SAYING TO A REASONABLE MEDICAL PROBABILITY THAT HAD A CARDIOLOGIST BEEN CALLED IN RESPONSE TO THE 7:42 RHYTHM STRIP SHOWING "V" TACH AND BECOME INVOLVED -- HE WOULD HAVE HAD SOME MINUTES TO GET THERE, I TAKE IT; RIGHT?

A RIGHT.

Q WOULD 8:00 O'CLOCK HAVE BEEN A TIMELY RESPONSE?

A RIGHT.

Exhibit I

IN THE MATTER OF THE ARBITRATION BETWEEN

NAGUIB BECHARA AND NABILA SAAD,	)
CLAIMANTS,	)
VS.	)
KAISER FOUNDATION HOSPITALS, ET AL.,	)
RESPONDENTS.	)

DEPOSITION OF: DONALD F. NORTMAN, M.D.

DATE TAKEN: OCTOBER 19, 2006

REPORTER: ANNA GREY

CSR NO. 12020

LOS ANGELES, CALIFORNIA OCTOBER 19, 2006

2:23 P.M.

-OOO-

DONALD NORTMAN, M.D.,
AFTER SOLEMNLY STATING, UNDER PENALTY OF PERJURY, THAT THE EVIDENCE GIVEN IN THIS ISSUE OR MATTER SHALL BE THE TRUTH, THE WHOLE TRUTH, AND NOTHING BUT THE TRUTH, WAS EXAMINED AND TESTIFIED AS FOLLOWS:

EXAMINATION

BY MR. CANNON:

Q DOCTOR, CAN YOU TELL US YOUR NAME FOR THE RECORD.

A YES; DONALD, D-O-N-A-L-D; FRANKLIN, F-R-A-N-K-L-I-N; NORTMAN, N-O-R-T-M-A-N.

Q DR. NORTMAN, YOU GAVE ME, BEFORE WE GOT STARTED, A COPY OF YOUR C.V. CURRENT AND ACCURATE?

A IT'S THE MOST CURRENT ONE I HAVE, AND IT'S ACCURATE, YES.

Q ANYTHING NEEDED TO BE ADDED TO IT?

A I DON'T BELIEVE SO. I'VE DONE ADDITIONAL LECTURES. ACTUALLY, I'M NOT SURE IF IT'S

A YES. IT IS.
Q AND SO WITHIN FIVE OR TEN MINUTES?
A YES. HE COMES BACK, SEES THE PATIENT, STARTS AN I.V. -- "START I.V. NITROGLYCERINE, START I.V. HEPARIN, AND GIVE PLAVIX. AND THEN WE'LL SORT OUT WHETHER WE CAN GIVE HIM A BETA BLOCKER AFTER WE WATCH HIM FOR A FEW MINUTES."
Q IN YOUR OPINION, WAS THE FAILURE OF DR. BOND NOT TO START PLAVIX OR ADMINISTER PLAVIX DURING THE TIME HE TOOK CARE OF THE PATIENT A CAUSE OF ANY INJURY TO MR. BECHARA?
A YES, IT IS.
Q WHAT INJURY DID MR. BECHARA SUFFER BECAUSE DR. BOND DID NOT INITIATE PLAVIX EITHER IMMEDIATELY UPON ASSESSMENT OF THE PATIENT OR ANYTIME DURING THE TIME HE TOOK CARE OF THE PATIENT?
A CARDIAC INJURY, WHICH ULTIMATELY WAS MORE SEVERE IN THE DELAY IN ALL THERAPIES THAN IT NEEDED TO BE, AND YOU KNOW, I'LL IN PART DEFER TO THE CARDIOLOGIST TO DISCUSS THE DEGREE.
AS AN INTERNIST AND NEPHROLOGIST, I'D SAY THAT I THINK THE CARDIAC INJURY WAS EXACERBATED, AND AS A NEPHROLOGIST IN THE CAUSATION ISSUE, THE MORE THE CARDIAC INJURY WAS, THE MORE THE RENAL INJURY WAS.

AND I BELIEVE UNLIKE YOUR EXPERT, AS WE'LL GET TO, THAT A SUBSTANTIAL, IF NOT THE MAJORITY OF THE CAUSAL INJURY TO MR. BECHARA'S KIDNEYS OCCURRED UP TO AND THROUGH THE CARDIAC SURGERY AT KAISER AND AT -- KAISER SUNSET AND AT KAISER ANAHEIM AND IN THE AMBULANCE ON THE WAY.

Q EXPLAIN TO ME IN WHAT WAY MR. BECHARA SUFFERED ADDITIONAL CARDIAC INJURY BECAUSE OF THE FAILURE BY HIM TO RECEIVE PLAVIX.

A PLAVIX HELPS PREVENT FURTHER PLATELET AGGREGATION AND ACUTE THROMBI OR RUPTURED PLAQUES AND MAY EVEN HELP DISSOLVE THE ACUTELY FORMED ONES.

Q CAN YOU SAY IN A REASONABLE MEDICAL PROBABILITY THAT IF MR. BECHARA HAD BEEN STARTED ON PLAVIX BY DR. BOND THAT HE WOULD HAVE NOT SUFFERED ANY CARDIAC INJURY?

A NO. ANY CARDIAC INJURY? I WOULDN'T SAY THAT.

Q DO YOU BELIEVE TO A MEDICAL PROBABILITY HE WOULD HAVE SUFFERED SOME CARDIAC INJURY EVEN IF DR. BOND AND EVERYONE ELSE WHO YOU BELIEVE WAS BELOW THE STANDARD OF CARE HAD MET THE STANDARD OF CARE?

A YES.

Q CAN YOU QUANTIFY FOR ME WITH RESPECT TO HIS CARDIAC INJURY HOW MUCH INJURY YOU BELIEVE

MR. BECHARA WOULD HAVE SUSTAINED WITH ALL APPROPRIATE CARE AS YOU WOULD DEFINE IT VERSUS HOW MUCH HE DID SUSTAIN?

A I CANNOT QUANTIFY THAT, AND I'D LEAVE IT TO A CARDIOLOGIST TO TRY, ALTHOUGH I THINK IT'S GOING TO BE VERY DIFFICULT. I DO BELIEVE, OTHERWISE I WOULDN'T BE SITTING HERE BEING AN EXPERT FOR MR. SCHNEIDER, THAT THE -- SOME OF THE DELAYS AND FAILURES UP UNTIL THE END OF THE BYPASS OPERATION MADE THE DIFFERENCE BETWEEN HIS SUFFERING ENOUGH CARDIAC FAILURE TO GET PERMANENT RENAL FAILURE AS AGAINST MILD TRANSITORY RENAL FAILURE OR NONE AT ALL.

Q WHAT I'M TRYING TO UNDERSTAND IS YOU'VE TOLD ME THAT THE PATIENT SUFFERED ADDITIONAL CARDIAC INJURY, AND I'M TRYING TO FIND OUT HOW MUCH ADDITIONAL?

MR. SCHNEIDER: HE JUST ANSWERED THAT HE'S GOING TO DEFER THAT TO A CARDIOLOGIST. THAT'S WHAT I UNDERSTOOD.

MR. CANNON: SO HE'S GOING TO TESTIFY THAT IT WAS THERE, BUT HE HASN'T -- HAS NO WAY TO QUANTIFY HOW MUCH IT WAS?

MR. SCHNEIDER: I THINK THAT'S WHAT HE JUST SAID.

THE WITNESS: WELL, I QUANTIFIED -- I QUALIFIED IT. ARE YOU LOOKING FOR A PERCENTAGE OF THE ACUTE INJURY? I MEAN I THINK THERE ARE THINGS THAT ARE UNANSWERABLE IN MEDICINE EVEN WHEN YOU'RE AN EXPERT AND THERE'S NO LITIGATION GOING ON. I CAN'T TELL YOU THAT -- AND IT'S THE ACUTE INJURY, BECAUSE CLEARLY, HIS HEART FUNCTIONED VERY POORLY ACUTELY, AND THANK GOODNESS, SUBSTANTIALLY RECOVERED.

I WOULD SAY THAT WELL OVER 50 PERCENT OF THE ACUTE INJURY, THE SUBSTANTIAL MAJORITY OF IT COULD HAVE BEEN PREVENTED WITH REASONABLE ORDINARY DECEMBER 2004 TREATMENT OF AN ACUTE CARDIAC ISCHEMIC EVENT.

BY MR. CANNON:

Q WELL, ALL RIGHT, LET'S TALK ABOUT PLAVIX. AS I UNDERSTAND IT, PLAVIX WOULD HELP INHIBIT THE FORMATION OF NEW CLOTS?

A CORRECT. OR A BUILDUP OF CLOTS ON THE ONES ALREADY THERE OR AN EXTENSION OF THE LENGTH OF THE OBSTRUCTION.

Q AND HOW LONG IS IT THAT PLAVIX TAKES BEFORE IT HAS THAT EFFECT?

A I THINK IT'S HOURS. I DON'T THINK IT'S MINUTES. BUT YOU HAVE TO GET THE DOSE IN BEFORE IT

Q DID YOU SAY THAT THAT WAS RELATED TO THE ATHEROEMBOLI THAT YOU BELIEVE OCCURRED?

A MORE TO A PROBABILITY, BECAUSE I SAID I COULDN'T SAY TO A PROBABILITY THAT IT SUBSTANTIALLY CONTRIBUTED TO THE ISCHEMIC HYPOTENSIVE LOW PROFUSION A.T.N. THAT I THINK DID OCCUR WAS THE SUBSTANTIAL CAUSE OF HIS ACUTE AND SUBSEQUENT CHRONIC RENAL FAILURE.

Q A.T.N. STANDS FOR "ACUTE" --

A "ACUTE TUBULAR NECROSIS." IT'S THE MOST COMMON CAUSE OF CATEGORY 2 OF ACUTE RENAL FAILURE, WHICH IS INTRINSIC RENAL DISEASE, AND PART OF THESE JUDGMENTS ARE JUST SIMPLY BASED ON WHAT WE KNOW ARE STATISTICAL PROBABILITIES FOR WHAT WE OBSERVED IN TERMS OF HIS RENAL -- ACUTE RENAL FAILURE AND SUBSEQUENT CHRONIC RENAL FAILURE.

Q SO YOU BELIEVE THAT MR. BECHARA SUFFERED ACUTE TUBULAR NECROSIS FROM HYPOTENSION?

A FROM A DECREASE IN EFFECTIVE RENAL PROFUSION WHICH IN PART HYPOTENSION IS ONE OF THE CAUSES OF DECREASED EFFECT OF BLOOD FLOW AS ARE THE PRESSOR DRUGS THAT DR. WARNER TALKED ABOUT.

Q ALL RIGHT.

A AND IT'S REALLY NOT A SEPARATE CATEGORY, A SEPARATE CAUSE OF RENAL ISCHEMIA.

Q LET ME SEE IF I UNDERSTAND IT. YOU BELIEVE THAT MR. BECHARA'S RENAL FAILURE WAS CAUSED BY ACUTE TUBULAR NECROSIS, WHICH IS A.T.N.; THE A.T.N. FROM MR. BECHARA WAS CAUSED BY DECREASED RENAL PROFUSION, ONE COMPONENT OF WHICH TO A MEDICAL PROBABILITY WAS HYPOTENSION? YES?

A YES.

Q ANOTHER COMPONENT TO A MEDICAL PROBABILITY WAS THE PRESSORS?

A YES.

Q ANYTHING ELSE IN YOUR OPINION TO A MEDICAL PROBABILITY THAT CAUSED MR. BECHARA'S DECREASED RENAL PROFUSION THAT CAUSED HIS A.T.N. AND RENAL FAILURE?

A YES.

Q WHAT ELSE?

A WELL, IT ACTS THROUGH THE LIMB OF HYPOTENSION, BUT THE ACUTE AND PROBABLY SEVERE, IF NOT POSSIBLY PROFOUND HYPOTENSION THAT OCCURRED AT THE TIME OF HIS V-TACK AMONG OTHER TIMES AND IN THE AMBULANCE.

Q OKAY. SO AGAIN, IT SOUNDS LIKE YOU'RE STILL TALKING ABOUT THE HYPOTENSION COMPONENT. I'M JUST TRYING TO UNDERSTAND. IT LOOKS LIKE HYPOTENSION IS ONE PART, THE PRESSORS ARE ANOTHER

PART. THOSE TWO ALONE OR TOGETHER IN YOUR OPINION TO A MEDICAL PROBABILITY CAUSED THE DECREASED RENAL PROFUSION FOR MR. BECHARA; RIGHT?

A RIGHT. SHOULD I DRAW YOU A PICTURE? I MEAN I COULD DO IT REAL QUICK.

Q WE'RE ALMOST AT THAT POINT. BUT LET ME JUST ASK ONE MORE QUESTION. ANYTHING ELSE THAT CAUSED THE DECREASED RENAL PROFUSION FOR MR. BECHARA, OTHER THAN THE HYPOTENSION OR THE PRESSORS?

A NO. THOSE ARE THE CAUSES, BUT AS YOU GO BACK UP THE TREE, BECAUSE IT'S ALL LEANING DOWN INTO DECREASED EFFECTIVE RENAL PROFUSION, YOU HAVE CARDIOGENIC SHOCK, THE HEART JUST SIMPLY NOT PUMPING, YOU HAVE PRESSORS, BY CAUSING -- FOR THE SAME MEASURED BLOOD PRESSURE, LESS EFFECTIVE RENAL PROFUSION BECAUSE IT'S -- IT CAUSES -- THE LEVOPHED THAT HE GOT OVER AT SUNSET CAUSES VASOCONSTRICTION OF THE SMALL ARTERIALS INSIDE THE KIDNEYS.

THE ARRHYTHMIAS ALSO CAUSE HYPOTENSION, AND HYPOTENSION, NOT THE MEASUREMENT ITSELF, BUT IT'S THE ACTUAL FLOW, EFFECTIVE FLOW OF THE BLOOD TO THE KIDNEYS, WHICH IS IN PART MEASURED BY SYSTEMIC BLOOD PRESSURE -- BUT I DON'T WANT TO GO OFF ON ANOTHER TEACHING POINT, AND THERE MAY BE A QUESTION

LATER THAT WILL RELATE TO IT, BUT THE LOWER THE BLOOD PRESSURE, THE MORE LIKELY IT IS UNDER CERTAIN -- UNDER MOST CIRCUMSTANCES THAT WILL BE INEFFECTIVE RENAL PROFUSION.

BUT IN THE MIDDLE OF SURGERY, ANESTHESIA ITSELF MAKES THE RELATIVE -- MAKES THE MEASURED BLOOD PRESSURE EFFECTIVELY PROFUSED KIDNEYS LESS WELL; AND THAT'S THE FACT KNOWN TO NEPHROLOGISTS BUT NOT, I THINK, TO MOST OTHER PHYSICIANS. WHETHER A LOT OF THESE PHYSICIANS RIGHTLY SAY "I DON'T REALLY UNDERSTAND THE CAUSE," THEY PROBABLY DON'T.

AND IN ESSENCE, THAT'S THE SAME POINT FOR THE PRESSORS. THE PRESSORS MAKE A READING OF A BLOOD PRESSURE HIGHER, BUT THE EFFECTIVE PROFUSION OF THE KIDNEYS MAY ACTUALLY BE IMPAIRED BY THE PRESSORS AND HAVING A 10 POINTS HIGHER READING ON THE SYSTOLIC PRESSURE AT A HUNDRED WITH LEVOPHED MAY BE LESS EFFECTIVE THAN PROFUSING THE KIDNEYS THAN NO LEVOPHED WITH A SYSTOLIC PRESSURE OF 90. THESE ARE ALL SUBTLETIES THAT RELATE TO THE WAY RENAL HEMODYNAMICS AND NORMAL PHYSIOLOGY OCCUR.

Q SO THE LEVOPHED, THAT'S A PRESSOR HE GOT AT SUNSET; CORRECT?

A CORRECT.

Exhibit J

RELEASE OF ALL CLAIMS

1. For and in consideration of the sum of Nine Hundred Thousand Dollars ($900,000.00) Claimants, NAGUIB BECHARA and NABILA SAAD (hereinafter referred to as "Releasors"), hereby release, discharge and acquit KAISER FOUNDATION HEALTH PLAN, INC., SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP and KAISER FOUNDATION HOSPITALS and his/her/their representatives, including, without limitation, agents, employees, servants, directors, officers, attorneys, assigns and successors (hereinafter referred to collectively as "Releasees"), and each of them, of and from any and all claims (specifically including any future wrongful death claims stemming from the death of claimant Naguib Bechara), demands, sums of money, actions, rights, causes of action, obligations and liabilities of any kind or nature whatsoever which Claimants, NAGUIB BECHARA and NABILA SAAD , may have had or claim to have had, or now have or claim to have, arising out of any act and/or omission on the part of the Releasees occurring at any time prior hereto, as alleged and contended in the arbitration entitled NAGUIB BECHARA et al. v. KAISER FOUNDATION HOSPITALS, et al., (OIA # 6669) the subject matter thereof or any claim or cause of action that could have been asserted by Claimants, NAGUIB BECHARA and NABILA SAAD, in said arbitration.

2. In consideration of the foregoing settlement described in Paragraph 1, Justin Bechara and Nabila Saad, heirs of claimant Naguib Bechara, hereby release, discharge and acquit Releasees from any future claims for the wrongful death of claimant Naguib Bechara related to any act and/or omission on the part of the Releasees occurring at any time prior hereto, as alleged and contended in the arbitration. Justin Bechara is also included within the "Releasors" herein and is referred to as such.

3. Contemporaneously with the execution of this Receipt and General Release (this "Release"), the action and arbitration shall be dismissed in its entirety, as to Releasees, with prejudice, with all parties to bear their own expenses, costs of suit and attorneys' fees. In this connection, Releasors' attorneys are hereby expressly authorized and instructed to execute and provide to counsel for Releasees all documents necessary to cause such dismissal. In this regard, Releasors hereby waive the right to seek relief from such dismissal under California Code of Civil Procedure, Section 473.

4. Releasors hereby acknowledge that payment of said monies to claimants NAGUIB BECHARA and NABILA SAAD constitutes full satisfaction and discharge of all of the claims, demands, sums of money, actions, rights, causes of action, debts, obligations and liabilities set forth in Paragraphs 1 and 2.

