THE STATE OF OHIO,)
) SS:
COUNTY OF CUYAHOGA.)

IN THE COURT OF COMMON PLEAS

FRANCES SMITH, Administratrix of the Estate of Alvester Smith, Sr., Deceased,

Plaintiff,

vs.

SAINT LUKE'S HOSPITAL, et al.,

Defendants.

Doc. 269

Case No. 100877

Deposition of SONG JOON LEE, MD, a Defendant herein, taken by the Plaintiff as if upon cross-examination before Lorraine J. Box, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the office of Charles Kampinski, Esq., 1530 Standard Building,, Cleveland, Ohio, on Monday, the 22nd day of September, 1986, commencing at 1:35 p.m., pursuant to notice and agreement of counsel.

APPEARANCES:

Charles Kampinski, Esq.,
On behalf of the Plaintiff.

Jacobson, Maynard, Tuschman & Kalur, by:
William D. Bonezzi, Esq. and Stephen J. Charms, Esq.,
On behalf of Defendant S. J. Lee, MD.

Reminger & Reminger, by:
Marc W. Groedel, Esq.,
On behalf of Defendants Timothy L. Stephens, MD and Curtis W. Smith, MD.

Arter & Hadden, by:
Rita A. Bartnik, Esq.,
On behalf of Defendants St. Luke's Hospital, J. E. Edmonson, LPT and K. Fedeshen, LPT.

Kitchen, Messner & Deery, by:
Janet D. Dann, Esq.,
On behalf of Defendant Agnes Sims.

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that this deposition may be taken in stenotypy by Lorraine J. Box; that her stenotype notes may be subsequently transcribed in the absence of the witness; and that all requirements of the Ohio Rules of Civil Procedure with regard to notice of time and place of taking this deposition are waived.

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SONG JOON LEE, MD,

the Defendant herein, called by the Plaintiff for the purpose of cross-examination as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposes and says as follows:

CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Would you state your full name, please?

A. First name is Song, S-o-n-g, middle name is Joon, J-o-o-n, last name is Lee, L-e-e.

Q. Dr. Lee, I'm going to ask you a number of questions this afternoon. If you don't understand any of them, tell me. I'll be happy to rephrase them. When you answer my questions, do so verbally. In other words, don't shake your head because she's going to be taking down everything we say. She can't take down a nod of your head.

A. Okay.

Q. Keep your voice up so all the attorneys can hear you.

A. Okay.

Q. All right. Where do you live, sir?

A. I live in Highland Heights.

Q. Okay.

A. Ohio.

Q. Your address?

A. 909 Belwood, B Like in boY, B-e-l-w-o-o-d, Belwood DEive, Highland Heights, 44143.

Q. How old are you, sir?

A. I'm 44.

Q. Your date of birth is what?

A. October 21, '41.

Q. All right. Where were you born?

A. I was born in Taegu, Korea.

Q. What was the name of the city?

A. T-a-e-g-u, Taegu. City in the south part of Korea.

Q. Okay. How long did you live in South Korea?

A. I lived there for 29 years.

Q. 29 years?

A. Right.

Q. All right, What did you do there? Did you go to school?

A. Yeah.

Q. Until when? Until how old?

A. Until 26 I graduated medical school.

Q. Graduated medical school?

A. Yeah. Then from 26 -- 29 years I stayed

in the Korean Air Force as officer surgeon.

Q. Okay. Before you went to medical school -- is the school system at all in South Korea like it is here in the United States? Is there elementary school?

A. Yeah. Elementary --

Q. Why don't you tell me what the school system is like and what you went through.

A. Six years of elementary school, three years of junior high school and three years of senior high school and premedical college, two years.

Q. What was the premedical college you went to?

A. To a liberal arts and science college.

Q. Is that the name of the college?

A. The college I attended?

Q. Yes.

A. Was Liberal Arts and Science College of Kyung Pook, K-y-u-n-g, P-o-o-k, National University.

Q. Okay. Where is that located?

A. Taegu, Korea.

Q. Taegu?

A. Yeah.

Q. Where had you gone to high school?

A. Kyung Pook, the same spelling as university. Kyung Pook High School.

Q. Okay. And the college that you attended, you said it was a liberal arts college?

A. For premed.

Q. Premed?

A. Yeah, premedical course.

Q. How long did you go to that college?

A. That college, two years.

Q. Two years. And did you graduate from that college?

A. Yeah.

Q. Received a degree?

A. I received a diploma.

Q. Diploma?

A. Yeah.

Q. What year was that, do you remember?

A. '63.

Q. All right. And what did you do right after graduation from that college?

A. I went into medical school.

Q. Okay. Where was that?

A. The same university, medical college.

Q. Is that South Korea also?

A. Yeah.

Q. Where is that in relation to Seoul?
A. It's about the -- about 400 miles the south of Seoul.
Q. South of Seoul?
A. Yeah.
Q. When did you start medical school?
A. '64 -- no, '63. March, '63.
Q. What did you do between the time that you graduated premedical school and going to medical school?
A. I immediately go into -- went right into the medical school.
Q. I thought you said you got your diploma in '62?
A. No, '63.
Q. Okay. So you went right to medical school after that?
A. Yeah.
Q. That started in March?
A. March of '63, yeah.
Q. That's when the semesters or the quarters start?
A. Yeah. March 1st they started.
Q. Okay. And how long did you attend medical school?

A. Four years.

Q. When did you graduate?

A. '67. March, '67.

Q. All right. You received a medical degree?

A. Yeah.

Q. What did you do after that, sir?

A. Three years of service in Korean Air Force.

Q. Okay. Is that required service?

A. Yeah. It's obligatory.

Q. That would have been until what, 1970?

A. 1970, yeah.

Q. What did you do in the Air Force?

A. As officer surgeon. I became a lieutenant, medical officer.

Q. Okay. And was this general surgery or any specialty?

A. No specialty. Almost like general practitioner here, but no practice on the preventive medicine. Internal medicine and some surgery.

Q. Where were you stationed?

A. Stationed -- I cannot understand what stationed.

Q. Where were you located while you were in

the Air Force?

A. Air Force, two years in Taegu, Korea.

Q. Right at home?

A. The same place I was born, and one year I was in on other side of mountain very close to Taegu.

Q. You never went over the seas or out of the country or anything?

A. No.

Q. You stayed pretty close to home this whole time?

A. Yeah.

Q. Went to school close to home?

A. I was born there.

Q. That was until 1970?

A. Yeah.

Q. How big of a medical school is it? How big was your graduating class?

A. Our class when we graduated, 80 students.

Q. How big was your college class?

A. College class, same.

Q. Same?

A. Same people.

Q. Same people. Just went straight from college into medical school?

A. Yeah.

Q. Graduated from medical school?

A. Right.

Q. How about high school, same people there too?

A. No.

Q. Some more?

A. One grade, about 600, close to that.

Q. Does the Korean system work similar to ours? Do you have a choice as far as going to medical school, is that what you wanted to do, or were you somehow chosen to go to medical school?

A. No. We choose. Individual choose what they like to.

Q. All right. What kind of discharge did you receive from the Air Force?

A. Discharge, you mean the work?

Q. No. When you got out of the Air Force, Korean Air Force, honorable -- or maybe that's not a term that they use. I don't know.

A. Just three-year term. In the beginning, we assign on the three-year term. Three years is minimum required years.

Q. Everybody has to be in the service?

A. Right.

Q. Do you get a choice as to which branch you want to go to or is that somehow determined as to the education you have? In other words, by going to medical school, did that then allow you to go into the Air Force as opposed to the Army?

A. Whatever we like to choose.

Q. Yeah.

A. But there's more competition in the Air Force. We have to take tests and all the physical examinations and everything. But there was not much limitation in qualification. We like to choose and we apply there and took tests.

Q. Okay. And you went as an officer?

A. Yeah.

Q. You got out in March of 1970?

A. Out of the --

Q. Air Force.

A. Air Force, no. In May, 1970.

Q. Okay. What did you do after you got out of the Air Force?

A. I prepared to come to United States.

Q. What was the purpose for coming to the United States?

A. To have better training with better facilities. Medical facilities with medical

education.

Q. When did you come here?

A. July, '70.

Q. July of 1970?

A. Right.

Q. And was it through some type of program you were coming here, an exchange program?

A. Foreign Education Council we call it. We took tests while we were senior years in medical school and while I was in military service, I prepared for the visa and I got it. And after I finish it, after I got out of the Air Force, I prepared for the passport to come over here and so I could arrive here in July 23rd of 1970.

Q. This program, the exchange of foreign students, is the purpose of it so that you can get training as you said here, better training and then go back to Korea?

A. That's the original purpose, but they allow us to stay here permanently. That's how I got granted a visa in the beginning.

Q. Why do they allow that?

A. They need -- United States need very badly the doctors, medical doctors.

Q. Doesn't Korea need them? Isn't that the

reason they let you come here?

A. Korea need them too, but we have pretty reasonable number of doctors already covering the -- all over the place.

Q. Where did you go -- by the way, are you married, sir?

A. Yeah.

Q. Children?

A. I have two children.

Q. Okay. Is this your only marriage?

A. Yeah.

Q. When were you married?

A. March of 1967, the year when I graduated from medical school.

Q. Okay. When you came here to the United States, where did you go?

A. I assigned directly to Fairview General Hospital.

Q. You came straight to Cleveland?

A. Yeah, Cleveland. Fairview General Hospital there. I did rotating internship.

Q. When you say you were assigned, who was it that determined where you were going to go, if you know?

A. We applied first. We were supposed to be

arranged by the internship and the matching program. But hospital gave me direct contract, so I accepted that. I got out of that program and I came into the hospital directly.

Q. All right. I'm confused. You're going to have to go slow. You're saying part of this program is being assigned somewhere here for training?

A. There was one of the systems, we call it N-I-M-P.

Q. NIMP?

A. Yeah, NIMP.

Q. What does that stand for?

A. National Internship Matching Program.

Q. Is that the program you came here under?

A. That's just doing the matching and arranging.

Q. I see. They set up where you're going to go?

A. Yeah. I got out of there and I directly come into west side, Fairview General Hospital.

Q. How did you get out of it?

A. If I make a contract with individual hospital, that's done.

Q. Did you know somebody at Fairview you

could do that with?

A. One of my friends one year ahead of me stayed there and gave me all the information. That's why I chose that.

Q. Who was that?

A. Dr. Choi. In the anesthesia department.

Q. Dr. Choi?

A. Yeah.

Q. He's also in the anesthesia department?

A. He's anesthesiologist in Fairview General Hospital now.

Q. He had been there and knew you and he gave you the information?

A. Yeah.

Q. That then let you get out of this matching program, which would have put you somewhere else, and come to work at Fairview?

A. Right.

Q. And the purpose of that was for you to get better additional training?

A. Right.

Q. And you did an internship you say at Fairview?

A. Yeah.

Q. How long was that?

A. That was one year.

Q. One year internship in 1970?

A. Yeah. From July 1970 to June 1971.

Q. Okay. What did you do after that?

A. I took pediatric residence in Brooklyn Jewish Hospital.

Q. In New York?

A. In New York for one year.

Q. Pediatric residency?

A. Right.

Q. What did you do after that?

A. After that I came back to Cleveland to take anesthesiologist residence.

Q. Residency?

A. Yeah.

Q. Didn't you like pediatrics?

A. I like it, but there was some advantage I took in anesthesia. More peace and quiet in anesthesiology department. Also more chance to get a place for practice in anesthesia.

Q. Did you have any problems in New York as far as the pediatric program?

A. No. I suppose to go to the second year, but I didn't take that program and I came back here.

Q. Did you have somebody in Brooklyn at the

hospital there who was in charge of your training?

A. There was a director of pediatrics.

Q. Who was that?

A. I remember. I'm sorry, I cannot remember, but I remember the assistant director, Dr. Ratner, R-a-t-n-e-r.

Q. R-a-t --

A. R-a-t-n-e-r.

Q. N-e-r?

A. Right.

Q. You decided voluntarily, you're telling me, that you didn't want to continue in pediatrics?

A. No, I didn't want to.

Q. Okay. So you came back to Cleveland?

A. Yeah. St. Luke's Hospital.

Q. Okay. That was for the purpose of what?

A. To take anesthesiology residence training.

Q. Okay. And how long did you do that?

A. For three years.

Q. Three years. From what years?

A. From July, '72 to June, '75.

Q. Okay. Who was in charge of your training?

A. Dr. Sankey, S-a-n-k-e-y.

Q. Is that the same doctor who had been a year ahead of you?

A, No. Dr. Sankey is director of anesthesiology.

Q. At St. Luke's?

Am at St. Luke's Hospital.

Q. Okay. After you completed your residency, then what did you do?

a, I stayed at staff at St. Luke's Hospital.

