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

IN THE COURT OF COMMON PLEAS

DOC. 263

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

Plaintiff,

v.

ST. LUKE'S HOSPITAL, et al.,

Defendants,

Case No, 100877

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Deposition of EDWARD D. LIN, a witness herein, taken by the Plaintiff as if upon cross-examination before Marguerite A, Sandly, RPR/CM 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 9th day of November, 1987, commencing at 2:10 p.m., pursuant to notice and agreement of counsel.

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APPEARANCES:

Charles Kampinski Co., L.P.A.,
By: Charles Kampinski, Esq.,
and
Christopher M. Mellino, Esq.,

On behalf of the Plaintiff.

Reminger & Reminger Co., L.P.A.,
By: Marc W. Groedel, Esq.,

On behalf of Defendants
Timothy L. Stephens, Jr., M.D.
and Curtis W. Smith, M.D.

Arter & Hadden,
By: Rita A. Bartnik, Esq.,

On behalf of Defendant
St. Luke's Hospital.

Jacobson, Maynard, Tuschman
& Kalur Co., L.P.A.,
By: Thomas H. Terry, III, Esq.,

On behalf of Defendant
S.J. Lee, M.D.

Kitchen, Messner & Deery,
By: Eugene B. Meador, Esq.,

On behalf of Defendant Agnes Sims, R.N.

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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 Marguerite A. Sandly; 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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EDWARD D. LIN,

a witness 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. My name is Edward Daniel Lin, L-i-n.

Q. Where do you live, sir?

A. I live at 556 Roxbury, R-o-x-b-u-r-y, Avenue, N.W., in Massillon, Ohio, 44646.

Q. All right. Doctor, I am going to ask you a number of questions this afternoon. If you don't understand any of the questions, please tell me and I will be happy to rephrase them. When you respond to my questions, please do so verbally. She is going to be taking down everything we say and she can't take down a nod of your head. All right?

A. I understand.

Q. How old are you, Doctor?

A. I am 34.

Q. Date of birth?

A. April 19th, 1953.

Q. Where were you born?

A. I was born in Taiwan.

Q. In what city?

A. Pingtung, P-i-n-g-t-u-n-g.

Q. And how long did you live there?

A. For eight years.

Q. And then did you come to the United States, or where did you go?

A. I went to Malaysia.

Q. Malaysia. And how long were you there?

A. Eight years.

Q. Okay. And that would bring us to age 16?

A. Right.

Q. And then where did you go after that?

A. Then I came to the United States.

Q. And where in the United States?

A. I went to Voorheesville, V-o-o-r-h-e-e-s-v-i-l-l-e, New York. That's a suburb of Albany.

Q. And how long did you live there, sir?

A. Approximately four months.

Q. And then where did you go?

A. I went to the State University of New York at Fredonia, F-r-e-d-o-n-i-a.

Q. Spell that again. I'm sorry. F-r-e-d --

A. O-n-i-a. Fredonia.

Q. And that's a state university?

A. That is correct.

Q. All right. And that's when you were how old?

A. 16.

Q. Is that a high school, college; what is that?

A. That's a state university in New York.

Q. So it is a college?

A. Yes.

Q. Okay. And how is it that you went to college at age 16?

A. I took the SATs and I scored high. I applied in December of 1969. I was accepted for January of 1970.

Q. Okay. What was your educational background before that? I mean what kind of education did you receive in Malaysia prior to coming to the United States?

A. I finished ninth grade in Malaysia.

Q. So if I understand correctly, you didn't, or you did not take the equivalent of tenth, eleventh and twelfth grade; is that correct?

A. That is correct.

Q. And you went to Fredonia, or the state university in Fredonia. And how long did you go there, sir?

A. Four years.

Q. And you graduated in?

A. December of 1973.

Q. At which time you were 20 years old, correct?

A. I presume so, whatever it calculates out to be.

Q. Well, if I am wrong, you tell me.

A. Yes, that is right.

Q. What did you do after that?

A. I received a research fellowship at the Roswell Park Memorial Institute.

Q. First of all, what was your major in college?

A. Biology.

Q. Biology?

A. Yes.

Q. That brought you to Massillon here?

A. Yes.

Q. A research fellowship, I'm sorry, where?

A. At Roswell Park Memorial Institute.

Q. Roswell Park?

A. R-o-s-w-e-l-l, Park, P-a-r-k, Memorial Institute. It was a division of the graduate school of the State University of New York at Buffalo.

Q. And what was your fellowship in?

A. Experimental pathology.

Q. What is experimental pathology?

A. It's a very broad field in which you can investigate all kinds of diseases, processes, methods of preventing them and so on, or treating them, as the case  ight be.

Q. How long was your fellowship for?

A. Three years.

Q. That would bring us up to when, 1977?

A. Right.

Q. Do you have a CV, by the way?

. Yes, I do. Do you mind if I refer to it?

Q. Yes, I'd like to see it, if you don't mind.

MR. GROEDEL: I think I attached it to my arbitration brochure.

Q. (BY MR. KAMPINSKI) Okay. Is this an extra copy?

A. No. That's what I was going to look at.

Q. Okay. I'm sorry. You were going to look at that to determine the years that you did the fellowship.

A. Right, just so I don't make any mistakes.

Q. What year?

A. What was your question, please?

Q. What years were the fellowship?

A. 1974 through '76.

Q. What did you do after that?

A. I then went to the University of Osteopathic Medicine & Health Sciences, which was in Des Moines, Iowa.

Q. And how long were you there?

A. From 1977 to 1980.

Q. Okay. And then what did you do after that?

A. I then did a general medical internship at the Middlefield Memorial Hospital in Buffalo, New York. And that's affiliated with the State University of New York, Buffalo School of Medicine.

Q. How long was that?

A. That was for one year.

Q. And after that?

A. After that I went to -- I was accepted into the University's diagnostic radiology

residency.

Q. Where at?

A. That's based in Buffalo, New York.

Q. How long did you do that?

A.

Q. Is that like a residency?

A. Yes. I was accepted into the residency, but I had to take a leave of absence.

Q. Why was that?

A. For financial reasons.

Q. Okay. And what did you do after that?

A. I then worked for six months full time as an emergency physician.

Q. Where at?

A. Primarily at the Middlefield Memorial Hospital in Buffalo.

Q. Okay. And this is what, 1982 or '83, that we're talking about?

A. 1982, right.

Q. And this was as an emergency room doctor?

A. Yes.

Q. And what did you do after that?

A. I then went to the Yale University School of Medicine where I was accepted into the anesthesiology residency.

Q. Why didn't you go back to the radiology residency?

A. Because I discovered that I was even more interested in anesthesiology than in radiology.

Q. Okay. And how long was your residency?

A. It was two years.

Q. Till 1984?

A. That is correct.

Q. And then what did you do?

A. I then moved to Massillon, Ohio, where I have been in private practice since.

Q. I notice that you are listed in Who's Who, a couple Who's Who; is that correct? Who's Who in the midwest and Who's Who among students in American Institutions and Colleges, right?

A. That is correct.

Q. How did you get into Who's Who?

A. I presume someone nominated me.

Q. And why, did you get a letter from them?

A. Yes.

Q. And then what did you do, have to pay some kind of fee to get listed?

A. No. I did not have to pay any fee whatsoever.

Q. You had to fill it out?

A. Yes. They asked for some bibliographic information.

Q. And then did you buy a volume?

A. No, I never did.

Q. Who are you in practice with in Massillon?

A. Dr. Louis A. Kovacs, K-o-v-a-c-s, and Dr. Roger Vincent.

Q. Are there different schools of training for an osteopath? Are there people who believe in holistic medicine as opposed to different kinds of treatment?

A. There are people who believe in holistic medicine, whether they are osteopathic physicians or allopathic physicians.

Q. Yes.

A. I am not sure what your definition of holistic medicine is. We believe that whenever possible we should take into account the role that the muscles and bones in our body play in our overall well-being and also whenever appropriate allow the body's own ability to regenerate itself in time of illness or disease.

Our training is essentially the same as

that of the M.D.s, with the exception that we also learn manipulation.

Q. You do not have an M.D. degree, do you?

A. No, I do not.

Q. Is it necessary to get a state medical degree or take the state medical test to practice medicine in Ohio?

A. Certainly. The requirements for licensure are exactly the same as that for an M.D. And, for example, when I was at Yale, all my other fellow residents were M.D.s.