5. Releasors further warrant, represent and agree that in executing this Release, and in acceptance of said payment to NAGUIB BECHARA and NABILA SAAD, Releasors do so with full knowledge of any and all rights which Releasors may have with respect to the controversies herein compromised and that Releasors have received independent legal advice from Releasors' attorney, with regard to the facts relating to said controversies and with respect to the rights and asserted rights arising out of said facts. In this regard, Releasors understand, acknowledge and agree that such payment is not an admission of liability on the part of Releasees, or any of them, but to the contrary, represents a compromise of asserted claims, which are expressly contested, disputed and denied.

6. Releasors further state that Releasors are not relying and have not relied on any representation or statement made by Releasees, or any of them, with respect to the facts involved in said controversies or with regard to Releasors' rights or asserted rights. Releasors hereby assume the risk of all mistakes of fact with regard to said controversies and with regard to all facts which are now unknown to Releasors relating thereto. All rights under California Civil Code, Section 1542,

are hereby expressly waived. Section 1542 of the California Civil Code reads as follows:

> "§1542. A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him must have materially affected his settlement with the debtor."

7. Releasors further warrant and represent that no other person or entity has any interest in the matters released herein, and that Releasors have not assigned or transferred or purported to assign or transfer to any person or entity all or any portion of the matters released herein, with the possible exception of an arrangement as to fees with Releasors' attorneys.

8. Releasors agree to indemnify and hold Releasees, and each of them, harmless from and against any and all claims, demands, damages, debts, liabilities, obligations, costs, expenses, liens, attorneys' fees, actions and causes of action (whether or not litigation be commenced) arising from any matter released herein or in connection with any lawsuit or other proceeding brought or prosecuted contrary to the provisions of this Release. In this connection, Releasors agree that this Release may be pleaded as a defense and/or as a cross-complaint, counterclaim, cross-claim or third-party complaint in each such lawsuit and proceeding. This includes but is not limited to any and all medical liens, attorney liens, or other liens which are a result of the accident, casualty or event. Releasors NAGUIB BECHARA and NABILA SAAD agree to satisfy any and all liens.

9. This Release shall inure to the benefit of Releasees and shall be binding upon Releasors and their assigns, representatives, heirs and successors.

RELEASORS ACKNOWLEDGE THAT THEY HAVE READ THIS RECEIPT AND GENERAL RELEASE AND THAT THEY FULLY KNOW, UNDERSTAND AND APPRECIATE ITS CONTENTS AND THEY EXECUTED THE SAME AND MAKES THE SETTLEMENT PROVIDED FOR HEREIN VOLUNTARILY AND OF THEIR FREE WILL.

Nothing in this arbitration decision or settlement agreement prohibits or restricts the enrollee from discussing or reporting the underlying facts, results, terms and conditions of this Settlement Agreement to the Department of Managed Health Care.

IN WITNESS WHEREOF, the undersigned have executed this Release Of All Claims as of the date hereinafter appearing.

DATED: November 13, 2006

Claimant, NAGUIB BECHARA

DATED: November 13, 2006

Claimant, NABILA SAAD

DATED: November 13, 2006

NAGUIB BECHARA
on behalf of JUSTIN BECHARA, a minor

I am a licensed attorney at law, and I hereby represent and declare that I have fully explained the foregoing Receipt and General Release to Releasors who, in turn, acknowledge to me an understanding of this document and the legal effect thereof and signed it in my presence.

Dated: _____

GARY M. SCHNEIDER, Attorney at Law

BY: _____
GARY M. SCHNEIDER, Esq.
Attorneys for Claimants
NAGUIB BECHARA and
NABILA SAAD

Exhibit K

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF FLORIDA

Case No. 1:08-MD-01928-MIDDLEBROOKS/JOHNSON

IN RE TRASYLOL PRODUCTS LIABILITY
LITIGATION – MDL-1928

This Document Relates to:
Naguib Bechara and Nabila Saad,
Individually and as next friend of Justin
Bechara, a Minor

v.

Bayer, A.G., et al

Cause No. 08-CV-80776-Civ-Middlebrooks/Johnson

PLAINTIFF'S FACT SHEET

Please provide, to the best of your knowledge and ability, the following information for each individual on whose behalf a claim is being made. If you are completing this questionnaire in a representative capacity, please respond to the questions in sections I.A and II through VIII with respect to the person to whom Trasylol was allegedly administered ("Trasylol User"). In filling out this form, please use the following definitions: (1) "health care provider" means any hospital, clinic, medical center, physician's office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dietary, psychiatric or psychological care or advise, and any pharmacy, weight loss center, x-ray department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, physician, psychiatrist, osteopath, homeopath, chiropractor, psychologist, nutritionist, dietician, or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you; (2) "document" means any writing or record of every type that is in your possession, including but not limited to written documents, documents in electronic format, cassettes, videotapes, photographs, charts, computer discs or tapes, and x-rays, drawings, graphs, phone-records, non-identical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form. You may attach as many sheets of paper as necessary to fully answer these questions.

A number of questions set forth below solicit information for a specified period of the past fifteen (15) years. Please respond fully to each such question for the specified time period of fifteen (15) years preceding the alleged surgery involving the administration of Trasylol.

I. Case Information

A. Please state the following for the civil action that you filed:

1. Name of the Trasylol User: Naguib Bechara

2. Case caption: Naguib Bechara, et al v. Bayer, A.G., et al; In the United States District Court for the Southern District of Florida, C.A. No. 08-CV-80776

3. Name, address, telephone number, fax number and e-mail address of principal attorney representing you:

Michael T. Gallagher
Name

The Gallagher Law Firm
Firm

2905 Sackett Street
Street Address

Houston, Texas 77098
City, State and Zip Code

713-222-8080 713-222-0066
Telephone number Fax number

Pamm@gld-law.com; shawnaf@gld-law.com; rebeccam@gld-law.com; lisak@gld-law.com
E-mail address

B. If you are completing this questionnaire in a representative capacity (on behalf of the estate of a deceased person or a minor), please state:

1. Your name: N/A

2. Address:

3. In what capacity you are representing the individual:

4. If you were appointed by a court, state the court & date of appointment:

5. Your relationship to deceased or represented person:

6. If you represent a decedent's estate, state the date of death of decedent: _____

C. If you are claiming the wrongful death of a family member, list any and all heirs of the decedent: N/A

II. Personal Data of the Trasylol User[1]

A. Main name or any other names used and dates of use: Naguib Bechara- lifetime

B. Identify each address at which you have resided during the last fifteen (15) years (including your current address, if applicable), and list when you started and stopped living at each one:

Address	Dates of Residence
7691 E. Camino Tampico, Anaheim, CA 92808	1997-present
265 S. Leandro St., Anaheim, CA 92807	1990-1997
7961 E. Camino Tampico, Anaheim, CA 92808	1989-1990
Corvette St., Garden Grove, CA 92641	1986-1990
929 S. Bruce St., Anaheim, CA 928	1983-1986

C. Driver's License Number and State Issuing License: C0041200 CA

D. Social Security Number: [redacted]-4704

E. Date and place of birth: [redacted]/1954 Banha Egypt

F. Sex: Male X Female _____

G. For each current of former marriage, please list the following information for each spouse:

Name of Spouse	Date of Birth	Date of Marriage	Date Marriage Ended	How Marriage Ended	Occupation (current spouse only
Nabila Saad	[redacted]/1954	1/7/1989	N/A	N/A	none

[1] In sections II through VIII, the Trasylol User is also referred to as "you" or "your."

Lee Knight		01/31/1983	09/1986	Divorce	Cosmetologist

Has your spouse filed a loss of consortium claim in this action? Yes X No___

H. For each of your children, list his/her name, date of birth, and address:
J[redacted] B[redacted] [redacted]/1992 7691 E. Camino Tampico, Anaheim, CA 92808

I. Employment Information.

1. Current Employer (if not currently employed, last employer):

Name	Address	Dates of Employment	Job Title	Name of Supervisor
Miller's Fab	1130 N. Kraemer Bl. Anaheim, CA 92806	06/03	Project Manager	Harold Miller

2. List the following for each employer you have had in the last FIFTEEN (15) years:

Name	Address	Dates of Employment	Job Title	Name of Supervisor
Steel Detailing Corp.	Unknown	1/00 to 03/03	Project Manager	Henry Ives
Builders Steel	Unknown	3/95 to 01/00	Project Manager	John Reed
Delta Steel	Unknown	12/90 to 2/95	Owner	None
Superior Metal Fab. Inc.	Unknown	2/82 to 11/90	Project Manager	Ronald DiDonato

J. Schools you have attended (high school and beyond only):

Name of School	Address	Dates of Attendance	Degree or Diploma Awarded	Major or primary field of study
Faculty of Engineering Cairo, Egypt	Zagazig University	1972-1979	Bachelor of Science	Architectural Engineering
Cal Poly Pomona, CA	Cal State Pomona, CA	1983	N/A	Architecture

K. Have you ever applied for worker's compensation, social security, or state or federal disability benefits? X Yes ____ No

If "Yes," then as to each application separately state:

1. Date (or year) of application: 2005
2. Type of benefits: Social Security Disability
3. Amount awarded: $2,900/mo.
4. Reason for your claim: unable to work
5. If denied, reason for denial: Does not apply
6. To what agency or company did you submit your application (e.g., Pennsylvania Division of Social Security): Baltimore

L. Have you ever been out of work for more than thirty (30) days for reasons related to your health (other than pregnancy)? X Yes ____ No

If "yes", set forth when and the reason: 2005, 2006, 2007 heart & kidney conditions.

M. Were you ever rejected or discharged from military school for any reason relating to your health, physical, emotional or psychiatric condition? ____ Yes X No

If "yes," then describe the condition, set forth the year in which you were rejected or discharged from military service, and identify the military branch in which you were serving, or were considered for service, at that time.

N. Have you ever filed a lawsuit or made a claim, other than in the present suit, relating to any bodily injury, sickness or disease? ____ Yes X No

If yes, state the court in which such action was filed, the case name and/or names of adverse parties, and the civil action or docket number assigned to each such claim, action or suit.

O. Have you ever been convicted of or pled guilty to a felony and/or other crime?
_____Yes _X_ No

If yes, state the date of such conviction or plea, the court in which such conviction or plea was entered and the nature of the felony and/or other crime. _____

P. Have you ever been denied life insurance? _____Yes _X_ No

If "yes," state the date of such denial, the name of the insurance company and the stated reason for such denial if known. _____

III. Health Care Providers of the Trasylol User

Provide the requested information of each of the following healthcare providers and healthcare facilities:

A. Beginning with your current family and/or primary care physician(s), please list your family and/or primary care physicians for the last fifteen (15) years:

Name	Address	Approximate Dates
Dr. Timothy Ho	Kaiser Permanente, Lakeview, Street, Lakeview Medical Center, Anaheim, CA	1992-2004
Dr. Sant George	Kaiser Permanente Anaheim, CA- may now be located at Kaiser in La Palma, CA	2005-2006
Dr. Alec Doce	Kaiser Permanente, Anaheim Hills, CA	2006 to present

B. Each hospital, clinic, or health care facility where you have received inpatient or outpatient treatment (including treatment in an emergency room) or been admitted as a patient during the last fifteen (15) years:

Name	Address	Admission/Treatment Dates	Reason for Admission/Treatment	Treatment Received

Kaiser Permanente	Anaheim, CA	1992 to Present	Various	Various
Kaiser Permanente Medical Center	Los Angeles, CA	12/2004-01/2005	heart surgery	bypass & dialysis
West Anaheim Medical Center	Anaheim, CA	2005	CardioRehab	Rehab
Kaiser Permanente Pavilion	Orange, CA	2003	Physical exams	rehab & diagnosis

C. Each surgery or operation that you have undergone in the past fifteen (15) years, including but not limited to any heart-related surgeries:

Names and Address of Hospital	Type of Surgery or Operation	Date of Surgery or Operation	Reason for Surgery or Operation
Kaiser Permanente Los Angeles, CA	HeartCABG	12/21/04	CAD
Kaiser Permanente Anaheim, CA	Bladder cancer removal	04/06/07	Bladder Cancer

D. Every other physician or other healthcare provider or healthcare facility whom you have seen or from whom you have received treatment, or at which you've been treated, in the last fifteen (15) years:

Name	Address	Dates of Treatment/ Admission/ Visit	Reason for Treatment/ Admission/Visit	Treatment received
Dr. Chang	Kaiser La Palma address unknown	1998	Pulmonary Congestion	Inhalers cough syrup

E. Each pharmacy that has dispensed medication to you in the last fifteen (15) years:

Name	Address	Years When You Used Pharmacy
Kaiser Pharmacy	address unknown Anaheim, CA	1992-present
Kaiser Pharmacy LA Med. Center	address unknown Los Angeles, CA	12/2004-01/2005
Kaiser Pharmacy Yorba Linda, CA	address unknown	06/2005

* Please attach additional pages if necessary.

IV. Medical Background of the Trasylol User

A. Height 5'5

B. Current Weight 180
Weight at the time of the procedure alleged in Section V.A. 198

C. Smoking/Tobacco Use History

1. Never smoked cigarettes _____
2. Past smoker of cigarettes X
Date you stopped smoking 1990
Amount smoked: on average 5 cigarettes per day for 15 years
3. Current smoker of cigarettes _____
Amouut smoked: on average _____cigarettes per day for _____years
4. Any other form of tobacco use (pipe tobacco, snuff, chewing tobacco, dipping, cigars)? _____Yes X_____No

If "yes," then state:
a. What form: _____
b. Dates of use: _____
c. Amount of use: _____

D. Drinking History

1. Do you now drink or have you in the past drunk alcohol (beer, wine, whisky, etc.)? _____Yes X_____No

2. If yes, check below which best describes your alcohol consumption during the 12 months leading up to the date of the procedure described in Section V.A.?
_____ 1-5 drinks per week
_____ 6-10 drinks per week
_____ 10 or more drinks per year

E. Illicit Drugs

1. Have you ever used (even one time) any illicit drugs of any kind within one (1) year before the procedure alleged in Section V.A.? Yes____ No X
Don't recall _____

If Yes:
(a) What did you use? _____
(b) How often did you use in the year preceding the procedure? _____

F. To the best of your knowledge, during the past fifteen (15) years, have you ever suffered from or been diagnosed by a doctor or other health care provider with:

		Yes	No	I Don't Recall
1.	High cholesterol	X		
2.	Elevated triglycerides	X		
3.	Hypertension/high blood pressure	X		
4.	Obesity	X		
5.	Diabetes	X		
6.	Thyroid disorder	X		
7.	Autoimmune disease (Including HIV or AIDS)	X		
8.	Abnormal heart rhythm	X		
9.	Congestive heart failure	X		
10.	Angina	X		
11.	Myocardial infarction (MI) Or heart attack	X		
12.	Atherosclerosis		X	
13.	Venous thrombosis	X		
14.	Peripheral vascular disease (PVD or PAD)	X		
15.	Stroke or transient ischemic attacks (TIAs)	X		
16.	Fainting	X		
17.	Miscarriage	X		
18.	Bleeding or clotting disorders	X		
19.	Chronic Lung Disease	X		
20.	Chronic obstruction pulmonary disease (COPD) or other respiratory disorder, including asthma	X		
21.	Liver disease or jaundice	X		
22.	Metabolic syndrome		X	
23.	Shock		X	
24.	Heparin induced thrombocytopenia		X	
25.	Anemia	X		
26.	Arrhythmia	X		
27.	Ventricular Tachycardia	X		
28.	Atrial Fibrillation	X		
29.	Mitral Insufficiency	X		
30.	Enlarged prostrate		X	
31.	Bladder stones (cancer)	X		

If "yes," please state separately for each:

Type of condition	Date of Diagnosis	Diagnosing Doctor
CAD,CHF	12/2004	Dr. Bartz, Steve/ Dr. Pfeffer, Thomas
CKD-Kidney Failure	12/2004	Dr. Patel, Shailesh
Bladder Cancer	3/2007	Dr. Newman, Frank
Chronic Depression	6/2005	Dr. Boulos
ATHMA (COPD)	1998	Dr. Chang
Hyperstension	2005	Dr. Alec Dose

V. Trasylol

A. Administration to the Trasylol User

If so, state:

1. Date of administration: 12/21/2004
2. Physician who administered Trasylol: Dr. Pfeffer, Thomas
3. Physician who prescribed Trasylol: Don't know
4. Hospital or Medical Center where Trasylol was administered: LA Medical Center
5. Nature of procedure during which Trasylol was administered: CABG
6. Physician(s) or surgeon(s) performing the procedure (including anesthesiologist(s)): Don't know Kaiser Permanente LA Medical Center- see medical records attached hereto
7. When you, your agents, representatives or anyone acting on your behalf first learned that Trasylol had been administered: 7/9/08

B. Prior to or during your hospitalization for the procedure alleged in Section V.A., were you, your agents, representatives or anyone acting on your behalf (other than your lawyers in this case) given any written instructions, warnings, or other information regarding Trasylol? _____Yes _X_____No

If yes, please state when the written instructions, warnings or other information were given and identify each person or entity from whom they were received.

1. Date:
2. Person and/or Entity (with address): _____

C. Prior to or during your hospitalization for the procedure alleged in Section V.A., were you, your agents, representatives or anyone acting on your behalf (other than your lawyers in this case) given any oral instructions, warnings, or other information regarding Trasylol? _____Yes X_____No

If yes, please state:

1. Date on which such oral instructions, warnings or other information was given to you, your agents, representatives or anyone acting on your behalf:

2. Person who gave the information to you, your agents, representatives or anyone acting on your behalf (with address):

3. A complete description of the oral instructions, warnings or other information:

D. Where you, your agents, representatives or anyone acting on your behalf given any description of the risks associated with the surgery identified in V.A. above?
_____Yes _____No (I don't remember- see medical records attached hereto)

If yes:

1. Provide a description of the risks of which you, your agents, representatives or anyone acting on your behalf were advised:

2. Identify the Health Care Provider who advised you, your agents, representatives or anyone acting on your behalf of such risks:

E. What other medication, including aspirin, were you taking when you were administered Trasylol or at any time during the two weeks before or after you were administered Trasylol.