Q. From 1975 to the present time?

A, Right,

Q. Have *you* worked anyplace else?

A, No.

Q. Are you part of a group at St. Luke's?

a, Yeah.

Q. What's the name of the group?

A. Anesthesia Associates, Cleveland.

Q. Are *you* a shareholder in that group?

Am Yeah.

Q. Now Bong have you been a shareholder in that group?

A. This new group started '82.

Q. You've been a shareholder since it started?

A, Yeah.

Q. Was there a group before that?

A. Yeah.

Q. What was the name of the group before that?

A. Cleveland Anesthesia Associates.

Q. Were you a shareholder of that group?

A. Yeah.

Q. How long were you --

A. There was about a year.

Q. Okay. How about before that?

A. Before then, under Dr. Sankey, Doc Sankey had a group of Anesthesia Associates of St. Luke's.

Q. Were you a shareholder of that?

A. Yeah. For about three years I remember. Before that I just -- I worked as a staff -- employee staff.

Q. You're still an employee of the corporation, aren't you?

A. Yeah, right.

Q. Of the Anesthesia Associates?

A. This Anesthesia Associates, I didn't get what you mean by shareholder, but we -- dividing the profits.

Q. Okay. That's a shareholder to me. Is it a corporation?

A. Not incorporation, but this Anesthesia Associates, Incorporated has a name of Dr. Trusso.

Q. Trusso?

A. Yeah. He's director of anesthesia department.

Q. Do you have an employment contract with that group?

A. Yeah.

Q. Is your compensation based upon profits of the group?

A. Right.

Q. Okay. How is the work divided, do you know? Is there something in the employment contract that indicates how long you should work, when you should work?

A. There's no such limitation.

Q. Who decides that?

A. The director.

Q. Dr. Trusso?

A. Yeah. When Doc Trusso is not in hospital, the second -- assistant director, Dr. Buckley.

Q. Buckley?

A. Yeah. She's a lady.

Q. Okay. How many anesthesiologists are there in the group?

A. Nine.

Q. Pardon me?

A. Nine anesthesiologists. I'm pretty sure.

Q. Is it all for St. Luke's?

A. Yeah.

Q. Have you had any additional training since your residency?

A. No. Just postgraduate education. Postgraduate course.

Q. I'm sorry?

A. Postgraduate course.

Q. Course?

A. Yes, course. Provided by the university or --

Q. What course?

A. I attended about four semesters at Case Western Reserve Universities, that is held there, used to be a lecture, and some test.

Q. In what courses?

A. Postgraduate course.

Q. I mean in medicine, in accounting, in what?

A. Anesthesia.

Q. Anesthesia?

A. Yeah.

Q. Who teaches that course?

A. All the professors in anesthesia

department, in Case Western.

Q. When did you take those courses?

A. When I was senior year in -- no, no, I'm sorry. From two years, one year when I was in junior resident, and another year as senior resident.

Q. In the 1970s?

A. Yeah. '74 or '75.

Q. My question was after your residency, have you had any additional training?

A. No.

Q. When you say that either Dr. Trusso or his assistant would determine when you worked, was this done monthly? Weekly? Would a schedule come out?

A. That means assigning the patient by the schedule or the date of on call and night call. All those kind of assignment being done by our chief,

Q. Did the group just have St. Luke's that it covered or were there other hospitals that it covered?

A. Just St. Luke's.

Q. Was that true in 1984 also?

A. 1984, yeah.

Q. Do you remember how many anesthesiologists there would have been in the group then?

A. 1984, I remember about nine.

Q. Okay. Would you have responsibilities or duties that extended beyond the operating room, for example, into the recovery room?

A. Yes.

Q. Okay. How is it that that came about? Was that always true, that the anesthesiologist would be responsible for covering a patient into the recovery room?

MR. BONEZZI: Objection to the form of the question. You may answer, Doctor.

A. Yeah.

Q. That was always true?

A. Not always true. Whatever I did, my case, I'm covering in recovery and responsibility is not soley to the anesthesiologist but the surgeon and resident and nurse and us it's shared. The anesthesiologist is most closely watching the patient.

Q. If the treating physician leaves, is it then up to you to take care of whatever responsibility he would have theoretically shared

with you in the recovery room?

MR. BONEZZI: Objection. You can answer.

A. I'm sorry. In the recovery room?

Q. Yes.

A. Whatever case I did?

Q. Yes.

A. Not always do so. If I'm busy on another case, whatever, that patient -- mainly if anesthesiologist available, they will call, but the case of what I did, I'm responsible.

Q. Have you ever been sued before, Doctor?

A. No.

Q. Did you have the night shift responsibility in October of 1984? Was there one anesthesiologist who did night shift or were there more than one or do you remember?

A. One anesthesiologist and a nurse anesthetist to stay in hospital and another physician is available.

Q. Another what, physician?

A. Yeah. Staying at home.

Q. On call?

A. Yeah. On call.

Q. Okay. Would you rotate that position or

were you always on nights?

A. Not always night. Yeah. We rotate evenly, yeah.

Q. How would your shift work? Would you work day and night for 24 hours on, 24 off, something like that?

A. Weekend, like Saturday I have to work 24 hours.

Q. How about a weekday, Tuesday or Wednesday?

A. Usually started in afternoon.

Q. Started in the afternoon?

A. Afternoon when I'm on call, I'm starting in afternoon about 12:00.

Q. What time?

A. About 12:00, until in the morning of next day.

Q. I see.

A. At 7:30, whatever.

Q. Are there places for you to sleep in the hospital?

A. Yeah.

Q. Who decides, Doctor, whether a patient after an operation should go to intensive care or into recovery room? Who makes that decision?

A. We discuss with anesthesiologist, is

discussed with surgeon, most -- both have to agree.

Q. Both have to agree?

A. Yeah.

Q. Who makes a decision, Doctor, as to whether or not a patient can undergo a surgery? Is it the doctor who is going to do the surgery or the anesthesiologist or both? Who makes that decision?

MR. BONEZZI: Objection to the form of the question. You may answer.

Q. (BY MR. KAMPINSKI) You can answer.

A. That's depending on the surgeon.

Q. Let's say an orthopedic surgeon.

A. Yeah. Orthopedic surgeon, if surgeon say this is necessarily an urgent or how urgent this is or emergency, we listen to a surgeon and make decision made by surgeon.

Q. Do you have to give him information so he can make a decision?

A. Yeah, for elective case we can do that. But once a surgeon said, This is emergency, most of the case we have following.

Q. In other words, once he says it's an emergency, you don't have any input anymore as to whether or not it's appropriate to do surgery, it's just done because it's an emergency?

MR. BONEZZI: Objection. You may answer.

A. Yeah. But -- okay. Patient is in serious condition, okay, patient that die, okay, there is no hope, if surgeon decided it's not to do, we don't do.

Q. I don't understand what you just said.

A. Yeah. Surgeon is the one that made the deciding.

Q. But my question is to what extent you have input in that decision, and I think you told me, and I don't want to put words in your mouth, you correct me if I'm wrong, if he tells you it's an emergency case, then you really don't have any input, he just goes ahead and he does it?

A. Yeah, once he said that.

Q. Was Mr. Smith an emergency case on October 17th?

A. That was what Dr. Smith said.

Q. He told you it was an emergency?

A. Doc Smith told resident, resident told me.

Q. What resident did he tell?

A. Do you want to know the name?

Q. Absolutely.

A. Dr. Gill, G-i-l-l.

Q. Dr. Gill?

A. Yeah.

Q. Do you know why Dr. Gill went to California? Do you have any idea?

A. No. He finish training is why.

Q. Dr. Gill was a resident in what, anesthesiology or orthopedics?

A. Orthopedics.

Q. How do you know that Dr. Smith told Dr. Gill it was an emergency?

A. He explained it to me.

Q. Who explained it?

A. Dr. Gill.

Q. Did he tell you why it was an emergency? You tell me what Dr. Gill told you.

A. This is an emergency. Should be done. Okay. And I call Doc Smith directly just before the surgery. He was in the hospital in the -- he was in the St. Luke's Hospital. He explained why it had to be done immediately.

Q. What did he explain?

A. With delaying of surgery, reduction is extremely difficult. It have to be done today. Today at such time. He said about 12:00, but we -- nobody was available at 12:00, but we -- that's why

I called somebody who is available, the second call. There was nurse anesthetist that was waiting for any kind of emergency case at home, so we call her up, and we started immediately about 3:00.

Q. Let's go slow. Let's back up a little because I want to make sure I understand exactly what you were told, Doctor. The resident, the orthopedic resident approached you first?

A. Yeah.

Q. That was Dr. Gill?

A. Right.

Q. Where in the hospital did he approach you? Is there someplace within the hospital that you stay? Do you have offices for the anesthesiologists?

A. I understand he was in hospital.

Q. Where did he come and see you at?

A. Out by the phone. I was in operating suit.

Q. You were in the operating suit?

A. Yeah.

Q. You had another case that you were doing?

A. Two cases were going on.

Q. Dr. Gill, was he in one of those surgeries?

A. No.

Q. He called you?

A. Right.

Q. He told you that there was an emergency that had to be done?

A. Yeah.

Q. Did he tell you what the nature of the emergency was or did he tell you to call Dr. Smith?

A. That was the case. It was on the -- what is it -- three days ago, and was -- he explained he was in the SICU after surgery and he has, I don't know, bad heart and lungs.

Q. This is Dr. Gill telling you?

A. Yeah.

Q. He's got a bad heart and lung. What else?

A. That's all. But it have to be done. That's all he told me.

Q. Did he tell you why it had to be done?

A. Why it had to be done. With delaying, it made extremely difficult because unable to reduce some of the dislocated hip.

Q. Dr. Gill told you the same thing as Dr. Smith?

A. Yeah.

Q. Did Dr. Gill or Dr. Smith or anybody tell

you how it became dislocated?

A. Yeah. It was dislocated.

Q. Did they tell you how it became dislocated?

A. At that point I didn't ask him how.

Q. Whether you asked or not, did anybody tell you?

A. No.

Q. Did you ever find out?

A. No, I didn't find out.

Q. Do you know now as you sit here today, how it became dislocated?

A. No.

Q. Is it your job as an anesthesiologist to get information about the patient to determine what you might have to do either during the operation or after the operation? For example, you told me that Dr. Gill told you he had a bad heart and lung. That is important for you as an anesthesiologist to know?

A. Yeah.

Q. He also told you there was a surgery three days earlier?

A. Right.

Q. And you said that he told you that he

went to SICU after that?

A. Yeah.

Q. Did you go see the patient?

A. Yeah.

Q. You did?

A. Yeah.

Q. Checked him out?

A. Patient was in the room.

Q. In what room?

A. In his regular floor.

Q. Okay.

A. Third floor.

Q. Okay.

A. And I found he was in SICU for, I counted time, four hours.

Q. You looked at the chart then?

A. Yeah. I read his SICU chart.

Q. Did you review his entire chart?

A. I tried to review. I cannot say entire, but --

Q. The important things, lab readings, things like that, right?

A. I tried to review, yeah.

Q. Did you review the nurses' notes, doctors' orders, lab results, did you review those

things?

A. Yeah. Honestly, I have to say I read everything that was posted in the chart.

Q. I'm sorry. You reviewed the laboratory findings that were posted in the chart?

A. Which was posted in the chart, front page of the laboratory test.

Q. Well, you looked at the date of it, didn't you?

A. Yeah.

Q. And you saw that the one that you reviewed was three days earlier, didn't you? You know what I'm talking about, don't you, Dr. Lee?

A. That's what I found later.

Q. You prepared a form, an anesthesia form, right, for preparatory to the man going to surgery, which was wrong, didn't you?

MR. BONEZZI: Objection. You can answer.

Q. (BY MR. KAMPINSKI) Didn't you, sir?

A. Yeah, I'm supposed to, yeah.

Q. Why was it wrong, Doctor?

A. I'm sorry, I looked at the one sheet.

Q. Why don't you show me what you looked at. There's the original record.

A. Okay.

Q. You can refer to page numbers so that we know exactly what you're talking about.

A. Okay. Page 126.

Q. And why don't you identify what page 126 is for the record.

A. Okay. Laboratory findings in 126.

Q. The next page is what, 127?

A. Yeah.

Q. Then 128 follows after that?

A. Right.

Q. 129, these are all laboratory findings, aren't they?

A. Yeah.

Q. Were they all -- and 130, 131, 132, did you look at all of them, 133, did you look at all of them, sir?

A. I don't remember if I looked at all of them. What I -- what I picked out of the date in the first page.

Q. Why don't you find your presurgery report, Doctor, in the record. What page is that, Doctor?

A. 152.

Q. Okay. You prepared that, did you not?

A. Right, I did,

Q. And you prepared that before surgery?
A. Yeah, before surgery.
Q. It's dated November 17th, right?
A. Right.
Q. And proposed operation, CR, what's that stand for?
A. Closed reduction.
Q. This is all in your writing; is that correct? This entire sheet?
A. Yeah.
Q. You put down his age, his height, his weight, and his blood pressure?
A. Right.
Q. Where did you get the blood pressure? Did you take it yourself?
A. No. From the nurses' notes.
Q. From the nurses' notes. Why don't you find the nurses' notes where you got that blood pressure from.
A. In the admitting nurse' notes.
Q. The admitting nurses' notes?
A. Yeah.
Q. When was he admitted, Doctor?
A. I remember November 12th.
Q. Page 40 you're looking at? Why don't you

tell me what page you're looking at, Doctor.