Q. Do you take the Boards just as M.D.s do --

A. Yes.

Q. -- for certification?

A. Yes.

Q. Have you done that?

A. I have taken the written exam once.

Q. Did you pass?

A. No, I did not.

Q. How about the orals?

A. You have to pass the written first.

Q. I see. When did you take that?

A. 1985, July.

Q. Why haven't you taken it again?

A. I have been very busy setting up a pain

service at my hospital and involved with some research there and that has taken up the bulk of my time. I intend to take it next year.

Q. How is it that you got involved in this case, sir?

A. I was requested by Mr. Groedel to review the case.

Q. And how is it that he came to you? Have you testified for him or his firm before?

A. No.

Q. Have you reviewed cases for other people before?

A. I have reviewed cases for another attorney, but I have never testified for anyone.

Q. Who is that?

A. Mr. Gary Banas.

Q. Anybody else?

A. No.

Q. How is it that Mr. Groedel got your name, do you know?

A. I think you'd have to ask him.

Q. I am asking if you know. If you don't know, you don't know.

A. I don't believe I do.

Q. Have you, yourself, ever been involved

in a lawsuit, sir?

A. Yes, I have.

Q. And when was that?

A. I would not be able to give you the specific time.

Q. This year, last year, the year before that; when was it?

A. Well, there is one case that is pending, which involves an alleged dental injury.

Q. Alleged what?

A. Dental injury.

Q. Why are you involved in that case?

A. I was the anesthesiologist.

Q. Who are you being represented by?

A. Mr. Banas.

Q. What firm is he with?

A. Buckingham, Doolittle & Burroughs.

Q. Any other lawsuits?

A. There was one last year whereby I saw a patient preoperatively. I canceled the surgery because I had determined that the patient had recently had a heart attack and the patient had, in the process of the cardiology work-up, sustained a fatal arrest about two or three days later while in the hospital. The case was dropped

subsequently.

Q. Where was that case filed?

A. I beg your pardon?

Q. Where was that case filed?

A. I presume in Stark County.

Q. And who represented you in that case?

A. Mr. Banas.

Q. And where is the current case pending at?

A. I am not sure that I know.

Q. Stark County, Cuyahoga County?

A. Probably Stark County.

Q. Any other suits?

A. There is one other one. This one dates back to, I have to check the date, I believe 1982 when I was working as an ER physician. Did you want me to tell you about the case?

Q. Please.

A. Okay. It was a mobile obese diabetic male that I saw in the emergency room who complained of having, quote, passed out, unquote, at home.

When I saw him in the emergency room he was alert and oriented. The physical examination was not remarkable for someone of his habitus. He has some borderline abnormal laboratories.

Because I was not familiar with this patient, I spoke with the family physician who was taking care of this patient and I recommended that this patient be admitted to the hospital and he agreed. So I made arrangements for the patient to be admitted, and my care of that patient terminated at that point.

I was unaware of anything else that happened until I received a notice that I was being sued. And I found out that later on on that day the family physician discharged the patient to be followed in his office. And on the following day the patient sustained a cardiac arrest and was brought back to the emergency room dead on arrival.

Q. Where was that lawsuit at?

A. It's in Buffalo, New York.

Q. Still pending?

A. Yes.

Q. Who are you being represented by on that case?

A. Daniel Roach.

Q. Have you been deposed in any of these cases?

A. I was deposed for this very last case that I described.

Q. The Buffalo case?

A. That's the only case for which I have been deposed.

Q. Any other lawsuits, sir?

A. No.

Q. I take it in the case that was dropped in Stark County, you believed it was appropriate based on your examination of the patient to cancel surgery once you became aware of the fact that he had had a prior MI?

A. Yes.

Q. And I take it in the case that you are involved in in Buffalo, it's your position that you are not responsible since you didn't have primary active care of that patient?

A. Absolutely. And not only that, I made arrangements for the patient to be admitted to the hospital.

Q. Yes. And was it the family doctor in that situation who was the attending?

A. Yes.

Q. So the attending was then the responsible party for his care?

A. Yes. I might add that even the case of the tooth injury --

Q. Yes.

A. -- pre-existing x-rays, dental x-rays showed that the patient had extensive erosion of his bones and the plaintiff does not have a complaining fact and there has never been any sediment of any amount.

Q. I am sure you can tell that to the jury.

A. Well --

Q. Who is the plaintiff's attorney in that case?

A. Which case, sir?

Q. The one that's pending in Stark County.

A. Elk & Elk.

Q. And who are the plaintiff's attorneys in the Buffalo case?

A. I believe the name is Wexler, Mark Wexler.

Q. And who was the attorney in the other case that was dropped?

A. I am not sure. The name Runfola kind of -- you know, Runfola & Bearfield. Is there such a law firm? I am not sure.

Q. I am not either, but I will find out for you.

Okay. What did you review, Doctor,

prior to giving a report in this case?

A. I reviewed the hospital records of Mr. Smith, both for his --

Q. Well, I have got your report of June 3rd and I can see what you put down there in terms of having reviewed. Is there anything in addition to that that you looked at?

A. Since then I have reviewed the deposition of Dr. Downs, John B. Downs.

Q. Okay.

A. A deposition by Dr. --

Q. Well, you had Downs' deposition?

A. Well, at the time when I reviewed it, it was a partial.

Q. Okay.

A. I only reviewed a part of his deposition.

Q. Okay.

A. Since then I have reviewed his full deposition.

Q. Okay. What else?

A. I reviewed the depositions of Drs. Jackson, Oliver and Gill.

Q. Okay. Anything else?

A. And Dr. Smith.

Q. Have you --

A. Oh, I'm sorry, and Dr. Lee.

Q. Any others? I'm sorry.

A. No, that's it.

Q. Have the opinions in your report changed at all by virtue of you having reviewed these additional depositions?

A. No, I don't believe so.

Q. Did you receive any letters from Mr. Groedel or anybody else in his firm that set forth any facts that you relied on for purposes of rendering an opinion?

A. I believe he has sent me a cover letter in which he gave me some particulars about the case, but I did not rely on his letter in any way in forming my opinion.

Q. What is your opinion regarding this case, Doctor?

A. Well, in summary, I believe this is the case of a patient who was admitted to the hospital for a surgical procedure. The surgeons involved requested the assistance of certain medical physicians to participate and assist in the case, in the care of this patient. And for whatever reason, the medical doctors involved, and by that I mean specifically Dr. Jackson, Dr. Oliver and

Dr. Lee, failed to do what was necessary to provide appropriate care to this patient, and that as a result he suffered complications and died.

Q. Okay. Well, let's start with Dr. Jackson. What did he do wrong?

A. What did he do wrong?

Q. Yes.

A. Okay. I believe Dr. Jackson did not carefully review his office records prior to writing his consultation note, both for the first hospital admission as well as for the second. I believe he failed to point out the significance of the patient's long-standing hypertension, as well as history of episodes of congestive heart failure, evidence of coronay insufficiency, and failure to optimize the patient's blood pressure prior to surgery.

Q. Which surgery?

A. Both the first, the proposed first surgery and the second actual surgery.

Q. Well, are you talking about the first hospitalization where he was discharged without --

A. That is correct, sir.

Q. -- without surgery?

And the second surgery you're referring

to then is the one of November 14th, 1983?

A. Yes.

Q. What about the third surgery then, in your parlance, which would have been November 17th, do you believe that he had any involvement in that at all based on all the deposition testimony?

A. It is more his lack of involvement, as far as the third surgical procedure is concerned, that I felt was negligent.

Q. Well, if he didn't know about it, how was he negligent?

A. It was his responsibility to know about it.

Q. In other words, he should have been there the whole day making sure that they did not take him to surgery?

A. No. It is not necessary for him to be there the whole day, but it is necessary for him to be kept abreast of the changing conditions that his patient was under going and to pursue abnormal laboratories or symptoms that the patient was presenting.

Q. Well, who was supposed to tell him, Doctor? Would it have been the attending who was supposed to tell him?

A. No, sir.

Q. No?

A. It was incumbent upon himself to do that. He had indicated, not only in his first consultation note, but by his second one that he would follow this patient. He also testified in his deposition that he felt it was his responsibility to take care of the patient in general.

Q. What did Dr. Oliver do wrong?

A. Dr. Oliver failed to investigate very significant abnormal laboratory findings. In this case the two percent Mb fraction of the CPK enzymes, and failing to bring that to the attention of the other attending physicians involved.

Q. Okay. Do you believe that was, that that failure was less than that required of the acceptable standard of care of an intensive care unit doctor?