Name of Drug	Dates Taken	Name of Prescribing Doctor
I don't know- see medical records attached hereto		

VI. Injuries, Symptoms, Diagnoses, Ailments & Damages of the Trasylol User

A. Are you claiming that you have developed or may develop any injury or damage (including any alleged physical, mental, emotional, psychological or psychiatric injury or damage) as a result of taking Trasylol? __X__ Yes _____ No

If "yes," then for each such injury, damage or condition, separately state:

Nature of Condition	Date you first became aware of the injury, damage or condition	How you first became aware of it
Kidney Failure	12/24/04	My wife told me after I came to
Dialysis, Hemodialysis	12/30/04	18 days after surgery
Heart Failure	1/05	

For each such injury, damage or condition, have you consulted with healthcare provider(s) for your alleged Trasylol related injury?

__X__ Yes _____ No

If "yes", for each healthcare provider state:

Name	Address	Dates of consultation and/or Treatment
Dr. Shailesh Patel	22550 Savi Ranch Pkway, Yorba Linda, CW92887	December, 2004 to the present
Fresenius Medical Care (FMC North America)-dialysis center	2020 E. First St., #110 Santa Ana, CA 92705	December, 2004-December, 2005
Dr. Baudelio Herrada and Dr. Kujubu, Los Angeles Medical Center	4867 Sunset Blvd., Los Angeles, CA 90027	December, 2004 while hospitalized

B. Do you allege that the administration of Trasylol aggravated a pre-existing condition?
_____Yes _X_____No

If so, for each such pre-existing condition, provide:

Description of Pre-existing condition	Date when condition first arose	Date when condition first diagnosed	Health care provider who provided care for this condition (with address)

C. Has any healthcare provider told you, your agents, representatives or anyone acting on your behalf, orally or in writing, that any of the injuries, damages or conditions that you describe above are due to your use of Trasylol? _____Yes ___X___No

If "yes," then state and describe:

1. What you (or your agents, representatives or anyone acting on your behalf) were told: _____

2. Who told you (or your agents, representatives, or anyone acting on your behalf) and when: _____

D. Excluding future medical expenses to be addressed by case-specific expert(s), are you claiming that you have paid or will have to pay any expenses as a result of having taken

Trasylol? __X__ Yes _____ No

If "yes," then for each item separately identify:

For What	Amount of Fees or Expenses	Person or Company to be paid
past medical expenses associated with Trasylol related injuries	amount is being determined and this answer will be supplemented	health care providers

E. If you claim psychological, mental, or emotional injury as a consequence of using Trasylol, state whether you have been treated for any psychological, psychiatric (including depression) or emotional problems prior to the use of Trasylol at issue.
_____ Yes __X__ No

If "yes," then complete the following:

Condition for which Treated	Dates of Treatment	Treatment provider (name and address)

F. Are there persons (other than those already identified in this Fact Sheet) you believe are witnesses to your claimed injuries or the damages? If so, please provide their name and address:

1. Nabila Saad-wife
2. Osama Mitry MD
3.
4.
5.

VII. Other Medications or Drugs Used by the Trasylol User

To the best of your knowledge, state whether you used any of the following medications during the fifteen (15) years prior to the date of your alleged Trasylol injury, circle all medications you have used, state the first and last dates you took the medication, and identify the doctor that prescribed the medication

Medication	Dates Used (first to last use)	Prescribing Doctor	Reason for Prescription
Blood pressure medication (including bot not limited to Benazepril, Lotensin, Captopril, Capoten, Capozide, Enalapril, Renitec, Basotec, Fosinopril, Monopril, Lisinopril, Lisodur, Lopril, Novatec, Prenivil, Zestril, Moexipril, Univasc, Perindopril, Aceon, Coversyl, Quinapril, Accupril, Ramipril, Altace, Ramace, Ramiwin, Tritace)	I don't know- see medical records attached in Plaintiff's possession.		

Medication	Dates Used (first to last use)	Prescribing Doctor	Reason for Prescription
Aminoglycoside antibiotic medication (including but not limited to Amikacin, Amikin, Apramycin, Apralan, Gentamicin, Gentamicin and Prednisolone Acetate, Gentamicin Sulfate Ophthalmic, Garamycin, Pred-G, Genoptic, Kanamycin, Kantrex, Neomycin, Neosporin, Mycifradin, Neo-Fradin, Neomycin Sulfate, Neo-Tab, Netilmicin, Netromycin, Paromomycin, Humatin, Paromycin, Streptomycin, Tobramycin, Nebcin, Tobi, Tobramycin and Dexamethasone, Tobradex, Tobramycin and Dexamethasone Opthalmic Ointment, Tobradex Ointment)	I don't know- see medical records attached in Plaintiff's possession		

Medication	Dates Used (first to last use)	Prescribing Doctor	Reason for Prescription
Any diuretic medication (including but not limited to Bumentanide, Bumex, Eplerenone, Inspra, Furosemide, Lasix, Hydrochlorothiazide, HydroDIURIL, Microzide, Metolazone, Zaroxolyn, Spironolactone, Aldactone)	None		
Any pain reliever or anti-inflammatory medication other than aspirin (including but not limited to Celecoxib, Celebrex, Diclofenac, Voltaren, Cataflam, Arthrotec, Ibuprofen, Advil, Dristran, Genpril, Haltran, IBU, Menadol, Midol, Motrin, Nupin, Vicoprofen, Indomethacin, Indocin, Ketorolac, Toradol, Nabumetone, Relafen, Naproxen, Aleve, Anaprox, Naprelan, Naprosyn)	Motrin and/or ibuprofen- may have been prescribed one or to others, but I cannot remember	over the counter	muscle and back pain
Lithium (Lithobid)	None		

Any and all other prescription and non-prescription medications, including herbal or homeopathic remedies. Name:	Possibly Tylenol; approximately six months before heart surgery on 12/21/2004, I was prescribed a round of steroid treatments for headaches, but cannot remember the name of the medication; unable to remember any others. See also medical records in Plaintiff's possession	Dr. Timothy Ho	headaches

*Attach additional pages if necessary

VIII. Family History of the Trasylol User

A. 1. To the best of your knowledge did any child, parent, sibling, aunt, uncle, or grandparent of the Trasylol User have diabetes or any type of kidney disease?
Yes _____ No _____ (I don't know)

2. To the best of your knowledge did any child, parent, sibling, aunt, uncle, or grandparent of the Trasylol User have a stroke, myocardial infarction (heart attack) or any other type of heart disease?
Yes _____ No _____ (I don't know)

B. If yes, then state separate for each:
Relatives name: _____
Relationship to you: _____
Type of health problem: _____
Date and cause of death if applicable: _____

Relatives name: _____
Relationship to you: _____
Type of health problem: _____
Date and cause of death if applicable: _____

Relatives name: _____
Relationship to you: _____
Type of health problem: _____
Date and cause of death if applicable: _____

Relatives name: _____
Relationship to you: _____
Type of health problem: _____
Date and cause of death if applicable: _____

IX. Request for Production of Documents Directed to Plaintiff(s)

Please produce the following documents (including but not limited to emails and internet articles) with this Fact Sheet, to the extent that such documents are currently in your possession or in the possession of your lawyers:

1. All documents you or anyone acting on your behalf reviewed in preparation of this Fact Sheet.

2. A copy of all medical records regarding the Trasylol User from any physician, hospital or health care provider who treated the Trasylol User for any disease, condition or symptoms referred to in response to the questions above.

3. To the extent not included in the foregoing, all records relating to any examination of the Trasylol User by a physician or other health care provider, conducted for any purpose during the past fifteen (15) years).

4. If the Trasylol User has been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.

5. Reports of all diagnostic tests, cardiac function, circulatory function, blood tests, and kidney function tests administered to the Trasylol User within the past fifteen (15) years.

6. Copies of all documents from physicians, health care providers or others relating to the use of Trasylol, or to any condition you claim is related to the use of Trasylol, or recording the administration of Trasylol to the Trasylol User.

7. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts or other materials provided to the Trasylol User or his or her agents, representatives or anyone acting on the Trasylol User's behalf (other than your attorneys in this case) in connection with the use of Trasylol.

8. All prescriptions, prescription records, drug containers and labels, informational brochures, advertisements, package inserts and other document setting forth warnings and/or instructions relating to any medications or drugs identified in subsection *VII* of this Fact Sheet.

9. Any diaries, calendars, date books, or other documents which reflect use by the Trasylol User of prescription medications and/or which record or reflect the occurrence, duration or severity of any injury, illness or disease affecting the

Trasylol User within the past fifteen (15) years.

10. Any releases, covenants not to sue, and any other agreement(s) between you and any other person relating an any way to the claims asserted in this lawsuit.

11. All press releases or other public statements made by or on behalf of you relating to this litigation.

12. All documents recording any communication concerning Trasylol that you or anyone acting on your behalf had with any governmental body, regulatory agency, trade group. Pharmaceutical manufacturer or distributor, members of the press or news media, or other person (other than your lawyers in this case).

13. All statements obtained from or given by any person having knowledge of facts relevant to the subject of this litigation.

14. All documents that relate to Trasylol, any alleged side effect of Trasylol, or the alleged injuries that are the subject of this lawsuit.

15. All documents relating to Trasylol or any alleged health risks or hazards related to Trasylol in your possession, or the possession of the Trasylol User, at or before the time of the injury alleged in your Complaint.

16. All documents you or anyone acting on your behalf (and not your lawyer) obtained directly or indirectly from any defendant.

17. All photographs, drawings, journals, slides or videos relating to the injuries alleged in your complaint.

18. All documents that record, reflect or relate to any pecuniary loss or other damages, including all out of pocket expense documentation, that you claim resulted from the administration of Trasylol as alleged in the Complaint.

19. If you complaint includes a claim of loss of support or loss of earnings or earning capacity, the federal income tax returns of the Trasylol User for each of the last fifteen (15) years.

20. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider.

21. Copies of letters testamentary or letters of administration relating to your status as plaintiff

22. Decedent's death certificate (if applicable).

23. Any medical or coroner's reports regarding decedent's death (if applicable).

X. Authorizations

Complete and sign the attached authorizations for release of records.

XI. Declaration

I declare under penalty of perjury that all of the information provided in this Plaintiffs' Fact Sheet is true and correct to the best of my knowledge, information and belief formed after due diligence and reasonable inquiry, that I have supplied all the documents requested in Part IX of this Plaintiffs Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the authorizations attached to this declaration.

Signature Date

18. All documents that record, reflect or relate to any pecuniary loss or other damages, including all out of pocket expense documentation, that you claim resulted from the administration of Trasylol as alleged in the Complaint.

19. If your complaint includes a claim of loss of support or loss of earnings or earning capacity, the federal income tax returns of the Trasylol User for each of the last fifteen (15) years.

20. If you claim any loss from medical expenses, copies of all bills from any physician, hospital, pharmacy or other health care provider.

21. Copies of letters testamentary or letters of administration relating to your status as plaintiff.

22. Decedent's death certificate (if applicable).

23. Any medical or coroner's reports regarding decedent's death (if applicable).

X. Authorizations

Complete and sign the attached authorizations for release of records.

XI. Declaration

I declare under penalty of perjury that all of the information provided in this Plaintiffs' Fact Sheet is true and correct to the best of my knowledge, information and belief formed after due diligence and reasonable inquiry, that I have supplied all the documents requested in Part IX of this Plaintiffs' Fact Sheet, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the authorizations attached to this declaration.

Signature

8-18-08
Date

Exhibit L

THEGALLAGHERLAWFIRM
Attorneys at Law
2905 Sackett Street
Houston, TX 77098
(888) 222-7052 toll free
Facsimile (713) 222-0066

Michael T. Gallagher
Board Certified- Personal Injury Trial Law
Texas Board of Legal Specialization

November 18, 2008

Ms. Elizabeth Curtin
Sidley Austin LLP
One South Dearborn
Chicago, IL 60603

Via Federal Express

In re: Trasylol Product Liability Litigation- MDL-1928; C.A. No. 9:08-cv-80776-DMM; *Naguib Bechara, et al v Bayer A.G., et al*; In the United States District Court for the Southern District of Florida

Dear Ms. Curtin:

Please allow this letter to serve as supplementation of Plaintiff's previously filed Fact Sheet, and pursuant to your letter of October 29, 2008:

V.A.3.

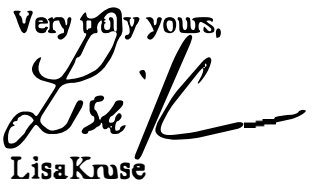
See medical records previously provided and additional medical records attached hereto from Kaiser Permanente Medical Center. Plaintiff assumes that either his surgeon, Dr. Thomas Pfeffer, or anesthesiologist whose name would be reflected in his medical records that have been provided prescribed the Trasylol, but Plaintiff has no personal knowledge as to who prescribed the Trasylol

To further supplement pursuant to your request, I am enclosing executed authorizations signed by the Plaintiff and a witness. I am also enclosing tax record release authorizations that are undated.

Finally, I am also enclosing additional records from Kaiser Permanente Medical Center to supplement those medical records previously provided in Plaintiff's Fact Sheet.

Please do not hesitate to contact me should you have any additional questions.

Very truly yours,



Lisa Kruse
Legal Assistant to Michael T. Gallagher

Exhibit M

THE GALLAGHER LAW FIRM
Attorneys at Law
2905 Sackett Street
Houston, TX 77098
(888) 222-7052 Toll Free
Facsimile (713) 222-6666

Michael T. Gallagher
Board Certified-Personal Injury Trial Law
Texas Board of Legal Specialization

September 4, 2009

Ms. Julie Hardin
Fulbright & Jaworski, LLP
1301 McKinney, Suite 5100
Houston, Texas 77010

Via Email

In re: Trasylol Product Liability Litigation- MDL-1928; C.A. No. 9:08-cv-80776-DMM; *Naguib Beehara, et al v. Bayer A.G., et al*; In the United States District Court for the Southern District of Florida

Dear Julie:

Pursuant to your letter of August 24, 2009 and to supplement Plaintiff's previously filed Fact Sheet, and our initial supplementation by letter dated November 18, 2008 to Ms. Elizabeth Curtin, I am providing the following information:

II. B To supplement and provide current address:
5059 E. Fairfield St., Anaheim, CA 92807
D/Residence: 3/09 to the present

To supplement and provide street number on Corvette St.: 12172

II. H To supplement and provide current address for Justin Beehara:
5059 E. Fairfield St., Anaheim, CA 92807

II. I (1) To provide correct name of employer: Miller's Fab & Weld Corporation

II. I (2) To supplement and provide addresses of former employers:

Steel Detailing Corp.
1532 W. Commonwealth Ave.
Fullerton, CA 92833

Builders Steel
3670 Placentia Ave.

Riverside, CA 92501

Delta Steel
1875 S. Lewis St.
Anaheim, CA 92806

Superior Metal Fab. Inc.
174 S. Liberty Ave.
Anaheim, CA 92801

II. J To correct date of attendance for Faculty of Engineering, Cairo, Egypt: 1972-1977

To supplement previous answer:

Name of School: LA Trade Tech
Address: Los Angeles, CA
D/Attendance: 1982
No degree
Field of study: steel construction

II. K (2) To amend previous answer:
Type of benefits: Social Security/State Disability

II. K (3) To amend previous answer:
Amount awarded: $2400

II. K (6) To amend previous answer:
Agency application submitted to: Baltimore/Sacramento

II . N To amend previous answer:

Yes, Los Angeles Superior Court v. Kaiser Permanente; medical malpractice lawsuit not involving Trasylol.

III. B To supplement previous answer:

[redacted] REDACTED

III. D To supplement previous answer:

[redacted] REDACTED

[redacted]

[redacted]

[redacted]

REDACTED

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

REDACTED

[redacted]

III. F (30) To amend previous answer, [redacted]

[redacted]

To supplement previous answer regarding treating doctor information for [redacted] REDACTED

[redacted]

VI. A To supplement previous answer:

REDACTED

[redacted]

To supplement previous answer regarding health care providers:

[redacted]

REDACTED

[redacted]

D/treatment: [redacted] REDACTED

VI. F To supplement previous answer:

[redacted]

REDACTED

With respect to the notebook that is referenced on SCPMG 380-381 of Mr. Bechara's medical records, Mr. Bechara has not been able to locate this notebook. He recently moved and while he is fairly certain that he still has the notebook, he has not been able to locate it. He will continue his search and if he is able to locate it, we will promptly provide you with a copy.

Very truly yours,

Lisa Kruse
Legal Assistant to Michael T. Gallagher

Exhibit N

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

IN RE TRASYLOL PRODUCTS LIABILITY LITIGATION,	)	Case No. 08-01928-MD-MIDDLEBROOKS
	)	West Palm Beach, Florida
	)	September 10, 2009
	)	3:34 p.m.

PAGES 1 - 22

TRANSCRIPT OF DEFENDANT'S EMERGENCY MOTIONS
BEFORE THE HONORABLE DONALD M. MIDDLEBROOKS
U.S. DISTRICT JUDGE

Appearances:

For the Plaintiffs:
GALLAGHER LAW FIRM
BY: MICHAEL T. GALLAGHER, ESQ.
2905 Sackett Street
Houston, Texas 77098
(Appearing Telephonically)

For the Defendants:
SQUIRE, SANDERS & DEMPSEY, LLP
BY: PATRICIA ELAINE LOWRY, ESQ.
1900 Phillips Point West
777 So. Flagler Drive, Suite 1900
West Palm Beach, Florida 33401
(Appearing Telephonically)
BARTLIT, BECK, HERMAN, PALENCHAR & SCOTT
BY: JOHN PHILLIPS, ESQ.
54 West Hubbard Street, Suite 300
Chicago, Illinois 60610
(Appearing Telephonically)

Reporter:
(561) 514-3728
Karl Shires, RPR
Official Court Reporter
701 Clematis Street, Suite 258
West Palm Beach, Florida 33401

THE COURT: This is the case of the Trasylol Products Liability, MDL1928, with respect to Bechara versus Bayer Corporation. The case number is 08-01928.

Who's on the line?

MS. LOWRY: Your Honor, Pat Lowry from Squire Sanders.

