STATE OF OHIO, SS:
COUNTY OF LORAIN.

IN THE COURT OF COMMON PLEAS

JAMES J. ARMSTRONG, Executor of the Estate of NANCY ARMSTRONG,

Plaintiff

vs. Case No.

EMH REGIONAL HEALTHCARE SYSTEM, d/b/a AMHERST HOSPITAL, et al., CV126180

Defendants

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The deposition of DR. ANDREW M. LONDON was held on Thursday, May 9, 2002, commencing at 9:11 a.m., at Kinko's Copies, 300 North Charles Street, Baltimore, Maryland 21201, before Marianne R. Hewitt, Notary Public.

APPEARANCES:

DONNA TAYLOR-KOLIS, ESQUIRE
On behalf of Plaintiff

RONALD WILT, ESQUIRE
On behalf of Defendant
Dr. Paul Bartulica

RONALD A. RISPO, ESQUIRE
On behalf of Defendant
Dr. Briccio Celerio

REPORTED BY: Marianne R. Hewitt

STIPULATION

It is stipulated and agreed by and between counsel for the respective parties that the filing of this deposition with the Clerk of Court be and the same is hereby waived.

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Whereupon,

DR. ANDREW M. LONDON,

called as a witness, having been first duly affirmed to tell the truth, the whole truth, and nothing but the truth, was examined and testified as follows:

EXAMINATION BY MR. WILT:

Q Dr. London, please state your full name.

A Andrew Monroe London.

Q And your business address.

A 201 East University Parkway, Baltimore, Maryland 21218.

Q Doctor, I've been provided a three-page curriculum vitae by counsel.

MR. WILT: And do you have a copy of that there, Donna?

MS. TAYLOR-KOLIS: No, but he does.

THE WITNESS: I do.

BY MR. WILT:

Q All right. And as it begins with your date and place of birth, and I believe it's on the third page has a bibliography and it has one citation.

Doctor, is that a current and updated curriculum vitae, as far as you know?

A It doesn't seem like that because there are several citations on mine.

Q When the last -- my bibliography has A. M. London and R. Burkman: Tubo-ovarian Abscess with Associated Rupture and Fistula Formation into the urinary bladder.

That's the only citation I see under bibliography.

A I have several others.

Q You have others.

A Yes.

Q All right.

A I'll give it to Donna.

Q Okay. Well, we're not -- I've got some questions for you, why don't you hold on to it.

When did you publish these other papers or chapters or whatever they happen to be?

A The second paper came out in 1999. I was a contributor to a book in 2001. There's a patent on an instrument that I've invented in 2000.

Q Does either paper that you published in 1999 or 2001 do you believe would be particularly germane to the subject or subjects that we're going to be discussing in this deposition today?

A No.

MR. WILT: Why don't you go ahead and attach a copy your curriculum vitae to the deposition as Defense Exhibit Number 1 or A.

(Defense Deposition Exhibit Number A was marked for purposes of identification.)

BY MR. WILT:

Q Now, Doctor, immediately prior to this deposition there was a discussion that Mr. Rispo and I had that apparently because the video camera was not

on on our end you and counsel for the plaintiff were able to overhear; is that correct?

A Yes.

Q All right. And in that discussion -- well, you just tell me what you recall hearing about that discussion?

A The only thing that I really picked up on that I was listening to was a discussion by both of you on her life expectancy and quality of life during that time.

Q Okay. And what I would -- let's just go ahead and take that then since you've already heard us discuss that.

Are you going to be giving any opinions regarding Mrs. Armstrong's life expectancy had she not passed on August 7th?

A No, I'm not.

Q All right. Have you ever treated a patient with a diagnosis of amyloidosis?

A No, I have not.

Q Okay. So you have no opinions, I take it,

then regarding that condition and what effect it would have upon Mrs. Armstrong's life expectancy and/or quality of life?

A No, only what I've read in the depositions.

Q All right, fair enough. Doctor, I've been provided a report by Ms. Kolis that is dated May 29th, 2001.

Do you have a copy of that report there?

A Yes, I do.

Q First other than this report did you make any other notes regarding your review of the records and depositions in this case?

A Yes, I did.

Q All right. Do you have those notes there with you, Doctor?

A Yes.

Q All right. Could you first identify the notes that you've made other than this report dated May 29th.

MS. TAYLOR-KOLIS: Ron, I don't want to

interrupt but just for purposes to make this easy, I know that you've only recently come into possession of this file.

There was an original report dated May 8th, 2000. So there are two.

MR. WILT: Oh.

MS. TAYLOR-KOLIS: There's an original report and this May 29, 2001 was the supplemental report following the depositions. So I don't know if you have located it in your file.

MR. WILT: I don't have a May 8th report, Donna, and Ron says he doesn't have that either.

MS. TAYLOR-KOLIS: Well, there was an original report, so I'm not sure. And it's not much different but, you know, it's there. So we can mark them.

MR. WILT: All right. Let's do this -- I appreciate that, Donna.

Let's do this, let's attach the May 8th report as Defense Exhibit B.

MS. TAYLOR-KOLIS: Okay.

MR. WILT: The May 29th report as Defense Exhibit C.

MS. TAYLOR-KOLIS: Hand them to her so she can mark them.

THE WITNESS: Okay.

MR. WILT: And when she gets through marking those, Doctor, if you would, because I don't have the May 8th report with me, if you could just tell me what the differences are between the two reports

(Defense Deposition Exhibit Numbers B and C were marked for purposes of identification.)

THE WITNESS: The May 8th report was my original review and discussed the findings of the x-ray, the abnormal EKG and the outcome of the case.

It expressed my feelings about some of the breaches that Dr. Bartulica had deviated from.

And the follow-up report I believe was after 1 had further records from other physicians.

There wasn't much difference between the two.

BY MR. WILT:

Q Since I have the May 29th, 2001 report why don't you take a look and review that and tell me if that report fairly and accurately summarizes your opinions in this case?

A Those are my initial opinions.

Q All right. I understand, Doctor, those are your initial opinions, but I want to know if that fairly and accurately summarizes your opinions as you sit here today?

I have several other areas I feel were breaches in the care that was rendered to Nancy Armstrong.

All right, Doctor. And when did you form these other opinions that are outside of this report?

As I re-reviewed the records.

Q Okay. So your new opinions aren't based upon obtaining any new information, it's just based upon further review by yourself; is that correct?

A Correct.

Q Okay. And when did you make Ms. Kolis

aware *of* these new opinions?

A I have no recollection *of* the dates. Somewhere between May 8th and May 29th and within the last six months, I would suspect.

Q All right. So within the last six months you made Ms. Kolis aware *of* these new opinions.

Did you make her aware by correspondence or did you just talk to her over the phone?

A Telephone.

Q All right. So why don't you tell me your new opinions.

A I'm not sure of your question. Are you asking me where I feel the breaches were in the treatment of Nancy Armstrong?

Q No, Doctor, what I'm asking for is we've now established that you have additional opinions other than what is contained in your May 29th, 2001 report.

I would like to know what those additional opinions are?

A Okay.

MS. TAYLOR-KOLIS: First of all, go through your report and make sure that they're not additional. Deal with what's ever in there, and then if there's anything else you didn't say tell him what those are.

THE WITNESS: The opinions are probably more accurately enhancements of what I felt in the 29th and why they are my opinions and they became stronger.

The only additional ones as far as the breaches in the pre-operative evaluation speak to these two issues of EKG and chest x-ray, and one other one based on blood in the urine on August 5th, 2000 -- on August 5, 1999.

So it relates to the pre-operative evaluation, the pre-surgical evaluation in the hospital just before surgery both by Dr. Bartulica and by the Department of Anesthesia, Dr. Celerio.

BY MR. WILT:

Q All right. Tell me about the blood in the urine.

A As part of her pre-surgical testing on August the 5th there was found to be blood in the urine, I believe it was one plus.

This was neither evaluated, nor looked at, nor further addressed.

Q Do you have an opinion as to what caused the blood in the urine?

A No, but I can give you the most likely cause.

Q Well, first I want to know if you're going to be giving an opinion to a reasonable degree of medical probability as to what the cause of the blood in the urine was?

A No.

Q And then we can speculate. Okay. Now tell me what your guess is as to what the cause of the blood in the urine was?

A The overwhelming reason usually for blood in the urine is urinary tract infection.

Q All right. Is a urinary tract infection -- put it this way. Is a simple urinary tract

infection with no involvement of the kidneys a contraindication to a hysterectomy?

A In and of itself alone probably not, and I stress the word probably not. It depends on the type of procedure being done. If the bladder was to be instrumented. So it could be in certain situations and in others it would not be.

Q In the situation of this case we had a planned abdominal hysterectomy and I think he was going to also do a bilateral oophorectomy, would a simple urinary tract infection with no evidence of more extensive involvement be a contraindication by itself?

A To use your words, if it had been evaluated for no further extensive involvement, no. But it needed to be evaluated to be sure that was the case.

Q Okay. Do you see in the medical records or in the autopsy report any evidence that there was more extensive involvement of this urinary tract infection?

A No, I did not.

Q All right. Now, if I understood your earlier testimony correctly, after we cover this urinary tract infection the fact that you believe that should have been further evaluated by Dr. Bartulica or the anesthesiologist, you then believe that or the rest of your opinions are then encompassed in this May 29th report; is that correct?

A Yes.

Q All right.

A Yes.

Q And that's what I'm going to work from, Doctor, if that's -- and if you have any other opinions that come to mind, be sure and let me know.

A Yes, sir.

Q Okay.

A Yes. sir.

Q Have you ever given a deposition before?

A Yes, I have.

Q Okay. On how many occasions and specifically, Doctor, I want to know in the context

we're here today where you're acting as an expert commenting on other physician's care in a medical negligence case.

A I've probably given 15 to 20 depositions. I don't keep count, but I would suspect it's in that range.