A. Could you please repeat the question.

Q. Do you feel that that failure was a departure from the acceptable standard of care required of such a doctor?

A. Yes, I believe so.

Q. And do you believe that that departure contributed to cause the death of Mr. Smith?

A. Yes, I believe so.

Q. How about Dr. Lee?

A. Dr. Lee in his preanesthetic assessment of the patient failed to check on the appropriate laboratory findings -- by appropriate I mean not only the type, but also the recentness of the tests -- by failing to recognize the very poor medical condition that the patient was in, by failing to use appropriate evasive monitoring, by failing to inform the surgeon of the patient's intraoperative course, by failing to attend to the patient's medical problems in the recovery roam in an aggressive and timely manner, by failing to call for additional assistance possibly from other consultants when he apparently was unable to take care of the patient's problem himself.

Q. Anything else?

A. There may be some other things, but I can't think of them offhand.

Q. What is the -- And did these failures, in your opinion, Doctor, contribute to cause Mr. Smith's death?

A. Yes.

Q. To a reasonable degree of medical certainty?

A. Yes.

Q. Were there any other doctors or nurses that you believe didn't provide appropriate care to Mr. Smith?

A. I believe that the house staff failed to, in this case the surgical house staff, failed to investigate abnormal laboratory findings and failed to notify the attendings of abnormal laboratory findings of the deteriorating status of the patient.

Q. Now, what findings are we talking about here?

A. Well, specifically the falling hemoglobin and signs and symptoms of gastrointestinal distress, which may not entirely be GI related. By that I mean, some of those symptoms could indicate that the patient was having anginal episodes.

Q. And without investigation there's just no way of telling, I take it is what you are trying to say?

A. Right.

Q. Okay. Before, and I am going to jump

back for just a second, Doctor, but when you mentioned the things that Dr. Lee didn't do appropriately, one of them was that he failed to advise the surgeon of intraoperative, I think you said, complications or course?

A. Course.

Q. Okay. What was there about the intraoperative course that he should have advised him about?

A. The fact that the patient had a profound drop in blood pressure, which he had some difficulty in reversing.

Q. And do you believe that's why he gave him the Neo-Synephrine drip?

A. Well, I am not certain that that Neo-Synephrine drip was ever used.

Q. Why is that?

A. Well, in the nurses' notes it said patient came in with a drip.

Q. Yes.

A. And subsequently it said that the drip was discontinued. I know that Dr. Lee in his deposition said that he never used it. And I know for a fact that it is not a rare practice for anesthesiologists to have vasoactive substances

ready and plugged into the IV tubing and not use it. I do know that he used other vasoconstrictors. So I know the patient's blood pressure was lowering and he did have to give some drugs to bring it up. But whether he actually used a Neo drip or not, I don't think that I can say for sure.

Q. Okay. Does it matter for purposes of your opinion?

A. No, it does not.

Q. Okay. Why should he have advised the surgeon of that?

A. Because the surgeon's primary responsibility is to do surgery. When they're in the operating room, they concentrate on the surgery. There is no reasonable expectation that the surgeon should know what's going on with the patient's cardiovascular or pulmonary situation. Just as the anesthesiologist is not expected to know the details of the surgical procedure going on at the other end. This is a teamwork process and the surgeon relies on the anesthesiologist to notify him of medical problems that may have been encountered and so on.

And if Dr. Lee had notified Dr. Smith that he was having blood pressure problems with

the patient, I think that a decision would have been made to send the patient directly to SICU. I do want to add, however, that just because the patient did not go to SICU in and of itself is not negligence.

Q. All right. But would it be fair to assume that he would have received some type of care addressed to his condition had he gone to SICU as opposed to what did occur here in the recovery room?

A. A patient -- The patient's problems could have been properly taken care of if a physician who is knowledgeable about managing cardiovascular problems was available in the recovery room. I believe primarily, for the most part, if the patient had been appropriately monitored and a very careful anesthetic given in this case, I mean a spinal, that is what we refer to as a low dense block, allowing the anesthetic to take its primary effect in the extremities upon which the procedure was to be done, then his cardiovascular system then would have been lesser disturbed. He would not have had a profound fall, a fall in blood pressure.

And also with the appropriate evasive

monitoring it would have been possible to fine-tune his blood pressure to as close to normal as possible, such that it is possible for this patient to simply go to the recovery room, recover and actually go back to the floor.

Q. So you believe that the anesthetic that was given was inappropriate for this particular procedure and for -- or should I say for this particular man?

A. The anesthetic was inappropriately given by the anesthesiologist; but the anesthetic that was chosen, the spinal, I think it was appropriate.

Q. How was it inappropriately given, too high, too much; what are we talking about?

A. Well, the level was too high.

Q. Okay.

A. I should, I think in fairness to Dr. Lee, I should say that even with a great deal of care, it is possible for one to get a higher than intended level, but it's very unlikely.

Q. Well, he doesn't even list the level that he administered, does he?

A. He did not list it; however, the recovery room nurse noted what the level was when the patient was there and from that you can

surmise that it was at least at that level.

Q. Which was what?

A. I believe the nurse described a level just below the nipple line.

Q. Right.

A. Which would be about T-5.

Q. And is that too high for this procedure?

A. It's higher than necessary certainly.

Q. What should have been given?

A. If there had been -- I think a very satisfactory level would be T-10, at the level of the umbilicus.

Q. Okay. And how did giving it at T-5 adversely affect the cardiac status of this patient?

A. It caused a greater than necessary degree of sympathetic block, such that a greater amount of blood vessels was caused to dilate and, therefore, resulting in the more profound fall in blood pressure.

Q. And how did that then adversely affect or cause the ultimate demise of Mr. Smith?

A. A patient with cardiovascular problems, such as Mr. Smith, would tolerate hypotension poorly, because with low blood pressure the heart

would not be as well profused.

Q. P-r-o-f-u-s-e-d?

A. Right.

Q. And you think that's what occurred here?

A. Yes. That is what occurred here.

Q. And do you believe that the failure as to adhere to the standard of care by the house staff, that is their failure to be apprised of the lab findings, notifying the attending of the deteriorating status of the patient, do you believe that those failures contributed to cause the death of Mr. Smith?

A. Yes, I believe so.

Q. Okay. What do you believe the duties are of the attending physician, regardless of what specialty he may be, whether it be orthopedic or internal; just generically, what would the duties of an attending be for a patient who has difficulties that encompass specialties other than just his own?

A. What are his responsibilities?

Q. Yes, sir.

A. His responsibilities are to take care of the patient's problems in areas in which he has proper expertise and to seek the assistance of

other physicians to take care of the patient's problems that relate to areas outside of his expertise.

Q. What is his responsibility to ensure that the care given outside of his expertise is, in fact, given appropriately? Can he just turn his back and assume that it will be, or does he have to do something in addition to make sure that it will be?

A. I think he can turn his back and assume that it is properly taken care of if the person to whom he's referring the patient to is known to be a reasonable prudent physician, reasonable prudent and competent physician.

Q. Could anybody having examined Dr. Lee's credentials and his actions in this case have made that assumption?

MR. GROEDEL: Objection.

MS. BARTNIK: Objection.

MR. TERRY: Objection.

Q. (BY MR. KAMPINSKI) Would you have made that assumption?

A. I have no basis, in looking at Dr. Lee's training, to say that he would not have the expertise to take care of this patient.

Q. How about his actions? I mean, I questioned him about having any knowledge about the CPK and he didn't know what it was. Is that somebody to whom you would feel fairly competent in leaving a patient with cardiology problems?

MR. GROEDEL: Objection.

MS. BARTNIK: Objection.

MR. TERRY: Objection.

A. I have reviewed Dr. Lee's deposition and I believe in fairness to him I would like to say it was evident from reading his deposition that Dr. Lee has a very significant problem in expressing himself, and for that matter in understanding questions that were posed to him. The very first time he was asked about that Mb CPK he answered that it related to cardio enzymes, and when the question was posed to him, what is two percent Mb CPK, I believe he thought he was expected to give a number and he was therefore unable to give that answer.

I believe his deposition indicated that he, in fact, knew what Mb CPK is.

Q. (BY MR. KAMPINSKI) Okay. Is there anything in any of the other depositions that you've read where somebody's answered, No, I don't

know, where you believe they in fact did know?

A. I could not specifically tell you offhand. If you --

Q. I just wondered if you could glean that from the paper itself or --

A. I beg your pardon?

Q. When somebody says, No, I don't know, and you say yes, I think they did know, I wonder how it is that you can do that; is that something you learned in your training, in your background, your years of extensive anesthesiology?

MR. GROEDEL: Objection.

A. I would not normally be able to tell that, except in that particular instance Dr. Lee did give the correct answer --

Q. Yes.

A. -- initially.

Q. Okay. In a hospital where there are, where there are residents or interns that are supervised by the attending, what are the responsibilities of the attending vis a vis those residents, interns, and what they do in your opinion?