MR. PHILLIPS: John Phillips from Bartlit Beck for Bayer also.

MS. LOWRY: And, your Honor, we're still waiting for a couple other people to join. I apologize for the technical difficulties. We thought we had it all worked out, and then it failed at the last minute.

THE COURT: All right. Is anybody on for the plaintiffs?

MS. LOWRY: Not yet, your Honor. Mr. Gallagher will be joining us.

THE COURT: Was this part of the technical problem or is he just not available?

MS. LOWRY: No, it's part of the technical problem. It is my fault, your Honor, and I apologize. It sounded like somebody just joined us.

MR. GALLAGHER: Mike Gallagher.

THE COURT: Okay. Is that it or is there somebody else joining?

MS. LOWRY: I think that's it, your Honor.

THE COURT: Okay. This is a hearing on a emergency motion to quash a deposition. And I've read the emergency motion and a plaintiff's response that came in just a few minutes ago.

Is that it with respect to written filings?

MR. GALLAGHER: That would be it, your Honor. This is Mike Gallagher for the plaintiff.

THE COURT: Okay.

MR. PHILLIPS: And this is John Phillips, Bayer. That's all we filed, your Honor.

THE COURT: Where are these depositions taking place? Are they in California? Is that what's happening?

MR. PHILLIPS: That's right. In the Los Angeles area.

THE COURT: And so the lawyers are all from somewhere else; is that the case?

MR. PHILLIPS: Yes, your Honor.

THE COURT: This disclosure of the prior litigation is awfully late, and I can see how that would present the defendants a problem with deposing this doctor. Why shouldn't you try to work something out on this, Mr. Gallagher?

MR. GALLAGHER: Well, for one reason, your Honor, the doctor never testified with regard to any issues related to Trasylol or renal failure or causation in the arbitration

proceeding according to the attorney that handled that proceeding with whom I spoke.

And my position is this. Since we've come here, this is the second time that we have scheduled this deposition. If after taking the deposition they feel that there was something that jeopardized their position, then they could ask the Court, petition the Court to redepose this particular person. He has no positions on renal failure. He has no positions on Trasylol. He is, by the way, one of their opinion leaders. There are several documents in their files indicating that they've had contact with him over the years.

If anyone is jeopardized by this revelation, it is the plaintiff and that's because we suddenly for the first time this late in the game found out that our client had asserted a claim against Kaiser Permanente for essentially the same kinds of injuries that are involved in the instant litigation. So the net result of that is that the excerpts that were retained by the plaintiff in that litigation against Kaiser Permanente were saying that it was the fault of Kaiser Permanente, not Trasylol. They never mentioned it. And they by virtue of positions that they've taken become at least the allies if not the witnesses for the defendants in this case. The only one that's hurt here by this revelation that at this late date we find out that our client has filed

a separate claim for the same damages is the plaintiff.

We're the ones that now have to overcome this burden. They're the ones that under California law get an apportionment reduction on noneconomic loss. They get a credit for any damages that we recover on economic loss. We have to overcome the fact that in all probability our witnesses will be cross-examined with depositions by witnesses previously retained by Mr. Bechara. There may be some issue about that, but that's discretionary with the Court. And the only possible person that could be hurt in this entire circumstance are the plaintiff's lawyers and Mr. Bechara. There can be no damage. They welcome the fact that we now have another lawsuit out here in which Mr. Bechara made a claim that it's not consistent with the claim he's making now.

Trasylol was never mentioned with regard to this one doctor who is one of their opinion leaders. He has no opinion on -- I talked to him very briefly in connection with his deposition. He has no opinion on renal failure. He has no opinion on Trasylol other than he used it on a regular basis. He has no opinion with regard to the quality of care that was rendered anywhere. And he eventually is a very neutral doctor who will only testify as to the surgeries that he performed and the consequences of that surgery from a physical standpoint on the plaintiff.

It really doesn't have anything to do with the underlying renal failure claim at all other than the CABG failure that preceded the renal failure was done at the same hospital. And he only saw the plaintiff two or three times after that because at Kaiser Permanente they turned the care over as -- these records have been here forever, by the way, showing his involvement. And there are only two or three entries after the surgery in which Dr. Pfeffer's name is mentioned because the care is turned over primarily to cardiopulmonologists and what they call intensivits who are doctors who specialize in the general medical care of people who are in intensive care, and it's a -- it appears to me to be an unnecessary delay.

I'm terribly sorry that the information was late in coming. My client felt like he was under a confidentiality agreement in connection with his settlement with Kaiser Permanente. And when he answered the initial fact sheet, he felt like he could not divulge that. When the second fact sheet was sent to him, he became somewhat concerned and after conferring with me and then with his other lawyer here in California he was told that he could, that he could go ahead and answer the question -- that he had to go ahead and answer the plaintiff's fact sheet, and he did. But his initial reason for not doing so was that he thought -- well, it was confidential. There's no reason to delay this deposition,

Judge.

THE COURT: Well, except the injury on your side sounds -- I can see how you can really be harmed by this, but it's self-inflicted by your client.

MR. GALLAGHER: This would not be the first time, your Honor.

THE COURT: No, I guess not. But why aren't you better off giving -- because they want -- I agree they can probably make some hay out of this, but shouldn't they get a chance to gather their ammunition before you go forward with this deposition, especially if you're going to use it at trial?

MR. GALLAGHER: Well, but there's really no ammunition to gather to use with regard to this doctor. He's not an expert at all in renal failure and will not testify to any issues related to renal failure. He doesn't even qualify under Daubert. He's a cardiovascular surgeon.

THE COURT: But apparently whatever he did --

MR. GALLAGHER: In fact, he told me in my conference, he said I will not address in any shape, form, or fashion the issue of renal failure. I cannot give you causation on it. That is for a nephrologist. That is not my area of specialty.

THE COURT: But apparently -- was he charged with malpractice as well in this earlier arbitration?

MR. GALLAGHER: No, sir, he was not a defendant.

THE COURT: What was the theory of the earlier? Did the hospital --

MR. GALLAGHER: The theory of the earlier case was there was a delay in the diagnosis and that the delay in the diagnosis led to certain problems that at least some of the doctors felt contributed to the renal failure.

THE COURT: Well, doesn't that go to the heart of what the defendants are going to want to argue?

MR. GALLAGHER: Well, it's already been argued for them quite well. I mean, his deposition doesn't go there. If they want to take the -- if they want to take the other doctors that testified in the case and want to retain them as experts, they probably would be free to do that. But, you know, the -- at the time this all happened too, Judge, this was in 2004, I mean 2004 and it was at a time when there was not a great deal of information in the public domain relative to any possible causal connection between renal failure and Aprotinin. And certainly there weren't any articles on the market about the mechanism of action by which Aprotinin promotes clotting and viscosity and thereby may reduce blood supply if you have, if you have -- if you're in a compromised state already because of your cardiac condition. So there wasn't anything out there and nobody attributed this to Trasylol. Nobody ever thought about it. It was just, hey,

they waited too long and the cause was the delay.

I mean, if I were a defendant, and I was for a long time at the same firm Ms. Lowry practices with, I probably wouldn't say anything about this until the time of trial and then pop the deposition and start trying to use them. That certainly doesn't have to be -- these other doctors -- they may want to take the other doctors. They may not want to. But this doctor is not -- he's not involved in that. He just has no opinions on it whatsoever. But what he does have an opinion on is the severity of the heart injury that the man received which is relevant and the nature of the problems that he has as a consequence of that which I need to differentiate. And I welcome the opportunity to try this case and would love to try it even given the fact that they've already settled with one other defendant.

MR. PHILLIPS: Your Honor --

THE COURT: And it looks like the plaintiff didn't provide any information about how -- about the settlement or what happened in that earlier case; is that right?

MR. GALLAGHER: He did not. He answered -- your Honor, because of the confidentiality agreement, he answered negatively to the question about whether or not he had ever had a claim or a personal injury action. And we didn't become aware of it until we asked him to supplement. And then he told one of my secretaries, he said there's something

that's bothering me, I need to talk to Mr. Gallagher, I need to talk to my lawyer. And then after those conversations is when we amended right away and brought it to their attention. But also when we brought it to their attention we said, you know, that he had a claim and we didn't -- we couldn't find anything about it, and I think because of Julie Harden. And we're all friends that are on the line. I mean, nobody here is trying to get a leg up on anybody else.

THE COURT: My question is really a lot different.

MR. GALLAGHER: We tried to find more data about it. We were unable to do so. But we did tell them and we gave them our numbers over the weekend and said, look, if -- you know, if you need us, get in touch with us. And that was last Friday. This deposition is set for this Friday.

And in fairness to them, they took the first deposition of Dr. -- of Mr. Bechara yesterday, and then they said, well, we don't want to go forward. Well, Mr. Bechara's deposition which was canceled today has nothing to do with the doctor's whatsoever. And this doctor has nothing to do with the litigation. He was not a party to it. He just happened to be the treating physician, and he doesn't know what caused the renal failure. He just knows what he did and that the renal failure didn't occur during the period of time that he was on his operating table.

THE COURT: But I guess my question is in the

deposition did the plaintiff also refuse to talk about the arbitration and what happened and how it was resolved?

MR. PHILLIPS: Your Honor, this is John Phillips from Bartlit Beck representing Bayer. And I was in the deposition yesterday. May I answer that?

THE COURT: Sure. I thought I read that somewhere in one of these papers.

MR. PHILLIPS: Yes.

THE COURT: At advice of counsel he refused to disclose what happened in the arbitration.

MR. PHILLIPS: That's correct, your Honor. He was instructed not to answer those questions concerning the resolution of the matter, and he was unable to provide us any information about the basis of the claims, the identity of the defendants or anything else.

Mr. Gallagher has made a series of representations within the last five or ten minutes about what happened in that litigation, what other people testified to, what his client testified to. Your Honor, unfortunately only Mr. Gallagher has the record of his client's prior malpractice lawsuit and the recovery that it appears he obtained. We don't have any of that record.

And I'd like to have a moment or two to come back to what the disclosure obligations are, why they were ordered by your Honor back in Pretrial Order No. 4, and why we would

be prejudiced from going forward.

MR. GALLAGHER: Well, let me say that I don't have -- I don't have the order. I don't have the papers or pleadings initiating the action. I don't have the discovery that you're permitted to propound in the California and Kaiser Permanent cases. We were given the depositions, and I've offered to make a copy of Dr. Pfeffer's deposition available to them. We do know the amount of the settlement which I just found out from the lawyer that represented him. And that is a matter that is -- it's not relevant for anybody other than the Court to apply the amount of the settlement to any verdict that may or may not be recovered. Certainly they can be made aware of it. But as far as any of the experts or anyone else, nobody else is permitted to be cross-examined on, well, did you know he got a "X" hundred thousand dollar settlement. And we will file with the Court under seal, I just found out, the amount of the settlement. That's not relevant to anyone other than the Court and how it affects the law.

The things that I found out with regard to the doctor to what his issues were, were not in violation of any duty that I owed under -- and I'm trying to be acutely aware of the duties that I owe federal court or any court as far as that's concerned and have honored that duty to the letter throughout my career. The things that I found out from what

the doctor may or may not say were based upon conversations that I had with the doctor in connection with his deposition of which the Court does permit us to have. And we had reserved 30 minutes for the last time the case was set for deposition -- the last time the deposition was set, and that was canceled but by nobody's fault. We're not throwing stones at anybody here. And I had a chance to talk with him about that. I had a chance to talk with him very briefly since then. And if the Court let's it go forward, I will, of course, talk with him tomorrow.

MR. PHILLIPS: Your Honor, may I address the disclosure issue briefly?

THE COURT: Yes, I guess. What I am really interested in is why you are disadvantaged and why you have -- why both parties or why the plaintiff feels a need to go forward tomorrow. I can see how if you're out in California that's an issue. The disclosure -- I have a hard time seeing how this isn't very relevant to the case and the disclosure is a problem. But it's really the timing of the disclosure at this point since they have at least made some.

MR. PHILLIPS: I agree with that, your Honor. This is John Phillips representing Bayer. I'm Mr. Derringer's partner at Bartlit Beck. I know he was before you just yesterday during the status hearing. And first we want to thank you for making time for us on such short notice.

I agree with both of the items you just mentioned. There is a very clear disclosure obligation embodied in your Honor's 2008 Pretrial Order No. 4 that requires certain relatively detailed disclosures from both sides. With respect to each plaintiff, among the required disclosures is a description of, including a case caption, the names of the parties, the case number of any prior lawsuits involving the plaintiff or the injuries that are at issue in this case. Your Honor's order required each plaintiff to provide that information back in August of 2008, and we did receive what's called a plaintiff's fact sheet in your order back in August of 2008. In addition to the materials or, I'm sorry, the information that I just described that it's required to be provided there, documents that go to those lawsuits are to be provided as well.

In the August 2008 plaintiff's fact sheet upon which we've been relying there's no description, no disclosure whatsoever of this prior lawsuit. We have never been provided even right up until now with any of the documents concerning that lawsuit. We don't have a copy of the lawsuit or the arbitration demand. We don't have a copy of any of the pleadings. We don't have the plaintiff's own sworn testimony in the case. And we don't have the prior testimony of Dr. Pfeffer who I'm to depose tomorrow or any of the other treating physicians that Mr. Gallagher has just

alluded to.

And so the prejudice to us, your Honor, from going forward is that only one party here has access to all of the information about that prior lawsuit, a lawsuit that involved this surgery, this plaintiff, this cardiac surgeon, and the facility of which we will be deposing him tomorrow, Kaiser. And it's fundamentally unfair in the face of very clear disclosure obligations that your Honor ordered a very long time ago and under which I think the disclosure has worked quite well in almost every case. But yesterday we learned that it just flat out wasn't followed here, and we're in a terrible position where we have to go depose a doctor who's been deposed before, who is on the record talking about this plaintiff and his surgery and other of his colleagues who treated the plaintiff in connection with the surgery at which he received Trasylol have all testified, and only the plaintiffs have all of that information.

And Mr. Gallagher has made a number of representations about what the prior litigation was about, what it showed, what it didn't show, what the impact to his client is, what the impact to my client is and, unfortunately, we don't have any basis on which to cross-examine his client when we deposed him yesterday or the doctor tomorrow until we have the same information. And because it's information that is expressly called for by your

Honor's order back in 2008, we believe that before we should be required to go forward with Dr. Pfeffer's deposition tomorrow and other discovery in the case we ought to have the materials that Mr. Gallagher and his colleagues and his client put together in connection with the prior lawsuit that involved the same injuries that we're being sued for. Without that material we're just -- we believe we're prejudiced in preparing our defense and completing discovery particularly in a case that the plaintiffs -- it's one of the three cases that plaintiffs have chosen as a potential trial pick for early next year.

MR. GALLAGHER: This is Mr. Gallagher, your Honor. May I respond very briefly?

THE COURT: I have a question first. There were two things you said that I wanted -- you said Mr. Gallagher and his colleagues had prepared the prior suit. Was it other lawyers or was it Mr. Gallagher and his firm?

MR. PHILLIPS: Yes, your Honor. What we were told yesterday is that another lawyer in Los Angeles represented the plaintiff. So I'm not aware of any involvement by Mr. Gallagher himself in that earlier case. Although, just from what he described it sounds like he has access to some of that information, No. one. Number two, the disclosure obligation expressly requires the production of both information and documents in the possession of the plaintiff

himself or his counsel. And in my view even if he had some other counsel representing him in that case that's different from Mr. Gallagher, the disclosure obligation to us doesn't just go away because he changed lawyers. This is material that is expressly called for irrespective of which counsel represented him in the earlier lawsuit.

THE COURT: All right. My other question -- you said you shouldn't have to go forward with this deposition or other discovery. Your motion is directed to this deposition.

MR. PHILLIPS: That's correct.

THE COURT: What other discovery are you doing and what's your -- what's the relief you're seeking? This deposition or something else?

MR. PHILLIPS: Yes, your Honor. The only relief we're seeking now is with respect to the deposition that is to begin first thing tomorrow morning. The only reason I referred to other discovery is that we have one other doctor whose deposition we've been trying to schedule, we've not received dates from him, and I don't know if -- it's Dr. Patel. He's on plaintiff's expect to call witness list. I don't know and the plaintiff yesterday wasn't able to tell us whether he was deposed in his prior lawsuit. So, I believe that we ought to have the material that Mr. Gallagher or his client have or have access to before we have to take any of these treating physicians. But this motion -- because

it's the only deposition scheduled currently, your Honor, this motion only goes to the deposition that's scheduled to start tomorrow which is Dr. Pfeffer.

THE COURT: Why can't you go forward and if you show that this additional information, once you get it, would have been useful to you, then seek leave to further cross-examine him?

MR. PHILLIPS: Well, I believe that -- well, first of all, Dr. Pfeffer is a third party and this is a trial type deposition. He lives in California. He's outside of the subpoena power of the Court. And I believe our questioning tomorrow would be or could be very different depending on what he has testified to before, what opinions he expressed, what opinions the other treating physicians who were treating Mr. Bechara alongside him in December of 2004 have said.

We don't even know what position the plaintiff took in that lawsuit, whether it's consistent or inconsistent with what he's saying now. And we ought to -- I believe we ought to have a chance to review that material before we walk in and even start the deposition. And I don't think it's fair for the plaintiff, for Mr. Gallagher to have all of that information. And by the way, he noticed the deposition. He will be starting the questions. For him to have access to all of that information with this doctor, we are in the dark for one full day of deposition with a third party, critical

third party who performed the operation and administered and prescribed the Trasylol. For us to begin the deposition completely in the dark strikes us as unfair.

MR. GALLAGHER: May I respond now, your Honor?

THE COURT: Sure. And why -- Mr. Gallagher, and as you do -- you know, I can see why they want this information before deposing him.

MR. GALLAGHER: We have it here for them.

THE COURT: And so I think the best you're going to likely come out, and I want to see if you really want to do this, is go forward with the understanding that if they in their cross later on figure out they have questions they would like to ask this doctor, you can't use this deposition without producing this fellow for further cross. I think that may be -- that's probably the best you can do. What I want to know is whether you really want to do that.