A. Page 68.

Q. Page 68. Why did you take his blood pressure off the admitting note, Doctor?

A. That's his normal blood pressure in the regular time. That's why I took it.

Q. Did you make that assumption or you knew that to be a fact?

A. I cannot answer it.

Q. Why not?

A. With --

Q. Did you compare it with other blood pressures in the chart to come to a conclusion that that was his normal blood pressure? Why did you pick that one as opposed to any other one in his chart?

A. He was under medications.

Q. Yeah.

A. And that medication worked and his blood pressure was controlled in beginning.

Q. So.

A. That's all.

Q. What medication was he on?

A. I'm sorry, I have to look at it. He was on Hydralazine for the blood pressure.

Q. You can go back to page 152. We're going to be talking about that for a little bit,

A. And Lasix for the diuretic purpose.

Q. Okay. And what's the next thing on that line, Doctor? It looks like X plus or U plus. What is that?

A. That's potassium.

Q. Potassium?

A. Yeah.

Q. Next thing under medical history -- it's important for you as an anesthesiologist to take history, isn't it?

A. Right.

Q. That's why this box is there, right?

A. Yeah.

Q. And did you go through the chart to get a full. and complete history so that you could adequately deal with this patient both before, during and after surgery, sir?

A. I tried to do my best in given time,

Q. I'm sure you did. But the question is did you go through the chart to try to get a full, complete, fair history?

A. I cannot say it.

Q. All right. When it says HPT for cardiac,

what does that mean?

A. Hypertension.

Q. Hypertension. You knew that Mr. Smith was hypertensive. What does that mean, Doctor?

A. Hypertension may arise heart problem, including congestive heart failure or left ventricle hypertrophy. That means big or large heart combined with congestive heart failure also it can cause.

Q. Does it have an effect on blood pressure?

A. Blood pressure, high blood pressure may cause heart failure, yeah.

Q. Is that important for you as an anesthesiologist to know that he had hypertension?

A. Yeah.

Q. Was it important to determine whether it was because of cardiomegaly or because of congestive heart failure? Was that important for you?

A. Right.

Q. All right. And did you determine whether or not he was in congestive heart failure before allowing the surgery to go forward?

MR. BONEZZI: Objection.

A. Yeah, it is important.

Q. Did you determine that, whether he was in congestive heart failure?

A. Yeah.

MR. BONEZZI: Objection.

A. Right.

Q. Was he?

A. He was -- by my record, it didn't say any -- he had congestive heart failure.

Q. We know your record's wrong, don't we?

MR. BONEZZI: Objection.

A. No.

Q. We don't know that?

A. There was no diagnosis of congestive heart failure in the beginning.

Q. By whom? By you or by anybody else?

A. By anybody else.

Q. Okay. How about any -- let's go on. The next thing is respiratory. What's that say, Doctor?

A. COPD means chronic obstructive pulmonary disease.

Q. Why is that important for you to put down?

A. That's important because the gas exchange -- air exchange in the lung and oxygenation of the blood is vital to the patient.

Q. It's vital to the patient?

A. Yeah.

Q. Why was he in the surgical intensive care unit after the first operation? Did you check that out, Doctor?

A. Yeah.

Q. Why?

A. Cardiopulmonary problem.

Q. What were the nature of the problems that caused him to be put into SICU?

A. It was impairment of ventilation, also very uncontrolable high blood pressure and also impairment of air exchange -- impairment of ventilation, and also uncontrolable blood pressure.

Q. What does CNS stand for?

A. Central nervous system.

Q. You've got a zero there. No problems?

A. Yeah, no problem.

Q. Renal, no problems?

A. No problem.

Q. Endocrine, liver, hematologic, no problems?

A. No problems.

Q. In the next box, Doctor, you've got review of systems. Under remarks, what I'd like do, if you would

findings are and what they mean.

A. Okay. Remarks?

Q. Yes.

A. There was arterial blood gas. It was done on November 15th.

Q. Um-hmm.

A. Arterial blood pH is 7.36. PCO2, tension of oxygen in the blood, 44. PO2, tension of oxygen of 17. Hemoglobin, percentage of hemoglobin saturation with oxygen, 93. BC means bicarbonate. Sodium bicarbonate -- I mean bicarbonate is 34. That means acceptable arterial blood gas.

Q. You got this off of one on what, November 15th?

A. Yeah.

Q. That would be page what, 134 for the record, Doctor? If you'd turn to page 134 and tell me if that's what you got that information from.

A. Yeah.

Q. Okay. And were all those -- were all those normal, Doctor?

A. Yeah, I would say pretty good.

Q. Okay. A little low, aren't they, PCO2 and the PO2?

A. PO2 is a little low, yeah, but is

acceptable.

Q. Okay. But that was what, two days before?

A. Yeah.

Q. Had any been done since then?

A. I didn't see any record of that.

Q. Did you order any?

A. No.

Q. Why not?

A. I didn't expect any -- I didn't suspect any getting worse since the respiration remain the same in nursing notes.

Q. So you looked at the nursing notes?

A. I directly asked to the patient, he can breathe all right? But to me, it was a shortness of breath. But shortness of breath had been staying since he got out of the surgical intensive care unit. I assume that's staying stable.

Q. But you looked at the nurses' notes to determine that respirations had stayed pretty stable, right?

A. Right.

Q. Well, if you looked at the nurses' notes, you realize Mr. Smith had had indications of coffee ground emesis; you're aware of that?

A. No.

Q. You just told me you looked at the nurses' notes. You didn't see that in the nurses' notes, Doctor? Show me the nurses' notes that showed his respirations to be, I think -- and I don't want to put -- misphrase what you said, but I think you said stable. The same maybe. Show me where it says that.

A. Okay. ABD wedge in place, respiration unlabeled, resting, and quietly in bed. This was November 16th.

Q. What page is that, Doctor?

A. 71.

MR. BONEZZI: Excuse me. These records also contain SICU records?

MR. KAMPINSKI: I think they do.

MS. BARTNIK: It's the whole chart.

Q. (BY MR. KAMPINSKI) So you read page 71, right?

A. Yeah.

Q. Read page 72 and 73, is that correct, Doctor? Right?

MR. BONEZZI: Look at it, Doctor.

A. Yeah. I didn't pay any attention on this blood loss.

Q. On what, on the blood loss?

A. No, I mean the coffee ground.

Q. You see that now, don't you, page 73, I believe the 2:30 p.m. entry? Would that have made any difference to you, Doctor?

A. I looked at it and passed over it.

Q. You looked at it and passed over it. Not important to you?

MR. BONEZZI: Objection. You may answer, Doctor.

A. I didn't pay any attention to this.

Q. If you would have seen it, would it have been important to you, Doctor?

A. Yeah.

Q. Why is that, sir?

A. Any low blood count.

Q. Why is that important especially in a patient who is having difficulty breathing with respiration? Why is low blood count important?

A. This emesis you mean?

Q. Yeah. That's what I thought we were talking about.

A. It's just I'm -- the blood count is the carrier of the oxygen for the exchange, so when you ask me, I can say that, but on this patient, I didn't look at this part.

Q. I understood that. I understood it when you said it, I still understand it. My question is if you would have seen it, would it have been important to you?

A. Yeah.

Q. Okay. And the reason it would have been important is what? What is the importance of the patient having coffee ground emesis?

A. A blood loss.

Q. Why is that important to you as an anesthesiologist for the purposes of deciding whether or not somebody is suitable to go to surgery?

A. If blood loss, too much blood loss causes anemia.

Q. Right.

A. That anemia deteriorating and vascular homeostatic, that's lowering blood pressure, so it indicate intravascular blood volume may cause some change in vital signs and oxygen carrying capacity will be decreased.

Q. Making the heart work harder?

A. Yeah.

Q. Putting an additional strain on an already weakened heart perhaps --

MR. BONEZZI: Objection.

Q. -- if a person already had a weakened heart?

A. Yeah, I understand, yeah.

Q. What is in your opinion, Dr. Lee, a significant blood loss in a patient having a hemoglobin level of let's say 15?

A. 15 is quite normal.

Q. Right. What would you say would be a significant blood loss in such a person?

MR. BONEZZI: Are you asking if there is increase in the hemoglobin?

MR. KAMPINSKI: Yeah.

Q. Generally.

A. There was some blood loss.

MR. BONEZZI: That's not the question.

Q. (BY MR. KAMPINSKI) I'm asking a general question, Doctor. In a person who has got hemoglobin level of 15, what would you consider to be a significant blood loss in such a person? What level would you expect to see for significant blood loss?

A. Significant blood loss, we accept this differently. We accept the hemoglobin with 10.

Hemoglobin with 10 is significant.

Q. But is someone who goes from 15 to 10 reflecting the fact that he's losing blood?

A. I assume so.

Q. And so if you were aware of that, that would cause you some concern as an anesthesiologist for someone who is about to go in for surgery, wouldn't it?

A. Hemoglobin 10 perfectly all right. We accept up to hemoglobin 10.

Q. You may accept it, but the question is isn't it important to you to know it, because you may not accept it, depending upon what else it tells you, right?

MR. BONEZZI: Objection.

Q. If you knew that there was a loss from 15 to 10, you'd know that that person was losing blood, wouldn't you, Doctor?

MR. GROEDEL: Objection.

Q. Wouldn't you, sir?

MR. BONEZZI: You answer.

A. Yes, we have to find out.

Q. And then you have to find out why he's losing blood, don't you?

A. Right, right.

Q. And if in fact that person has coffee ground emesis, that's a clue, isn't it, as to why he might be losing blood?

MR. BONEZZI: Objection. You may answer.

A. He had surgery.

Q. I understand.

A. He lost blood before and here this -- the coffee ground emesis, it can be a part of the course.

Q. It can also be a hemorrhage, can't it?

MR. BONEZZI: Objection. You may answer.

A. Could be because -- indicate blood compensation from the first surgery too.

Q. You checked all these things out, you checked out what it was, right?

A. Blood count, human blood count.

Q. I mean, you're telling me these things that it could be and you as an anesthesiologist getting a patient ready for surgery, you went and determined what it was, right?

A. No.

Q. No. Why not?

A. All my information is from the first time

hemoglobin and I assumed that he lost some blood. I don't know. But I didn't check it.

Q. If you would have cheeked it, Doctor, and seen the result that was there to be seen, apparently, on November 17th, would you have done any further investigation as to the reason for the blood loss?

MR. BONEZZI: Objection. You may answer.

A. I would have gone by the last result of the hemoglobin.

Q. I understand you would have gone by it because that's what it was. The question is what would you have done about it? Would you have done anything? Would you have checked further or done additional tests or suggested additional tests to try to find out why this man was losing the blood four days post surgery?

A. I didn't pay any attention apart.

Q. I know that. My question is if you had known it, if you would have known it, if you would have seen it or if somebody would have told you or if Dr. Jackson would have been notified and he would have told you he ordered additional blood work done because of this man's falling hemoglobin,

if you would have been told those things or seen those things, would you have asked for additional tests or done additional tests yourself to try to find out why this man was losing blood?

A. Yeah, I should have done that.

Q. And none of that was done, was it, sir?

A. No.

Q. Doctor, were you aware of the fact that there was a KUB taken on Mr. Smith?

A. I didn't know.

Q. You never looked at it, right?

A. I didn't look at any other finding except chest x-rays.

Q. Were you aware of any lab abnormalities after the first surgery? Did you check out any of the tests or results from the first surgery?

A. I don't remember.

Q. What page again was your anesthesia --

MR. BONEZZI: 152.

Q. Did you put down any other abnormalities on here? For example, what's a 2 percent MB fraction on a CPK? Do you know what that is, Doctor?

A. That CPK is specific for the heart cardiopulmonary muscle injury.

Q. What's 2 percent MB fraction?

A. I'm sorry, I don't have any idea what it is.

Q. I know. If you would have seen it, you wouldn't have known what it was?

A. No. I didn't see that part.

Q. I'm not asking you if you saw that, but I'm asking you if you know what it is. Do you know what a 2 percent MB fraction is?