Q Okay. Over how long of a time period or over how many years?

A Probably over 10 years.

Q Now, I take it you review more cases or you have reviewed more cases than just 15 to 20 over the years.

A That's correct.

Q Do you have any estimate of approximately how many cases you reviewed for attorneys in a medical negligence action?

A My suspicion is somewhere around 15 a year, maybe a little less.

Q And you know what the next question is, Doctor, and that is about what percentage of those that you review on behalf of the plaintiff as compared

to the defendant?

A Probably 65 to 75 percent for the defense.

Q And of those cases that have gone to deposition, approximately what is the percentage breakdown?

A About the same for -- about 65 to 75 percent for the defense.

Q Now, Doctor, when you review cases for the defense is that primarily for physicians in Maryland or do you review them for physicians outside of Maryland?

A Both.

Q Do you believe that if you looked at just cases outside of the State of Maryland that the percentage of cases that you would review would be predominantly for the plaintiff as compared to the defendant?

A Yes.

Q And what if we eliminate the cases that originate in the State of Maryland, what would you guess the percentage of cases that you review for

plaintiff as compared to defendant?

A Probably 60 percent plaintiff, 40 percent defense outside of Maryland.

Q And if we look at cases that you review within the State of Maryland and eliminate the ones outside of the State of Maryland, what would you say the percentage breakdown would be?

A 95 percent defense.

Q All right. And, Doctor, have you had the opportunity to testify in a trial?

A Yes, I have.

Q Have you ever testified in the State of Ohio?

A No, I have not.

Q Where have you testified at trial?

A In Maryland.

Q Any other states?

A No.

Q Do you know how Ms. Kolis got your name in this case?

A No, I don't.

Q Do you advertise your services as a medical expert in any journals?

A No.

Q Do you know if your name -- well, let me ask it this way.

Do you know if any expert referral groups that do advertise send you any cases?

A I would have no idea if groups advertise or don't advertise.

Q In other words, there are some groups out there that advertise in journals that they will help obtain legal or medical experts, and they will provide names to lawyers or other people that want medical experts.

Do you know if any of the cases that you've reviewed through the years, over the years have originated from one of these referral sources?

A I would have no idea.

Q All right. So every time you're contacted to review a case it's directly by an attorney involved in the case; is that correct?

A The cases seem to come from attorneys. There was a group several years ago that was sending me some cases, and I don't know whether they were a referral service or not. 1 don't remember the name of them.

Q You don't remember the name of them.

A No.

Q How many cases did you get from them, Doctor?

A A couple, I can't remember.

Q All right. How did that situation work, did the group –– well, describe what you mean by group, I'm confused?

A I don't know whether they're a group or not. I was asked to review some records and called and the records came. And I called whoever the coordinator was to say there was merit or no merit in the case and that was it.

Q Did you ever speak to an attorney in those cases?

A I don't remember.

Q Okay. Now, I see here on your curriculum vitae it states that you're an instructor in obstetrics and gynecology at Johns Hopkins.

A Yes.

Q Okay. Could you tell me what that entails?

A It's an academic position. I trained at Hopkins, I stayed there, I do some teaching of the residents and medical students. I have continued to do that since 1978.

Q Do the medical students come to your office and rotate through, or do you go to Hopkins and actually give lectures?

A Both.

Q About how often?

A I had a monthly seminar I was doing with the residents at Hopkins and it's every couple of years that they come to the office, however, they often come to our hospital and rotate on an every six-week basis. They did that in the past, they have not done that in the last year.

Q On the monthly seminar that you do, do you still give that monthly seminar?

A I haven't in about four months, but I believe in the fall I'll be starting up again.

Q Is there a particular topic that you usually talk about?

A Yes.

Q And what is that?

A Menopause and problems associated with it and contraception.

Q Do you have a special interest in menopause and contraception outside of your --

A Yes.

Q Go ahead, tell me about that special interest.

A Just something I developed over the years and have published several chapters in the book that you'll have on my curriculum vitae, and just an interest I have as the population ages.

Q Okay. I take it you're board certified in obstetrics and gynecology.

A Yes.

Q Any other board certifications?

A No.

Q Do you hold yourself out as an expert in any other medical specialties other than obstetrics and gynecology?

A No.

(A discussion was held off the record.)

BY MR. WILT:

Q Doctor, why don't you go ahead and summarize for me the facts of this case or the pertinent facts of this case as you understand them and upon which your opinions are based.

A Are you asking for a review of her medical history, or just the pertinent points in August? I'm confused by the question.

Q Okay. I want to know what pertinent facts that you have gleaned from the medical records upon which your opinions are based and that you think are particularly relevant to your opinions in this case.

MS. TAYLOR-KOLIS: And you're absolutely

allowed to look at any material that you have.

THE WITNESS: Okay.

MS. TAYLOR-KOLIS: I mean you can look at your records, that's fine.

THE WITNESS: Well, it essentially involves some of the history with Mrs. Armstrong, that she was having pelvic pain, was seen by several gynecologists, the last which was Dr. Bartulica who started to work her up and evaluate her for her pain with sonograms and ultimately recommended surgery based on these sonograms and her history of pain.

He had scheduled surgery for August the 7th, 1999. She went for pre-surgical testing on August 5th, 1999 at which time the nurse contacted Dr. Bartulica that she had an abnormal chest x-ray showing effusion and infiltrate and the recommendation being follow to resolution.

Dr. Bartulica was informed and made a note that he was informed of this and said to send her to the hospital, that this was not a problem, that she should come in on the 7th of August for her surgery.

On the morning or I don't know the time, it had to be the morning because she was operated on Late morning, she was seen by the anesthesiologist, Dr. Celerio, who did a pre-anesthesia assessment, felt that she was not a surgical risk at that time.

She was operated on and shortly after the surgery was begun was noted to have dark blood and underwent a cardiopulmonary arrest. Resuscitation attempts were ultimately unsuccessful,

And that really summarizes the long and the short of the pertinent history at this time.

BY MR. WILT:

Q All right. First, do you have any criticisms of Dr. Bartulica based upon the history that he had obtained from Mrs. Armstrong and based upon the findings from his -- from the sonograms and his own evaluation, do you have any criticisms of his recommendation of a hysterectomy for treatment of her -- suspected, what? I forgot the word, Doctor. Adenomyosis.

A If she truly had adenomyosis at her age,

hysterectomy probably is the appropriate treatment.

Q And can we -- and I guess my question is given all the information in 1999 that Dr. Bartulica had I'm assuming that you don't have any criticisms of him for at least recommending this as treatment for her complaints?

A You mean --

Q Not whether he went ahead with it but just recommending it, initially.

A Removing all of her other past medical history and her medical problems using this purely in a hypothetical normal healthy woman with this diagnosis, was it an appropriate recommendation, is that the question?

Q Okay. What I'm saying is -- yeah, Doctor, let's just try that.

A The answer is yes, it was appropriate.

MS. TAYLOR-KOLIS: There you go.

BY MR. WILT:

Q Now, let's take Mrs. Armstrong. Was it an appropriate recommendation for surgery in July of 1999

with the caveat of assuming she is determined to be an appropriate risk by -- through pre-admission testing?

A I'm going to take exception to the term pre-admission testing. Pre-surgical evaluation would be more appropriate.

Q That's fair. All right, that's fine.

A If that's the case --

Q Let's go ahead and add that then.

A If that's the case and she were in appropriate health and with her history this was an appropriate recommendation to proceed with the hysterectomy.

Q And I guess what we're -- what I'm trying to get at is the fact that Mrs. Armstrong has a medical history that contains a small brain tumor that fact by itself would not be an absolute contraindication to the surgery Dr. Bartulica recommended, can we agree on that?

A I wish I were smart enough to be able to tell you that, but I'd have to rely on appropriate consultation from a neurologist or neurosurgeon to

tell me that this was stable and that the surgery was not contraindicated or a problem. I'm not trained in that area.

Q Do you have any -- well, okay. Let me ask you this then, Doctor.

Do you have an opinion -- let's just limit it to the tumor in the brain, did that tumor in the brain play any role in her cause of death?

A Based on the autopsy reports it did not seem to.

Q All right. And, Doctor, do you have any medical information that you can point me to that indicates that that tumor was anything but stable as of August of 1999?

A No, I do not.

Q And before I forget, Doctor, why don't you go ahead and tell me what you have reviewed in this case.

A I have the hospital records of --

Q Doctor, I'm sorry, but you're going to have to be a little bit more definitive than that

because we've got hospital records from a lot of different places.

A Oh, I'm going to, I'm sorry.

Q Oh, okay. I'm sorry.

A That's okay.

Q Go ahead.

A I have hospital records from Amherst Hospital admission. I have records of Dr. Paul Bartulica, Dr. Stan Richardson. I have records from St. John Westshore and miscellaneous outpatient and admissions throughout her history. I have office notes of Dr. B-O-Y-E dash D-0-E, I can't pronounce that.

MS. TAYLOR-KOLIS: Boye-Doe.

THE WITNESS: Boye-Doe.

BY MR. WILT:

Q Boye-Doe.

A I have letters from Dr. Alan Kravitz, Timothy Lyons, Geoffrey Mendelsohn. I have the autopsy coroner's report. Depositions of Dr. Bartulica, Celerio, Dr. Smithson and Dr. Richardson.

Q All right. Can we agree that Mrs. Armstrong had a thorough cardiac -- cardiovascular workup a few months prior to Dr. Bartulica's surgery?

A Define a few months prior, please, if you would. What month are we talking about?

Q I believe we're talking April.

A In April yes, she underwent several cardiac studies.

Q Well, that's not quite my question. My question is can we agree that she had a thorough cardiovascular workup in April of 1999?

A I would have to consult a cardiologist to say whether it was thorough or not. I could not tell you whether it is or is not.

Q Okay. You reviewed the deposition of Dr. Richardson, correct?