MR. GALLAGHER: Even -- see, we have not had his deposition. I have not read his deposition yet. What I know about what he will testify to is what he told me. If we get them the deposition this afternoon -- it's 51 pages, and we've had it here available for them to pick up or we'll go deliver it to them. I mean, I just --

THE COURT: Well, it's probably not just his deposition. It's what your client's posture was in that earlier proceeding, the position he took and whether -- I

mean, apparently he blamed somebody else for this injury --

MR. GALLAGHER: Kaiser Permanente.

THE COURT: -- and then didn't disclose it when this -- I don't see how the existence of a confidentiality order provides any excuse for not disclosing it.

MR. GALLAGHER: I don't either, your Honor. And we just visited with it as soon as his lawyer and I got together.

THE COURT: I appreciate that. But now you're in a situation of how you want to deal with it. They're entitled to have information.

MR. GALLAGHER: I'm trying to figure out what that is and somehow I think that if the Court is inclined to say let them take the deposition and then if they feel that they have to take it again, we have to produce him again, I would just bet -- I would bet just about any amount of money at the conclusion of the deposition and when we appear before you in court in connection with this case they're probably going to say they need to take the deposition again.

THE COURT: Probably.

MR. GALLAGHER: Therefore, my position is that I would rather get -- I don't have all of this information they're talking about, but I think I can get it from the lawyer that handled the case. I will get everything that he has in his file, get it to them, and then we'll start with a

clean slate and just -- because I don't want to take his deposition and give them six months to come back and potshot at him again.

THE COURT: All right.

MR. GALLAGHER: But I can understand the Court's position. Not that that's important, but I do appreciate His Honor's -- the position portends.

THE COURT: It sound like you all can work it out then; is that right?

MR. GALLAGHER: I think we can work out just about anything. I really wanted this to go forward just because of the expense that's been involved in coming out here, but I don't want it to go forward and have to have him deposed again. But I do -- I, like the rest of the lawyers on the phone, appreciate your time and thank you very much for taking your time with us.

MR. PHILLIPS: Just to clarify, your Honor -- this is John Phillips from Bayer again. If I understand correctly, we have a commitment that the deposition will not happen tomorrow but that we will be provided with the -- you know, as promptly as Mr. Gallagher is able the material that are called for by the plaintiff's fact sheet or from our discovery request and that we will work together to promptly schedule that deposition after we've received those materials.

MR. GALLAGHER: Yes, and I will try to get -- I will get everything the other lawyer has in his possession.

And by the way, I do want the Court to understand -- because it just occurred to me that the Court may be of the impression that the first lawyer handled the first case and then referred this case to me. There was a hiatus of some years between the resolution of that case, and the case ultimately came to me from a lawyer in Texas with no connection with the lawyer that handled the case out here. So I was not involved in that first case at all. Had I known anything of it, it would have been in our initial disclosure.

THE COURT: Yes. Okay. I understand. I appreciate your putting -- you're in a bad situation as well, and I'm glad you all are able to work together to work through it.

MR. PHILLIPS: Thank you for your time, your Honor.

THE COURT: Okay. Have a good day.

MR. PHILLIPS: Thank you.

(Proceedings concluded at 4:07 p.m.)

C E R T I F I C A T E

I, Karl Shires, Registered Professional Reporter, certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

Dated this 14th day of September, 2009.

_____

Karl Shires, RPR

Exhibit O

THE GALLAGHER LAW FIRM
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Houston, Texas 77098
(713) 222-8080 Fax (713) 238-7852

Michael T. Gallagher
BOARD CERTIFIED - PERSONAL INJURY TRIAL LAW
TEXAS BOARD OF LEGAL SPECIALIZATION

September 22, 2009

Ms. Julie Hardin
Fulbright & Jaworski, L.L.P.
1301 McKinney, Suite 5100
Houston, Texas 77010-3095

Via Hand Delivery

Re: Cause No. 08-80776-Civ-Middlebrooks/Johnson; Naguib Bechara, et al vs. Bayer AG, et al. In the United States District Court, Southern District of Florida

Dear Ms. Hardin:

Enclosed please find our expert Disclosure, as well as a copy of our expert reports, Curriculum Vitae, fee schedule and list of cases in which they have testified.

For scheduling purposes, the only day Dr. Deutsch is available for deposition between now and November 9th is on November 2nd. Please confirm your availability so that we can advise his office, as they are currently holding this date. Dr. Quigg is unavailable from October 16th to November 1st. Working around those dates, please give us proposed dates for his deposition as soon as possible.

Sincerely,

THE GALLAGHER LAW FIRM

Pamela McLemore
Legal Assistant

:pm
Enclosures

THE UNIVERSITY OF CHICAGO
DEPARTMENT OF MEDICINE
SECTION OF NEPHROLOGY
5841 SOUTH MARYLAND AVENUE • MC 5100
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RICHARD J. QUIGG, M.D.
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September 11, 2009

RE: Naguib Bechara

I. Background and Qualifications

I am a medical doctor, currently licensed in Illinois. In addition, I am a Professor of Medicine at the University of Chicago. I graduated *summa cum laude* from the Boston University Six-Year Medical Program in 1981. Thereafter, I completed a residency in Internal Medicine at the State University of New York-Stony Brook in 1984, followed by a four-year fellowship in Nephrology, which I completed in 1988. I was Assistant Professor of Medicine at the Medical College of Virginia from 1988-1994, following which I joined the faculty at the University of Chicago, where I have remained since. In 1999, I was granted indefinite tenure and became Chief of the Section of Nephrology; in 2001, I was promoted to full Professor.

I have 121 original publications, reviews and book chapters in highly respected scientific sources. These have concentrated on mechanisms, outcomes and therapeutic options for acute kidney injury of a variety of forms. I have consistently been an invited speaker at national and international conferences and visiting Professor for a number of academic institutions in the US and abroad; these have totaled over 50 instances in my career.

The first medical research I performed was as a fourth-year medical student in 1980 in the laboratory of Dr. Norman Levinsky (then, Chair of Medicine at Boston University School of Medicine) on the renal kallikrein-kinin system, which included analyzing the effects of the inhibitor of this physiological system, aprotinin. This was the springboard for the remainder of my investigative career examining renal pathophysiology.

I was certified by the American Board of Internal Medicine for Internal Medicine in 1984 and Nephrology in 1986. I have been a practicing Internist and Nephrologist for the past 21 years. In addition to the practice of medicine, I have been involved in translational medical research, the education and training of physicians in Nephrology and Internal Medicine, and as an academic leader. In support of this is my having three active federal grants from the National Institutes of Health (NIH), two of which are in their third decade of continuous funding. I was the Chief of the Section of Nephrology at the University of Chicago for ten years, and continue to serve as Program Director of our Fellowship Program that has trained a large cohort of young Nephrologists.

My practice of medicine includes a significant in-patient responsibility, during which time I am involved in the care of patients who have undergone cardiac surgery, with subsequent problems involving their kidneys, blood pressure, and/or fluid and electrolyte disturbances. Over the 25 years I have been practicing Nephrology, I have personally cared for hundreds of such patients.

A true and accurate copy of my full *curriculum vitae* is also enclosed as "Exhibit A" to further illuminate my professional qualifications.

I have testified as an expert on aspects relating to standard of care and/or causation at deposition and trials a number of times over the past decade; these have been both for the defense and plaintiff. A list of cases is attached as "Exhibit B."

II. Summary of Opinions

All opinions set forth in this report are within a reasonable degree of medical certainty and are based upon my education, training and experiences as a physician, and specifically relying on my practice of Nephrology over the past 25 years. I have reviewed in detail the medical records relating to the patient, Mr. Naguib Bechara; these have been complete and sufficient to render my opinion. The full list of materials I have reviewed are contained in the attached "Exhibit C." In addition, I reviewed depositions relating to the arbitration proceedings of Naguib Bechara and Nabila Saad versus Kaiser Foundation Health Plan, Inc., et al. (contained in the attached "Exhibit

D"). Moreover, I have reviewed relevant medical literature related to the use of Aprotinin in cardiac surgical patients (contained in the attached "Exhibit E"), as well as a number of general expert reports compiled for this action (contained in the attached "Exhibit F").

Mr. Bechara had significant underlying severe coronary artery disease, and presented December 21, 2004 with an acute myocardial infarction. He responded to aggressive treatment, including four-vessel coronary artery bypass surgery that evening with prompt restoration of cardiac function and no permanent cardiac effects. He received 2 million KIU units of Trasylol. Post-operatively he went from normal intrinsic renal function to dialysis-dependent renal failure. This renal failure was totally unexpected based upon the situation and medical events. Therefore, my conclusion within a reasonable degree of medical certainty is that the effects of Trasylol resulted in permanent renal injury and dialysis-dependence, the former of which he never recovered from.

III. Case synopsis

Mr. Bechara is an Egyptian male; in December 2004, he was 50 years old, 5'5", and 200 pounds (**215**) (giving calculated body surface area and body mass index of 2.04 m^2 and 33.3 kg/m^2, respectively). His past medical history was remarkable for asthma and hyperlipidemia. In the prior month (11/15/04), he underwent colonoscopy and was found to have four hyperplastic polyps but no evidence of cancer. He was on no medications. His cardiac risk factors consisted of hypercholesterolemia (e.g., LDL and HDL cholesterol 168 and 30 mg/dL, respectively), positive family history, and tobacco use (**11, 41, 111**).

His kidney function was normal, as evidenced by a measured serum creatinine of 1.0 mg/dL on 12/21/04 at 8 am (**25**) (estimated glomerular filtration rate (GFR) = 99 ml/min/2.04 m^2), normal urinalysis (12/23/04) (**295**), and normal renal ultrasound (12/27/04) (**488**).

On December 21, 2004 he presented with abrupt onset of chest pain to Kaiser Permanente Anaheim Medical Center. He was also exhibited non-sustained non-sustained ventricular tachycardia (**12, 111**). At 2 am, his troponin I was 0, which rose to 10.2 ng/mL at 8 am (**24**),

consistent with an acute myocardial infarction (MI). The electrocardiogram also showed evidence of an acute anteroseptal MI (12). At 12:10 pm he underwent emergent cardiac catheterization which showed high degree atherosclerotic coronary artery disease. An intraaortic balloon pump (IABP) was also placed (12). He was transfered to Kaiser Permanente Los Angeles Medical Center.

In the arbitration proceedings between Mr. Bechara and Kaiser Foundation Health Plan, there were some criticisms levied by the deponents towards several of the treating physicians at Kaiser Permanente Anaheim Medical Center; namely, Drs. Bond, Bartz, Pantagco and Rodriguez; as well as one unnamed nurse (**Nortman 35; Pelikan 17**). These criticisms revolved around delays in instituting "appropriate" diagnostics and therapy for what was felt by the deponents as clearly being a cardiac presentation (e.g., **Bond 14**), obtaining a "timely consult" (**Bond 35**), and transferring the patient to Kaiser Permanente Los Angeles Medical Center, given the distance involved (**Bond 47**). The cardiologist, Dr. Pelikan, did note in his deposition "it's hard to know" whether any delay from 3:10 - 10:00 am resulted in "Mr. Bechara suffer(ed) any injury to his heart" (**Pelikan 44-45**).

His blood pressures while at Anaheim Medical Center were recorded in the medical record, and discussed by the deponents. In response to the question "from his presentation to the emergency room to 6:00 am, do you see any time periods of hypotension," the answer was "no" (**Pelikan 74**). For the period "6:00 to Noon ... that was over 100 (systolic blood pressure) except for 6:30, where it was 96?" the answer was "yes" (**Pelikan 73**). In response to the question "do you have any blood pressures recorded between 12:43 and when he's in the ambulance,?" the answer was "right" with a further description of blood pressures that ranged as low as a transient 71/52, as well as "it then comes up over 100 for a couple of readings" (**Pelikan 72**).

During the 1 hour 14 minute transfer from Kaiser Permanente Anaheim Medical Center to Kaiser Permanente Los Angeles Medical Center(i.e., 5:13 - 6:27 pm), his blood pressures were frequently monitored (**AMR Southern California records**). Initially, the blood pressure was 86/46 (5:13 pm), but quickly rose to 140/94 (5:27 pm) and 136/80 (5:41 pm). Later it became lower once again, recorded as 88/42 (6:00 pm).

Thus, Mr. Bechara presented early in the morning of 12/21/04 to Kaiser Permanente Anaheim Medical Center, was found to have evidence for an acute myocardial infarction for which he received appropriate therapy, underwent diagnostic cardiac catheterization, and was transfered that afternoon to Los Angeles Medical Center. Although there were episodes of hypotension and occasional ventricular tachyarrhythmias, these were relatively circumscribed and not out of the ordinary for such a patient.

The evening of admission to Los Angeles Medical Center, he underwent coronary artery bypass surgery (12/21/04). He had four vessels bypassed (212). His total anesthesia time was 4 hours 20 minutes (6:40 - 11:00 pm); time of surgery, 3 hours 5 minutes (7:30 - 10:35 pm); cardiopulmonary bypass ("pump") time, 1 hour 12 minutes (8:15 - 9:27 pm); and aortic cross-clamp time, 43 minutes (8:17 - 9:00 pm) (215). Two hundred mL of Trasylol (2 Million KIU) was included in the cardiopulmonary bypass circulation (237). Thus, cardiac surgery was performed in a timely fashion, successfully, quickly, and with no complications. Although this was his first cardiac surgery, which, as anticipated, went uneventfully, he was exposed to Trasylol.

His preoperative cardiac index was 2.2 (L/min-m^2). On post-operative days 1, 2, and 3, it improved to 2.9, 3.2 and 3.4 , respectively (41-43). Thus, on the fourth post-operative day (12/25/04), his IABP was removed (45). The subsequent day (12/26/04), his cardiac index was 3.6 (46). A transthoracic echocardiogram on 12/28/04 was interpreted as showing, "overall left ventricular function appears to be preserved (537)." Consistent with this, a multigated acquisition (MUGA) scan showed a left ventricular ejection fraction of 55 percent (12). On 12/28/04, he underwent cardioversion for atrial flutter (53). His cardiac arrhythmias stabilized thereafter; in fact, on 1/14/05 he underwent electrophysiological studies which showed "no inducible sustained ventricular arrhythmias (541)." The conclusion of these events included, "Low cardiac output syndrome resolved (11)." Thus, he initially had left ventricular dysfunction and arrhythmias; these were reversed with prompt coronary artery bypass surgery.

Post-operatively he developed acute renal failure, as evidenced by serial measurements of serum creatinine (254-265). Figure 1 shows the derived estimated GFRs over time. The Nephrology

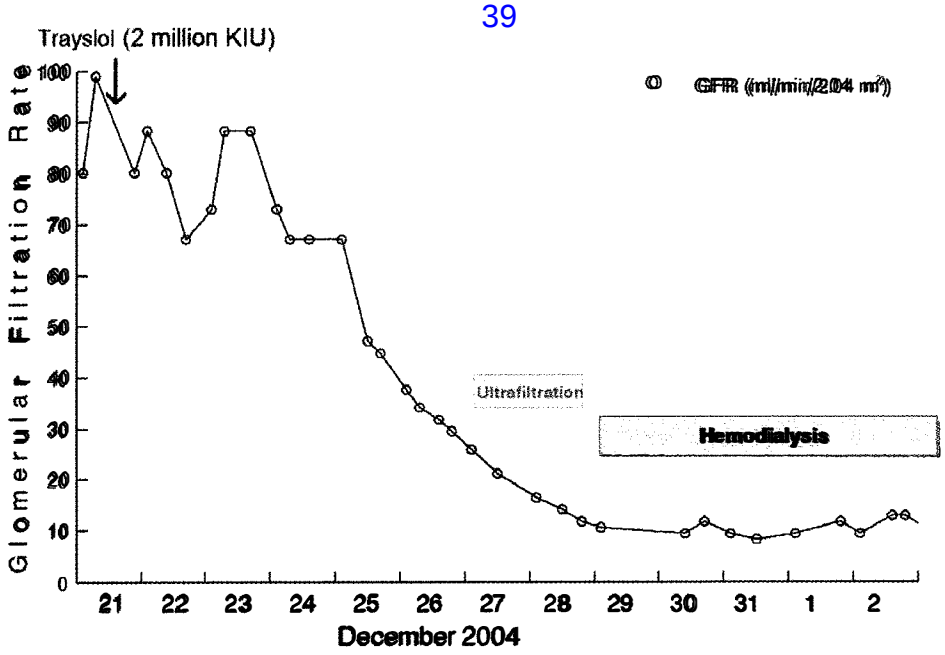

Figure 1. Estimated glomerular filtration rates over time early in hospitalization calculated from measured serum creatinine values.

consultant, Dr. Baudelio Herrada, commented on 12/27/04, this was "acute renal failure, likely secondary to poor forward flow leading to decreased perfusion of the kidneys, less likely ATN (acute tubular necrosis) due to prerenal cause or cholesterol emboli syndrome (**115**)."

Relevant data relating to differential diagnosis of acute kidney injury included: Urinary electrolytes - Sodium 44, Potassium 64, Chloride 78 mEq/l (12/27/04) (**296**); urine eosinophils - "RESULT: NONE SEEN" and "moderate WBC seen" (12/27/04) (**296**); C3 240 mg/dL; C4 92.3 mg/dL (12/27/04) (**312**); Urinalysis - "CASTS/LPF: NONE SEEN" (12/28/04) (**296**); Eosinophils - never greater than 4% of total WBCs (**241** and **244**). All of these were normal values. Moreover, they did not support the differential diagnoses raised by Dr. Herrada of "prerenal cause or cholesterol emboli syndrome." In addition, Dr. Herrada himself noted there was "no documented episode of hypotension, and the only significant event was the discontinuation of the balloon pump on 12/25;" and "he had 3,897 in, 2,228 out (ml of fluid intake and urine output)" (**114-116**). He received no angiotensin-converting enzyme inhibitors or aminoglycosides during this period. These objective data, taken together with the steadily improving cardiac outputs noted post-operatively, provide substantive evidence against the possibility raised of "poor forward flow leading to decreased perfusion of the kidneys." Specifically, there was no evidence for hypoperfusion (i.e., normal hemodynamics, considerable urine output, urine electrolytes showing substantial sodium) or interstitial nephritis/atheroemboli (urinalysis showing no eosinophils or casts). Parenthetically, Dr. Nortman

in his deposition stated the possibility of atheroemboli was "slight" (**Nortman 77**) and that "ischemic ATN (acute tubular necrosis) was the most likely cause" (**Nortman 81**).