A. Can I see -- what page?

Q. Do you know what a 2 percent MB fraction is, Doctor? Either you do or you don't. Do you, sir?

A. No, I don't know.

Q. Okay. The hematocrit that you've got under your lab ASA status, where was that taken from, Doctor?

A. 48.9.

Q. Right.

A. Supposed to be from the laboratory sheet.

Q. Once again, what page was that just so there's no confusion?

A. 126.

Q. 126?

A. Right.

Q. Could you show me where on 126?

A. 126, November 12th where it was admitting blood test.

Q. So the very first one at the top of that page that says November 12th?

A. Yeah.

Q. Doesn't it have other ones on there, Doctor?

A. Oh, yeah. He has other ones.

Q. It's got November 15th, November 16th on there, doesn't it, on the bottom of that page, that same page?

A. Yeah.

Q. Page 126. Does it have further hemoglobin, hematocrit levels, tests?

A. Yeah.

Q. Is it your testimony, Doctor, that this was the page that was in the chart at the time that you filled out your form?

MR. BONEZZI: Objection.

A. Yeah. I took this.

Q. Why didn't you take the bottom part? Why didn't you look at that?

A. I missed it.

Q. It showed that his blood level was

falling daily, didn't it, looking

A. Yeah.

Q. Didn't it?

A. Yeah.

Q. And in your looking thrc

did you see any investigation by a

that was occurring?

A. No.

Q. What's the K for, going back to page 152?

That's your next entry.

A. Potassium.

Q. 4.6?

A. Yeah.

Q. Where did you get that level from?

A. There was a first potassium available in

the chart. Yeah, page 130. That's November 12th.

Q. Were there later ones taken?

A. Yeah.

Q. Where are those?

A. Last one was November 16th, 4.4.

Q. What page is that?

A. 131, 4.1, the last one.

Q. I'm sorry, 13 --

A. Page 131. Upper part. Yes. Last one,

4.1.

Q. How about the BUN/CR, BUN creatinine?

A. Yeah. BUN creatinine changes manifest renal function.

Q. Where did you take that from?

A. That same page, 131, first -- 131. BUN creatinine, went down on November 14th.

Q. Okay. Then you've got EKG. What does that -- what's that say after EKG?

A. Okay. Pretty much atrial contraction and left ventricular strain.

Q. What does that mean?

A. Atrial contraction is atrium is causing an extra beat.

Q. Causing an extra beat?

A. Yeah. Left ventricular strain is another word, left ventricle is enlarged because of the high blood pressure or some other increased pulmonary pressures.

Q. Because of the pulmonary pressures?

A. Either one.

Q. Are you saying because of pulmonary pressures the ventricle was enlarged?

A. Increased pulmonary resistance, that means in the case of congestive heart failure --

Q. I thought you told me there was no

diagnosis of congestive heart failure?

A. It can be the cause of -- no, not confirm the diagnosis here.

Q. I don't see a diagnosis anywhere of congestive heart failure. Could you show me where that is, Doctor, anywhere in this chart?

A. There's still no confirm the diagnosis, but in chest x-ray source, possible intervascular marking due to possibly either left ventricular enlargement or congestive heart failure. Something like that.

Q. Something like that?

A. Yeah.

Q. Where did you get this information that you put next to EKG? You didn't put it next to chest x-ray, which was what you were talking about, but you put it next to EKG. Where did you get that information?

A. The EKG is from the first EKG reading.

Q. Were there more than one?

A. Yeah, there was more than one, but it would be the first page here.

Q. What page?

A. 136.

Q. The PAC and ventricular strain, left

ventricular --

A. Anterior -- left ventricular --

Q. He said left ventricular strain. I take it you're reading now from page 136, right?

A. Yeah.

Q. Then it says anterior lateral wall myocardial ischemia, correct? That's what it says?

A. Yeah, correct.

Q. What does that mean? Does that mean evidence of damage from a heart attack?

A. Not because of damage.

Q. Myocardial ischemia?

A. Circulation, coronary circulation doesn't give enough oxygen to the myocardial tissues.

Q. That's what happens in a heart attack, doesn't it?

A. It can cause heart attack.

Q. Did you put that down under EKG?

A. No, I didn't.

Q. Is that important to you as an anesthesiologist to know?

A. Yeah, that's important.

Q. Where are the other EKGs that were taken that you were talking about, Doctor? Would you tell me where they are, please? I thought you told

me there were other EKGs. Where did they disappear to, Doctor?

MR. BONEZZI: Objection.

Q. What happened to them? Did you order one?

A. No, I didn't order them.

Q. Why not?

A. Indicated from --

Q. I'm sorry?

A. All these came from surgical intensive care units. Indicated from surgical intensive care. This is rhythm strip, but you can see how it was.

Q. That's something else, an EKG?

A. No, not --

Q. So there were no other EKGs?

A. I didn't -- I don't know.

Q. Was this EKG on the 14th done before surgery?

A. Yeah.

Q. Is that standard on somebody who has cardiology problems such as Mr. Smith to do an EKG to determine whether or not there's any additional insult to the heart taking place right before surgery, sir?

MR. BONEZZI: Objection.

Q. Is that normal to do an EKG on someone

such as this before surgery?

A. I don't remember. But --

MR. BONEZZI: Doctor, listen to his question. He asked whether or not it's normal to take one before someone goes to surgery. That was his question.

Q. (BY MR. KAMPINSKI) Is it?

A. I don't know. I don't remember whether medical clearance was done with this EKG or not. I don't know.

Q. Would it surprise you, Doctor, to know that Dr. Smith has testified that you're the one that cleared this patient for surgery? Would that surprise you, sir?

A. No.

Q. Did you clear Mr. Smith for surgery or did Dr. Smith clear Mr. Smith for surgery? Who cleared this man for surgery on November 17th?

A. Dr. Smith.

Q. Would it surprise you to know that he says you're the one that cleared him for surgery? Would that surprise you, Doctor?

A, Yeah.

Q. Were you assuming that he was the one that was clearing this man for surgery?

A. We had to together. Had to be together.

Q. All right. And together you're saying that you were partially responsible for the clearance of this man for surgery?

MR. BONEZZI: Objection.

A. The final decision to do the surgery is his.

Q. Is his?

A. Yeah.

Q. Does he rely on input from you in making that final decision?

MR. BONEZZI: Objection.

Q. Do you have to go to him to say, Fine, this man can undergo surgery, in my opinion?

MR. BONEZZI: Objection.

A. Yeah.

MR. BONEZZI: Listen to his question, Doctor.

Q. Do you understand? Doctor, please, I'm not trying to trick you, but I do want answers to my question. If you don't understand them, tell me you don't. I'll rephrase them as many times as I have to.

MR. BONEZZI: He's talking about surgery now. Nothing other than surgery.

A. Um-hmm. Not in very good condition for surgery, but is acceptable for spinal anesthesia is what I gave my opinion.

Q. So it was your opinion that this man was acceptable for a spinal anesthetic, but as you sit here today, you're telling me that it's your opinion he was not a good candidate for surgery, period?

MR. BONEZZI: Objection.

Q. Whatever surgery was going to be done?

A. No, not good condition at the time.

Q. Why is that, in your opinion, sir?

MR. BONEZZI: Objection.

Q. To a reasonable degree of medical certainty.

MR. BONEZZI: As he looks at it now?

MR. KAMPINSKI: As he looks at it right now.

MR. BONEZZI: Objection. You may answer.

A. Okay. High blood pressure. The way of breathing in the shortness of breath. That's all I remember.

Q. How about the loss of blood?

A. I didn't check the loss of blood.

Q. I understand that.

MR. BONEZZI: That's not what he's asking, Doctor. Listen to his question.

A. Loss of blood, it didn't matter much with the spinal anesthesia.

MR. BONEZZI: Doctor, listen to his question. He's still asking about the surgery, not about you giving clearance for anesthesia.

MR. KAMPINSKI: Right.

MR. BONEZZI: Do you understand?

A. Loss of blood -- I'm sorry. You ask me again.

Q. You were telling me why in your opinion you didn't think Mr. Smith was a good candidate for surgery, and you gave me two reasons, and I asked you if an additional reason would be the loss of blood that Mr. Smith was undergoing. Would that also be a reason for his not being a good candidate for surgery? When I say surgery, I mean the surgery he underwent, that is, the reduction, or the attempted reduction of his hip replacement, as opposed to any other type of surgery such as trying to find out why he was bleeding.

A. Yeah.

MR. GROEDEL: Objection.

MR. BONEZZI: You may answer.

A. Possibly he is to open and during same kind of procedure, hip prosthesis, at that point he was no blood -- in case of open reduction --

Q. We're talking about closed reduction.

A. Closed reduction, he's acceptable.

Q. For what, surgery?

A. Yeah.

Q. Or for anesthesia?

A. For both ways -- for both.

Q. How was the operation? Was it fairly straight forward? Was it an easy procedure or did they have to expose Mr. Smith to a great deal of force and pressure?

A. I don't remember well, but it was all right. The procedure was all right. Reduced the dislocated hip successfully.

Q. How long did it take, Doctor?

A. I have to see.

Q. Sure.

A. About an hour.

(Short recess was taken.)

Q. (BY MR. KAMPINSKI) Dr. Lee, let me just clear up a couple things. You started to tell me about open reduction. Am I correct, sir, in

assuming that one of the reasons you didn't do anything further is that you were told that this was an emergency situation?

A. Yeah.

Q. Is that a fair statement?

A. Yeah.

Q. And you were told that by both Dr. Gill and by Dr. Smith?

A. Right.

Q. And the reason they told you it was an emergency was what?

A. If delayed, it's extremely difficult to reduce the dislocated hip.

Q. So that delays would cause additional difficulty?

A. Yeah.

Q. And that's what you were told?

A. Yeah.

Q. And so you just went along with their decision to do this as an emergency?

A. Yeah, I assumed that, yeah.

Q. Okay. If it wouldn't have been an emergency or if you would have been told that this was elective, that it could be done a day later, two days a week, three weeks, would you have done

anything different in terms of your work-up before surgery?

MR. GROEDEL: Objection.

MR. BONEZZI: You may answer, Doctor.

A. Yeah. I would have done differently.

Q. What would you have done, sir?

MR. GROEDEL: Objection.

A. I would repeat all the level tests and I would like to do it on the weekday where everybody is around, all the anesthesiologists staying on the floor.

Q. Why is that?

A. So that means more help immediate.

Q. Did you need help?

A. Yeah, I assumed so.

Q. Why did you need more help?

A. I cannot say. I'm sorry. Start with good helpers to start an IV line and monitoring system, arterial line or CVP central line, whatever needed.

Q. Did you have that help that night?

A. No.

Q. Why not?

A. Well, I had this extra nurse available, so I started, but we monitored everything. Blood

pressure, in my judgment at that time --

Q. I'm sorry, your what?

A. I had monitoring system available.

Q. You did or didn't have?

A. I did. One of the nurses was enough to give me hand.

Q. Who was the nurse that you're talking about?

A. Nurse anesthetist.

Q. Who was that?

A. Name is Joan Allen.

Q. What was his name?

A. Joan Allen, J-o-a-n, first name, last name Allen, A-l-l-e-n.

Q. Joan Allen, is that a man or woman?

A. Lady. CRNA.

Q. She's what?

A. Certified Resident Nurse Anesthetist.

Q. Doctor, did you ever get a degree in this country or medical license?

A. Medical license, yes.

Q. When was that?

A. That was -- first one, first I took exam '73, Pennsylvania.

Q. '73 where?

A. '72 -- September of '73 I got Pennsylvania license and September of -- maybe I'm wrong. September of '73 I got Ohio license by reciprocity.

Q. How is it you got a Pennsylvania license? You didn't tell me about any schooling or anything you did in Pennsylvania.

A. Because I took their --

Q. The test?

A. Yeah.

Q. Why would you take it in Pennsylvania as opposed to Ohio or New York or someplace where you were? What was there about Pennsylvania that attracted you there? Easier test or what?

MR. BONEZZI: Objection. You may answer, Doctor.

A. The requirement was lower. The requirement for documentation is easier.

Q. In Pennsylvania?

A. Yeah. Then passing rate is high.

Q. Then after a while you can just get reciprocity from another state without having to take an additional test?

A. Ohio, without test.

Q. In Ohio you got one just on reciprosity?

A. Yeah.

Q. Did you ever have to take any -- or any additional tests anywhere for any additional licensing or were you just able to renew that every year?