A Yes, I did.

Q Can we agree that as her primary physician he did not feel that at least as of --

(Sneezing.)

BY MR. WILT:

Q Bless you. -- the end of July that her -- any changes in her clinical status were due to cardiovascular difficulties?

A I'm not sure I was able to get that from the deposition.

He had seen her for her -- as her primary care and was not aggressively treating her for any new problems.

So if that's how you want to interpret that that's fine, but I am not sure I got that out of the deposition. I didn't get it the other way either that she was having problems.

Q All right. You are aware Dr. Richardson did get an EKG in July of '99.

A Yes.

Q All right. And at that time he did not attribute -- well, let's go back.

Do you interpret EKGs?

A No, I do not.

Q All right. So you would defer any interpretation of an EKG to a board certified

cardiologist.

A Or internist or family practitioner, someone who read EKGs regularly.

Q And what was your understanding of Dr. Richardson's interpretation of the July 1999 EKG on Mrs. Armstrong?

A I have to look at that EKG, and I don't believe I have Dr. Richardson's EKG at that time. I have EKGs that were a little more recent than that.

Q Well, you know, actually, Doctor, I'm more referring to Dr. Richardson's deposition because I want to know what your understanding is to his interpretation not what shows up on the sheet.

Do you have a recollection?

A No, I'd have to look in there. If you want to -- in the interest of time if you want to tell me what page you're on I can --

MS. TAYLOR-KOLIS: You can look in the back, there's an index that should say EKG.

THE WITNESS: It makes it too easy. What I have here is page 45, line 11 next to EKG, can you

please read the record what you have written there? Sinus rhythm, consider anterior MI.

BY MR. WILT:

Q You just go ahead and read these two pages, 45 and 46.

A You got that information off the EKG that had been performed two days before; is that right?

Urn-hum.

Q Doctor, let me interrupt you. Just read it to yourself.

A Oh, I'm sorry.

Q That's okay.

A I'm sorry, I was in Dr. Celerio's. I apologize.

Q Let me just ask a question, Doctor, maybe we can get through this if this will help refresh your recollection.

Can we agree that Dr. Richardson, based upon his review of the July EKG, did not find any evidence of an acute myocardial infarction or ischemia?

A I believe that was the case, yes.

Q All right. And also based upon Dr. Richardson's deposition, and you can tell me if you recall this or not, he did not attribute for dizziness, shortness of breath or sweating to a cardiovascular problem as it existed in July of 1999.

A To the best of my recollection that's what I believe he said.

Q All right. Now, let's talk about the chest x-ray. And you know what, before we get there I'd like to know a little bit about your procedures and how it works when you get a patient ready for surgery.

And let's just take a -- if you have a patient, hypothetically, who is being followed by a primary care physician and you discuss the patient with the primary care physician and the primary care physician indicates that they do not see from their standpoint contraindication for surgery, tell me what you do at that point as far as evaluating the patient, when do you send the patient for surgery and up until

the time you walk into the operating room?

A The scenario you just gave doesn't exist.

Q Okay.

A It is not a matter of discussion with the primary care, it's a matter of the primary care actually seeing the patient specifically for pre-surgical evaluation. Not just coming in for a check, not just have this blood level checked or that medication checked.

Is this patient safe to have surgery? Is a specific question. Is she medically cleared?

At that point the physician, the primary care physician will send back a letter, a history and physical, which we physically must have and surgery has been delayed on more cases than I care to account because the primary care did not fax it in time or mail it in time, and we have to sit there waiting for an office to open so we can have that letter faxed to us before our anesthesiologist will agree to put someone to sleep.

So we must have a pre-surgical clearance,

not just evaluation but clearance that this is safe.

Q All right.

A Assuming we have that following along with your question, if the patient has been cleared for surgery, that her medical problems have been taken care of then the anesthesiologist reviews that history and physical and really ultimately can have the final say, though it is at the discretion of the operator as well.

And I have canceled cases many times the day before, the morning of for nothing more than a cold and congestion because they may not be able to breathe properly and they're in increased risk for pulmonary problems.

So there is no advantage in operating on somebody when it is not the safest you can get them. I don't think you, anybody would want their loved one or themselves operated on unless then that situation.

So when I walk through the door I talk to the patient? Any new problems, any questions, any concerns?

I would inform them of any abnormal findings as to why I would have to delay the surgery or why I might even want to change the anesthesia type from a general to a local.

That I'm concerned that they do have to have the surgery under an immediate situation because of whatever reason and to make it safer anesthesiology and I have consulted and we feel that this is the safest way or that should be canceled until proper resolution of the issues have taken place.

Q All right.

A Safety first for the patient.

Q All right. Now, you indicated that you can cancel surgery. Have you ever had an anesthesiologist cancel surgery?

A Absolutely.

Q Tell me about how that works and what type of situations?

A The most common situation is the patient says she has a cold and may have some congestion or decreased breath sounds that he doesn't like or she in

that case may not like and feels that it is unsafe to have the patient under general anesthesia or sometimes even regional anesthesia.

There have been cases were the patient has eaten inadvertently where it became unsafe and it would have been eight hours before surgery could then take place under that situation.

They have not liked the EKG report and without a cardiologist consultation have said they would not put the patient to sleep until this was resolved by a cardiologist, not just the internist.

So those have been the most common situations that have occurred.

We try to get all of this taken care of beforehand so the patient doesn't make arrangements at work and have her family taken care of and come in and be inconvenienced by saying I'm sorry, Mrs. Smith, you have to go home today, until we can get this evaluated.

If we get this taken care of beforehand it's much more professional and smooth and obviously

safer.

I'm sorry for the long-winded answer.

Q No, actually I'm not complaining. Trust me if you get long winded I'll let you know.

Now, in this case can we agree that the cause of death was directly associated with the giving of a general anesthetic?

A It was certainly --

Q And when I say that -- go ahead, I'm sorry. If you can answer that.

A It was certainly contributory. Was it with general anesthesia the cause of death? I don't think I've seen that in any records and could not attribute it to that but it was certainly one of the factors that contributed to the cause of death.

Q How did it contribute?

A The patient is being paralyzed, the patient is being oxygenated or breathed for by the anesthesia. Medications that certainly affect pulmonary function and cardiac function are being given.

This is way out of my area of expertise, these are very vague generalities.

And if somebody is in various states of compromise there may not be the cardiac or pulmonary reserve to overcome that position of compromise.

Q Let me ask you, was this a procedure that could have been performed under -- with an epidural or any other type of anesthesia?

A Are you asking as a generality or in her particular case?

Q As a general.

A Oh, yes, it can.

Q Would that type of anesthesia, if you know, decreased the risks associated with compromising her cardiovascular state?

A In general I have to say I don't know but there's some basic guidelines that from being a surgeon and dealing with anesthesia that I know and that is that regional anesthesia can be associated with a profound blood pressure drop. And this has to be very carefully watched.

Somebody who is under a state of pre-operative cardiac or pulmonary compromise this could throw them over the edge and put them into a situation of arrest.

So it may not have been safer but it can be if the patient is breathing on their own. It depends if it is cardiac or pulmonary and this is not an area that I can give you expert commentary on.

Q All right. Did the incision by Dr. Bartulica contribute to the death or do you think by the time he made the incision the dye was already cast?

A I'm not sure the incision had anything to do with it at that point.

Q So can we agree by the time he made the incision the dye was already cast as far as Mrs. Armstrong's outcome?

A That's not an unreasonable statement.

Q Okay. Did the adenomyosis in -- the suspected adenomyosis, would that cause infiltrates in the lungs?

A No.

Q Do you have an opinion as far as the EKG that was performed in August of 1999, I believe it was August 5th, 1999 her pre-admission testing, as to what those abnormalities were caused by?

A As you asked earlier, do I interpret EKGs? And the answer was no.

I read the interpretation, and she had an anterior myocardial infarction of indeterminate age. And to me that means they don't know the age of it. Was it new, was it old?

Going back to even to your question earlier with Dr. Richardson -- excuse me -- said that she had no problems in July when he evaluated her, I think it was, or April.

And then so something happened between April and the 5th of August that we don't have the age of, just needed an evaluation to find out.

Q Right. Well --

A Unfortunately, there is such a thing as silent MI, and she may not have symptoms from it at

that point in time.

Q Okay. I guess my question, though, is do you or are you aware was there any significant difference in her EKG in August as compared to the one taken in July?

A I don't have the one from July to tell you. Based on what we saw in Dr. Richardson's notes that there does seem to be a change in the anterior MI. But, again, I don't have that EKG to tell you.

Q Okay. And ultimately you would defer to a cardiologist as to whether there was any significant changes in those two EKGs, correct?

A Or someone who was good at interpreting EKGs. It could be the internist or family practitioner as well but someone needed to interpret it who was comfortable with EKGs in dealing with cardiac symptoms in cardiac patients.

Q Well, let me ask you, Doctor, in your practice just like you alluded to earlier, ultimately if a patient had a question on an EKG you can't take that patient to surgery until it's evaluated by a

cardiologist; is that correct?

A Evaluated is probably the more appropriate question. I suspect ultimately it would be a cardiologist, so probably in the large majority of cases that is true as opposed to the internist evaluating it.

Q Right.

A In many cases the internist may say it's fine. I've had a cardiologist evaluate it. This has been gone through, but it must be a recent evaluation for anesthesia to accept that evaluation. It can't be from several months ago, several years ago,. several millennia ago.

Q Well, no. Actually, I'm going to a different point and my point is, ultimately even though family practice and internists do look at EKGs the ultimate expert on reading an EKG and its interpretation is within the field of cardiology, can we agree on that?

A No, there are internists and family practitioners who certainly can read these very, very

well and can interpret them. And when there's an issue they often defer to the cardiologist when it's outside of the basics.

Q Right, but that's my point. The ultimate expert on interpreting an EKG is going to be the cardiologist, that's the final say.