He required renal replacement therapy as of the sixth post-operative day (12/27/04) (**1150**). For the first two days, he underwent ultrafiltration (**49, 52**); thereafter he underwent hemodialysis. These dialysis treatments were required daily from 12/29/04 - 1/4/05 (**1152-1158**), and then on 1/6, 7, 9, 10, 11, 13, 14, 16 and 18 (**1159-1167**); thus, he had a total of 18 renal replacement treatments during his hospitalization. For this, he required a left internal jugular dialysis catheter (placed 12/27/04) (**1150**), right subclavian vein dialysis catheter (placed 1/3/05) (**1157**), left subclavian vein dialysis catheter (placed 1/9/05) (**1161**), and a tunneled right internal jugular vein dialysis catheter (placed 1/18/05) (**235**). He was discharged on 1/18/05 to undergo continuous thrice weekly hemodialysis as an outpatient (**12, 109**), which continued over the year of 2005 until 12/17/05 (addressed further below).

Thus, he developed acute renal failure post-operatively in the setting of completely normal baseline renal function; based upon all the information available this *could not* be explained by conventional differential diagnoses of "poor forward flow leading to decreased perfusion of the kidneys ... ATN due to prerenal cause or cholesterol emboli syndrome." Essentially, there was an absence of traditional factors that would be expected to cause renal failure. This was of such a severe nature, that he had end-stage renal disease (ESRD) requiring renal replacement therapy for his entire hospitalization (and thereafter for one year).

Other medical problems while hospitalized at Los Angeles Medical Center included pulmonary, infectious, and central nervous system disease processes, as will be summarized.

Post-operatively, he had a prolonged mechanical ventilation requirement. Along with the clear evidence for hypervolemia and pulmonary edema, the potential diagnosis of ARDS (acute respiratory distress syndrome) was raised (**51**). He required increasing concentrations of inspired oxygen and positive end-expiratory pressures to maintain arterial oxygenation. With renal replacement therapies of ultrafiltration and hemodialysis his respiratory status improved, such that

he was able to be extubated on 1/10/05 (92). A complicating factor was the development of apparent aspiration pneumonia, which was successfully treated with antibiotics (11). Thus, his respiratory failure appeared to be multifactorial, and was contributed to by renal failure and consequent fluid overload.

His mental status was impaired early post-operatively, followed by a seizure (61-62). Work-up for this included a CT scan on 12/29/04 which showed "age-related atrophy (493)." A follow-up electroencephalogram showed no seizure focus. An important etiology for his altered mental status was uremic encephalopathy due to the concomitant renal failure.

He was discharged 1/18/05 on the following medications: Gemfibrozil and Lovastatin (for hyperlipidemia); Amiodarone (anti-arrhythmic); Fluoexitine (anti-depressive); aspirin; Nephro-Vite (vitamin supplement for ESRD patients); and, recombinant human erythropoeitin (hormonal replacement for ESRD patients) (13). It was stated by Dr. Satinder Sidhu: "The patient is ambulatory, with healing incisions. Awake, alert, free of overt congestive heart failure, and free of any acute problem except for hemodialysis, and he is entered in the hemodialysis program three times a week." (12).

Two days after discharge (1/20/05), he presented to Placenta Linda Hospital with chest pain. He was transferred to Kaiser Permanente Medical Center, Orange County (KFH-MD 14). His serum creatinine was 10.1 mg/dL (KFH-MD 15), consistent with end-stage kidney disease. He was found to have considerable fluid overload and pulmonary edema, and underwent hemodialysis on 1/20 and 1/21/05 with substantial fluid removal (3.8 liters the first treatment) (KFH-MD 9). There was no evidence for a myocardial infarction. An echocardiogram while fluid overloaded showed normal left ventricular size with moderately decreased systolic function (KFH-MD 86). He was discharged on 1/21/05 to begin outpatient thrice-weekly hemodialysis (KFH-MD 10) which began 1/24/05 (SSA-RD-Elkton 96). Overall, the presentation with fluid overload, pulmonary edema and congestive heart failure can be attributable to his end-stage renal disease, as particularly evidenced by the reversal with two dialysis treatments.

On 2/14/05, he presented to Kaiser Permanente Medical Center, Orange County, with shortness

of breath (KFH-MD 184). His work-up included a negative pulmonary angiogram which ruled-out pulmonary embolism. Overall, "it was felt that his shortness of breath was caused by fluid overload secondary to congestive heart failure/acute renal insufficiency" (KFH-MD 180). A measured creatinine clearance on 2/16/05 was 6.5 ml/min, consistent with end-stage kidney disease (24 hour urinary creatinine 537 mg, serum creatinine 5.7 mg/dL, KFH-MD 221). An echocardiogram on 2/17/05 showed normal chamber sizes and ventricular wall thicknesses; there was "mild to moderate global reduction of left ventricular systolic function" (KFH-MD 241). Attempts at diuresis had some success in achieving fluid removal, yet he required hemodialysis on 2/17/05 for fluid removal (KFH-MD 194), following which he was discharged (KFH-MD 181). An outpatient clinic note by the Nephrologist Dr. Patel on 2/19/05 stated "I have asked the patient to undergo hemodialysis today" (KFH-MD 195). Thus, he required a four day hospitalization because of congestive heart failure/pulmonary edema, which can be directly attributed to volume overload from his post-cardiac surgery renal failure.

On 6/10/05, he underwent creation of a left arm arteriovenous fistula at Kaiser Permanente Anaheim Medical Center (KFH-MD 332). This was because of the need for ongoing hemodialysis.

The medical records from Fresenius Medical Care Dialysis Service, South Orange County, detail an ongoing requirement for chronic hemodialysis; as noted above, this began after his discharge from Kaiser Permanente Medical Center, Orange County on 1/24/05. From these medical records, dialysis was able to be discontinued on 12/17/05. Thus, he required renal replacement therapy for the period from 12/27/04 to 12/17/05 for post-cardiac surgery renal failure.

Thereafter, while no longer dialysis-dependent, he had persistent chronic kidney disease as evidenced by serial measurements of serum creatinine over the subsequent four years at the Southern California Permanente Medical Group (SCPMG 50-52 and 989-990). These serum creatinine values (SCr, as mg/dL) are provided in tabular function below by date. Also shown is the estimated glomerular filtration rate (eGFR) calculated using the MDRD GFR calculator (accessible at http://www.kidney.org/professionals/KDOQI/gfr_calculator.cfm) corrected for the patient's body surface area (2.04 m^2).

Date	SCr	eGFR
9/13/2006	3.1	27
11/15/2006	2.9	28
12/15/2006	2.9	28
2/19/2007	2.9	28
4/12/2007	2.9	28
4/26/2007	2.6	33
6/30/2007	2.5	34
9/29/2007	2.6	33
1/16/2008	2.4	35
4/26/2008	2.3	38
8/1/2008	2.4	35
11/12/2008	2.5	34
2/4/2009	2.3	38
6/27/2009	2.0	44

His most recent serum creatinine is 2.0 mg/dL which corresponds to an eGFR of 44 ml/min/2.04 m^2. These data illustrate the presence of persistent severe (Stage 3-4) chronic kidney disease over these three years. Consistent with this is the presence of persistent secondary hyperparathyroidism (e.g., **SCPMG 990**) with its attendant effects on calcium/phosphorous/vitamin D metabolism and bone health. For example, even as recently as 2/5/09, his parathyroid hormone level was elevated at 109 pg/mL (**SCPMG 1030**).

The treating nephrologist Dr. Patel answered in the affirmative during her deposition to the following questions: "his kidney disease was considered to be end-stage?" and "is it no longer an expectation that his kidney will ever be normal again?" (**Patel 32**).

In February 2009, he had a stress echocardiogram (**SCPMG 1063**), in which "findings are consistent with prior apical myocardial infarction; no indication for further cardiovascular evaluation." Thus, he was largely stable from a cardiovascular standpoint, indicating successful coronary artery revascularization in December 2004.

On 5/2/07, he underwent a TURBT (transurethral blatter tumor) resection procedure at Kaiser Permanente Medical Center, Anaheim (**KFH-MD-364**) for low-grade noninvasive papillary

carcinoma (KPAMC-PD-2). Follow-up cystoscopy on 2/17/09 revealed only papillary urothelial hyperplasia with no evidence of carcinoma (SCPMG 1002).

Thus, Mr. Naguib Bechara presented December 21, 2004 with chest pain, and an acute myocardial infarction. His coronary artery disease was treated successfully by bypass surgery. Thereafter, he had a mild degree of left ventricular dysfunction attributable to the myocardial infarction occurring at this time.

At the time of coronary artery bypass grafting surgery he had normal renal function by *all* criteria. Although there were episodes of hypotension due to left ventricular dysfunction and occasional ventricular tachyarrhythmias, these were relatively mild and circumscribed and were reversed with prompt coronary artery bypass surgery. Despite this being uncomplicated surgery, and his having a relatively uneventful post-operative course, he developed acute kidney injury resulting in end-stage kidney disease (i.e., requiring renal replacement therapy) for one year post-operatively, and thereafter chronic (non-dialysis dependent) kidney disease of a moderately severe nature. There was an absence of traditional risk factors for the development of acute renal failure post-bypass surgery; this, taken together with the known risks of Aprotinin/Trasylol as a clear cause of acute renal failure, brings me to the conclusion that this severe renal injury was a direct consequence of the exposure of the patient to 2 million KIU of Trasylol during surgery.

IV. Adverse Effects

The development of renal failure brings with it significant morbidity and mortality. Since the outset of Medicare's End Stage Renal Disease Program in 1973, patient data relating to kidney disease have been compulsively compiled and thoroughly reviewed in the yearly U.S. Renal Data System Annual Reports.[1]

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[1]Here, the most recently available report, namely the USRDS 2008 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States (National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2008) will be referred to (accessible at http://www.usrds.org/adr.htm) .

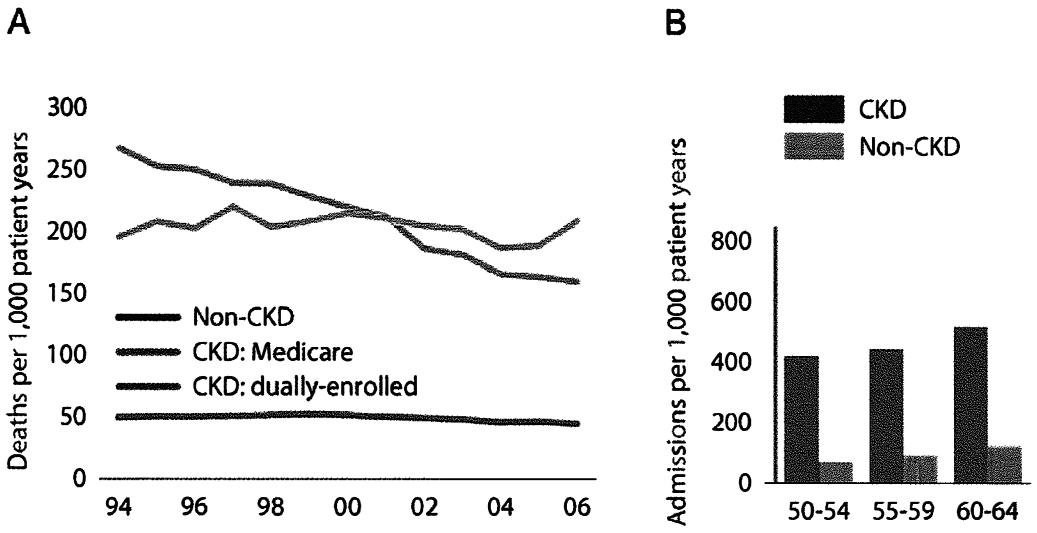

Figure 2. All cause mortality rates in Medicare (A) and hospitalization rates in Medstat (B) patients with or without chronic kidney disease.

The consequences of end-stage renal disease are disastrous. For instance, the life expectancy of a male aged 50-54 in the general US population as of 2004 was 29.2 years; contrasted is the life expectancy of a male aged 50-54 with end-stage renal disease on dialysis, which was 6.3 years (Table H.31, page 210). Thus, the development of end-stage renal disease results in a nearly 80 percent reduction in life span.

Not only is survival affected, there is a significant reduction in quality of life, partly attributable to the necessity to undergo the dialysis procedure three times weekly, but also related to feelings of ill being, and a number of comorbidities, often requiring hospitalization. Thus, it was no surprise that Mr. Bechara required hospitalization three times in 2005 - twice for fluid overload and once for creation of an arteriovenous fistula necessary for dialysis.

Patients with non-end stage chronic kidney disease are increasingly recognized as having excessive mortality and morbidity directly referable to the underlying kidney disease (i.e., not attributable to other underlying diseases). This can best be presented graphically (from the USRDS ADR, Volume 1, Atlas of Chronic Kidney Disease) which show a four-fold greater mortality rates (Figure 2A) and incidences of hospitalization (Figure 2B).

In fact, in the introduction to Chapter 3 on Morbidity and Mortality, it is stated "Data on cause-specific hospitalization rates illustrate the complexity of complications in the CKD population .... congestive heart failure, for instance, is a common complication of CKD - particularly in more advanced CKD stages - and related hospitalization rates are six times higher than in the non-CKD population. This discrepancy is even greater among patients with large employer group health plan (EGHP) coverage with CHF hospitalizations at least ten times greater for those with CKD than for those without. Rates of hospitalization for atherosclerotic heart disease are ... 3-4 times higher in the EGHP populations. Additional causes of hospitalization among CKD patients that occur at 2-5 times the rate seen in the non-CKD population include peripheral vascular disease, cerebrovascular accident/transient ischemic attack, acute myocardial infarction, and those associated with arrhythmia. Infectious complications have been noted in the CKD and dialysis populations secondary to multiple defects in the ability to kill bacteria. Pneumonia rates are ... up to six times greater in EGHP patients with CKD, compared to those without recognized kidney disease. Similar findings are noted in hospitalizations for bacteremia/septicemia and urinary tract infections, with rates in EGHP patients some 7-14 times higher than in the non-CKD group."

Thus, the development of chronic kidney disease in Mr. Bechara is a devastating consequence of Trasylol use during cardiac surgery, and has been associated with considerable morbidity to-date. His life expectancy has been reduced significantly, the coexisting medical problems affected negatively, and his quality of life substantially diminished.

Exhibit A
Curriculum Vitae
(Prepared September 11, 2009)

Personal Information

Name: Richard John Quigg, Jr., M.D.

Date & Place of Birth: [redacted] 1957
Euclid, Ohio

Family: Married to Patricia Anne Montgomery
Children, J[redacted] (1991), C[redacted] (1999)

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URL: nephrology.uchicago.edu

Education

Boston University Six-Year Medical program, B.A., Medical Sciences (Mathematics minor)	1975-1981
Boston University School of Medicine, M.D.	1977-1981

Postdoctoral Training

Resident in Internal Medicine, University Hospital, SUNY-Stony Brook	1981-1984
Clinical Fellow in Nephrology, Boston University Medical Center	1984-1985
Research Fellow in Nephrology, Boston University Medical Center	1985-1987

Appointments

Research Instructor in Medicine, Boston University School of Medicine	1987-1988
Assistant Professor of Medicine, Medical College of Virginia	1988-1994
Associate Professor of Medicine, The University of Chicago	1994-2001
Granted Tenure, The University of Chicago	1999
Chief, Section of Nephrology, The University of Chicago	1999-2009
Director, University of Chicago Functional Genomics Facility	2000-present
Professor of Medicine, The University of Chicago	2001-present

Medical Licensure

State of New York	1982
Commonwealth of Massachusetts	1984
Commonwealth of Virginia	1988
State of Illinois	1994

Certification

Diplomate, American Board of Internal Medicine	1984
Diplomate, American Board of Internal Medicine, Subspeciality in Nephrology	1986

Memberships in Professional Societies

Member, International Society of Nephrology	1986
Member, American Society of Nephrology	1986
Member, American Association for the Advancement of Science	1988
Member, National Kidney Foundation	1990
Member, American Association of Immunologists	1992
Member, American Heart Association, Council on the Kidney in Cardiovascular Disease	1993
Member, University of Chicago Cancer Research Center	2000
Member, American Society for Biochemistry and Molecular Biology	2002
Member, American Society for Clinical Investigation	2003

Honors and Awards

Boston University Six-Year Medical Program, Summa cum laude	1981
Research Fellowship Award, American Heart Association, Massachusetts Affiliate (declined)	1985
Individual National Research Service Award, National Institutes of Health	1986-1988
American Society of Nephrology Travel Award (to attend the Xth International Congress of Nephrology, London)	1987
First Independent Research Support Transition Award, National Institutes of Health	1989-1994
XIVth International Complement Workshop Travel Award (Cambridge, England)	1991
American Society of Nephrology Travel Award (to attend the XIIth International Congress of Nephrology, Jerusalem)	1993
XVth International Complement Workshop Travel Award (Kyoto, Japan)	1993
Falk Award of Excellence, Arthritis Foundation, Greater Chicago Chapter	1996-1997

University of Chicago Teaching

Lecturer, Clinical Pathophysiology	1995-present
Lecturer, Topics in Internal Medicine	1996-present
Core Director (glomerular diseases), Fellows' Lecture Series	1999-present
Program Director, University of Chicago Nephrology Fellowship Program	1999-2001
Morning Report, University of Chicago Internal Medicine Program	1999-present
Lecturer, Clinical Transition Series for MSTP Students	2000-present
Complement and hypersensitivity lectures (6), Pathology 308	2000-present
Systemic lupus erythematosus lecture, Immunopathology of disease	2005

Trainees (and Current Position)