A. I think the responsibility of the attending is to [illegible]e the residents what

appropriate treatments or investigations to undertake when presented with the information about the patient's physical findings, laboratory tests and so on that are performed by residents.

In other words, in that, in a teaching situation, the residents follow the patients closely. They then tell the attending physician when they make rounds, if they do make rounds, that such and such is new or this is changed with the patient. And then, based on the information that is presented to the attending physician, the attending physician then advises the residents what to do.

Q. Well, I take it that the information that you say the residents should have advised the attending of, and I think you told me that the failure to tell them contributed to cause Mr. Smith's death, isn't that information that the attending should have then, right?

A. I think it is -- Well, it is available to the attending.

Q. Yes.

A. But in a teaching situation, attending physicians, when they have residents working beneath them, do not customarily review the charts

themselves personally.

Q. Excuse me, Doctor. Didn't you just tell us earlier that Dr. Jackson had an independent duty to know what was going on with the patient, regardless of who was to tell him, right; is that correct?

A. If --

Q. Did you tell me that, sir?

A. Please rephrase what you just said.

Q. Didn't you say earlier that Dr. Jackson had an independent duty to know what was going on with the patient and did not have the responsibility to rely on anybody at the hospital to tell him, that he had to know that himself? That's what you said, isn't it, sir?

MR. GROEDEL: Objection.

A. I don't remember specifically, but if I did, it pertains to the patient's medical problems. And I would say that only because Dr. Jackson did have, did not have a medical resident working beneath him. If he did, it would have been the medical resident's primary responsibility to do so.

Q. Is the attending, in your opinion, responsible for the failures of the residents to apprise him of information that he should have?

MR. GROEDEL: Objection.

Q. (BY MR. KAMPINSKI) Is that his responsibility?

MR. GROEDEL: Go ahead.

A. Please repeat the question.

Q. Yes. The attending, in a teaching situation, is training these people, these young men and women who want to become dedicated physicians such as yourself, right?

A. Right.

Q. I mean that's his job to train them?

A. Yes.

Q. And isn't he then responsible for what they do in that teaching context; if they fail to do something appropriately, isn't he then responsible for their activities or failure to act?

MR. GROEDEL: Objection. Go ahead.

A. If he is aware that the house staff is supposed to do something and -- In other words, if he told the house staff that you should investigate something based on what the house staff has told him and the house staff didn't, then I think that he would, he had failed in his responsibility to follow-up on that.

Q. What was the condition of Mr. Smith when

he went to the recovery room on February 17th, 1983? And you can refer to the record if you want.

A. It was very serious.

Q. And what was the attending's responsibility at that time in terms of either seeking or ensuring that appropriate care was being given to this patient?

A. Which attending are you referring to?

Q. Dr. Smith. He is the only attending that I am aware of in this particular case.

A. Well, okay, his responsibility at that instance is to rely on the recommendations of the anesthesiologist as to the disposition and care of the patient after anesthesia.

Q. Should he have called back to see how his patient was doing?

A. I don't know whether he should have or not.

Q. That's what I am asking.

A. I can't answer that question.

Q. Okay. You don't agree, though, that Mr. Smith was in good condition when he left the operating room and went to the recovery room, do you, sir?

MR. GROEDEL: Objection.

A. I don't believe he was in good condition, no, based on my knowledge of what his intraoperative anesthetic course was.

Q. Okay. And certainly that's confirmed by the recovery room note of 5-25, isn't it, sir, that he wasn't in good condition?

A. You mean Mr. Smith was not?

Q. That's correct.

A. Yes.

Q. Okay. What effect did the giving of sodium pentothal have on Mr. Smith?

A. It has an effect of lowering blood pressure.

Q. What effect did it have on him in this particular case?

A. I believe it lowered his blood pressure further.

Q. Did it have an effect on his heart also?

A. Yes.

Q. What effect?

A. It was a myocardial depressant. It can depress the cardioactivity of the heart.

Q. And is that what was needed when it was given to Mr. Smith?

A. No. That was not what was needed. I

think the purpose of why it was given was to render the patient unconscious of the unpleasant effects of intubating him.

Q. Did it have the effect of killing him?

A. I can't say that it had the effect of killing him. I don't think it was a helpful drug at that point in time.

Q. What about the -- withdraw that.

A. I should say that perhaps, and again in fairness I should state that given a group of patients with cardiovascular disease, if they were intubated without pentothal, under normal circumstances a certain percentage of them would come down with MIs, because intubation is a very stressful procedure. And I think it was a judgment call on the part of Dr. Lee to use it. I think that the dose that he used perhaps was too high.

Q. What do you think the cause of death was here? Do you think it was an aspiration or an MI, or do you know?

A. I believe the primary insult is to the heart. The aspiration probably aggravated the hypoxia that the patient was already suffering as a result of suboptimal cardiac function.

Q. When do you think the aspiration occurred?

A. I know for sure that it occurred when they suctioned gastric contents from the endotracheal tube. As to when it happened before that, I think it would be anybody's guess really.

Q. Well, we heard from a doctor Saturday and he opined that it occurred between 9:00 and 9:15. And if you look at the recovery room record --

MS. BARTNIK: 9:15 and 9:55.

MR. KAMPINSKI: Right. I'm sorry. 9:15 and 9:55.

Q. (BY MR. KAMPINSKI) And he gave that opinion based upon the change reflected in the blood pressure, pulse and respiration between that time and the fact that there was no charting for a period of 40 minutes and that all other charting was done five, ten, fifteen minutes apart; and he will opine that an aspiration occurred during that period of time which was unrecognized by the nurse. Do you agree or disagree with that, Doctor?

A. I can neither agree nor disagree. As I said earlier, I don't believe it's possible for anyone to say with any degree of certainty as to when it might have occurred prior to the time the

patient was intubated.

Q. Okay. Is that something that should have been observed by a careful nurse watching just one patient in the recovery room, is that, an aspiration?

A. I would say so, yes.

Q. And if an aspiration occurred, Doctor, and it were recognized, is that treatable; does that, if it's observed, normally result in death or does that happen all the time and it's treated and it's taken care of?

A. Aspiration is a very serious thing and it carries with it very significant morbidity and mortality.

Q. Okay.

A. In a patient who was already as compromised as Mr. Smith was at that point in time, I really don't believe that it would have made a great deal of difference in terms of whether or not he would have died.

Q. When do you think it occurred? Are you talking now about the aspiration that occurred when he was intubated or if, in fact, it occurred previously? What are we talking about?

I mean, I don't want your testimony to

be misread later in terms of the time you are giving now.

A. I understand. I believe I have given testimony that I don't know when Mr. Smith aspirated, other than to say I know he must have aspirated by the time he was intubated.

Q. And is that what your testimony is geared to in terms of it wouldn't have mattered at that point, or are you saying if it occurred between 9:15 and 9:55 it probably wouldn't have mattered?

A. I think even if it had happened between 9:15 and 9:55 it would not have made a great deal of difference, no.

Q. Okay. How about prior to 9:15, do you have any opinions as to whether or not Mr. Smith probably would have survived had he been given appropriate treatment prior to that time?

A. I think he still had a reasonable chance of improving when he initially arrived at the recovery room.

Q. Okay. How about up to 9:15? And I use that point only because we do see some change in terms of the vitals at 9:55. And in fairness to you, the doctor Saturday suggested that up until

that time it was still probable that he could have survived had he received, had the alleged aspiration been treated appropriately.

A. I am not sure if I understand what the question is.

Q. Okay. I will try and rephrase it then. You may not have an answer, but in fairness to you, is there any particular point in time that night where you believe that Mr. Smith, regardless of the treatment received, would not have survived? And when I say would not, I am talking about in terms of probabilities, that is 51 percent or more. Is there some point in this record that you think no matter what would have been done, the chances are that he would no longer have survived, that it's more probable that he would not have survived?

And if you don't have an answer, that's okay too. I am just trying to figure out what you are going to say.

A. I don't believe I have an answer, except to say that he significantly deteriorated by 9:55.

Q. Okay.

A. And from that point on his chances simply became progressively less.

Q. Okay. All right. Prior to that time

would it be fair to say that had he received appropriate treatment and care, that he probably would have survived given correct treatment? And when I say probably, once again that is defined as 51 percent or more.

A. I see. Yes, I would believe so.

Q. Okay.

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

MS. BARTNIK: I have just a few, Doctor.