A I'm sorry, yes. I think that would probably be what most people believe.

Q All right, thank you. What do you believe, as you sit here today, was causing the infiltrates on the x-ray from August 5th?

Let me find that report. Actually, you know what, Doctor, why don't you turn to that report because I want to be precise. I think actually it says right lower lobe atelectasis, infiltrates with small right effusion.

What in your opinion was causing that?

MS. TAYLOR-KOLIS: He's reading from -- you're not looking at the right document.

Are you looking at the PAT one or the final?

THE WITNESS: I have this.

MR. WILT: I am looking at the wet read.

MS. TAYLOR-KOLIS: Okay.

MR. WILT: The PAT.

MS. TAYLOR-KOLIS: That's fine. Okay.

THE WITNESS: Is it this one?

MS. TAYLOR-KOLIS: Yeah.

THE WITNESS: Okay. I can't answer that. There are -- the most likely cause of this kind of thing could be a pneumonia. Until it's evaluated I don't know that. This never had a chance to be evaluated or reviewed by an internist at that point.

It says right effusion follow for resolution. This didn't have the opportunity to be followed to resolution. If it was a pneumonia and a viral pneumonia, a week, ten days, whatever it usually gets better.

BY MR. WILT:

Q Okay. And let me ask you if a patient has pneumonia of any degree, do you believe that is an absolute contraindication to surgery for adenomyosis?

A Yes.

Q Based upon the autopsy in this case, do you believe that Mrs. Armstrong had pneumonia in August of 1999?

A Give me one moment to get to the autopsy report.

Q Take all the time you want, Doctor.

A The microscopic on the autopsy report showed congestion. I can't tell whether it's consistent with pneumonia or not.

Q Would you defer to a pathologist in that regard?

A Or a pulmonologist in conjunction with a pathologist.

Q Okay. All right. Doctor, can we agree that the PAT chest x-ray interpretation is significantly different from the final interpretation?

MR. WILT: What do you keep smiling at, Donna?

MS. TAYLOR-KOLIS: There's all these people walking by.

MR. WILT: Oh.

MS. TAYLOR-KOLIS: This room was really hot, so we have to have to door open. It's like, you know, it's like traffic.

MR. WILT: I thought maybe there was a really cute guy out there you were, you know, flirting with or something.

MS. TAYLOR-KOLIS: No.

THE WITNESS: To me they're not much different.

BY MR. WILT:

Q Okay. Why not?

A Well, my impression is that this is the nurse who gets the report and calls Dr. Bartulica and it says right effusion and infiltrate. And they're calling it consolidation.

Those two things are pretty close to me to be the same. I would interpret them as close to the same.

Q Okay. What about the cardiomegaly?

A That is the only thing that is different

that wasn't reported on the preliminary read.

Q Would that be a significant finding, Doctor?

A Absolutely.

Q Why would it be a significant finding?

A It suggests cardiac dysfunction or malfunction.

Q Which do you think is more significant as far as the patient's risk for surgery, the evidence of cardiomegaly or right lower lobe consolidation?

A You're asking me a question in a vacuum. It's --

Q Absolutely.

A That's a difficult one to answer because if she's had cardiomegaly for years, has been worked up, has been stable, unchanged, the cardiologist says she has good pulmonary function based on recent testing, then that may not be a problem at all.

If this is a new finding showing severe dysfunction, that would overshadow the pulmonary.

If it was stable the pulmonary could

overshadow the cardiac. You don't know until you look.

Q What was your understanding in review of these records as to Mrs. Armstrong's cardiac function in April of 1999?

A She had several tests, which I have, and she had on April 17th an asymptomatic and stable hemodynamic response to the Persantine test. I don't understand the Persantine test, I don't do that.

But that her heart was stable at that time, that she had preexisting cardiac disease that was stable, at least by their testing.

Q Did she have any chest x-rays then?

A Well, she had some chest pain, she had a thallium stress test.

Q Here's my question, Doctor. Was there any evidence in April of 1999 that she had cardiomegaly?

A Under the x-ray file from Dr. Richardson I do not see a chest x-ray itself. I see EKGs. Under my tab of cardiac studies I do not see a chest x-ray to confirm or deny that diagnosis.

Q All right. So you don't have any information one way or the other whether she had preexisting cardiomegaly.

A Which is what worries me.

Q Do you believe Dr. Bartulica had a duty to investigate further the results of the chest x-ray, PAT reading?

A Yes.

Q Okay. What do you believe he should have done?

A Step one with an abnormal chest x-ray was to follow the recommendation. It was a simple recommendation, follow to resolution.

Have her seen by her internist, in this case Dr. Richardson, get follow-up chest x-rays, make sure it was clear to resolution.

During that time he would have then gotten the final report on the cardiomegaly and would have been able to have Dr. Richardson or a cardiologist or both further evaluate to see is this is a new finding? Is her cardiac function stable enough to undergo

surgery for the suspected adenomyosis?

Q That same, would you have suspected the anesthesiologist to have done the same thing upon review of this x-ray report?

A Yes.

Q Doctor, I want to turn to your report on the second page, the May 29th report.

First I'd like to know, are you going to be testifying to a reasonable degree of medical probability that this patient's exposure to Redo or Redux had any or was a proximate cause of her death?

A No, I will not be.

Q All right. In the last, second to last -- actually, I'll just read it. "I feel that had these evaluations been done before surgery, that she would have been treated appropriately and would have survived her surgical procedure."

I'd like for you to elaborate for me what you mean by treated appropriately?

A Let me start with the first word evaluated. Had she been evaluated the lungs would

have been followed to resolution, cleared.

Q Okay.

A She would not have then had a pulmonary problem that relates to the dark blood that she was originally noted to have after Dr. Bartulica's incision, which speaks to decreased aeration of her dark blood. It usually talks to less oxygen being received.

Her cardiac function would have been maximal given her situation, whatever that situation would be at that time on the either between the 5th and 7th of August and when the surgery was ultimately done. She would have been in maximum condition.

The cardiologist would have seen her. I don't know the cardiac medications that are used but if there was some dysfunction and the cardiologist determines that the procedure should and can go ahead, they would try to maximize her state of wellness.

There was also an informed consent issue that the patient needed to be aware at that time what her risks were based on what findings might or might

not have been found.

Q Do you have any opinion as to her ASA risk?

A No, I do not.

Q Okay. Let's assume, if you will, that Mrs. Armstrong -- let's assume she was always a poor risk for surgery.

What type of treatment would you have recommended for her adenomyosis?

A Given the fact that she's already been worked up in the scenario I presented to you is now true.

Q Right.

A And that she knows her risks.

Q Yeah. And let's assume that she's not a good surgical candidate, okay. She gets worked up and she's not a good surgical candidate, what would you recommend for treatment of her adenomyosis nonsurgically?

A Well, first understand that the autopsy did not show she had adenomyosis but assuming that Dr.

Bartulica --

Q Well, her pelvic pain.

A Her pelvic pain. There's lots --

Q Right.

A There are lots and lots of scenarios for pelvic pain from analgesia to biofeedback to Gn-RH agonists which are used for endometriosis to see if this would relieve her pain.

There are pain centers. There are certain nerve conduction studies that are being done to map pain for people like this who have actually undergone surgical procedures and biopsies by laparoscopy or by more invasive radiologic procedures.

And they are not good candidates, so you try to give them good quality of life and a lot of times this is accomplished.

At some point the patient may actually say I understand, I've been told by my cardiologist, my pulmonologist or whoever that I have significant surgical risk, but I can't live like this. I want to have the procedure.

And with their understanding and your understanding that they are under risk and the family's understanding, the quality of life issue then becomes a factor.

Someone like this or someone as you presented who is in poor surgical risk, a pre-anesthesia consult days to a week or ten days up to even ten days before is done all the time.

And the anesthesiologist then has the time to get records that they want, discuss with the patient their options, make sure they have all the information that's appropriate to them, and they can present an informed opinion to the patient that they should have a certain type of anesthesia over another type.

And with someone's loved one, see, then they can say listen, you know, your risk is a lot. Do you really think you need this? And they can say I can't live like this or I want to try some other treatment or modality to try and give myself less pain.

I have some questions about her pain that she was only on Darvocet, I believe, before surgery. And certainly there's a lot more potent pain medications that might have been tried to relieve her pain.

So pain is a very, very subjective quality. Nobody can really judge it but the patient. And every patient always has the decision should I have it, should I not have it, do the risks outweigh the benefits, do the benefits outweigh the risk?

And that's a discussion that we have with patients all the time.

Again, I apologize for the long-windedness.

Q Now, you indicated, obviously, that the autopsy did not reveal adenomyosis.

That is not uncommon in patients who undergo a hysterectomy for suspected adenomyosis, is it?

A If I understand your question is someone -- is it common for someone with adenomyosis not to

have it found or someone who you suspect adenomyosis not to have it?

I've got two sides to that question.

Q Both.

A It is someone who actually has it, it is no, it is they should find it. The pathologist will find it.

Q Okay.

A Especially if that's what your pre-op diagnosis is they cut further sections. Meaning they have a block of tissue and like slicing a loaf of bread they could go a quarter of the way through the loaf, they may need to go halfway or all the way through that loaf of bread looking at each different slice to see is it really there.

Q Right.

A And on numerous occasions we've actually had to ask them can you cut further? And they go yeah, we missed it the time. It's actually there. So they usually do find it.

On somebody who you suspect adenomyosis

because it is a surgical diagnosis, it's not really a clinical diagnosis, you find all kinds of other things and it may not be adenomyosis.

There are numerous other things that can cause pelvic pain, including one of the most difficult ones for us which is unknown, things look normal.