Mitchel L. Galishoff, M.D., Nephrology practice	1991-1993
Jessy J. Alexander, Ph.D., Research Associate Professor, University of Chicago	1995-1998
Brigitte Schiller, M.D., Director of Research and Laboratory Services, Satellite Healthcare	1997-1998
Patrick Cunningham, M.D., Assistant Professor of Medicine, University of Chicago	1998-2001
Pierce Park, M.D., Hepatology Fellow, Univ. of Nebraska (Renal Fellow at John Hopkins)	1999-2001
Guohui Ren, M.D., Ph.D., Research Associate Professor, McGill University	1999-2003
Lihua Bao, M.D., Research Assistant Professor, University of Chicago	1999-2004
Mona Doshi, M.D., Assistant Professor of Medicine, Wayne State University	2000-2002
Satayanarayana Chekuri, M.D., Nephrology practice	2002-2004
OGB Aneziokoro, M.D., Nephrology practice	2002-2004
Tipu Puri, M.D., Ph.D., Assistant Professor of Medicine, University of Chicago	2003-2005
Menaka Karmegam, M.D., Fellow in Medicine, University of Chicago	2005-present

Committees

Program Committee, American Heart Association, Council on the Kidney in Cardiovascular Disease	1996-1999
Clinical Affairs Committee, Section of Nephrology, The University of Chicago, Acting Chairman (1998)	1996-1999
Department of Medicine Search Committee, Chairman of Medicine, The University of Chicago	1998
Institutional Animal Care and Use Committee, The University of Chicago	1998-2000
Councilor, Central Society for Clinical Research	1999
American Society of Nephrology 2004 Annual Meeting Program Committee	2003-2004
NIDDK Glomerular Disease Workshop Planning Committee	2004-2005
American Society of Nephrology Basic Science Committee	2004-2010

Editorial Boards

Kidney International	1997-present
Clinical and Experimental Nephrology	2003-present
Clinical and Translational Science	2007-present

Other Professional Experience

Ad hoc reviewer, VA Merit Review	1989-1996
American Society of Nephrology 23rd and 34th Annual Meetings	1990 & 2001
Chairman, Basic/Experimental Immunology Abstract Review Subcomittee, American Society of Nephrology 25th Annual Meeting	1992
American Heart Association, Cardiorenal Physiology/Pathophysiology, Abstract Reviewer	1998-2000
National Kidney Foundation, Illinois Chapter, Grant-in-aid Reviewer	1998-2002
Ad Hoc Reviewer, NIDDK Special Emphasis Panels (P01 Site Visits)	1998-2004
Ad Hoc Reviewer, NIH General Medicine B Study Section (Ended)	2000
NIH Pathology A Study Section (Ended)	2000-2003
Chairman, "Management of Glomerulonephritis: Frequently Asked Questions," 2001 ASN/ISN World Congress of Nephrology	2001
National Kidney Foundation Basic Science Study Section	2003-2005
Chairman, "Genetic Kidney Diseases," National Kidney Foundation Clinical Meetings	2004
Member, NIDDK D-Subcommittee	2004-2008
Ad Hoc Reviewer, Pathobiology of Kidney Disease Study Section	2007
Reviewer, George M. O'Brien Kidney Research Center Program (Current Section Chair)	1996 & 2008
Member, NIDDK F-Series Review Committee	2009-2012

Invited Lectures (2000 to Present)

Medical Grand Rounds, Loyola University, February 29, 2000, "Role of ANCA and Other Autoantibodies in Renal Disease"
Invited Speaker, American Association of Immunologists Annual Meeting, May 14, 2000, "Use of Complement Activation Inhibitors in the Treatment of Autoimmune Diseases"
Chicago Nephrology Day, June 1, 2000, "Applying Microarray Technology to Renal Disease"
The University of Chicago Clinical Research Training Program, February 20, 2001, "The Design and Analysis of Clinical Investigations"
Medical Grand Rounds, The University of Illinois at Chicago, February 22, 2001, "Diagnostic and Therapeutic Considerations in Rapidly Progressive Glomerulonephritis"
Visiting Professor, February 26-27, 2001, Medical University of South Carolina
Invited Speaker, NIH Conference "Targets for New Therapeutics in Systemic Lupus Erythematosus," January 12, 2002, "Treatment of SLE by Inhibition of Complement Activation"
Department of Pathology Seminar Series, The University of Chicago, January 24, 2002, "Renal Ischemia Reperfusion Injury - Old and New Ways to Approach the Question"
Medical Grand Rounds, The University of Chicago, March 12, 2002, "Diabetic Renal Disease"
Association of Medical Laboratory Immunologists 15th Annual Meeting, August 26, 2002, Plenary Session, "The Use of Microarrays in Experimental and Diagnostic Pathology"
Chairperson, American Heart Association 75th Annual Meeting, November 17, 2002, Plenary Session, "The Use of Functional Genomics in Cardiovascular Sciences"
Invited Speaker, The 7th Research Forum on Progressive Renal Diseases, Nagoya, Japan, February 8, 2003, "Use of Contemporary Molecular Biological Tools to Dissect the Pathogenesis of Experimental Renal Diseases"
Visiting Professor, University of Pennsylvania, April 21-22, 2003
Invited Speaker, World Congress of Nephrology Satellite Symposium, Kloster Seeon, Germany, June 13, 2003, "The Role of the Complement System in Renal Disease"
Visiting Speaker, Guy's and St. Thomas Hospital, Hammersmith Hospital and University of Wales College of Medicine, United Kingdom, December 16-19, 2003, "Role of the Complement System in Experimental Systemic Lupus Erythematosus"
Speaker, Peruvian Society of Nephrology, February 26, 2004, " Lupus Nephritis - Observations from the Experimental Animal and Potential Treatment Options in Clinical Disease"
Visiting Professor, Boston University Medical Center, April 26-27, 2004
Invited Speaker, National Kidney Foundation Meetings, April 28, 2004, "Career Choices in Nephrology"
Visiting Professor, UT Southwestern Medical Center at Dallas Excellence in Immunology Lecture Series, December 1, 2004, "Role of Complement in Experimental Systemic Lupus Erythematosus"
Medical Grand Rounds, The University of Chicago, May 17, 2005, "Is the Movie GATACA Science Fiction?"
Invited Speaker, 42nd Japan Complement Symposium, Nagoya, Japan, August 19-20, 2005
Invited Speaker, American Society of Nephrology Annual Meeting, November 10, 2005, "Complement Activation and Tubulointerstitial Nephritis"
Visiting Professor, Indiana University Medical Center, January 11-12, 2006
Visiting Professor, Tri-Service General Hospital, Taipei, Taiwan, Republic of China, June 18-23, 2006
Visiting Professor, SUNY-Upstate Medical Center, September 21, 2006
Invited Speaker, American Society of Nephrology Annual Meeting, November 16, 2006, "Regulation of Experimental Autoimmune Nephritis by C3a and C5a"
Visiting Professor, New York University School of Medicine, December 18, 2006
Invited Speaker, World Congress of Nephrology, Rio de Janeiro, Vascular Biology Symposium, "Why the Interaction of Factor H with the Glomerular Endothelium is So Important," April 21, 2007
Medical Grand Rounds, The University of Chicago, October 16, 2007, "The End-Stage Renal Disease That Went Away - Case Reports of Wegener's Granulomatosis and 1° Anti-Phospholipid Syndrome"
Invited Speaker, American Society of Nephrology Annual Meeting, November 4, 2007, "Complement Activation in Membranous Nephropathy: Can We Intervene Therapeutically"
Visiting Professor, Mt. Sinai School of Medicine, December 14, 2007, "What Does the Mouse Have To Do With Translational Research in Nephrology?"
Invited Speaker, American Society of Nephrology Annual Meeting, November 6, 2008, "Inhibiting Complement Activation: Therapeutic Potential and Pitfalls?"

Main Research Support (as Principal Investigator; Total Direct Costs Listed)

Past

National Institutes of Health, R29 DK41873, "Complement Activation on the Glomerular Epithelial Cell," $350,000	1989-1994
National Kidney Foundation of Virginia, Research Grant, "Complement Activation on the Glomerular Epithelial Cell," $20,000	1992-1993
American Heart Association, National Center, Grant-in-Aid, "Abnormal Complement Regulation in Glomerulonephritis," $120,000	1993-1996
National Institutes of Health, R01 DK41873, "Abnormal Complement Regulation in Glomerulonephritis," $492,081	1994-1998
Arthritis Foundation, Greater Chicago Chapter, Biomedical Sciences Grant, "Isolation and Characterization of Rodent Immune Adherence Receptors," $20,000	1996-1997
National Kidney Foundation, Grant-in-Aid, "Effects of Complement Inhibition in Glomerulonephritis," $20,000	1997-1998
Arthritis Foundation, Greater Chicago Chapter, Biomedical Sciences Grant, "Effects of Complement Inhibition in Experimental Rheumatoid Arthritis," $60,000	1998-2000
National Institutes of Health, R01 DK41873, "Role of the Complement System in Glomerulonephritis," $656,167	1998-2002
Alexion Pharmaceuticals, "Use of Monclonal Anti-C5 Antibodies in Idiopathic Membranous Nephropathy," $12,674	1999-2002
Arthritis Foundation, Biomedical Sciences Grant, "Effects of Complement Inhibition in Experimental Systemic Lupus Erythematosus," $250,000	1999-2002
National Institutes of Health, R01 DK55357, "Pathogenic Role of the Complement System in Murine Lupus," $684,125	1999-2003
National Institutes of Health, Administrative Supplement for Gene Profiling Resources, R01 DK55357, $35,000	2000-2001
National Institutes of Health, R21 DK57684, "Genetic and Pathologic Alterations in Murine Diabetes," $200,000	2000-2002
American Heart Association, Midwest Affiliate, Grant-in-Aid, "Endothelial Cell Targeting of Complement and Selectin Inhibitors in Ischemia-Reperfusion Injury," $110,000	2000-2002
National Institutes of Health, Administrative Supplement for the Study of Type I Diabetes Gene Targets, U24 DK58820, $33,113	2001-2002
National Institutes of Health, Autoimmunity Center of Excellence, U19AI46374-02, "Anti-C5 Therapy of Lupus Nephritis," $589,781	2001-2004
National Institutes of Health, NIDDK Biotechnology Centers, U24 DK58820, "Massively Parallel DNA Analysis," $1,030,719	2001-2004
GeneLogic, "Gene Changes in the Kidneys and Blood Cells of Patients with Active Lupus Nephritis and the Response of These to Successful Treatment," $512,966	2002-2004
Antisense Therapeutics, "Evaluation of Antisense Therapies in MRL/lpr Mice, A Spontaneous Model of Lupus," $180,058	2004-2005
National Institutes of Health, R01 DK41873, "Role of the Complement System in Glomerulonephritis," $816,253	2002-2006
Juvenile Diabetes Research Foundation, Innovation Grant, "Role of Epigenetic Alterations in Diabetic Nepropathy," $100,000	2006-2007

Current (*with Priority Score of most recent competitive application*)

National Institutes of Health, R01 DK55357-06, "Pathogenic Role of the Complement System in Murine Lupus," $1,175,000 (*PS = 152*)	2005-2010
National Institutes of Health, R21 DK74012-02, "Targeting Complement Inhibitors to the Proximal Tubule," $275,000 (*PS = 152*)	2006-2008
National Institutes of Health, R01 DK41873-20, "Role of the Complement System in Renal Disease, $1,062,500 (*PS = 132*)	2007-2012
National Institutes of Health, T32 DK07510-20, "Nephrology Research Training," $1,020,000 (*PS = 126*)	2008-2013

Publications 1983-1991

1. Graber, M.L., **R.J. Quigg**, W.E. Stempsey, and S. Weis. 1983. Spurious hyperchloremia and decreased anion gap in hyperlipidemia. *Ann. Intern. Med.* 98:607-609.
2. Weinberg, M.S., **R. Quigg**, and R.L. Krane. 1983. Retroperitoneal bleeding: hidden culprit of acute renal failure. *Urology* 21:291-294.
3. Weinberg, M.S., **R.J. Quigg**, D.J. Salant, and D.B. Bernard. 1985. Anuric renal failure precipitated by indomethacin and triamterene. *Nephron* 40:216-218.
4. **Quigg, R.J., Jr.**, B.A. Idelson, D.C. Yoburn, J.L. Hymes, E.C. Schick, and D.B. Bernard. 1985. Local steroids in dialysis-associated pericardial effusion. A single intrapericardial administration of triamcinolone. *Arch. Intern. Med.* 145:2249-2250.
5. Cybulsky, A.V., **R.J. Quigg**, and D.J. Salant. 1986. The membrane attack complex in complement-mediated glomerular epithelial cell injury: Formation and stability of C5b-9 and C5b-7 in rat membranous nephropathy. *J. Immunol.* 137:1511-1516.
6. **Quigg, R.J., Jr.**, B.A. Idelson, A. Greenfield, R.K. Babayan, F.W. LoGerfo, and D.B. Bernard. 1986. Transplant ureteral obstruction masquerading as recurrent rejection episodes: management by percutaneous antegrade balloon dilatation. *Am. J. Kidney Dis.* 8:67-70.
7. Cybulsky, A.V., W. Lieberthal, **R.J. Quigg**, H.G. Rennke, and D.J. Salant. 1987. A role for thromboxane in complement-mediated glomerular injury. *Am. J. Pathol.* 128:45-51.
8. Cybulsky, A.V., **R.J. Quigg**, J. Badalamenti, and D.J. Salant. 1987. Anti-Fx1A induces association of Heymann nephritis antigens with microfilaments of cultured glomerular visceral epithelial cells. *Am. J. Pathol.* 129:373-384.
9. Cybulsky, A.V., **R.J. Quigg**, and D.J. Salant. 1988. Role of the complement membrane attack complex in glomerular injury. *In* Contemporary Issues in Nephrology. Immunopathology of Renal Disease. C.B. Wilson, B.M. Brenner, and J.H. Stein, editors. Churchill Livingstone, New York. 57-86.
10. Salant, D.J., A.V. Cybulsky, **R.J. Quigg**, and J. Badalamenti. 1988. The membrane attack complex of complement. *In* Nephrology: Proceedings of the Xth International Congress of Nephrology. A.M. Davison, editor. Bailliere Tindall, London. 481-494.
11. **Quigg, R.J.**, A.V. Cybulsky, J.B. Jacobs, and D.J. Salant. 1988. Anti-Fx1A produces complement-dependent cytotoxicity of glomerular epithelial cells. *Kidney Int.* 34:43-52.
12. **Quigg, R.J.**, D.R. Abrahamson, A.V. Cybulsky, J. Badalamenti, A.W.M. Minto, and D.J. Salant. 1989. Studies with antibodies to cultured rat glomerular epithelial cells: Subepithelial immune deposit formation after in vivo injection. *Am. J. Pathol.* 134:1125-1133.
13. Cybulsky, A.V., D.J. Salant, **R.J. Quigg**, J. Badalamenti, and J.V. Bonventre. 1989. Complement C5b-9 complex activates phospholipases in glomerular epithelial cells. *Am. J. Physiol. Renal,Fluid Electrolyte Physiol.* 257:F826-F836.
14. **Quigg, R.J.**, A. Nicholson-Weller, A.V. Cybulsky, J. Badalamenti, and D.J. Salant. 1989. Decay accelerating factor regulates complement activation on glomerular epithelial cells. *J. Immunol.* 142:877-882.
15. Salant, D.J., **R.J. Quigg**, and A.V. Cybulsky. 1989. Heymann nephritis: Mechanisms of renal injury. *Kidney Int.* 35:976-984.
16. Cybulsky, A.V., J.V. Bonventre, **R.J. Quigg**, L.S. Wolfe, and D.J. Salant. 1990. Extracellular matrix regulates proliferation and phospholipid turnover in glomerular epithelial cells. *Am. J. Physiol. Renal,Fluid Electrolyte Physiol.* 259:F326-F337.
17. Cybulsky, A.V., J.V. Bonventre, **R.J. Quigg**, W. Lieberthal, and D.J. Salant. 1990. Cytosolic calcium and protein kinase C reduce complement-mediated glomerular epithelial injury. *Kidney Int.* 38:803-811.
18. **Quigg, R.J.**, R. Gaines, P.E. Wakely, Jr., and A.C. Schoolwerth. 1991. Acute glomerulonephritis in a patient with Rocky Mountain spotted fever. *Am. J. Kidney Dis.* 17:339-342.
19. **Quigg, R.J.**, A.V. Cybulsky, and D.J. Salant. 1991. Effect of nephritogenic antibody on complement regulation in cultured rat glomerular epithelial cells. *J. Immunol.* 147:838-845.
20. **Quigg, R.J.** 1991. Glomerular injury induced by antibody and complement. *Sem. Nephrol.* 11:259-267.
21. **Quigg, R.J.** 1991. Isolation of a novel complement regulatory factor (GCRF) from glomerular epithelial cells. *Kidney Int.* 40:668-676.