- - -

BY MS. BARTNIK:

Q. Are you an attending physician now in a hospital?

A. Yes, I am.

Q. Do you have any residents under you ever?

A. I don't have any anesthesia residents under me. I do have other residents who rotate through anesthesia.

Q. So while they are rotating though through your department, you are the attending physician and they're your residents?

A. Yes.

Q. Do the residents ever communicate with you through writing in the chart?

A. Not without telling me also verbally.

Q. Well, is it an acceptable method for the residents to communicate to you through the chart?

A. Only -- I mean they can write it, but they should also tell me first.

Q. Okay.

A. Or immediately after they wrote it, within a reasonable time of when they discover an important finding, they should communicate it to me, make sure that I know about it.

Q. Just so I understand what you're saying, you are saying that it is not acceptable to you for a resident to write a finding in the chart, they must also tell you?

A. That's right. In other words, it would not be acceptable, not only to me, but I know for that matter attendings in general, for a resident to notify the attending or write something in the chart and leave it up to the attending to find out for himself or herself.

Q. Do you regularly read the residents' progress notes for your patients?

A. I don't regularly have residents rotate

under me, but when I do, yes, I do read their notes.

Q. Do you independently look at the laboratory values for the tests that have been done?

A. Not necessarily, no.

Q. So you would rely on the residents to tell you either in their notes or verbally or whatever, however, what those values were?

A. Yes. In fact, I should say that when I do have residents beneath me, I rely on them probably entirely to obtain the lab values.

Q. And if they do not do something properly, do you believe that you are responsible for their conduct as their teacher and as their attending?

A. If they do -- If they do note something improperly -- In what course? That's a very broad statement.

Q. You can't answer that question?

A. Well, if I told them to do something or I told them not to do something, and they did just the opposite of what I told them to do, I would of course be very upset with them. But I don't think I would be responsible for their action as such, because I had specifically told them to either do

something or not do something and yet they independently took an opposite course of action.

Q. What if they get a lab value on a patient and that lab value comes into the chart and they don't tell you about it and the patient suffers some type of consequence because no one's noted it --

A. Uh-huh.

Q. -- and that's your patient, you are the attending, do you consider yourself responsible for that outcome?

MR. GROEDEL: Objection. Go ahead.

A. That depends on whether that laboratory finding is relevant to what I have to do. I think that's a difficult question to answer. I think that the primary responsibility, that the fault would lie very largely upon the resident.

See, a resident is not someone who is grossly inexperienced with little education. They are physicians, they have had a substantial amount of training. They have learned, not only in their medical school years, but in the internship some basic medical knowledge, and if they apply the basic medical knowledge in a prudent manner, it is extremely unlikely that they would, that they

would be remiss in not recognizing certain problems or overlooking significantly abnormal laboratory values.

Q. You said in response to Mr. Kampinski's questioning that the surgical house staff failed to investigate abnormal lab values and then they failed to tell the attendings about those abnormal lab values and also about the GI symptoms; was that your testimony?

A. Yes, I believe so.

Q. Are you saying that those two failures somehow were deviations from the standard of care for residents?

A. Yes, I believe so.

Q. Tell me how the failure to investigate the abnormal lab values and specifically the drop in the hemoglobin contributed to cause Mr. Smith's death, because that was also your testimony.

A. Well, when the two percent Mb CPK came back, it is --

Q. Well, let me stop you there. I believe you said that the abnormal lab value that you were concerned about was the drop in hemoglobin, you didn't mention the CPK Mb fraction.

A. If I didn't, that was an omission on my

part. I also intended to include that.

Q. Let's stick with the CPK then and let's go to the two percent hemoglobin.

A. When you have a two percent CPK, Mb CPK in a test result, it indicates to you that some myocardial injury had occurred even though of the very low level.

It is incumbent upon anyone who is primarily involved in the care of this patient to investigate to see whether this, whether the next test is going to show that the enzyme is going up or going down further.

In other words, I know for example that some --

Q. I just want to know how the failure of the residents to further test that caused Mr. Smith's death.

A. I was about to explain.

Q. Okay. Well, I just wanted to remind you what the question was. I thought you were going off on a tangent.

A. All right. If the next test came back showing that the Mb CPK level is much elevated, then there is no question that the patient is, in fact, in the process of evolving into an MI, and

not getting over an MI as some of the other physicians who were involved in the case or who have reviewed the case believe.

If I may make an analogy. If you see a person at the door with his hand on the doorknob, you don't know whether that person is on his way out or had just come in. You need to observe that same individual at the next phase, a short interval later. Then you will know whether the person is on his way in or is on his way out.

The same holds true for the CPK, or Mb band. The one isolated test does not tell us whether the patient is about to have a heart attack, that he is evolving into something bigger or if he has already had it and we are seeing the tail end of the spell of cardiac enzymes into the blood. And if the second test comes back higher, then it will be very obvious that this patient, instead of being transferred to the floor, should stay in the ICU unit and receive the full protocol for treating patients who have had an acute MI.

Q. Okay. So then tell me how, tell me all the steps that you have to go through before we get to Mr. Smith's death; you're saying that the CPK would have been elevated a second time?

A. Not necessarily.

Q. Correct?

A. It could be isolated.

Q. I want you to tell me the chain of events from the residents' failure to further investigate that test to Mr. Smith's death, because you said that was a proximate cause. I just want to understand that.

A. I didn't say there was proximate cause, but I said it contributed to Mr. Smith's death. I believe there is a difference.

Q. What do you believe is the difference?

A. Well, proximate cause means, in my mind anyway, means the cause that directly led to something. To have contributed to have something simply means one of the factors that ultimately led to.

Q. So you don't think that the residents' failure to follow-up on this cardiac enzyme was the proximate cause of Mr. Smith's death?

MR. KAMPINSKI: Well, wait a minute. Wait a minute. Now you are throwing your own terminology on to what he just explained to you was his difference between proximate cause and contributing cause.

MS. BARTNIK: Well, using his own definition.

MR. KAMPINSKI: Wait a minute. Wait a minute. Just go --

MS. BARTNIK: He just --

MR. KAMPINSKI: It may be different than a legal definition, which I may submit indicates that any contributing cause is a proximate cause of death. All right.

MS. BARTNIK: Fine. I will note your objection, but I'd like you to answer the question if you can.

Q. (BY MS. BARTNIK) Are you saying then, Dr. Lin, and just tell me if I am wrong, that the residents' failure to further investigate the cardiac enzyme was not, as you define it, the proximate cause of Mr. Smith's death?

A. That is correct.

Q. Okay.

A. I don't believe that that in and of itself is the proximate cause.

Q. What do you believe, under your definition of proximate cause, was the proximate cause of Mr. Smith's death?

MR. KAMPINSKI: Objection.

A. I believe the proximate cause of Mr. Smith's death is the lack of appropriate monitoring for the second surgical procedure by the anesthesiologist, and the failure to aggressively attend to his cardiac problems in the recovery room. Because I believe, even had the patient had an MI and has an active GI bleed, it was still possible with appropriate monitoring to take care of this patient for his second surgical procedure.

Q. Did you read the deposition of Nurse Sims?

A. No.

Q. Either one?

A. I have not.

Q. You have though reviewed the nursing notes, correct, for that time in the recovery room?

A. Yes, I have.

Q. Are you going to offer any opinions at the trial of this case as to whether any conduct of either of the nurses in the recovery room deviated from the acceptable standard of care?

A. I do not believe that the nurses deviated from the standards of care in the recovery room.

Q. Do you believe they deviated from the standard of care at any other time?

A. I believe they may have.

Q. In what respect?

MR. MEADOR: Are you talking apart from the recovery room?

MS. BARTNIK: Yes. That's what he said.

A. I believe that at some point, either during his first or second hospitalization, he had complained of epigastric discomfort and shortness of breath. I recall one nurse's note that was at six o'clock, and I don't remember the specific date, patient was sitting up in bed complaining of shortness of breath. And I don't believe there is any indication anywhere that the physicians were notified of his complaints.

I am not saying that they were not, but I just didn't find any record to indicate that the physicians taking care of the patient were so notified. And I think that the patient should have -- I beg your pardon. I believe the nurses should have notified the physicians taking care of the patient that he had such subjective complaints.

MR. GROEDEL: I think that was the

first hospitalization.

A. All right.

Q. (BY MS. BARTNIK) Would you be able to find the notation that you are thinking of in the chart by looking it up? I don't want to take up too much time, but if you can, I would like to know if you're referring to some specific note and if you have it in your mind and if you have --

And, Marc, if you know what he is talking about --

MR. GROEDEL: I don't, but I think it was the first hospitalization. I think.

A. I am not really prepared to say that the nurses were actually negligent in failing to tell the physicians involved. I think it was poor of them to not have done so.