Q Right. And I guess that's my point. Just so, you know, a jury understands some day, just because the pathology or the autopsy report does not reveal adenomyosis in the uterus, that does not mean that Dr. Bartulica was -- that fact alone, in a vacuum as you would put it, does not indicate that Dr. Bartulica was inappropriate for recommending this surgery for treatment of her pelvic pain.

A No, it does not. He acted on the information he had and that was reasonable and appropriate.

Q Okay. Doctor, as a surgeon I'm assuming that before any patient undergoes a general anesthetic you expect the anesthesiologist to do an independent evaluation of the patient and that anesthesiologist

makes their own determination as to what they believe that patient's risks are for a general anesthetic, correct?

A Yes.

Q Why do you expect them to do that?

A They are the ones actually controlling the breathing, they are the ones controlling the blood pressure, to some extent the cardiac function and maintaining the patient's stability while we do our procedures.

They have that ultimate responsibility for the breathing of the patient and making sure blood pressure and hydration and temperature are maintained.

So they want it as safe as possible and do their own independent evaluation, however, I can supersede them at any time if I feel that it is not appropriate to do the surgery when the patient comes in and I'm uncomfortable because she has a cold and I know I'm going to be dealing with a potential pneumonia or problems afterwards.

So often it's a joint decision but

anesthesia has say that is not irrevocable. When they say we are not going to do this, it's not arguable.

Q Okay. Have you ever operated on a patient whose had an abnormal EKG after -- and let's say the EKG is evaluated by a cardiologist, do you operate on patients with abnormal EKGs?

A After it's been adequately evaluated and they tell me that it's stable yes, I have.

Q Right, all right. Have you ever performed an abdominal hysterectomy on a patient with cardiovascular disease?

A Yes.

Q And, Doctor, if Dr. Richardson had any concern about Mrs. Armstrong undergoing a general anesthetic, do you believe he had an obligation to tell Dr. Bartulica that when they spoke a few days prior to her surgery?

A It was clear from Dr. Richardson's deposition that he was not asked to pre-operatively evaluate, he was asked about management of her anticoagulation status before surgery and was called

in the middle of the patients, not a formal consultation, he was asked a question.

I don't think he had the opportunity, in fact, I know he did not have the opportunity to evaluate this patient pre-operatively to give an opinion one way or the other that he was worried or not worried.

Catching somebody in the hallway with a question by another doctor is not the most appropriate consultation, and we call it a curbside consultation. It's very commonly and that can put a patient into not the best care.

So he answered the question that was asked of coagulation but did not do and nor had the opportunity to do a pre-operative testing and evaluation.

Q Okay. But actually my question was if Dr. Richardson had a concern based upon the fact that he had been seeing this patient and had seen her within a couple of weeks of that time about this patient undergoing a general anesthetic, did he have an

obligation to voice it when he was informed the patient was going to be undergoing surgery?

A Common sense would dictate, of course, yes.

Q Okay. Doctor, what journals do you subscribe to?

A The American Journal of OB/GYN, The Obstetrics and Gynecology, The OB/GYN Survey, and I review about eight journals on line for content and then pick and choose the articles from JAMA to Lancet to British Medical Journal, Endocrinology, Endocrinology and Metabolism, and I subscribe to Menopause and also scan another menopause journal called Maturitus.

Q Well, why do you review these journals?

A Interests, things that would be appropriate to my practice or patients, to my writing, to any articles that just may be of interest that would not be in the mainstream that I might not see that could be of benefit to my patients, practice and future knowledge.

Q Another way of saying that is by reviewing these articles one reason would be it helps you keep abreast of, I guess, the medical knowledge out there.

A I like to stay a little ahead of the Internet and my patients if I can, as difficult as that is in this day and age.

Q So the answer would be yes.

A Yes.

Q How about -- excuse me, we're in our library.

How about any textbooks that you keep in your office?

A Oh, there are numerous textbooks I keep in the office and at home.

Q Okay. Why don't you list those for me.

A Oh, I have hundreds. I'm a book fanatic.

Q Well, tell me the ones that you would refer me to if I wanted to learn more about adenomyosis and surgical, and the surgical, pre-surgical workup for it.

A Oh, my gosh there are numerous sources.

First doing a journal search on the Internet on the numerous medical web sites would probably be the most up to date and that could be numerous sources.

The textbooks are often out of date before they come out. I subscribe to a very large textbook, it's six volumes. It's called Sciarria, S-C-I-A-R-R-1-24, which every year updates come out and new chapters are put in and taken out.

Certainly Tolin's Textbook of Surgery, which is often updated. There are numerous other textbooks, Hunt's Textbook. The names are escaping me at this point.

There's some books on postoperative complications that I have. I have endocrinology textbooks. Obstetrics textbooks.

Q What textbooks do you or would you recommend to your residents if they had questions regarding adenomyosis and the surgical treatment of it?

A I might not recommend any text, I'd probably recommend an Internet search because of the

latest. If they were looking for basics, if these were medical students the standard textbooks that the medical schools recommend, which can change.

Drougmueller's Comprehensive Gynecology is a very basic start. Novak's Textbook of Gynecology, a very basic start. The Sciarria series that I mentioned, a basic start.

This is for Adenomyosis 101 and certainly going on from there. The more specific literature, that would be gotten through a search.

Q Do you consider the periodicals that you've listed for me to be fairly reliable sources of information?

A I think you just said it correctly, fairly reliable not always reliable.

Q Right. Would that be the same for Sciarria's and Tolin's and Drougmueller's and Hunt's?

A I believe that's a fair statement, yes.

Q Doctor, have we covered all of your opinions as they relate to the care and treatment provided by Dr. Bartulica for Mrs. Armstrong?

A It's been so disjointed, I'm not sure. If I could reiterate them and maybe we could, that way we've covered it.

That he failed to do an adequate history and physical to know she was at a high risk for surgery, following which his breach was not to have appropriate pre-surgical evaluation and/or treatment, having that case in the operating room, failing to cancel the surgery based on an abnormal EKG of undetermined age and not knowing whether it was a new or old finding, and an abnormal chest x-ray which was recommended to follow it to resolution.

I believe those are the concerns I have, and a minor one which we answered was not finding out the source of the blood in the urine.

Q Doctor, just so I'm clear I don't see anywhere on your report of May 29th, 2001 that you provided to me any reference to Dr. Bartulica not obtaining an adequate history and physical as a criticism.

A I think it just speaks to the fact that

the information was not on the chart for anesthesia to review, so they had all the information as well. And he had this in his office but it was not relayed.

Q Okay. And that wasn't my question. My question was, that's not illuminated in your report of May 29th, 2001, is it?

A No, it is not.

Q All right. So we have another additional criticism along with the UCI that we've already discussed.

A Yes, sir.

Q All right. What was your understanding as to what was available in the chart for anesthesia to review?

A I have the pre-anesthesia assessment and the chest x-ray was there, the EKG was looked at and there was just -- it looked like just a minimal history was available for her cardiac past, I should say, is probably the best way to put it.

Most of this was in the pre-anesthesia patient self-assessment where she -- where Nancy

Armstrong talked about what her symptoms were, and I saw nothing in the way of a history from Dr. Bartulica's office to indicate those issues or address them.

Q In the pre-anesthesia workup does the patient -- I'm trying to find it. -- list her medications?

A The self-assessment, is that what you're asking?

Q Yeah, the pre-anesthesia assessment.

A Well, I see a pre and post-anesthesia assessment, and I see a pre-anesthesia patient self-assessment. They're two different documents.

Q I want to talk about the pre-anesthesia assessment first.

A By the patient or by the anesthesiologist.

Q Yeah, it was filled out by the anesthesiologist.

A Yes, there's a list of medications.

Q All right. And would you expect that to -- those list of medications to alert a physician as

to potential underlying problems?

A Yes.

Q All right. In the anesthesia history was the anesthesiologist aware that this patient had undergone several prior surgeries?

A The cardiac catheterization in 1986, there is something I just can't read on here, it just did not come through. It says anesthesia history, several surgeries. Nothing specific is listed.

Q Okay. And just so I'm clear, whether Dr. Bartulica put an H and P directly in his chart or not, do you believe there was sufficient information present in the chart that the anesthesiologist should have stopped the procedure?

A I don't believe there was adequate information but even if there had been the pre-anesthesia assessment had some issues in it that would have caused the anesthesiologist to cancel it. There are remarks in here that speak exactly to that.

Q All right. So let me ask my question again. So whether or not the H and P was present or

not I think we're -- we can agree that in your opinion, at least, there was adequate information contained in the pre-anesthesia assessment, the pre-anesthesia patient self-assessment such that you believe the surgery still should have been canceled.

A Yes.

Q All right. Can we agree that a physician can render care to a patient within the applicable standard of care and the patient still suffer a bad outcome?

A Yes.

Q Can we agree that complications can occur during medical treatment that are in no way related to departures from standards of care?

A Yes.

Q Have you ever been sued for medical malpractice, Dr. London?

A Yes.

Q On how many occasions?

A Five.

Q And in those five occasions did any of

those go to trial?

A No.

Q In those five occasions did -- well, let's -- was your deposition ever taken?

A In three of them.

Q And just generally, Doctor, what were the allegations in those three cases?

A Failure to diagnose breast cancer. The second one was an abnormal pattern on fetal heart tracing. And failure to -- the third was failure to treat preeclampsia.

Q And, Doctor, in either of those three cases do you know if the plaintiffs retained an expert who opined that your care was below standards of care?

A Yes, they did.

Q Were any of the five cases settled on your behalf?

A Three of the cases were settled on my behalf.

Q Do you believe that in any of the five cases that your care was below standard of care?

A No.

Q All right, Doctor, I'm going to try this again.

Have we now covered all of the opinions that you have in this case regarding the care and treatment provided by Dr. Bartulica?

A I believe I've covered them all at this point.

Q All right. And, Doctor, can we agree if that between now and the time of trial if you should happen to either, A, receive new information or, B, go back and review these documents again and form any new opinions that you'll be sure to let Ms. Kolis know and I'm sure she'll let me know.