Publications 1992-1999

22. **Quigg, R.J.** 1992. Inhibition of the alternative pathway of complement by glomerular chondroitin sulphate proteoglycan. *Immunology* 76:373-377.
23. **Quigg, R.J.**, M.L. Galishoff, A.E. Sneed, and D. Kim. 1993. Isolation and characterization of complement receptor type 1 (CR1) from rat glomerular epithelial cells. *Kidney Int.* 43:730-736.
24. **Quigg, R.J.** and A.E. Sneed. 1994. Molecular characterization of rat glomerular epithelial cell complement receptors. *J. Am. Soc. Nephrol.* 4:1900-1908.
25. **Quigg, R.J.** and V.M. Holers. 1995. Characterization of rat complement receptors and regulatory proteins. CR2 and Crry are conserved, and the C3b receptor of neutrophils and platelets is distinct from CR1. *J. Immunol.* 155:1481-1488.
26. **Quigg, R.J.**, B.P. Morgan, V.M. Holers, S. Adler, A.E. Sneed, and C.F. Lo. 1995. Complement regulation in the rat glomerulus: Crry and CD59 regulate complement in glomerular mesangial and endothelial cells. *Kidney Int.* 48:412-421.
27. **Quigg, R.J.**, V.M. Holers, B.P. Morgan, and A.E. Sneed. 1995. Crry and CD59 regulate complement in rat glomerular epithelial cells and are inhibited by the nephritogenic antibody of passive Heymann nephritis. *J. Immunol.* 154:3437-3443.
28. **Quigg, R.J.**, C.F. Lo, J.J. Alexander, A.E. Sneed, and G. Moxley. 1995. Molecular characterization of rat Crry: widespread distribution of two alternative forms of Crry mRNA. *Immunogenetics* 42:362-367.
29. **Quigg, R.J.**, M. Brathwaite, D.F. Gardner, D.R. Gretch, and S. Ruddy. 1995. Successful cyclophosphamide treatment of cryoglobulinemic membranoproliferative glomerulonephritis associated with hepatitis C virus infection. *Am. J. Kidney Dis.* 25:798-800.
30. Takahashi, K., Y. Kozono, T.J. Waldschmidt, D. Berthiaume, **R.J. Quigg**, A. Baron, and V.M. Holers. 1997. Mouse complement receptors type 1 (CR1, CD35) and 2 (CR2, CD21). Expression on normal B cell subpopulations and decreased levels during the development of autoimmunity in MRL/*lpr* mice. *J. Immunol.* 159:1557-1569.
31. He, C., J.J. Alexander, A. Lim, and **R.J. Quigg**. 1997. Production of the rat complement regulator, Crry, as an active soluble protein in *Pichia pastoris*. *Arch. Biochem. Biophys.* 341:347-352.
32. **Quigg, R.J.**, J.J. Alexander, C.F. Lo, A. Lim, C. He, and V.M. Holers. 1997. Characterization of C3-binding proteins on mouse neutrophils and platelets. *J. Immunol.* 159:2438-2444.
33. Nangaku, M., **R.J. Quigg**, S.J. Shankland, N. Okada, R.J. Johnson, and W.G. Couser. 1997. Overexpression of Crry protects mesangial cells from complement- mediated injury. *J. Am. Soc. Nephrol.* 8:223-233.
34. Alexander, J.J., C. He, S. Adler, V.M. Holers, and **R.J. Quigg**. 1997. Characterization of C3 receptors on cultured rat glomerular endothelial cells. *Kidney Int.* 51:1124-1132.
35. **Quigg, R.J.**, A. Lim, M. Haas, J.J. Alexander, C. He, and M.C. Carroll. 1998. Immune complex glomerulonephritis in C4- and C3-deficient mice. *Kidney Int.* 53:320-330.
36. **Quigg, R.J.**, C. He, A. Lim, D. Berthiaume, J.J. Alexander, D. Kraus, and V.M. Holers. 1998. Transgenic mice overexpressing the complement inhibitor Crry as a soluble protein are protected from antibody-induced glomerular injury. *J. Exp. Med.* 188:1321-1331.
37. Schiller, B., C. He, D.J. Salant, A. Lim, J.J. Alexander, and **R.J. Quigg**. 1998. Inhibition of complement regulation is key to the pathogenesis of Heymann nephritis. *J. Exp. Med.* 188:1353-1358.
38. **Quigg, R.J.**, Y. Kozono, D. Berthiaume, A. Lim, D.J. Salant, A. Weinfeld, P. Griffin, E. Kremmer, and V.M. Holers. 1998. Blockade of antibody-induced glomerulonephritis with Crry-Ig, a soluble murine complement inhibitor. *J. Immunol.* 160:4553-4560.
39. Van Dixhoorn, M.G., D. Salazar-Exaire, T. Sato, M.R. Daha, **R.J. Quigg**, J.A. Bruijn, W.G. Couser, and E. De Heer. 1998. Anti-vitronectin antibodies enhance anti-Thy-1-induced proteinuria in PVG/c, but not in Wistar rats. *J. Am. Soc. Nephrol.* 9:994-1007.
40. Alexander, J.J., A. Lim, C. He, R.L. MacDonald, V.M. Holers, and **R.J. Quigg**. 1999. Renal, central nervous system and pancreatic overexpression of recombinant soluble Crry in transgenic mice. A novel means of protection from complement-mediated injury. *Immunopharm.* 42:245-254.
41. **Quigg, R.J.** 1999. We should inhibit complement in glomerular proteinuria. *Kidney Int.* 56:2314-2315.

Publications 2000-2001

42. **Quigg, R.J.**, C. He, B.K. Hack, J.J. Alexander, and B.P. Morgan. 2000. Production and functional analysis of rat CD59 and chimeric CD59-Crry as active soluble proteins in *Pichia Pastoris*. *Immunology* 99:46-53.
43. **Quigg, R.J.** 2000. Modulation of disease using recombinant human endogenous complement inhibitors. *In* Therapeutic Interventions in the Complement System. J.D. Lambris and V.M. Holers, editors. The Humana Press, Totowa, N.J. 155-170.
44. Cybulsky, A.V., M.H. Foster, **R.J. Quigg**, and D.J. Salant. 2000. Immunologic mechanisms of glomerular disease. *In* The Kidney: Physiology and Pathophysiology. D.W. Seldin and G. Giebisch, editors. Lippincott-Raven, Philadelphia. 2645-2697.
45. Cunningham, P.N., V.M. Holers, J.J. Alexander, J.M. Guthridge, M.C. Carroll, and **R.J. Quigg**. 2000. Complement is activated in kidney by endotoxin but does not cause the ensuing acute renal failure. *Kidney Int.* 58:1580-1587.
46. Schiller, B., P.N. Cunningham, J.J. Alexander, L. Bao, V.M. Holers, and **R.J. Quigg**. 2001. Expression of a soluble complement inhibitor protects transgenic mice from antibody-induced acute renal failure. *J. Am. Soc. Nephrol.* 12:71-79.
47. Cunningham, P.N., B.K. Hack, G. Ren, A.W.M. Minto, B.P. **Morgan**, and **R.J. Quigg**. 2001. Glomerular complement regulation is overwhelmed in passive Heymann nephritis. *Kidney. Int.* 60:900-909.
48. Park, P., M. Haas, P.N. Cunningham, J.J. Alexander, L. Bao, J.M. Guthridge, D.M. Kraus, V.M. Holers, and **R.J. Quigg**. 2001. Inhibiting the complement system does not reduce injury in renal ischemia reperfusion. *J. Am. Soc. Nephrol.* 12:1383-1390.
49. Alexander, J.J., B.K. Hack, P.N. Cunningham, and **R.J. Quigg.** 2001. A protein with characteristics of factor H is present on rodent platelets and functions as the immune adherence receptor. *J. Biol. Chem.* 276:32129-32135.

Publications 2002

50. Bao, L., M. Haas, S.A. Boackle, D.M. Kraus, P.N. Cunningham, P. Park, J.J. Alexander, R.A. Anderson, C. Culhane, V.M. Holers, and **R.J. Quigg**. 2002. Transgenic expression of a soluble complement inhibitor protects against renal disease and promotes survival in MRL/*lpr* mice. *J. Immunol.* 168:3601-3607.
51. **Quigg, R.J.** 2002. Use of complement inhibitors in tissue injury. *Trends. Mol. Med.* 8:430-436.
52. **Quigg, R.J.** 2002. Role of complement and complement regulatory proteins in glomerulonephritis. *Springer Sem Immunopathol* 24:412-428.
53. Sogabe, H., **R.J. Quigg**, N. Okada, T. Miyata, R. Inagi, K. Kurowaka, T. Fujita, and M. Nangaku. 2002. Gene therapy for a model of renal injury using an adenovirus vector encoding the soluble rat Crry gene. *Clin. Exp. Nephrol.* 6:216-223.
54. Park, P., M. Haas, P.N. Cunningham, L. Bao, J.J. Alexander, and **R.J. Quigg**. 2002. Injury in renal ischemia-reperfusion is independent from immunoglobulins and T lymphocytes. *Am. J. Physiol Renal Physiol* 282:F352-F357.
55. Ren, G., B.K. Hack, A.W. Minto, P.N. Cunningham, J.J. Alexander, M. Haas, and **R.J. Quigg**. 2002. A complement-dependent model of thrombotic thrombocytopenic purpura induced by antibodies reactive with endothelial cells. *Clin. Immunol.* 103:43-53.
56. Wyss-Coray, T., F. Yan, A.H. Lin, J.D. Lambris, J.J. Alexander, **R.J. Quigg**, and E. Masliah. 2002. Prominent neurodegeneration and increased plaque formation in complement-inhibited Alzheimer's mice. *Proc. Natl. Acad. Sci. U. S. A*10837-10842.
57. **Quigg, R.J.** 2002. Use of complement inhibitors in tissue injury. *Trends Mol. Med.* 8:430-436.
58. Bao, L., O.B. Spiller, J.P. St, M. Haas, B.K. Hack, G. Ren, P.N. Cunningham, M. Doshi, D.R. Abrahamson, B.P. Morgan, and **R.J. Quigg**. 2002. Decay-accelerating factor expression in the rat kidney is restricted to the apical surface of podocytes. *Kidney Int.* 62:2010-2021.
59. Alexander, J.J., A.K. Saxena, L. Bao, A. Jacob, M. Haas, and **R.J. Quigg**. 2002. Prominent renal expression of a murine leukemia retrovirus in experimental systemic lupus erythematosus. *J. Am. Soc. Nephrol.* 13:2869-2877.
60. Ghosh, S., D. Sica, A.C. Schoolwerth, **R.J. Quigg**, M. Haas, I. Fakhry, and T.W. Gehr. 2002. The role of the renin-angiotensin system in cholesterol and puromycin mediated renal injury. *Am. J. Med. Sci.* 324:296-304.
61. Cunningham, P.N., H.M. Dyanov, P. Park, J. Wang, K.A. Newell, and **R.J. Quigg**. 2002. Acute renal failure in endotoxemia is caused by TNF acting directly on TNF receptor-1 in kidney. *J. Immunol.* 168:5817-5823.
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Publications 2003-2004

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Patents/Computer Programs

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2. Scott, R., Wright, S. J., Kurtz, S. A., Clark, T., Dyanov, C., and **R. Quigg.** Method for determining biological expression levels by linear programming. US Patent Number 7,031,845 issued April 18, 2006.
3. Wang, Q., Li, X., and **R.J. Quigg.** MicroRNA 377 as therapeutic target in diabetic nephropathy. Provisional filing August 18, 2008. UCHI 21117.0016U1

Exhibit B
Testimony at Trial or Deposition (Richard J. Quigg, Jr., M.D.) 2005-2009

Case:	Campillo v. Mercola, et al.
Court:	Cook County, Chicago, Illinois
Retained by:	Plaintiff
Attorney:	Miner, Barnhill & Galland (Paul Strauss)
Deposition date:	10/19/04
Trial date:	7/11/05

Case:	Renee Hurley-Lacy v. Illinois Masonic Medical Center, et al.
Court:	Cook County, Chicago, Illinois
Retained by:	Defendant
Attorney:	Johnson and Bell (Brian C. Fetzer)
Deposition date:	4/27/05

Case:	Ann G. Willis v. Jewish Hospital, et al.
Court:	Court, Louisville, Kentucky
Retained by:	Defendant
Attorney:	Weber & Rose (Karen L. Keith)
Deposition date:	5/4/05

Case:	Sweat v. Levy
Court:	Circuit Court of Broward County, Florida
Retained by:	Defendant
Attorney:	Wicker, Smith (Steven Y. Leinicke)
Deposition date:	5/4/05

Case:	Saia v. Arango
Court:	Circuit Court of Pinellas County, Florida
Retained by:	Defendant
Attorney:	Wicker, Smith (Kevin K. Chase)
Deposition date:	9/13/05 and 10/14/05
Trial date:	10/21/05

Case:	McKinley v. Hermida, et al.
Court:	Circuit Court of Fort Broward County, Florida
Retained by:	Defendant
Attorney:	Wicker, Smith (Linda McCullough)
Trial date:	11/28/05

Case:	Townsend v. Total Renal Care, et al.
Court:	Circuit Court of Cook County, Illinois
Retained by:	Plantiff
Attorney:	Richard L. Berdelle, Jr., P.C.
Deposition date:	6/10/06

Case:	Charity Buchanan v. Steen Mortensen, M.D.
Court:	District Court of Sedgwick County, Kansas
Retained by:	Defendant
Attorney:	Foulston Siefkin (Holly A. Dyer)
Deposition date:	7/20/06
Trial date:	10/20/06

Case:	Leonard L. Kulisek v. Walgreens
Court:	Circuit Court of Cook County, Illinois
Retained by:	Defendant
Attorney:	Johnson and Bell (Michael Holy and Thomas Andrews)
Deposition date:	7/21/06
Trial date:	10/28/06

Case:	Burdick v. Eduardo Meza, M.D., Richard E. Field, M.D. and Ob-Gyn Assoc.
Court:	Circuit Court of the 17th Judicial County of Winnegago, Illinois
Retained by:	Plaintiff
Attorney:	Law Offices of Patrick J. Kenneally, Ltd. (Robert F. Geimer)
Deposition date:	10/11/06
Trial date:	2/15/07

Case:	Duke v. Neomedica Dialysis Centers and Mohamad Barakat, M.D.
Court:	Circuit Court of Cook County, Illinois
Retained by:	Plaintiff
Attorney:	Raymond & Raymond, Ltd. (Clark Raymond)
Deposition date:	10/30/06

Case:	Russel Darbon (administrator for Virginia Gettys) v. Dr. José Diaz
Court:	Circuit Court, Third Judicial Circuit, Madison County, Illinois
Retained by:	Defendant
Attorney:	Neville, Richards, & Wuller, L.L.C. (Tim Richards)
Deposition date:	8/28/07
Trial Date:	4/28/09

Case:	Spencer v. Zikos, et al
Court:	Circuit Court of Cook County, Illinois
Retained by:	Plaintiff
Attorney:	Malkinson and Halperin (John Malkinson)
Deposition Date:	10/3/07

Case:	Divito/Schnell v. Pillsbury et al.
Court:	Circuit Court of Cook County, Illinois
Retained by:	Plaintiff
Attorney:	Kralovec, Jambois, & Schwartz (Michael Shinsky)
Deposition date:	1/29/08

Case:	**Prather vs. Barnes Jewish Hospital, et al.**
Court:	**St. Louis, Missouri**
Retained by:	**Defendant**
Attorney:	**Teresa Bartosiak**
Deposition Date:	**6/3/08**

Case:	**Fogarty vs. LeBeau/Waste Management, et al.**
Court:	**Circuit Court of Cook County, Illinois**
Retained by:	**Defendant**
Attorney:	**Johnson and Bell (Attorney Conforti)**
Deposition Date:	**6/12/08**

Case:	Hanson v. Condell Medical Center, et al.
Court:	Circuit Court of Winnebago County, Illinois
Retained by:	Plaintiff
Attorney:	Blaizer, Kolar and Lewis (Joe Kolar)
Deposition Date:	7/15/08
Trial Date:	8/28/09

Exhibit C
Medical Records Reviewed

Provider	Bates identifier	Total pages
Kaiser Permanente Hospital (Los Angeles Medical Center)	-	1247
Southern California Permanante Medical Group	SCPMG	1137
Placenta-Linda Hospital	P-LH-MD	20
Kaiser Foundation Hospital (Anaheim Medical Center)	KFH-MD	514
Kaiser Permanente Anaheim Medical Center (Pathology Dept)	KPAMC-PD	4
Fresenius Medical Care	FreseniusMC	227
Social Security Administration	SSA-RD-Elkton	98
Kaiser Permanente Los Angeles Medical Center	KPLAMC-MD	52
Southern California American Medical Response	-	8

Exhibit D

Depositions Reviewed - Bechara v. Kaiser Foundation Health Plan

Deponent	Date Taken	Exhibits
Donald F. Nortman, M.D.	10/19/2006	2
Peter C. D. Pelikan, M.D.	10/12/2006	4
Howard A. Bessen, M.D.	10/9/2006	2
Thomas A. Pfeffer, M.D.	9/6/2006	6
Shailesh P. Patel, M.D.	9/13/2006	15

Exhibit E
Literature Reviewed

Brown JR, Birkmeyer NJ, O'Connor GT. 2007. Meta-analysis comparing the effectiveness and adverse outcomes of antifibrinolytic agents in cardiac surgery. *Circulation*. 115:2801-2813.

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Karkouti K, Beattie WS, Dattilo KM, et al. 2006. A propensity score case-control comparison of aprotinin and tranexamic acid in high-transfusion-risk cardiac surgery. *Transfusion.* 46:327-338.

Kincaid EH, Ashburn DA, Hoyle JR, Reichert MG, Hammon JW, Kon ND. 2005. Does the combination of aprotinin and angiotensin-converting enzyme inhibitor cause renal failure after cardiac surgery? *Ann. Thorac. Surg.* 80:1388-93.

Lemmer JH, Stanford W, Bonney SL, et al. 1995. Aprotinin for coronary artery bypass grafting: effect on postoperative renal function. *Ann. Thoracic Surg.* 59:132-136.

Lemmer JH, Dilling EW, Morton JR, et al. 1996. Aprotinin for primary coronary artery bypass grafting: a multicenter trial of three dose regimens. *Ann. Thoracic Surg.* 62:1659-1667; discussion 1667-1658.

Levy JH, Pifarre R, Schaff HV, et al. 1995. A multicenter, double-blind, placebo-controlled trial of aprotinin for reducing blood loss and the requirement for donor-blood transfusion in patients undergoing repeat coronary artery bypass grafting. *Circulation*. 92:2236-2244.

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Wagener G, Gubitosa G, Wang S, Borregaard N, Kim M, Lee HT.2008. Increased incidence of acute kidney injury with aprotinin use during cardiac surgery detected with urinary NGAL. *Am. J. Nephrol.* 28:576-582.

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Mangos GJ, Brown MA, Chan WY, Horton D, Trew P, Whitworth JA. 1995. Acute renal failure following cardiac surgery: incidence, outcomes and risk factors. ***Aust. New Zeal. J. Med.*** **25:284-289.**

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Exhibit F
Expert Reports Reviewed

Dr. Mark Dershwitz
Dr. Curt Furberg
Dr. Mark Heath
Dr. Mark Eisenberg
Dr. Chirag Parikh
Dr. Suzanne Parisian
Dr. F. Gary Toback
Dr. Luca Vricella

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Legal Fees 2008-9

Record review, written or telephone reports	$400/hour
Personal appearance at deposition or trial	$500/hour
Travel within Chicago	8 hours minimum
Travel outside of Chicago	2 day minimum (8 hours/day)