A. Renew that every year or every two years. It's just -- it's changing.

Q. Okay. Are you board certified, Doctor?

A. No.

Q. Okay. Did you ever take the test for board certification?

A. Yeah, I took.

Q. When did you take it?

A. Last one, I took oral test last year, but I didn't make it,

Q. How many times have you taken it?

A. The oral test was six times.

Q. Okay. How about the written?

A. Written, twice.

Q. Have you ever passed any of them?

A, Both written I passed,

Q. But not the oral?

A. Not the oral. part,

Q. Ail right. When did you call this Joan Allen?

A. After I checked the patient.

Q. Let me get the chronology right. You were called about 2:00, I think you said, by Dr. Gill?

A. Yeah, before 2:00. At that time we had two emergency cases going on.

Q. What time did you go up to see the patient, just approximately?

A. Around 2:30.

Q. 2:30. And what time did you call Joan Allen?

A. About 2:30.

Q. All right. And Joan Allen was what, just somebody on call who could come in and assist you?

A. Yeah. She's the person waiting for emergency case.

Q. And she came in to assist you in this particular case, in the Smith case?

A. Yeah.

Q. Did you have anybody assisting you in the two other emergencies?

A. Two other emergencies?

Q. Yes. When you were first called about Mr. Smith.

A. I was supervising. No, I'm sorry. I

have to recollect. When I was called in the morning before 12:00, I was supervising two of them.

Q. Okay.

A. And one case lasted longer. There was one -- I'm sorry. I can not remember well, but two cases, one was done earlier, another case, some abdominal obstruction, case lasted long, and so when this case -- this patient was brought up, still there was a case going on.

Q. Who was taking care of that?

A. That's certified nurse anesthetist.

Q. It was a nurse anesthetist taking care of the other case?

A. Yeah.

Q. While you left to do Dr. Smith?

A. Yeah.

Q. What would Joan Allen be? What is she again? Also a nurse anesthetist?

A. Right.

Q. Okay. But she's nowhere in the chart.

A. No. She help me in the beginning. We set up the room, I bring in the --

Q. Then what, did she stay there or leave or what?

A. She have to stay around in the office.

Q. She stayed around in the office but she didn't stay in the operating room?

A. After starting the case, stayed in office.

Q. You stayed in the operating room?

A. Yeah.

Q. What about the other surgery, you left that up to the nurse anesthetist?

MR. BONEZZI: Objection. You may answer, Doctor.

A. Yeah. Nurse anesthetist was taking care of, but I was available in case I needed. I call the nurse anesthetist to my room and was available immediately.

Q. Do you recall any problems in the surgery at all?

A. This surgery?

Q. Yes.

A. Low blood pressure. About anesthesia?

Q. Anything.

A. Patient vital signs, when he -- low blood pressure.

Q. Why don't you look at the surgical record. Page 150.

A. 150.

Q. And 151 on the back. That is all your

writing?

A. All my writing.

Q. All of it?

A. Yeah.

Q. You were telling me that there was a problem?

A. Low blood pressure, 80 over 50, and I indicated intravenus fluid and put the patient head down, it corrected by itself.

Q. This was during the surgery?

A. Yeah, during the surgery. And he vomited once. He vomited once yellow-colored vomit. I sucked it out through suction.

Q. Where is that?

A. I didn't write it down here.

Q. So you're recalling that? Do you recall anything else about the surgery?

A. About surgery, no, I cannot --

Q. Who assisted Dr. Smith, do you remember? Did anybody, or was it just him?

A. Maybe Scott Miller.

Q. Miller?

A. Yeah.

Q. How about Dr. Gill, did he assist?

A. I don't remember.

Q. But it was Miller, to your recollection?
A. Yeah, Miller was.
Q. Miller, Smith, yourself. Was anybody else in the operating room?
A. Maybe Dr. Gill was, but I don't remember.
Q. Okay. Anybody else that you recall, any nurses?
A. Nurses, I don't remember any nurses.
Q. No nurses?
A. No. There was nurse, but I don't remember who was there.
Q. Okay. And your job in the surgery was to do what, monitor the vital signs and -- of the patient?
A. Yeah.
Q. Did you run an EKG during --
A. Yeah, EKG.
Q. Where is it?
A. We don't have record of EKG, but EKG --
Q. I see that note there.
A. It was atrial fibrillation.
Q. Atrial fibrillation he was having during the surgery?
A. Yeah.
Q. What does that mean?

A. That means atrial -- well, fibrillating, so the sinus node, which is taking the role of pacemaker, is not working.

Q. It wasn't firing?

A. Wasn't firing. Atrial was fibrillating, so beat is irregular.

Q. Did that concern you?

A. Yeah, I concerned about that, especially the rate of the ventricular response was very important. It was to indicate through the surgery, not quite hematocrit, but having the same pace as preop, about hundred beat a minute, so I didn't give any treatment.

Q. This note that's written in the middle of this chart says "Patient was on CPR after" -- what's that say?

A. "In the recovery room." This note is quite --

Q. "After intubation in recovery room"?

A. "Intubation in recovery room, 11:35."

Q. This was written at the time of the code?

A. Yeah.

Q. Okay. What does it say up there in remarks up in the right-hand corner?

A. Patient identified. General condition,

fair. Spinal anesthesia. Blood pressure was fluctuated.

Q. Fluctuating?

A. Yeah, fluctuated.

Q. How do you give a spinal anesthesia, Doctor? What do you do?

A. We give local anesthetics mixed with Dextrose and Feldene and Parafon. Those medicines, the purpose of prolonging the action of local anesthetic effect.

Q. And then what do you do?

A. I put, we call, intrathecal.

Q. Intrathecal means what, between the --

A. Into the spinal canal.

Q. And what do you put in there?

A. Lumbar 3 and 4, between lumbar 3 and 4.

Q. L3 and 4?

A. Yeah.

Q. What actually did you put in?

A. I remember lumbar 3 and 4.

Q. What agent do you put into the space?

A. Tetracaine mixed with Dextrose.

Q. Okay. When you put it in at that level, what does it do? Numb from that level down or from that level up?

A. About the second or third level up and all the way down.

Q. Is the patient still awake?

A. Yeah, he's awake.

Q. The patient is awake?

A. Yeah.

Q. He was awake on the operating table?

A. All the time.

Q. He knew what was going on?

A. Yeah. First time when they make some manipulation, hasn't complained of pain, but I let them just hold a few more minutes and then pound delicately, anesthetize, so I let them go ahead.

Q. He was awake all this time while they were pulling and yanking on his leg?

MR. BONEZZI: Objection.

A. No. They don't -- they're paralyzed.

Q. I understand they don't feel anything below the waist. But he's awake?

A. He's awake, yeah.

Q. Do you recall him saying anything else?

A. No.

Q. Do you recall any discussions by Dr. Smith or Miller during this procedure as to what had caused it to go out of joint?

A. No. I didn't ask about the procedure of the surgery while was going on, I didn't ask. They try every angle and they find out they got it.

MR. BONEZZI: Doctor, listen to his question.

Q. They tried a bunch of angles and finally they got it?

A. Yeah.

Q. On the back of that sheet, 151, it's got post anesthesia note. Is that all written by you?

A. Yeah.

Q. When did you write that?

A. After pronounce dead.

Q. At the top it's got 5:45 p.m. Did you write that?

A. That one was immediately after I move the patient into the recovery room.

Q. Why don't you tell me what that says.

A. "Spinal anesthesia well -- 5:45 p.m., spinal anesthesia well tolerated though there was fluctuation of blood pressure. It was on -- he was on oxygen nasal prong cannula."

Q. Is there something other than nasal cannula that you can do with a patient who is having respiratory distress? Oxygen?

A. Yeah, oxygen. Either way can do it. Instead of nasal cannula, mask can be put on. And --

Q. Was a mask put on?

A. No. This was a nasal cannula instead of mask.

Q. Who makes that decision?

A. I did.

Q. Why did you choose nasal cannula instead of mask?

A. Nasal cannula patient can have a better feeling.

Q. Better feeling?

A. Better feeling, sometime complain of sense of choke with mask. But I left this nasal prong, which was being used from the operating room, and this vent. I didn't feel that should change to any other instrument.

Q. Doctor, on page 153, is apparently Dr. Gill's --

A. 153.

Q. -- report of the surgery.

A. Yeah.

Q. Do you recall Dr. Gill being there now?

A. Yeah.

Q. Okay, Now, in the middle of that

paragraph, there's a sentence that said, "Note that large amount of force was necessary to reduce this hip."

A. Yeah.

Q. All right. Is it that you just didn't pay attention to the procedure that they were doing, or you just don't recall this requiring a large amount of force? Do you understand my question, Doctor?

A. I remember they did hard work. That's all I remember.

Q. Hard work?

A. Yeah.

Q. When it says patient was transferred to -- well, what does that mean when you say they did hard work? Were they sweating? Were they pulling? Were they tugging? Were they beating on the leg? What were they doing?

A. They pulled and rotate and wasn't successful in the first time and they did it more, then they take x-ray more than few times and -- they kept taking x-rays and they tried pulling, rotating. Each angles. I cannot tell anything in detail.

Q. What do you mean you can't tell in detail?

Why can't you?

A. I paid attention to the patient is general condition.

Q. Okay. Was there a decision made to have this patient taken to intensive care after the surgery?

A. No.

Q. Page 166, I believe?

A. There was last part of the recovery room.

Q. 167. Expiration summary. Page 2. The last paragraph, the third sentence, Doctor, it says "The patient was transferred to the intensive care unit for recovery." That's not right, is it? He wasn't transferred to intensive care, was he?

A. No.

Q. Whose decision was it for this patient to go to the recovery room as opposed to the intensive care unit? Yours or Dr. Smith's?

A. I think both of us.

Q. Well, I mean did you talk about it? When you say you think, who made that decision?

A. From the beginning, we didn't think he would go to the intensive care unit.

Q. From the beginning, when was that discussed?

A. I didn't think this patient needed intensive care at that time. Patient had spinal anesthesia wearing off, minimal one or two hours, and he didn't have any bleeding during the surgery.

Q. You mean external bleeding?

A. External bleeding.

Q. How about internal?

A. Internal I cannot say.

Q. Well, if you would have known what the hemoglobin drops were for the preceding four days, would it have been important to maybe try to monitor that?

MR. BONEZZI: Objection. You may answer.

MR. GROEDEL: Objection.

A. The hemoglobin only is not the cause of intensive care needed. This can be compensated with the blood transfusion. It's not have to be done -- not necessary need intensive care unit, admission to intensive care unit for lowering blood count.

Q. Was a decision made as to who was going to be able to monitor Mr. Smith once he was transferred to the recovery room?

A, I was **the one --**

Q. Who made that decision? Was that a joint decision or you just took it upon yourself?

A. Not the joint decision. We didn't discuss about that.

Q. In other words, that was your job?

MR. BONEZZI: Objection.

A. Yeah.

Q. Okay, Were there also other people within the hospital to whom responsibility could be attached for the continued monitoring of Mr. Smith's condition, for example, the resident Dr. Miller since he was the orthopedic resident?

MS. BARTNIK: Objection.

MS. DANN: Objection.

Q. Do you understand my question?

A. Yeah.

Q. What's the answer to it?

A. I cannot say whose responsibilities --

Q. I mean if the nurse in the recovery room needed to talk to somebody about Mr. Smith while he was in the recovery room, would you be the only one she could talk to or could she talk to someone else?

A. She could talk with anybody.

Q. Anybody?

A. Surgeon or resident.

Q. The attending physician?
A. Yeah.
Q. Or the resident?
A. Yeah,
Q. But it was your job, it was your responsibility to follow him while he was in the recovery room, I take it; is that correct?
A. Right.
Q. Starting at page I think 155, I believe that's correct, are the records of the recovery room. Have you reviewed those, Doctor --
A, Yeah.
Q. -- before coming here today?
A. Yeah.
Q. Now, the very first entry there is 5:25 entry?
A. Um-hmm.
Q. Do you disagree with anything contained in that entry, Doctor?
A. I had a different opinion of the multifocal PVC. I explained the nurse this patient had atrial fibrillation during the surgery.
Q. You're going to have to speak up so we can all hear you.
A. Atrial fibrillation during the surgery,

you know, ventricular rates is irregular and also some PVC, some PVC. I counted PVC about less than seven minutes, so I explained there is not to be startled.

Q. Not to what?

A. Not to be startled.

Q. Not to be started what?

A. About --

Q. Not to be startled?

A. Yeah.

Q. This was the nurse at 5:25?

A. Yeah.

Q. Did you tell that same nurse the same thing later on in the evening at 9:30 or 10:00 --

MS. DANN: Objection.

Q. -- not to be startled by multifocal PVCs? Did you?

MS. DANN: I think it was leading.

MR. KAMPINSKI: You're right, I am. Let him answer the question. I want see what his answer is. Page 158 at 8:05, says, "Multifocal PVCs noted."

MR. BONEZZI: What's the question?

Q. (BY MR. KAMPINSKI) First of all, was it the same nurse, Doctor?

A. Different nurses.

Q. All right. Did you tell the second nurse the same thing then, not to be alarmed about the multifocal PVCs that she also saw?

A. I remember I did because about 6:00 something, she called me and she saw this patient after the first nurse left and she startled a little -- the nurse, the previous nurse explained it to her, but she was nervous and called me and I explained. They do -- I explained the same thing to the second nurse.