A I will do that.

Q All right, Doctor.

MR. WILT: I think those are all the questions I have at this time.

Mr. Rispo might have a few for you, though, I'll move out of the way.

MS. TAYLOR-KOLIS: Can we take a

five-minute break?

MR. WILT: Absolutely.

MS. TAYLOR-KOLIS: Okay.

(A recess was taken from 10:45 a.m. until 10:52 a.m.)

EXAMINATION BY MR. RISPO:

Q Doctor, if you're ready, you're still under oath, the Court Reporter is ready to go, I'd like to pick up where Mr. Wilt left off.

First of all, in terms of an introduction, I represent Mr. Celerio, the anesthesiologist in this case.

My name is Ron Rispo, and I'd like to ask you for more detail on your opinions, Doctor.

First of all, though, I want to be sure that we have now accounted for all reports which you have generated on this case either before or after the report of May 29.

I have no other reports in my possession.

Q Okay. Do you have any reports in your file from any other experts other than the defense

experts that have opined in this case?

A Just what I read at the beginning of what I brought with me. I brought everything I have with me.

Q Okay. Doctor, at the time of these events in 1999 you were not an anesthesiologist, were you?

A No, sir.

Q And you've never been board certified in anesthesiology either before or since.

A Correct.

Q And you're not board certified in critical care medicine.

A Correct.

Q Have you ever published in any areas involving anesthesia?

A No, sir.

Q Are you a recognized authority in anesthesia?

A No.

Q You're not a cardiologist either.

A No, sir.

Q And you're not a recognized authority in the field of cardiology.

A No.

Q Doctor, have you ever had a case involving a patient who had amyloid heart condition?

A Not to my knowledge.

Q Have you ever had a patient that you've taken to surgery who had congestive heart failure in her history?

A Yes.

Q Have you ever taken a patient to surgery who had ischemic heart disease?

A Yes.

Q Have you ever taken a patient to surgery who had a remote silent MI?

A That's a difficult question to answer because if it's silent I wouldn't know about it, but if you're talking about with EKG changes.

Q Yes.

A I've certainly taken patients with EKG changes, but not before evaluation by a cardiologist.

Q And in those cases where you have had patients with congestive heart failure or ischemic heart disease or a remote acute -- excuse me, a remote or silent MI, you've had information available to you before the surgery concerning those conditions.

A Yes, I did.

Q And you proceeded with surgery anyway.

A It's not quite in that order or scenario, but I had the information, but it had been evaluated pre-operatively by appropriate consultants either in cardiology or pulmonology or whatever to clear the patient that surgery was safe.

And I've had surgery canceled several times because it was not safe and the patient had an appropriate informed consent, they knew what the story was and they elected not to have the surgery.

Q In those cases, Doctor, where you had consultations with the primary care physician and had the benefit of a pre-admission testing exam and the primary care physician cleared the patient for surgery, did you ever cancel any of those surgeries?

A Actually I believe I have.

Q And in those cases that you did cancel what was the reason for cancellation?

A Upper respiratory infection.

Q Have you taken patients to surgery who had an upper respiratory infection?

A Only in an emergent situation such as Cesarean section, not electively.

Q In any of the patients that we've just discussed, Doctor, with the conditions of congestive heart failure, ischemic heart disease or remote silent MIs that you did take to surgery, did any of them die on the table?

A No.

Q Have you ever been in charge of a resuscitation effort?

A I've been in resuscitation efforts, I've never been in charge of one.

Q Are you ACLS certified?

A For another month, my two years runs out in another month.

Q You indicated earlier, Doctor, that you did not have a copy of the EKG studies that were done in April of '99 or July of '99; is that correct?

A Let me just look once again before I give you that answer.

I have July '99. I have August of '99. I do not see April, '99.

Q Would you read to me what the interpretation was of the July '99 EKG.

A July 6th, 1999 mark left axis deviation, possible old anterior MI -- anterior infarction, I'm sorry. ST changes in lateral leads, borderline abnormal changes possibly due to myocardial ischemia. Summary, abnormal, unconfirmed analysis. And then there's some signature.

Q And do you have the August EKG interpretation?

A Yes, I do.

Q Okay. Would you read that to me, please.

A It says sinus rhythm and then it looks like marked left axis deviation, consider anterior

myocardial infarction, something, age undetermined, abnormal.

Q What is the difference, if any, between those two EKG readings?

A That the age could not be determined on the one month later EKG, the one in August.

Q Otherwise they're the same.

A Otherwise it's the same EKG.

Q So the July EKG indicates an old or possibly old MI; is that right?

A It says possible old.

Q Okay. And it also indicates evidence of ischemia or possible ischemia.

A It says possibly due to myocardial ischemia.

Q Do you know from Dr. Richardson's deposition whether he believed the interpretation in July?

A What he talks about is that he said this is the one that is interpreted as showing left axis deviation but no evidence of acute ischemia, which

would be indicated by ST segment. So I don't think that it was a significant finding for ischemia at that point.

Q Do you believe that Dr. Richardson was correct in his interpretation of the July EKG?

A I can only go by what is written on the EKG and would be deferring to my experts on that if they felt that this was an issue or not an issue.

Q We do know that Dr. Richardson didn't agree with the interpretation as read by the cardiologist who performed the EKG.

A I don't know that it was a cardiologist that performed the EKG. A lot of times technicians do it and it's read as computer with these findings. So I don't know that that's a true or false statement.

Q Well, in any event we know he did not agree with the computer printout.

A At least he says that he doesn't think that it was acute ischemia.

Q In any event with respect to the computer printout the only difference between that and the

August EKG is that the July EKG said old and -- MI, and the August EKG said indeterminate.

A Well, the July one also said that it was possible myocardial ischemia, and that's not written on this August one. So there's a difference that way also.

Q Which is the more alarming of those two interpretations?

A The problem is I don't know and that's what's alarming. I need an evaluation to find out what is going on because I don't know. They both alarm me.

One say age indeterminate, now I've got under this situation a deposition, which I didn't have before. Now the internist disagrees with it.

This needs appropriate workup and evaluation so your question, which is an important question, can actually be answered by the doctor about to operate on her and the anesthesiologist about to put her to sleep and keep her vital signs stable.

Q Doctor, did I hear your testimony

correctly earlier in which you indicated that many internists could read EKGs --

(The video conferencing stopped abruptly at 11:03 a.m.)

(A recess was taken from 11:02 a.m. until 11:19 a.m.)

(A discussion was held off the record.)

MR. RISPO: Ms. Reporter, would you read back the last question.

(Record read by the reporter.)

BY MR. RISPO:

Q Very well. Doctor, I think the question was whether you had stated earlier that some internists could read EKGs very well.

A Most internists can do that.

Q Most internists.

A Yes.

Q Okay. Now, assuming that Dr. Richardson was an internist and treating physician for Mrs. Armstrong, what is your current impression of his ability to read an EKG?

A I have no impression. I gave a generalized statement. I don't know Dr. Richardson's training or expertise, but in general an internist should be able to read an EKG.

Q Well, if that's true then, Doctor, would it be reasonable for Dr. Bartulica and/or Dr. Celerio to assume that Dr. Richardson knew what he was talking about with respect to interpreting the July EKG?

A If they had his report saying that this EKG was stable and that she was stable for surgery and cleared for surgery, I think they could rely on that.

Q Okay. And, in fact, Dr. Richardson did read the EKG and reported, in his opinion, there was no evidence of acute ischemia.

A This was a month before surgery.

Q Yes.

A And then we have just before surgery myocardial infarction of undetermined age. I don't know whether that's new, old or indifferent because it was never evaluated.

Q Okay. The only difference, though,

between the April and the July EKG was that the July EKG said old and the August EKG said indeterminate.

A Plus the mention of ischemia that I mentioned before or blackout.

Q Which was in the July EKG, right?

A Yes, sir.

Q There was no evidence of ischemia in the August EKG.

A I don't interpret EKGs to answer that, there was none mentioned in the computerized generated report.

Q Nor is there any in Dr. Richardson's opinion.

A According to his deposition.

Q Doctor, if indeed Dr. Richardson had ordered a cardiac consult and obtained an EKG and cardiac stress test and a cardiac echo, do you have any reason to believe that the workup would have been any different from the workup that was performed in April of '99?

A I'm not a cardiologist to speak to that to

try and second-guess what another physician might order to clear a patient for surgery based on the findings not only of this EKG but of the chest x-ray as well.

Q You don't have the April '99 report, do you?

A No, sir.

Q If I told you that the cardiac echocardiogram indicated on April 15th, '99 that there was left ventricular wall thickness, mild to moderately increased in a concentric manner, that there was a suggestion of posterior wall hypokinesis, that there was global left ventricular systolic function which was lower in the limits of normal or lower than the limits of normal, perhaps mildly impaired, and that the right ventricular systolic function appears to be at lower limits of normal, mildly impaired, do you think those findings would have been important to report to Dr. Bartulica and Dr. Celerio?

A If asked to do a pre-surgical evaluation I

would think that would be important and it leads the -- both Dr. Bartulica and Dr. Celerio to want to find out what's going on.

And if they didn't have that reported and just having the EKG, calling off the surgery would have been prudent until they can at least find out is there more information available from the cardiologist or from Dr. Richardson or whatever consultations they had gotten for that because they don't know.

Obviously if it was going to be stable we would just do one in one person's life and say oh, that's it for the rest of your life. Obviously things can change.

This lady is certainly at high risk and has had a certainly a checkered medical career and things keep changing for her on a very short-term basis for a young lady.

Q Okay. We do know that Dr. Richardson had these records in his chart, don't we?

A I don't have Dr. Richardson's records, I have his deposition. I have a couple of things from

Dr. Richardson of -- I have some of his records, but I'm sure I do not have a complete chart.