Okay. Here's one potentially. The first hospitalization.

Q. (BY MS. BARTNIK) Is there a page number on the bottom?

A. It's so poor on mine. Ten. Probably page ten.

Q. Okay. And the date and the time of the note?

A. Okay. October 23rd, 1984 at two o'clock

in the morning. Resting quietly in bed, vital sign 170 over 118. That is a critically high blood pressure. Patient said he feels like, "I feel like I have a tight hat on my head. It always feels like this, this way when my blood pressure is up." And the six a.m. entry, sitting up at the side of bed complaining of shortness of breath.

I believe that's all for the first admission.

Q. Well, let's stop there then. Mr. Smith was discharged and his surgery did not proceed at that time, correct?

A. Yes.

Q. So nothing that the nurses did or didn't do during this first hospitalization related in any way to Mr. Smith's death; would you agree with that?

A. That is probably true. I get -- the point I was trying to make is, a patient with a blood pressure like that could have had an MI at that point in time and --

Q. Well, can you say that more probably than not he had an MI during this first hospitalization?

A. There's no way to tell which respectfully. As I said, he only had one. Mr. Smith has had complaints of shortness of breath, anginal-like symptoms before, not only prior to his first hospitalization, but they were noted many times in Dr. Jackson's office records.

So here's a patient with very significant underlying cardiac problems and, therefore, he is at risk of having a heart attack at any time that his blood pressure is not properly controlled.

Q. Basically I just want to find out what opinions you may give when you testify at trial, and I guess my question is: Are you going to testify at trial that Mr. Smith probably had a heart attack during this first admission?

A. I have no basis to say that he probably had a heart attack. He may have.

Q. Okay. Are there any other notes that you want to refer to that you say that the nurses, there is no indication that the nurses communicated certain complaints to the physicians and that that was a deviation from the standard of care?

A. I am not prepared to say that the

performance of the nurses on the floor was an actual deviation from the standard of care in the sense that they were negligent. They were not good in a few isolated instances.

Q. Let me ask you this: Do you read the nurses' notes on your patients?

A. Often times I do, not always.

Q. Do you think it's acceptable or proper standard of care for a physician to read the nurses' notes or do you believe --

A. A proper standard of care? I think it's proper.

Q. Is it the standard of care for attending physicians to read the nurses' notes or should the nurses read them to the doctors?

A. The nurses certainly aren't obligated, nor do I think it's practical, to read the notes to the doctors. I think that the doctors should, whenever appropriate, read the nurses' notes. I mean if they have any basis to believe that the patient may have some problems and it may not be evident to them, then they should read the nurses' notes to uncover certain things that the nurses may have failed to tell the physician.

Q. So in the end it's up to the physician

to make himself or herself aware of the patient's progress by either talking to the nurses or reading the nurses' notes, correct?

A. That is his responsibility from his angle. The nurses also have an independent responsibility to tell the physician.

Q. Okay. Please point out to me the points in the second hospitalization where you feel the nurses deviated from the standard of care of not advising the physician of what they found?

MR. GROEDEL: He already said that he was not going to say that.

MS. BARTNIK: He said they're not good.

Q. (BY MS. BARTNIK) You said they're not good, but they're not a deviation from care?

A. I don't think they're sufficiently serious that I would, that I feel very strongly that they had been negligent. No, I am not prepared to say they were negligent.

Q. I don't want to beat a dead horse.

A. I would like to --

Q. Well, there's no question. Just so I understand, what do you believe the cause of death was here?

A. I believe he died of a cardiac arrest.

Q. And do you believe that the arrest was caused by pulmonary aspiration?

A. I believe it was aggravated by it. I don't know whether it actually caused it or not.

MS. BARTNIK: All right. I have no further questions right now. Thank you, Doctor.

THE WITNESS: You're welcome.

- - -

BY MR. TERRY:

Q. Doctor, a cardiac arrest simply means the man's heart stopped, right?

A. Yes, sir.

Q. Do you have any opinion as to how it came to stop?

A. It would have to be ultimately, bottom line, from lack of oxygen to the heart muscles.

Q. Was it a myocardial infarction; did the man have a pulmonary embolism? Do you have any idea why his heart stopped?

A. I believe his heart stopped because his heart was not able to pump blood effectively within the body, including to itself.

Q. As a result of?

A. As a result of probably a myocardial

injury.

Q. Do you have any idea when the myocardial injury occurred?

A. Some of it did occur after the first surgery.

Q. The first surgery in this instance being on the 14th of November, correct?

A. That is correct.

Q. All right. And that's evidenced by the CPK Mb of two percent, right?

A. Right. Whether it happened again subsequently or prior to that time, I don't think anybody could say for sure.

Q. I don't want to make any mistake about it, you are not -- Was it a myocardial infarction or just some insult to the myocardium rather non-specific that we're talking about?

A. You mean after the --

Q. That made his heart stop on the 17th.

A. After the 14th? Please repeat the question.

Q. What made his heart stop on the 17th? Did he have an MI, did he blow out a wall of the heart; what happened, or do you know?

A. I believe he had an MI.

Q. And based on the information you have, you can't tell whether when the one enzyme was drawn, the one Mb CPK was drawn, whether he was in the process of having one MI that resolved or whether he was evolving; is that true?

A. Yes.

Q. And if the resident had taken and/or ordered a second, then you would have a better idea; is that correct?

A. Yes.

MS. BARTNIK: Objection.

Q. (BY MR. TERRY) Do you know whether or not that information was communicated by the resident to Dr. Smith prior to the surgery on the 17th?

MS. BARTNIK: What information?

MR. TERRY: The information regarding the Mb CPK fraction.

A. I have no information to indicate that it was.

Q. Do you have a belief one way or the other?

MS. BARTNIK: Objection.

MR. GROEDEL: Objection. Go ahead.

A. I don't think I do. I would tend to

doubt it. I should also add that Dr. Oliver, who was the intensivist involved in this patient's care, I think because he's the medical doctor -- by that, I make a distinction between surgical doctors and medical doctors.

Q. (BY MR. TERRY) I understand.

A. And internists and intensivists and anesthesiologists I classify as medical doctors.

I believe that he was the medical doctor with the responsibility of taking care of the patient at that time, had the primary responsibility to follow-up on that laboratory finding.

Q. All right. So Oliver is the one who should have ordered a follow-up --

A. More than anybody else.

Q. -- lab test?

And he should have apparently alerted the orthopedic people?

A. And the internists perhaps, since this patient ultimately will be transferred, his medical problem would ultimately be transferred to the care of internists.

Q. If Dr. Smith was aware of the Mb fraction on the 17th, would it have been

appropriate for him to conduct this surgery?

MR. GROEDEL: Objection. Go ahead.

Q. (BY MR. TERRY) Do you have an opinion on that?

A. The second one?

Q. The second one on the 17th.

A. If he had been aware of it, would it have been appropriate?

Q. That's correct.

A. I don't think the patient's dislocated hip could tolerate the waiting period that would normally be appropriate for cardiac rehabilitation, therefore he had to proceed no matter what. The question is under what circumstances to proceed, and that is a decision made by the anesthesiologist.

Q. Do you consider this to be emergency surgery?

A. Yes, I do.

Q. This is a man who, I believe you stated, had some kind of a GI bleed on the 17th?

A. There was evidence of that, yes.

Q. All right. And that's evidenced by the --

A. Guaiac positive, g-u-a-i-a-c.

Q. The coffee ground emesis, right?

A. And the falling hemoglobin.

Q. And he also had his hematocrit dropping, correct?

A. Yes.

Q. Hemoglobin is dropping, correct?

A. Yes.

Q. He's got enzymes in the blood indicating that there is some damage to the heart?

A. Well, that is from the sample taken on the 14th.

Q. All right. Last known?

A. Right.

Q. And you still consider that the surgery should have gone forward on the 17th; that it was proper to operate on this guy or to, excuse me, to take him in, put him through the stress of anesthesia in order to fix the hip?

A. Yes, because having a dislocated hip is a stress in itself as well that needed to be addressed.

Q. On a scale of stress, how would you rate going through the anesthesia that he went through on the 17th with the dislocation of the hip that existed prior to surgery?

MR. GROEDEL: Stress to what?

MR. TERRY: Stress to the heart.

A. That depends on what you do in preparation for the anesthesia. With appropriate monitoring and so on, the stress can be very significantly reduced.

Q. You have indicated that as far as Dr. Lee is concerned, just so I understand exactly what the criticisms are, that his preanesthetic assessment was inappropriate, right?