Q. Was Mr. Smith awake during this period of time, Doctor?

A. He was -- yeah. He was confused in the middle -- by this chart.

Q. Don't you have a recollection without looking at the chart? Do you remember going to see him that evening, his being awake?

A. He has been awake most of the time. When I called from the nurse, she was confused, but I checked the patient.

MR. BONEZZI: Look at the chart.

MR. KAMPINSKI: I want to see if he has a recollection without the chart.

MR. BONEZZI: That's fine.

Q. If he doesn't, we'll look at the chart. My question to him was do you have a recollection of him being awake that evening without looking at the chart?

MR. BONEZZI: He indicated that he remembers that he was awake.

Q. You do?

A. Yeah --

MR. BONEZZI: As it relates to specifics on the chart.

A. I explained to nurse I gave Lidocaine twice for the treatment of ventricular beat, that may cause sleepiness, and tne nurse seemed to be -- seemed to accept it, my explanation. So I checked the patient, I called and he answered and he opened eyes.

Q. Was he short of breath when he came into the recovery room, Doctor?

A. He was in shortness of breath from -- before the surgery.

Q. So that was the same?

A. Yeah. I found no difference preoperatively -- between preoperative stages of ventilation and postoperative in the recovery room.

Q. Was he on an IV?

A. Yeah.

Q. What was being given through the IV?

A. It was in the recovery room, lactate ringer.

Q. Lactate ringer?

A. Yeah.

Q. What's that?

MR. BONEZZI: Look at the chart, Doctor, make sure what he was on.

Q. (BY MR. KAMPINSKI) What's that? What's lactate ringer, Doctor?

A. That's really containing the lactate with some salt source.

Q. What's it for?

A. Provides like minimal potassium.

Q. For electrolyte balance?

A. Yeah, potassium. Some energy source.

Q. Was he placed on Dinamapp by Dr. Smith?

A. Yeah.

Q. What's the purpose of that?

A. No, not by Dr. Smith. The nurse did.

Q. The nurse?

A. Yeah.

Q. Okay. That first sentence it's got "Dr. Smith visited." Then it says, "Placed on Dinamapp

and cardiac monitor."

A. Yeah.

Q. Was that your order or Dr. Smith's or whose?

A. There's routine order in the recovery.

Q. Cardiac monitor is routine in the recovery room?

A. Yeah. Any patient with history of heart condition.

Q. And do you make a tape of that, of the monitor?

A. Beg your pardon?

Q. A tape, a readout.

A. Not all the time.

Q. Why not?

A. Reading strip, I don't do that all the time, but nurse, they do once in a while.

Q. Can you order it to be done so that when you come in you can see what was going on while you weren't in there? Can you order it done?

A. Yes, I can order it, but I didn't feel it necessary because I knew the patient pattern of the EKG.

Q. You did?

A. I knew what's going on and --

Q. Knew this patient pretty well by the time surgery was over, huh?

MR. BONEZZI: Objection.

A. Yeah.

Q. What's Neo-Synephrine drip?

A. That used for the raising blood pressure up.

Q. You ordered it discontinued at 5:40. Page 156. First entry.

A. By this record, I can recollect I put it in the patient IV line.

Q. It says drip --

A. Yeah. It's microdrips. Very minimal size of the IV needle --

Q. Wait. Let me stop you. It says Neo-Synephrine drip then it's D --

A. D then looks like I?

A. Discontinued.

Q. Did you stop it or did you start it?

A. I stopped. I took it out.

Q. Why?

A. Blood pressure is reasonably stable and I didn't think they were needed anymore.

Q. Who ordered it? You?

A. I did.

Q. When, 5:25?

A. It was --

MR. BONEZZI: Look to see when you ordered it.

Q. Tell me what page you're looking at.

A. I don't think I wrote on the chart. I brought the bottle from the operating room and I didn't use it, I just plugged it in case --

Q. You brought what bottle, Doctor?

A. Neo-Synephrine drip.

Q. You brought it from the operating room? It was just lying around there so you brought it in?

MR. BONEZZI: Objection.

Q. What did you do with it?

A. Put it into IV, but it wasn't used.

Q. You put it into the IV, but it wasn't used?

A. Right.

Q. So he didn't get any Neo-Synephrine drip?

A. I didn't -- not being used.

Q. It says discontinued.

A. Discontinued means to take it out.

Q. That implies to me at one time it was being used, but you're saying that's incorrect. It was plugged in but not being used?

A. Not used.

Q. How do you use it if it's plugged in as opposed to not using it? Is there a little button or switch or something?

A. Yeah. There was a clamp.

Q. You're saying the clamp was not on?

A. Not on.

Q. Doctor, if I look at page 155 under the IV infusing on the right or on the left-hand portion, 155, right over here, Doctor, what's that say? And I'm pointing to a portion right by the IV infusion. What's that say?

A. "IV infusion, 5D lactate ringer." That means 5 Dextrose plus lactate and ringer. "600 cc and was given" --

Q. "In the left arm"?

A. Yeah.

Q. What's the next thing say, "NS plus"?

A. Normal serum.

Q. "Plus 10"?

A. Plus --

MR. BONEZZI: Can you make that out?

A. Yeah. "Normal serum plus 10 milligram of Neo-Synephrine."

Q. You just "told me it wasn't given.

A. I don't remember. I didn't give --

Q. So it was given?

A. By this record, yeah.

Q. Yeah. And if you keep going, it's got it again, doesn't it, "BNS," that's normal saline, "plus Neo-Synephrine 150," right?

A. Yeah.

Q. Were they supposed to give it, Doctor? Did they turn that little knob when they weren't supposed to turn it or weren't they supposed to or what? I don't understand.

MR. BONEZZI: Objection.

MS. BARTNIK: Objection.

MR. BONEZZI: Do you understand the question?

A. Yes.

Q. What's the answer?

A. For the controlling blood pressure, it's supposed to be given.

Q. Yeah. So then why did you discontinue it if that's what its purpose was?

A. Because blood pressure becomes stable.

Q. So by 5:40 it was stable; is that your testimony?

A. Yes.

Q. How about the pulse, was it stable at 5:40, 5:45?

A. He had tachycardia.

Q. Is that normal or abnormal, sir?

MR. BONEZZI: Objection.

A. It's abnormal.

Q. That's too fast, isn't it?

A. Very fast.

Q. What did you do for it?

A. Has been fast for long time.

Q. That doesn't make it good though, does it?

MR. BONEZZI: Objection.

Q. What did you do for it, Doctor?

A. I didn't do much thinking about that.

Q. Why not?

A. I kept the patient breathe and we'd put with a good amount of oxygen.

Q. Through the nasal eastnula?

A, Yeah.

Q. Did you do arterial blood gas studies tc determine how much oxygen he was getting into his blood?

MR. BONEZZI: Objection.

Q. Did you?

A, I didn't feel it was necessary.

Q. You were wrong, weren't you?

MR. BONEZZI: Objection.

Q. Weren't you, sir?

MR. BONEZZI: Objection.

Q. It was necessary, wasn't it?

MR. BONEZZI: Objection.

Q. Wasn't it, Doctor?

A. I didn't think it was necessary because patient breathing condition was the same, shortness of breath, same pattern, same type, same rate of respiration, and I was really concerned about -- I wasn't really concerned about his way of breathing. Heart rate, it has been high in the preoperative stage and --

Q. Did you consult a cardiologist, get his opinion?

MR. BONEZZI: Objection.

Q. Did you, sir?

A. At that point I didn't.

Q. Was there a cardiologist available on call to be consulted?

A. I could --

Q. My question is was there a cardiologist available on call to be consulted?

A. I didn't check.

Q. Do you know whether there was one?
A. Yeah.
Q. There was?
A. Yeah, there was.
Q. Who was?
A. No, I didn't check for that.
Q. You just know there would have been one if you wanted a consult?
A. Right.
Q. Are there cardiologists available in the intensive care unit?
A. I didn't check either.
Q. How was his respiration, 32? Was that okay?
A. 32 was fast.
Q. You told me, Doctor, I think just a little bit ago, the nurse or whoever it was that was on at 5:25, you told her not to worry about the A fibrillating and uncontrolled ventricular STE on page 155, do you see them?
A. PVC?
Q. No. Let's start with A fib. That's atrial fibrillation, right?
A. Right.
Q. And uncontrolled ventricular, what's that

next word, STE?

A. Uncontrolled ventricular rate.

Q. That's rate?

A. Rate. That means high ventricular rate.

Q. And "Frequent multifocal PVCs noted, Doctor S. J. Lee aware." At that point you told her not to concern herself, right? You were aware of it and that it was just fine because you'd seen it all through the operation, right?

MR. BONEZZI: Objection.

Q. Is that right? Is that what your testimony is, sir?

A. Yeah, I told her this has been the rate.

Q. And then at 5:45, 20 minutes later, and five minutes after you discontinued the Neo-Synephrine drip, at 5:45, you're paged. It says "Anesthesia paged"?

A. Um-hmm.

Q. "Frequent PVCs, multifocal and coupling noted on monitor, no readout." That means she didn't get there quick enough to push it, no readout?

A. Um-hmm.

Q. That's the same nurse, isn't it, Doctor, that you told not to worry about it at 5:25, right? The shift change hadn't occurred yet, that's

Williams?

A. Yes, same nurse,

Q. Why did she call you at 5:45? What was there different at 5:45 than existed at 5:25 for her to page you?

MR. BONEZZI: Objection.

MS. BARTNIK: Objection.

MS. DANN: Objection.

Q. What is there, Doctor, different? Is it the coupling?

MR. BONEZZI: Objection.

A. There was disappearance of PVC for a while and it appeared again.

Q. But told her not to worry about it at 5:25. My question to you is what is there additional that occurred at 5:45 that caused her to worry enough to call you back? Is it the coupling aspect of that note that caused her to call you back, sir?

A. Yeah.

MS. BARTNIK: Objection.

MR. BONEZZI: Which one do you want him to answer first?

Q. I had hoped it was the same, but let's make sure it is. Is it the coupling aspect that's

noted in the 5:45 entry that's not noted in the 5:25 entry that caused her to call you back?

MS. BARTNIK: Objection.

MS. DANN: Objection.

Q. Is that what it is, Dr. Lee?

MR. BONEZZI: If you know, Doctor.

A. It can be a sign of possible ventricular fibrillation, but I treated --

Q. Wait. First just answer my question. Is that the difference that caused her to call you was the coupling?

MR. BONEZZI: Objection.

MS. BARTNIK: Objection.

A. Yes.

Q. And coupling is serious because of what you just said, it can be a sign of a worsening condition, can't it?

MR. BONEZZI: Objection. Go ahead and answer.

A. Yes.

Q. And you apparently showed up five minutes later at 5:50 because then you got readout monitor in place, "Dr. S. J. Lee in," right? Correct, sir? Am I reading that right?

A. Yeah.

Q. Did you order the readout monitor so you would be able to see the strip?

A. The nurse did that.

Q. She did that on her own?

A. Yeah.

Q. So that there was a different monitor she put on so she could show you the strip next time, I take it?

MR. BONEZZI: Objection.

A. Um-hmm.

Q. Now, you ordered apparently Lidocaine to be given, correct?

A. Right.

Q. And the reason for that was what, sir?

A. To treat ventricular contraction.

Q. Why didn't you order that earlier? You were aware of that when he came into the recovery room. What is there now at 5:55 that causes you to order Lidocaine?

A. I thought this coupling is more worse than the PVC.

Q. You believed the coupling was occurring, didn't you?

A. Yeah.

Q. Did you call a cardiology consult at that

time, sir?

A. No, I didn't.

Q. Did you order him to go to the intensive care unit at that time, sir?

A. No, I didn't.

Q. Have you had specialized cardiology training?

A. No.

Q. And the Lidocaine, what does it do for the multifocal PVCs with coupling? What does the Lidocaine do?

A. Lidocaine decrease -- also it may give treatment for the PVC. We give it for the total -- complete treatment of the PVC, but at that time it didn't work, I found out.

Q. What was it that was causing the PVCs at this time, sir, do you know?

MR. BONEZZI: Objection.

A. I explained that to nurse. Wearing off from the spinal anesthesia. It was sympathetic nerve a stimulation will be found -- spinal anesthesia was one of the sympathetic nervous activity and by wearing off the anesthesia, the nerve ending of sympathetic nerves increased excretion. That may be the course of PVC.

Q. Was his blood pressure still stable at 6:15?

A. Became a little higher.

Q. Higher. So you started the Neo-Synephrine drip again?

A. No. It prevent low blood pressure.

Q. Makes it go higher?

A. Yeah.

Q. I see. So what caused it to go higher now since the Neo-Synephrine drip had been taken off?

A. Recovering from anesthesia.

Q. That makes the blood pressure go higher too?

A. Yeah.

Q. He was still tachycardia?

A. Heart rate remained the same.

Q. The monitor at this time showed atrial fibrillation and ectopics?

A. Um-hmm.

Q. All right. The patient was confused, correct? Am I reading that correctly, sir?

A. Yeah.

Q. What are ectopics?

A, Ectopic beat the same as the PVC.