I do have something from April '99, and then I have his cardiac studies. So these are from his office. So the answer is yes, he did have them in his chart.

Q Okay. And did you mention earlier that you had a copy of the Elyria Memorial record of admission to the emergency room on January 4th, '99?

A I missed the first part of that question. What was the hospital?

MS. TAYLOR-KOLIS: Elyria Memorial.

BY MR. RISPO:

Q Elyria Memorial.

MS. TAYLOR-KOLIS: Oh, it's the big binder.

BY MR. RISPO:

Q Of January 4th.

A If I can lift it, yes. This jumps. Now here's 1-99.

Are you talking about January '99?

Q Yes, sir.

A It says EMH Regional Medical Center, is that what you're talking about?

Q Yes, sir.

A I see mammograms in January '99. I do not see -- I see --

Q If you would look, I might direct you to the chest x-ray.

A The chest x-ray. Under x-rays I have mammography, mammography, mammography and mammography. And I'm up to 4/99.

MS. TAYLOR-KOLIS: You know what, we might not have it.

THE WITNESS: I don't think I have it.

BY MR. RISPO:

Q Okay. Doctor, I'd like you to assume then for the purposes of this question that a chest x-ray done in January of '99 revealed cardiomegaly.

I would ask you based upon that assumption whether that was a significant finding that Dr. Richardson would or should have taken into

consideration if he were being asked for medical clearance for surgery?

A Well, he would have and you're talking January '99 because I have a chest x-ray from 4/99 that does not show cardiomegaly at that point.

It says the pulmonary vascularity and cardiac silhouette appear normal. And that's 4/21/99, no active cardiopulmonary disease.

Q Okay. Let's assume that she also had an earlier x-ray which did say that there was cardiomegaly present, would that be an important finding?

A Well, yes, it certainly would.

Q And if Dr. Richardson were asked to clear this patient for surgery in August, should he have mentioned the prior finding of cardiomegaly?

A Well, he wasn't asked, but I would think that he would report all findings that might be significant.

Q Okay. And if he had been asked for medical clearance in August, would it have been

incumbent upon him to report that the EKG in July indicated a possible old myocardial infarction and possibly due to ischemia?

A Well, the same answer, he would report any positive findings that he had and either clear or not clear the patient.

Q Okay. And if he had been asked and did not give that information to Dr. Bartulica, would you agree that his conduct would be in breach of the standard of care for an internist?

A He would have had to been asked to do a proper evaluation and clear the patient before that answer would be yes.

For a phone call note asking, which is all I really have in here, about her coagulation status, he was never asked and was not in the breach of the standard of care at that point.

Q I understand that, Doctor, and yet I do want to be sure that we understand each other that I'm asking upon hypothetical namely that Dr. Bartulica did disclose the fact she was having surgery and asked for

medical clearance.

A Under the hypothetical --

Q Yes.

A -- if you were asked for medical clearance -- if he had asked for medical clearance and medical clearance was not done without a physical and proper review of records and just done over the phone, that would be inappropriate and a breach in the standard of care.

Q Okay. Along the same lines, Doctor, did any physician diagnose primary amyloidosis prior to her surgery?

A No, sir.

Q And that's notwithstanding the fact that Dr. Richardson had seen her over a period of five months before the surgery, he did not diagnose it; is that correct?

A You're asking me something that's out of my field of expertise, and reading in the depositions this is a diagnosis that from what I understand can -- is almost never made before autopsy.

Q Okay.

A I could be wrong on that, you're out of my area of expertise. I'm taking what is there that he would not have been able to make the diagnosis with any degree of certainty.

Q So to be specific, however, there is nothing in the records that indicates Dr. Richardson diagnosed primary amyloidosis before surgery.

A No, nor could he have.

Q Secondly, even though the patient had a cardiac workup in April prior to her surgery in May, the cardiologist did not discover her condition of primary amyloidosis.

A That's correct.

Q Is that right?

A Yes.

Q And would you agree that the failure to diagnose primary amyloidosis is not a breach of the standard of care?

A Yes, it is not a breach in the standard of care.

Q And would you agree that the failure to diagnose amyloidosis by Dr. Bartulica is not a breach of the standard of care for him?

A That's correct.

Q And would you agree that the failure to a diagnosis -- diagnose primary amyloidosis was not a breach of the standard of care for Dr. Celerio?

A That's correct.

Q Would you agree that the cardiac history as we now know it to be, including her condition of primary amyloidosis and possible ischemia and primary -- and previous myocardial infarction were all causes of her death?

A Can you repeat the question, please.

Q Would you agree that her condition of primary amyloidosis and her heart condition as revealed on the EKG was a cause of her death?

A The ultimate cause of her death, yes.

Q And, in fact, it was the primary cause of her death, was it not?

A Yes.

Q Would you agree that assuming she had primary amyloidosis she would have died of that condition some time even if she did not have surgery?

A I think we can say that about all of us with or without disease. I mean that's not something you can say well, it's going to be tomorrow, next year, they can have four to five years, they can have longer or less and just based on what it says in the deposition so there's no way to tell.

But would she have ultimately died? Sure, a bus could have hit her. I can't answer that that is going to take her tomorrow.

(Pager interruption.)

THE WITNESS: Excuse me, I'm sorry, I just got a page.

MS. TAYLOR-KOLIS: One second. The Doctor got a page, sorry.

(A discussion was held off the record.)

THE WITNESS: I'm sorry, I apologize.

MS. TAYLOR-KOLIS: That's okay.

THE WITNESS: I apologize.

BY MR. RISPO:

Q Would you agree that given her heart condition as we now know it to be including primary amyloidosis, she would have died prematurely even if she had no surgery?

A Based on what I've seen if the depositions, that's the usual scenario.

Q Have you any other information from pathologists or specialists in the field of cardiology provided to you by Ms. Kolis to indicate that her life expectancy would not have exceeded five years?

A I have nothing to say one way or the other.

Q Did she provide you the information verbal1y?

A No.

Q Do you have any basis or reason to disagree with my statement?

A I am not a cardiologist, I have not studied the disease process enough to agree or disagree.

Q Doctor, if indeed Dr. Bartulica had called Dr. Richardson and asked about her prior condition and asked for medical clearance, and if indeed Dr. Richardson did tell Dr. Bartulica all of the things we now know about her cardiac condition including the assessments that were performed in April, the complaints that she had clinically of chronic long term shortness of breath, radiating pain and so forth, would it be, in your opinion, a breach in the standard of care for Dr. Bartulica to take her to surgery?

A Without appropriate clearance, yes. And without appropriate informed consent to the patient where she knows his risks of the surgery and alternatives to the surgery.

Q Doctor, none of this information was available in the chart for Dr. Celerio, was it?

A Define what information because Dr. Celerio in his pre-anesthesia checklist had a fa r amount of information that he gleamed himself.

Q Doctor, let me read to you a summary of the medical information available to Dr. Richardson

through his records.

Mrs. Armstrong had a family history of heart disease, her mother died at the age of 61. Mrs. Armstrong complained of chest pain from February 1996 all the way through July of 1999 at nearly every office visit.

EKG studies were reported as negative or indeterminate but thallium stress studies as early as September of '99 identified ischemic changes appearing in the ST waves.

Mrs. Armstrong continued to complain of shortness of breath and radiating pain to her neck, sometimes her back, under her right arm including January of '99 and again in July of '99.

Dr. Martin prescribed nitroglycerine to her for her chest pain. She had a history of taking Redux for a period of two months.

She had an echocardiogram in June of '98 which indicated mild to moderate thickness of ventricular wall, mild impairment of the left ventricular systolic function.

She was admitted to the hospital in January of '99 with abdominal pain, fever, nausea, vomiting, diarrhea for a period of three weeks.

She complained of light-headedness and back pain and the chest x-ray showed cardiomegaly.

Assume further that she had an echocardiogram in April of '99 revealing moderate thickness in the ventricular wall on the left and the right, reduction in systolic function on the left and the right of a mild nature.

She showed ST depressions again on the EKG, although considered nondiagnostic.

And assume that the thallium scan was reported as documenting right ventricular hypertrophy.

And assume that the cardiologist doing these studies recommended cardiac care for further studies and that those studies were not done.

Assume that the patient returned to Dr. Richardson on July 6th of '99 complaining of chest pain radiating to her left shoulder and difficulty breathing.

Complaining of difficulty walking up steps without loss of breath, difficulty sleeping because her chest hurts and her breathing is worse when she lies down.

Assume that Dr. Richardson recognized she was at risk for an MI but that he had a low suspicion.

Assume that the EKG study on July 6th of '99 indicated a possible old anterior myocardial infarct and that borderline changes possibly represented myocardial ischemia.

All that having been considered, Doctor, do you have an opinion whether Dr. Richardson fell below the standard of care if he were asked about the patient's history and medical clearance and he did not report those conditions to Dr. Bartulica?

MS. TAYLOR-KOLIS: I'm going to object to the question on the record.

Obviously this will become an issue for us at the pretrial. You have not cross-claimed Dr. Richardson.

My doctor will not be answering any

questions at trial, hopefully under the judge's instruction, regarding the question you just asked but if you have an opinion that you wish to share, go ahead and do it.

THE WITNESS: Could you repeat the question. No, I'm just kidding. I'm kidding, I'm sorry.

I do not have an opinion on Dr. Richardson's care. I am not an internist, board-certified internist or have training in internal medicine.

You used the word assumption very often that I would assume that this or that happened, and I cannot go on those assumptions.

I go back to the basics that you from a previous question, Dr. Celerio did not have that information.

Medical School 101, do a careful history and physical and that careful history and physical was not done.

And he had enough information on his

pre-anesthesia checklist that certainly this would peak his interest to find out more and did not do so.

She had decreased breath sounds that he wrote in his own handwriting on that pre-surgical assessment sheet and without that information it would be imperative upon him to get that before proceeding with a potentially dangerous and in this case fatal anesthesia and surgical procedure.