A. Yes, I believe so.

Q. In what respect?

A. He did not have the most current laboratory values entered in the chart. I don't believe that he was impressed about how serious the patient's underlying cardiovascular problems were, because he did not make a great deal of notation about it other than a history of hypertension and he noted -- I would like to refer to the record, if I may.

Q. Be my guest. Just tell me what you're referring to.

A. It says -- certainly. 152. Page 152, preanesthetic assessment.

Q. Specifically?

A. Under EKG, it says PAC, I think it says here left ventricular strain. I believe there was

an official EKG interpretation that showed ischemic changes, together with the left ventricular change. And that is very pertinent. It would indicate to me that the heart already was not getting as much blood flow as it needs ideally and, therefore, it's very important to do what's necessary to help benefit, to help improve the profusions of the heart.

There was an arterial blood gas noted on the preanesthesia evaluation. That arterial blood gas was, in fact, one obtained while the patient was on the ventilator. And the gases were very poor even with the assistance of the ventilator.

I think that given these kinds of gases and the history of cardiac arrhythmia in the SICU following the first anesthetic, very strong considerations should have been given to the patient's going to SICU after surgery; in addition to having the necessary evasive monitorings.

Q. All right. But in your opinion you still feel that he could have been operated on safely, correct, anesthesia still could have been given in a safe enough manner?

A. Right. That's a relative term.

Q. Relative to what?

A. Well, relative in the sense that the patient would not be free of risk from serious complications such as death, but the chances of him coming through alive would be very significantly enhanced.

Q. Based on the assessment of this individual --

A. Right.

Q. -- and based on what you consider to be appropriate anesthetic techniques, what do you consider his probability of surviving the procedure to be on the 17th of March?

A. If all the appropriate steps were taken?

Q. Yes, sir.

A. I would say better than 60 percent.

Q. You also -- I believe this goes part and parcel I assume with the inappropriate preanesthesia assessment, but you indicated that he failed to recognize the risk. Specifically what risk were you referring to?

A. The risk of a low hemoglobin and therefore impaired profusion to the heart and lungs; the risk of previous history of cardiac dirhythmias and therefore the likely recurrence of this problem; the risk of having sustained a

myocardial injury following the first anesthetic and therefore the much greater risk of a repeat injurious myocardial event which could result in death.

Q. You are basing that statement on the blood enzyme or on an EKG or what, the fact that there was an injury?

A. On the blood enzyme.

Q. All right. I thought you told me before that you couldn't tell whether that meant that this man was in a situation where he is evolving into an MI or whether he has got one that is resolving, and therefore now you can determine that; is that true?

A. No. It doesn't matter if he was evolving into one or whether he had just had one. Either way there was myocardial injury of some degree which was not determined. But whenever you have that, even if it's a small degree, then there is increased risk of a repeat injurious event when you subject them to the stresses of anesthesia and surgery again.

Q. Any other risks?

A. The fact that the patient is a COPD and probably needed repeated arterial blood gas

analysis in order to assist in the management of his partial oxygenation.

Q. What monitoring should have been done and when should it have been done?

A. The minimal amount of evasive monitoring for Mr. Smith for the second surgery would be arterial line and the pulmonary arterial catheter, otherwise known as a Swan-Ganz catheter, which would have been very helpful at best.

Q. Is the Swan-Ganz standard of care?

A. I can't say that it is a standard of care, no.

Q. The arterial is?

A. (Witness indicating).

MR. GROEDEL: Say yes for the record.

A. Yes. I thought I said yes.

Q. (BY MR. TERRY) Any other monitors, any other internal monitors that should have been used?

A. Well, that would be true of the other more routine ones, such as the precordial stethoscope, an EKG, I think a temperature monitor would have been very desirable. I don't believe that back in 19 --

MR. GROEDEL: '84,

A. -- 84, pulse of symmetry was widely used at that time, so I would not make any comments with regard to the care.

Q. Of those monitors that you mentioned, which of them rise to the, or the failure to use them would constitute a deviation from the standard of care?

A. The EKG and the arterial line.

Q. Is that in this case or in all cases?

A. In all cases that resemble this.

Q. Failure to advise the surgeon of the intraoperative course, what's the basis for that criticism?

A. Well, apparently Dr. Smith was not under the impression that the patient was going to have any problem.

Q. Do you have anything you are relying on or is that an assumption of yours or what?

A. Well, from my experience, if I tell the surgeon that the patient has had some problems intraop, he would heighten his concern and more likely than not they would participate to some degree in the immediate postoperative care of the patient either in actually assisting me in some way or in consulting with me about what additional

medical help to seek. For example, whether to have an internist see the patient, have the patient transferred to a unit and so on.

Q. That's your experience. Is there anything in this record that tells you that there was no communication between Dr. Lee and Dr. Smith about the difficulty during the intraoperative course, or Dr. Lee and any of the other residents, any of the residents that were with Dr. Smith?

A. I have no evidence that there was or wasn't communication.

Q. Okay. So that's an assumption?

A. That was an inference. Yes.

Q. And you could just as well infer that he did tell Dr. Smith and Dr. Smith decided not to do anything about it, couldn't you?

MR. KAMPINSKI: I am going to object.

MR. GROEDEL: Objection, because the record reflects that he didn't put down any complication. So if he didn't recognize any, how's he going to tell him about it?

MR. TERRY: Who didn't, Smith or Lee?

MR. KAMPINSKI: Lee, who has admitted negligence.

Q. (BY MR. TERRY) Now, the bad post-op care, the long and short of it, Doctor, you testified, if I am not mistaken, correct me if I am wrong, is that it's your opinion that at least up until 9:15 on the evening of the 17th, Mr. Smith probably would have survived with appropriate care?

MS. BARTNIK: Objection. I think you have the wrong time.

MR. KAMPINSKI: I think he said 9:55.

MR. BARTNIK: He did.

Q. (BY MR. TERRY) 9:55 or 9:15?

A. I believe I said 9:55. I will need to look at the nurses' notes in order to --

MS. BARTNIK: Chuck, you and I agree on that?

MR. KAMPINSKI: I'm easy to get along with. I always agree to the accurate facts.

A. Yes, I did say 9:55.

Q. (BY MR. TERRY) After 9:55 what is it that Dr. Lee did that was inappropriate? What did he do that caused this death?

A. Number one, the failure to immediately insert the appropriate evasive monitoring, because

the patient at that point still did not have either an arterial line or a Swan-Ganz catheter. That would have helped him know the cardiac status of the patient.

And I think at that point the patient's problem is sufficiently serious and complicated that it would have been helpful for him to get someone else to assist him, either intensivists, cardiologists or internists.

I believe he should have also, and I am not certain whether at this point he had gotten a blood gas or not, but if he hadn't, it would be extremely important for him to get one. Also to get a chest x-ray, which would help give additional useful information.

Q. And if he had done all that, I mean that's the proximate cause of the death here, the failure to get that monitoring information, get an EKG, a chest x-ray and get a consult; is that what I understand your testimony is?

MR. KAMPINSKI: The question you just asked him is what else didn't he do right after 9:55.

MR. TERRY: That was the proximate cause of the death.

MR. KAMPINSKI: No, you didn't add that.

MR. TERRY: Yes, I did.

MR. KAMPINSKI: No, you didn't. Now you are asking him a different question.

MR. TERRY: Yes, I did, but I will ask it again to make you happy.

MR. KAMPINSKI: No. Don't make me happy, because no, you didn't.

MR. TERRY: Excuse me.

Q. (BY MR. TERRY) On the 17th of March --

MS. BARTNIK: November.

MR. GROEDEL: Is it March or November?

Q. -- November, 1984, after 9:55, what didn't Dr. Lee do that was the proximate cause of the death of Mr. Smith?

A. Would you like me to answer that question again? I thought I had just answered it.

Q. Well, that's what I thought too. Those, as I understand it, though, the monitoring, the chest x-ray, would have given, and the EKG would have given him a clinical picture of what was going on, correct?

A. Right. It would better enable him to

treat what the underlying cause is.

Q. Was there anything in your opinion that could have been done after 9:55 on that date which would have prevented the death of this individual?

A. Well, since you asked me what he could have done, certainly all those things that I just mentioned can possibly enable him to be alive.

Q. Okay. Those give you a clinical picture, but they're not treatment, are they?

A. No, of course not.

Q. All right.

A. They give you useful information upon which to base the treatment. Okay?

Q. Okay.

A. Another element that must be present is taking the appropriate action based on the information that will be obtained from these additional tests.

Q. Okay. Now, the question is, and you may not have an opinion, is there any, is there any treatment that could have been administered to Mr. Smith after 9:55 that would have changed the outcome in this case?