Q. Nothing to be concerned with at that time, the same as it has been, right?

MR. BONEZZI: Objection.

Q. Right, sir?

MR. BONEZZI: Do you understand the question?

A. Yeah. The same.

Q. Nothing to be concerned with, right?

MR. BONEZZI: Objection.

A. I concerned.

Q. You were concerned?

A. Yeah.

Q. Did you get more concerned at 6:45? That's the next time you were in to see him, correct? You were there at 5 -- well, at 5:50, then you were in an hour later at 6:45. Actually 55 minutes.

A. Yeah.

Q. Did you get more concerned at that time or was a projectile emesis of large amount of tan fluid a normal occurrence after wearing off of spinal anesthesia?

MR. BONEZZI: Objection.

A. I didn't clear out what the cause of it.

Q. Why didn't you? Did you order any

additional tests? Did you get a consult from a gastroenterologist or endocrinologist or cardiologist or anybody?

MR. BONEZZI: Objection.

Q. Take them all one at a time if you want. Did you get a consult from anybody? Did you, Doctor, yes or no, sir?

A. His --

MR. BONEZZI: Doctor, the question is did you get a consult?

A. No, I didn't.

Q. And is Nurse Sims right when she says "No treatment given for any of the above-mentioned conditions"? You didn't give any treatment at that time; is that right?

A. I didn't give any treatment on this point.

Q. All right. What's trigeminal rhythm?

A. PVC every third beat.

Q. What's the significance of that?

A. Displaying PVC. Regularly appearing the -- regularly every three beats. Once every -- one PVC every three beats.

Q. Why is that important?

A. There was very sort of --

Q. Why is it important? It's once every

three beats?

A. It's more than usual. Every three beats is one -- in one minute, it can be about 20 times.

Q. So why is that important it's happening once every three beats as opposed to once every ten beats or four beats or six beats?

A. I don't know.

Q. She paged you at 7:00, 15 minutes after you had been there the last time, and told you that there were "Coupling PVCs and trigeminal rhythm noted." Do you remember that?

A. Yeah.

Q. What did you tell her? Did you tell her that "Pattern okay"? She's got that in quotes there.

MR. BONEZZI: Objection.

Q. Do you remember that?

A. Now I recollect I was with nurse the few times and then it returned to -- then it returned to 10 PVCs a minute and then it disappeared.

Q. You remember that now as you sit here?

A. Yes.

MR. BONEZZI: Objection.

Q. Before coming here today you don't remember that or did you?

MR. BONEZZI: Objection.

Q. When did you remember that?

MR. BONEZZI: When you asked him a question.

Q. When did you remember that as opposed to when Mr. Bonezzi remembers you remembering it?

A. From the beginning, from the recovery.

Q. Okay. When is the next time you came in to see --

A. Did he ask me?

MR. BONEZZI: Would you read the question back?

Q. (BY MR. KAMPINSKI) When is the next time you saw Mr. Smith?

A. In the recovery room?

Q. Anyplace. Anywhere. I assume that's where he stayed. I apologize, Doctor, yes, in the recovery room.

A. I checked by myself time to time, but I do not remember.

Q. According to the chart, Doctor, which Mr. Bonezzi wants you to look at to make sure your recollection was accurate, the last time that we see you seeing the patient, according to the chart, is 7:00, and my question after that was when the

next time is that you saw him in the recovery room after 7:00, according to the chart.

A. I was there the second floor, I checked the patient time to time, but not recorded here.

Q. The next time that shows is 9:50, isn't that correct, Doctor?

MS. DANN: Objection.

A. No. Before that --

Q. As far as the chart goes.

A. Yeah.

Q. I think the next time --

A. What is written by nurse here.

Q. But as far as the chart, as far as what she did write, 9:50 is the next time you were there?

A. Um-hmm.

Q. By the way, were you informed of his blood pressure at 9 p.m., 176 over 97?

A. I think I was notified, yes.

Q. Was that the only treatment that he was getting through the IV? Is that the only form of treatment Mr. Smith was receiving?

A. Yeah.

Q. And I take it the most important thing that he was getting -- he was getting the lactate ringers for the electrolyte balance, correct?

A. Right.

Q. He was getting Lidocaine for his heart?

A. Right.

Q. Was he getting anything else through the IV that was assisting him?

A. Until the 9:50?

Q. Yes.

A. I don't think he got anything.

Q. Was it important for him to be getting his IV, the medication through the IV?

A. Yeah.

Q. And for example, if he didn't get it for 45 minutes or an hour, could that be harmful to him in the condition that he was in?

MR. BONEZZI: Objection.

MS. DANN: Objection.

A. Not getting IVs, I cannot say is harmful, but the patient needed strict restoration of fluid.

Q. That's why he gets it IV and not by mouth, right?

A. Not by mouth.

Q. That's why you put it through the IV?

A. Right.

Q. But I assume that he's being given it through the IV or if he could take it by mouth or

if he could take it some other way because he needs the medication, that's why you're giving it to him?

A. Right.

Q. My question to you, sir, is it harmful if he's not getting the medication that you ordered for him?

A. Right.

Q. And if he weren't getting it for let's say a half hour or 45 minutes, would that be harmful?

MS. BARTNIK: Objection.

MS. DANN: Objection.

A. It may be harmful, yeah.

Q. Would you want to know in a patient such as this who has got irregular heartbeats, tachycardia, he's short of breath, he's showing different patterns on the strips, he's just been through surgery, and you yourself said you were not aware of all the facts, which you weren't aware of, would probably have not considered him a good candidate for surgery --

MR. BONEZZI: Objection.

Q. Should you have been notified if this IV was taken out of this man right away?

A. No.

Q. No? Should you have been notified that this IV was taken out of this man?

A. Yeah.

Q. Right away?

A. Right.

Q. Were you?

A. Yeah. When they called, the IV was -- I was notified.

Q. When were you notified?

A. I have to find it in the chart.

Q. 9:15. Page 142. No. Page 166.

MS. BARTNIK: I don't think you mean 166.

MR. BONEZZI: 159.

A. Yeah.

Q. Well, it says -- the note starts with 9:15, "Lung sounds clear. Patient coughing productively. White mucous, no expiratory wheeze at this time. Dr. Lee notified of infiltration of IV." Do you recall where you were, if you were notified, Doctor? Where were you that night?

MR. BONEZZI: Do you remember where you were before you were notified?

A. I don't remember. I stayed there on surgical floor for some time.

Q. Is that the same floor as the recovery room?

A. Same floor.

Q. Were you in another surgery?

A. Yeah, there was another surgery.

Q. Was it a complicated one, one that required your --

A. It was a long surgery.

Q. Long one. Did you have any help or did Joan Allen leave -- Joan Allen leave?

A. Nurse anesthetist that was to work case --

Q. Is that what you were trying to tell me before when you said it would have been better to have more help around?

A. In some way, yes.

Q. Because it took you, according to the chart here, 35 minutes after you were informed of the infiltration of the IV until you actually got there to try to restart it, and would the reason for that be that there just weren't enough people around to help this nurse infiltrate it since you were in another surgery? Do you understand my question?

A. Yeah. This is already -- 9:50, other than this patient, I may -- can be taken out, but

this patient had some problems --

Q. By the time you got there at 9:50, there was an elevation of pulse was noted. He had an expiratory wheeze and he was complaining that he couldn't breathe; isn't that right, Doctor?

A. I recollect at this time I thought the patient is about to be ready to be discharged from the recovery room.

Q. At 9:50?

A. Yeah.

Q. When he complained of not being able to breathe, he was diaphoretic?

A. I checked time to time and there was no PVC, present breathing was all right.

Q. That's in this chart, Doctor?

MR. BONEZZI: Doctor, please listen to his question and answer only the question that is asked of you.

Q. (BY MR. KAMPINSKI) Doctor, at 9:00 the monitor shows atrial tachycardia and occasional PVCs. Trigeminy run noted on monitor. You're saying that he's fine, he's ready to go out of the recovery room at that point?

MR. BONEZZI: Objection.

Q. Is that your testimony, sir?

A. Okay.

MR. BONEZZI: Did you hear what his question was?

A. Yeah.

Q. You can't just say things, Doctor, that are not supported by the record. You understand that, sir, don't you? You can if you want to, but I want you to understand the record is saying something different than what you're saying.

Is it your testimony at 9:00 he was ready to be taken out of the recovery room and go back to his regular room; is that your testimony?

A. Objection.

Q. There was no problem?

MR. BONEZZI: Answer his question. Listen to his question.

Q. Did he have problems at 9:00?

MR. BONEZZI: He wants to know as of 9:00 was he ready to be discharged, based upon what's in that record?

A. By this record, no, definitely not.

Q. How about at 9:50 when you finally came in to see him after being notified at 9:15 that the IV was out?

MR. BONEZZI: Objection.

Q. How about then, was he ready to be discharged at 9:50?

A. No.

MR. BONEZZI: Objection.

Q. He was in trouble, wasn't he, Doctor?

MR. BONEZZI: Objection.

Q. Wasn't he, sir?

A. Yeah.

Q. Did you call in a consult then?

A. No.

Q. Why not?

A. I thought I could treat.

Q. Did you transfer him to intensive care?

A. At that point I decided later.

Q. Did you transfer him at 9:50 to intensive care? Yes or no, Doctor?

A. No.

Q. Was he ever transferred to intensive care?

A. No, never.

Q. Did you call Dr. Smith and talk to him about transferring him to intensive care or getting a consult?

A. I called surgical -- I left --

MR. BONEZZI: Did you call Dr. Smith?

A, No.

Q. You let the nurse call who?

A. Call the surgical resident, orthopedic resident.

Q. You let her call. Did you tell her to call or did she want to call because she didn't think the patient was being treated correctly?

MR. BONEZZI: Objection.

MS. BARTNIK: Objection.

MS. DANN: Objection.

A. I remember I let the nurse call orthopedic surgeon.

Q. I don't understand what you mean when you say you let her call. Did you tell her to call or did you allow her to call? What do you mean you let her call?

A. I told her to call.

Q. Why did you tell her to call the surgical resident?

A. We have to move patient to intensive care unit.

Q. That would have been apparently Dr. Miller here?

A. Yeah.

Q. That wasn't until 10:30, according to this record, correct?

A. According to this record, I think so, yeah.

Q. All right. And what did he say? According to the record, she called him at 10:30, he was paged, then you notified Dr. Miller of the patient's condition at 10:37. All right. Then Dr. Smith's answering service was notified to contact recovery room at 10:43. All right. When you talked to Dr. Miller or when the nurse talked to Dr. Miller, what decision was made about transferring the patient?

A. Yeah.

Q. What decision was made?

A. Transfer the patient.

Q. To transfer him?

A. No. I didn't transfer him.

Q. Did you and Dr. Miller make the decision to transfer him at that time?

A. Yeah.

Q. Why wasn't he transferred?

A. What I thought at that time, he's in cardiac failure and pulmonary edema. That's all I thought.

Q. Well, thinking that, wasn't it even more important to have him transferred somewhere where

he could be dealt with adequately as opposed to the recovery room?

MR. BONEZZI: Objection.

A. Should I put all the time before the transferring -- I should have given immediate treatment for the operation and for the heart rate and for the blood pressure first.

Q. Are the facilities better in the intensive care unit for taking care of someone in respiratory distress and having atrial fibrillations, multifocal PVCs, than in the recovery room?

A. Yes.

Q. I take it it was your decision to leave him in the recovery room from 5:25 until 10:30 when you talked to Dr. Miller recommending that he be moved. Would that be a fair statement, Doctor, that it was your decision during that period of time?

A. I talked to the Doc Smith and myself. Neither had objection about putting him into recovery room.

Q. I understand. But between 5:25 and 10:30, was it your decision to keep Mr. Smith in the recovery room or did you confer with anybody else

during that period of time?

A. No, I didn't.

Q. Okay. So it was your decision then, correct?

A. Yeah.

Q. Did you speak to Dr. Stephens when he called or did the nurse speak to him?

A. I think the nurse.

Q. Okay. You didn't talk to him?

A. No.

Q. Did you talk to Dr. Miller? I think you said you did.

A. Yeah.

Q. Do you recall what your conversation was with Dr. Miller?

A. Patient had to be moved to SICU.

Q. Did you tell him why?

A. Probably development of cardiac failure.

Q. Did he tell you to call Dr. Stephens or did he say, Hey, I'll be right there, or what happened?

A. I cannot recollect, but he responded -- he agreed to what my suggestion. I don't remember what was said.

Q. You see, because I think you called him

at 10:30, and if you told him that the patient was in cardiac failure, I guess I need to ask you why it is he didn't come up until 11:15, if you know?