MR. GROEDEL: Objection. Go ahead.

A. Only that definitely treatments could

have been given which may have changed the outcome.

Q. All right. You do not, I take it, have an opinion as to any kind of medical probability as to whether any set course of treatment were to change the outcome after 9:55?

A. Would you repeat that.

Q. Do you or do you not have an opinion as to the degree of reasonable medical probability as to whether any treatment administered to Mr. Smith would have changed the outcome after 9:55 p.m.?

A. I think any figures that are proffered by anyone would be at best educated guesses.

Q. All right. What about the deterioration; Mr. Smith, at least the records indicate, was in fairly decent shape when his vital signs were last taken at 9:15, and then he had deteriorated between 9:15 and 9:55.

MR. KAMPINSKI: Objection to fairly decent shape. I don't think that's what the doctor testified to.

Q. (BY MR. TERRY) They were better at 9:15 than they were at 9:55, can we agree on that, Doctor?

A. Yes, I believe so.

Q. Do you have any reason to believe that

that was not a gradual deterioration? I mean, do you think that he just kind of coasted downhill there for 40 minutes or do you think that there was some incident that precipitated the change in vital signs; or do you have any opinion on that one way or another?

A. I don't believe that the vitals from 9:15 to 9:55 represent a drastic deterioration. And again, drastic and coasting down and so on are very subjective terms. I have no strong suspicion that something happened during that interval that resulted in the change. I think it's just most likely a general pattern of deterioration.

Q. All right. Do you think that it's appropriate that there are no notations, that apparently the vital signs at least were not written down during that period from 9:15 to 9:55?

MS. BARTNIK: Objection.

A. I am puzzled why there isn't an entry, but I cannot draw any conclusions from that.

There is a considerable time gap that is --

MR. TERRY: Thank you. Nothing else.

BY MR. MEADOR:

Q. You were just talking about a general pattern of deterioration that you observed from the notes of this patient here. Are you saying that you really can't say when the patient's chances were less than 50/50 of surviving?

MR. KAMPINSKI: Well, I object. I think he did say that.

MR. GROEDEL: Objection.

A. Yes, I did say that. I believe I said that after 9:55.

Q. (BY MR. MEADOR) Okay. At 9:55 the chances were 50/50 or 51 in favor of not surviving?

A. 51 in favor of not surviving.

Q. Okay. And you attribute that to a general pattern of deterioration. Do you not attribute it to whatever may or may not have happened between 9:15 and 9:55; is that true?

A. I have no information to tell me what might have happened between 9:15 and 9:55, therefore I cannot attribute it to what I do not know may have existed.

Q. Okay. Getting back to the discussion we've had about aspirations, what is your

definition of an aspiration?

A. Aspiration is the entry of gastric content into the airway and/or lungs.

Q. Okay. And there is evidence in the record here that indicates to you that there was an aspiration in this case?

A. The return of what appears to be gastric content from the endotracheal tube is very suggestive of an aspiration.

Q. And that's from the notes that indicate a tan fluid was suctioned from the patient; is that true?

A. Yes.

Q. Okay. But you have no idea when the aspiration occurred; is that true?

A. That is correct. And I am not even absolutely certain that an aspiration did occur. I think it's very likely. See, tan is a color that is sufficiently close to pink, that it is possible that the fluid that was obtained could be from pulmonary edema as a term of a cardio event. And when that happens there is a considerable amount of that fluid in the airways, but it would seem more likely that it was a gastric secretion than pulmonary edema fluid simply because of the

designation tan color.

Q. Okay. Would you say there is more of a 50 percent chance that it was gastric content as opposed to --

A. I would say.

Q. -- pulmonary edema?

A. I would say so, yes.

Q. Are there different kinds of aspirations? In other words, you testified that a nurse would see an aspiration; is that your testimony?

A. That a nurse would see it?

Q. Yes.

A. I don't believe that I testified to that. A patient could have aspirated without a nurse seeing it if the nurse was not observing.

Q. That's -- Even if a nurse was looking at a patient, a patient could aspirate something and the nurse not see it; isn't that true?

A. Yes. It's a matter of degree.

Q. You don't know when an aspiration occurred in this case, do you?

A. No.

Q. Isn't it true that it's just as likely that an aspiration occurred during the operation as opposed to after the operation?

MR. TERRY: Objection.

A. I can't say that it is as likely. Aspirations tend to occur during a time of relative loss of consciousness.

Q. Okay.

A. And, therefore, if the patient was awake throughout the operation and still had his protective airway reflexes, there's no reason to believe that he aspirated at that time.

Q. Okay. Well, isn't it true that the patient was even more awake in the recovery room and would have had a greater amount of those gag reflexes that you referred to?

A. You mean as a result of possibly pre-op sedation wearing off?

Q. Yes.

A. It would generally be true that with time the patient would be more awake in the recovery room. However, if the patient's cardiovascular status deteriorates, it can cause him to lose his consciousness as a result of loss of inadequate cerebral profusion than the effects of sedatives.

Q. You don't have any idea, from looking at the records here, that the patient aspirated

anything between 9:15 and 9:55, do you?

A. I have no information to base that assertion, no.

Q. So you can't say one way or the other?

A. That is correct. I wouldn't know. I would note that there is such a long time gap without anything, such as a nursing entry.

Q. Right. But that doesn't tell you there was an aspiration that occurred during that time period?

A. No, it does not. No.

MR. MEADOR: That's all I have.

MR. KAMPINSKI: Just a couple quick questions, Doctor.

- - -

BY MR. KAMPINSKI:

Q. If there was an aspiration, just going on further with this alleged aspiration --

A. Okay.

Q. -- would you expect some changes in the patient, such as a change in vital signs within some short period of time after the aspiration?

A. Yes. Assuming that it is a significant aspiration, yes.

Q. All right. And also in your report,

Doctor, there was, okay, there was a sentence on page two --

A. Yes.

Q. -- in the continuation of the paragraph where it says, "In my training and observations at the Yale New Haven Medical Center and other tertiary centers such as St. Luke's," you didn't mean St. Luke's, you don't have any experience at St. Luke's, do you?

A. No. I had recognized that as a semantic error after I wrote it. I should say other tertiary centers similar to St. Luke's.

Q. All right. And at least in the written notes of the nurses, there is no recognition of any loss of consciousness and obviously we don't know what occurred in that 40-minute period from 9:15 to 9:55, do we?

A. No.

Q. But we do know that at 9:15 the IV infiltrated, do we not, Doctor?

A. Yes.

Q. Okay. And what effect would that have had on Mr. Smith?

A. It depends on whether he was getting important medication by IV or not.

Q. Well, okay, let's take a look. He was getting Lidocaine, wasn't he?

A. I believe he was. I knew he received Lidocaine.

Q. Yes.

A. But I was not able to ascertain whether it was bolus or --

Q. Go back to 156, if you would, at six o'clock, I guess.

A. Okay.

Q. Lidocaine, 50 something, given IVP per Dr. Lee?

A. IVP means IV push. That means it's given -- (indicating).

Q. And that's it?

A. That's it.

Q. I see.

A. Both times, IV push.

Q. So you don't know whether he was getting any through his IV or not then, do you?

A. I don't believe there's mention of it, no.

Q. What treatment was he getting for his problems up until nine o'clock?

A. Up until nine o'clock?

Q. Sure. Was he getting any treatment?

A. No, other than oxygen and the two boluses of Lidocaine from what I am able to get out of the --

MR. KAMPINSKI: That's all.

MS. BARTNIK: Nothing further for me.

MR. TERRY: Nothing.

MR. KAMPINSKI: All right. You have a right to read your testimony and sign it; or you have the right to waive your signature.

MR. GROEDEL: We will not waive.

MR. KAMPINSKI: I am sure Mr. Groedel will advise you.

- - -

(Deposition concluded at 4:00 p.m.)

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I have read the foregoing transcript from page 1 to page 87 and note the following corrections:

| PAGE: | LINE: | CORRECTION: | REASON: |
|---|---|---|---|
| | | | |

_____
EDWARD D. LIN

Subscribed and sworn to before me this day of , 1987.

_____
Notary Public

My Commission Expires:

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

I, Marguerite A. Sandly, RPR/CM and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that EDWARD D. LIN 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 Stenotype 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 pursuant to notice and by agreement of counsel; 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 19th day of November, 1987.

Marguerite A. Sandly

Marguerite A. Sandly, RPR/CM and Notary Public within and for the State of Ohio
540 Terminal Tower
Cleveland, Ohio 44113

My Commission Expires: October 30, 1989.