MS. BARTNIK: Objection.

Q. Was he in a surgery or doing something else, do you know? Was he covering the emergency room, do you know?

A. Dr. Miller -- I don't remember.

Q. Patient was intubated at 11:00 by you. Do you remember that, Doctor?

A. Yeah.

Q. And there was a moderate amount of tan fluid suction. Where did it come from?

A. From stomach.

Q. From the stomach. What's the purpose of intubating a patient and where did he put the tube?

A. Decided to put the patient on ventilation in the surgical intensive care unit.

Q. He wasn't in the surgical intensive care unit.

MR. BONEZZI: Listen to his question.

Q. I'm asking about the 11:00 entry where you have "Patient intubated by Dr. Lee, mouth and tube suctioned for moderate amount of tan fluid." Where did you put the tube, Doctor, that you got

tan fluid out of the stomach?

A. Put the tube into the trachea.

Q. Trachea. And the fluid came from the stomach?

A. Yeah. Came from stomach.

Q. Could it have come from the lungs?

MR. BONEZZI: Objection.

A. I did suction some from the --

Q. From the tube, so that means it came from the lungs?

A. Multi fluid from stomach. I intubated.

Q. Did Mr. Smith, in your opinion, have gastrointestinal bleed?

A. I couldn't find any blood when he vomited in the operating room. The color was all right.

Q. Had stomach contents aspirated into the patient's lungs when you intubated Mr. Smith?

A. I had about 10 cc. He regurgitated some into the lung. It was a very minimum amount.

Q. Who did you talk to after Mr. Smith died? Did you talk to Dr. Smith and Dr. Stephens?

A. I don't think I called anybody.

Q. Was Dr. Stephens there? Did he show up?

A. Dr. Stephens was -- yeah. Doc Stephens was there.

Q. Did you talk to him about what happened?
A. Yes.
Q. Did he ask you why this patient wasn't transferred to intensive care?
A. No. We didn't discuss it at that point.
Q. What did you discuss?
A. I explained I was about to transfer this patient to surgery intensive care unit, and these things happen.
Q. Did you talk to the family at all?
A. I didn't talk to the family.
Q. Did you get involved into the decision as to whether or not to do an autopsy?
A. No, I didn't involve.
Q. Isn't it required to do an autopsy if somebody dies within a day of surgery?
A. I assume the surgical --
Q. You assumed they'd take care of that because that's what's done, isn't it?
A. I found it was not done.
Q. Why not?
A. I don't know.
Q. Did you ever talk to Dr. Smith or Stephens or Miller or Gill or anybody as to why no autopsy was done here?

A. No, I didn't discuss about that.

Q. What do you think the -- in your opinion, the infusing IV had to do with Mr. Smith's death, if anything?

MR. BONEZZI: Objection.

MS. DANN: Objection.

MR. BONEZZI: You may answer.

A. Medication infused through the IV?

Q. Sure.

A. I don't think I did anything wrong with --

Q. That will be up to somebody else to decide. My question is what do you think the lack of medication through the IV -- and I'm not saying that it was your fault or somebody else's fault, somebody else will decide that -- but just the fact of his not having an IV for that period of time, what effect do you think that had with respect to the ultimate death?

MS. DANN: Objection.

A. The IV?

Q. Yes.

A. Lack of an IV?

Q. Yes.

A. That's less fluid.

Q. Do you think that had an affect on his

dying?

A. No, I don't think so.

MS. DANN: Objection.

Q. Do you think the fact that the hemoglobin had dropped in this patient over a three-day period of time from approximately 15 to 10 had any affect on his ultimately dying?

MR. BONEZZI: Objection.

A. No, I don't think so.

Q. Do you think the monitoring or lack thereof in the recovery room had any affect on this patient's dying?

MR. BONEZZI: Objection.

MS. DANN: Objection.

MS. BARTNIK: Objection.

Q. Do you think he should have been monitored more in the recovery room?

MR. BONEZZI: Objection.

MS. DANN: Objection.

A. I felt at that time not necessary any further monitoring him, unnecessary. The patient had a spinal anesthesia.

Q. Yeah.

A. And we're waiting for the wearing off for the patient from anesthesia.

Q. Um-hmm.
A. The surgery was simple.
Q. Was what, simple?
A. Yeah.
Q. It wasn't very simple for Mr. Smith, was it?
MR. BONEZZI: Objection.
MR. GROEDEL: Objection.
MS. DANN: Objection.
A. I cannot tell --
Q. He died.
MR. BONEZZI: Objection.
Q. How simple is that, Doctor?
MR. BONEZZI: Objection. You don't have to answer that.
Q. (BY MR. KAMPINSKI) I think my question was whether or not you believed additional monitoring was necessary in the recovery room. That was my question. Now, if you'd answer that, I'd appreciate it.
MS. DANN: Objection.
MR. BONEZZI: Mr. Kampinski, he started to answer that question.
MR. KAMPINSKI: I don't think he did.
MR. BONEZZI: Yes, he did.

MS. BARTNIK: I believe he did. I object to that.

MR. KAMPINSKI: You can object to what you want.

Q. (BY MR. KAMPINSKI) If you'll answer it, I'd appreciate it.

A. There was spinal anesthesia, the surgery was done, and patient had the same type pattern over breathing and the preop, pattern of the breathing. And when the -- the patient in the process of wearing off the anesthesia, I felt at that time that patient would be normal condition wherever exactly as the preop status.

Q. Doctor, did you give due consideration to the history of this patient before surgery in retrospect sitting here now, having had a better chance to look at the records, realizing you had even taken the wrong readings off the wrong day's chart, did you give due consideration to this patient's history and the things that were happening to him between November 14th and November 17th and allowing him to go to surgery at all?

MR. BONEZZI: Objection.

Q. Did you?

MR. BONEZZI: Objection.

A. Retrospective?

Q. Yes.

A. Retrospective, I wouldn't let him go to surgery.

MR. KAMPINSKI: Why don't we take a five minute break.

(Short recess was taken.)

MR. KAMPINSKI: I have one more.

Q. (BY MR. KAMPINSKI) Doctor, how long does it usually take for an anesthetic such as you gave Mr. Smith to wear off?

A. About four hours.

Q. Four hours. So -- I'm sorry?

A. About four hours.

Q. So there was nothing unusual in the length of time that it took for this anesthesia to wear off, was there?

A. This person, it was unusual, yeah.

Q. Why?

A. Retrospectively, I assume this, I don't know, because of poor circulation.

Q. What because of poor circulation? That it took so long?

A. Absorption and distribution and excretion is slow, that's why -- absorption and excretion of

anesthetic agent becomes slow.

Q. In other words --

A. Because of poor circulation.

Q. So in other words, when he wasn't out and they started the procedure --

A. It wasn't out.

Q. He wasn't numb in the operating room and they started the procedure, which is what you were telling me about earlier, you're saying that was because of his blood loss and reduced capacity of oxygen in his blood or what?

MR. BONEZZI: Objection.

A. Effects of pain in the -- there was slow onset of anesthetic -- slow onset. I don't know what the cause of it.

Q. I guess I asked you earlier about it wearing off.

A. In the recovery room?

Q. Yes.

A. Yeah, it started wearing off.

MR. BONEZZI: His question was whether the length of time while he was in the recovery room wearing off from the agent is unusual.

A. In the recovery room?

Q. Right.

A. After surgery?

Q. Right.

A. I would say including the surgical time, supposed to be about three hours in the recovery room.

Q. So did it take longer than you would have expected it for it to wear off?

A. Yeah.

Q. And the reason for that is what, because of his underlying condition?

MR. BONEZZI: Objection.

A. Retrospectively, I assume that because of poor circulation.

Q. Poor circulation where?

A. Due to the heart condition.

Q. And the reason, I take it that you told me before that you would not have recommended surgery for this man is because of the severity of his heart condition that you were just not aware of and the increased loss of blood?

MR. GROEDEL: Objection.

Q. Would that be fair?

MR. GROEDEL: Objection.

A. Not only because of the loss of blood, but retrospectively, assume we don't know in the --

Q. Gastrointestinal bleed, for example?

A. No, not because of that.

Q. Because of what? What do you think it was, Doctor?

A. The heart.

Q. What problem?

A. Possibly myocardial infarction.

Q. And would additional EKGs have revealed that?

A. But I couldn't find a specific finding of myocardial infarction in the EKG. He showed ventricular rate, which he has been having already fluid in the beginning of surgery and recovery, throughout the recovery of time.

Q. We've been through this before a couple of times and I don't want to beat a dead horse too much more. Just a little bit more.

If a person has a bleed, all right, and if in fact they're losing blood, that makes the heart work harder, doesn't it?

A. Yeah.

Q. If the heart is already weakened, cannot that cause a myocardial infarction, Doctor?

A. Yeah, that can be a cause.

Q. And if you throw in an insult of a

surgery, however minor that might be to somebody who is used to seeing surgery such as yourself, couldn't that add additional insult on the heart in terms of having to work harder?

A. By looking at the chart, hemoglobin is 10 or 11 in the morning of surgery, I don't think it -- it didn't cause heart attack or anything.

Q. You don't know that. At the time you thought it was 13 or 14.

A. Retrospectively.

Q. But additional blood tests could have determined that, couldn't they, if you knew that? If you knew what the level was?

A. What was the last one?

Q. I think it was 10 something, 10-3 maybe? But it had been dropping every day since surgery, not just the one day postop, but every single day. In fact, his family doctor had ordered additional blood tests to be done and to have it monitored more closely on the day that he underwent surgery. Did you know that?

A. Yeah.

Q. You know it now. You didn't know it then?

A. Right.

Q. Would that be consistent with his dying,

Doctor?

A. No, I don't think so.

Q. No. Have you gone through this chart to see what the results of the KUB were?

MR. BONEZZI: When was that taken?

MR. KAMPINSKI: Taken November 17th, I believe.

MR. BONEZZI: I couldn't find it in the chart.

MR. KAMPINSKI: I'm looking for it too. That's what I want him to find is the reading of that KUB. Mike gave us a copy of it at the last deposition.

MS. BARTNIK: The film itself?

MR. KAMPINSKI: Yeah. She bring the films with her?

MS. BARTNIK: I didn't see them out there. Do you want me to look?

MR. KAMPINSKI: Yeah. That will give us the dates.

MS. BARTNIK: No, we don't have the films.

MR. KAMPINSKI: The 17th. 10 a.m.

MR. BONEZZI: Did you find one?

THE WITNESS: No.

Q. (BY MR. KAMPINSKI) You didn't ever read that yourself, did you?

A. No.

MR. KAMPINSKI: That's all I have. Some of the other attorneys may have some questions of you, Doctor.

MS. BARTNIK: I have no questions.

MS. DANN: No questions.

MR. GROEDEL: Doctor, I have one question for you.

CROSS-EXAMINATION

BY MR. GROEDEL:

Q. While the patient was in the recovery room from 5:25 until the code was called, did you yourself have any conversations with either Dr. Smith or Dr. Stephens about Mr. Smith?

A. No, not directly. Dr. Stephens appeared -- Dr. Stephens appeared in the recovery room.

Q. That was at about 11:00?

a, At the time that written in the chart,

Q. At the time of what?

A. Recorded in the chart.

MR. GROEDEL: Thank you, Doctor.

THE WITNESS: It was --

MR. BONEZZI: That's all.

MR. KAMPINSKI: You have the right to read your testimony. You have a right to waive your signature. Your attorney can advise you, of course.

MR. BONEZZI: My advice to you, Doctor, is to read the testimony. Indicate to the court reporter you'd like to read the testimony. You have to tell her.

THE WITNESS: Yeah.

(Concluded at 5:11 p.m.)

I have read the foregoing transcript from page 1 to page 131 and note the following corrections:

PAGE:	LINE:	CORRECTION:	REASON:

_____
SONG JOON LEE, MD,

Subscribed and sworn to before me this day of , 1986.

_____
Notary Public

My Commission Expires:

THE STATE OF OHIO,)
) SS: CERTIFICATE
COUNTY OF CUYAHOGA.)

I, Lorraine J. Box, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that SONG JOON LEE, MD, was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above set forth was reduced to writing by me by means of Stenotypy and was subsequently transcribed into typewriting by means of computer aided transcription under my direction; that said deposition was taken at the time and place aforesaid by agreement of counsel; that the reading and signing of the deposition by the witness were expressly waived; and that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I hereunto set my hand and seal of office at Cleveland, Ohio, this 3rd day of October, 1986.

Lorraine J. Box, RPR, Notary Public
Within and for the State of Ohio
540 Terminal Tower
Cleveland, Ohio 44113

My Commission Expires: June 20, 1987.