BY MR. RISPO:

Q Doctor, you didn't really answer my question. If I can come back to the question, do you have an opinion as to whether Dr. Richardson breached the standard of care if he failed to report that information to Dr. Bartulica --

A I --

Q -- and if he were asked for medical clearance?

A I thought I did answer that I have no opinion on whether he fell below the standard of care not being an internist, and if he did not do a full evaluation he did not do a medical clearance, a

medical clearance isn't done over the phone.

So **I** would have no opinion on that as well because he did not have the opportunity to do a pre-surgical evaluation and clearance. Clearance is not just over the phone.

Q As a corollary to that question, Doctor, let me ask you, if Dr. Bartulica had been told this information would it be a breach of the standard of care for him to take the patient to surgery?

A Yes.

Q And if he failed to relay this information to Dr. Celerio would it be a breach of his standard of care to let Dr. Celerio know what he knew of the patient's history?

A Only partially because Dr. Celerio we established would do his own independent pre-anesthetic assessment. Anesthesia assessment, excuse me. And would reach his own conclusions, and if he did not have adequate information it would be imperative upon him to seek that information.

Q Doctor, assuming that Dr. Bartulica did

ask for this information, did receive this information from Dr. Richardson and he still reported to Dr. Celerio that the patient had been medically cleared for surgery would that be a breach of the standard of care?

MR. WILT: Just note an objection.

THE WITNESS: In the hospitals I have ever worked at they need the physical clearance, not a note that says patient cleared, they would want to see what the internist said.

They would want to know what the actual reports were before they would go ahead and say this is cleared just on a say so.

My anesthesiologist would never tolerate that kind of thing, and I can take a stack of bibles out and swear she's been cleared but that would not be acceptable.

BY MR. RISPO:

Q Doctor, would Dr. Celerio have anyway of knowing whether the information provided to him by Dr. Bartulica that she was medically cleared was

inaccurate?

A He would have no way to judge the accuracy at all, he would need to determine this for himself based on his history.

Q Does the anesthesiologist such as Dr. Celerio have a right to rely upon the information provided to him by the treating physician and by the surgeon?

A He actually would rely greatly on that, but he would also use his own clinical judgment if he felt it was safe or unsafe to proceed or not proceed.

Q Doctor, does the anesthesiologist have a right to rely upon the admitting history and physical?

A Yes.

Q Does he have a right to rely upon the pre-admission testing?

A Yes.

Q Does he have a right to rely upon what the patient tells him?

A Yes.

Q Do you agree, Doctor, that at the time of

surgery Dr. Celerio did not have the benefit of the information that we have just discussed available to Dr. Richardson?

A That's correct, but he didn't need it. He had other damaging information that he needed to react to.

Q Okay. If he had that information, however, it would have made it a lot easier for him to make a decision what to do with it.

A He could have made a decision either way, it would have been the same decision.

Q Okay. Doctor, would you agree that Dr. Celerio did not have the final interpretation of the chest x-ray at the time when he proceeded to surgery?

A I have no way to know that one way or the other. It wouldn't make a difference as I stated earlier that there's not much of a difference. There was abnormal chest x-ray that needed evaluation and resolution.

Q Would you agree that the radiologist who did the wet reading on the chest x-ray film did not

record cardiomegaly?

A On the wet film that is correct, on the primary reading it was not stated.

Q Would it be a breach of the standard of care for a radiologist to fail to note cardiomegaly if he knew the patient was going to surgery?

MS. TAYLOR-KOLIS: Once again the same objection.

You have not cross-claimed anyone in this case why you can talk about causes. The Doctor is not going to be compelled to answer deviation questions but go ahead, Doctor, if you can.

THE WITNESS: I would expect a competent radiologist to report all abnormal findings, and if he missed the finding that was a gross finding I would consider that a breach.

BY MR. RISPO:

Q Would you consider cardiomegaly a gross finding?

A I'm not a cardiologist to speak to that. I would suspect it can be or it could be mild, I don't

know the extent of it.

Q Would you consider it a significant finding for purposes of evaluating a patient for surgery?

A Yes, I would.

Q Doctor, let's talk about the patient's pre-anesthesia workup.

What signs or symptoms there do you see that were alarming?

A Let me just go right to his remarks, decreased breath sounds and it says right something left. I don't know if it s greater than or less than but there was a decreased breath sounds, that's alarming right there.

Then you add to that that he noted she had a cardiac history by her cath., that she was on anticoagulants, this is a high-risk patient.

I was asked before do I have an opinion about the ASA rating, I don't have an opinion. I can only go that he rated her an ASA-3. I don't know what the criteria are, but I usually see the

anesthesiologist talking about ASA-1 or ASA-2.

He also had the benefit of the preliminary read, what you're calling the wet read of the x-ray, which was abnormal, and did not have that resolved to know whether that was good, bad, recent, old, new, yesterday, day before. He had no inclination of what that was.

And it incumbent upon him to further evaluate it in an uncomfortable and high risk patient to begin with before she even walked to the door, much less having these findings.

Q When, to your understanding, was Dr. Celerio first notified of this surgery?

A According to his deposition he was notified that he was on call I believe on that -- it was a Saturday on August the 7th, and that he knew about the case the night before but saw the patient on the morning of admission.

Q Would it be consistent with your reading then that he didn't know anything about the patient until 11:00 o'clock the morning before surgery?

A I don't know about the time 11:00 o'clock, but certainly the morning before surgery is a reasonable statement.

Q Okay. And none of the hospital records were in his possession prior to that.

A I don't know hospital procedures to answer that whether they get them the night before or not, so I can't speak to that.

Q Would you agree that the signs and symptoms that you just described earlier from the pre-anesthesia workup are equally consistent with other conditions which are benign and do not contraindicate surgery?

A They could be in another patient. In a high-risk patient certainly you have to prove that, you can't assume that because that gets people dead.

Q The only abnormal finding on x-ray was atelectasis; is that right?

A And effusion. Infiltrate and effusion with atelectasis, according to that note.

Q And that was in the presence of a normal

white blood count; is that right?

A Correct.

Q And no evidence of fever.

A Correct.

Q Under those conditions have you ever taken a patient to surgery with the same or similar atelectasis -- findings of atelectasis?

A Absolutely not.

Q You have not.

A I have not, nor will I.

Q You don't take any patient to surgery who has atelectasis.

A Not until it's been totally evaluated and cleared and the pulmonologist says this is a chronic situation, this will not affect her surgery.

Based on limited information I will not, have not and should not take a patient to surgery. It is not worth putting her life at risk until I know.

Q Well, how do you go about evaluating her atelectasis, Doctor?

A I don't, I'm not a pulmonologist. I would

cancel the surgery, I would send her for appropriate evaluation and have a follow-up chest x-ray done if I thought it was a nothing, I want to make sure it clears.

I could do exactly what was recommended on the wet read as you're calling it or preliminary read of follow to resolution, make sure it goes away.

The fact that it came up it could be benign, I hope it's benign, it's probably benign but those are words that you don't want to use in surgery, probably, could be, might be.

I've got to know that it's gone and that's the only right thing to do for a patient and only fair thing, and I think that's what we would all expect of our doctors before we undergo a surgical procedure.

Q If we are informed that the patient has no evidence of fever, a white blood count is normal, is that not, in fact, an indicator or consistent with a benign condition of atelectasis?

A It could be but some people's white count don't respond that quickly. Suppose this was a new

onset the night before and the white count hadn't had time to respond and tomorrow it could be up where she could have fever.

I don't like words like could be. It needs to be resolved exactly as the recommendation was there and hope that you are right that it is a benign process. And I can apologize to her and say, I'm sorry I had to cancel your surgery. This was a nothing but that way I know it and she's still safe.

Q Do you have any evidence to indicate that atelectasis was the cause of her death?

A No, but from a common sense point of view having difficulty potentially oxygenating lungs could throw her into compromise to create the cardiac condition that certainly killed her. I believe it was contributory.

Q As a matter of fact, Doctor, the primary cause of her death was her amyloidosis, was it not?

A Yes.

Q And as a matter of fact, whether she was submitted to surgery on August 9th, I think it was,

'99 or she was evaluated for a month or two months or three months or four months, Doctor, they would not have discovered her cause of death and the condition which was ultimately the cause of her death; is that right?

A They would not have discovered the amyloidosis but would she have died at the time of surgery, is that what you're asking?

Q Yes.

A There's no way to know that, but she was in a compromised position with her amyloidosis.

If we had that benefit of retrospect that she had a decreased oxygen state and it may have thrown her into that cardiac arrhythmia that the amyloidosis caused a pulmonary -- or excuse me, a cardiac dysfunction, she may not have died at that time. She may have had months, years, nobody knows.

Q Doctor, when you did your report of May 29th of 2001 you said nothing whatsoever that you had an opinion about the anesthesiologist, did you?

A No, I did not.

Q What has happened since then that caused you to offer the opinions that you are offering about the anesthesiology care?

MS. TAYLOR-KOLIS: Okay, I'm just going to interpose an objection/statement.

I think that he had made it clear when Mr. Wilt was talking to him that his purpose in this case was to evaluate Dr. Bartulica's conduct.

You obviously chose to ask him what he thought about Dr. Celerio and it's all tied up in one package so it isn't anything new.

I'm not going to offer him at trial as the expert against Dr. Celerio, let's put it that way, but you can still ask him.

BY MR. RISPO:

Q Well, let me ask you that. Let me ask you the question pointedly then, Doctor.

Do you have an opinion as to whether the care rendered by Dr. Celerio breached the standard of care when he agreed to take her to surgery?

A Yes, I do.

MR. WILT: Objection.

BY MR. RISPO:

Q What's your opinion?

A That he did breach the standard of care by taking her to surgery in the face of an abnormal EKG, chest x-ray and history without adequate evaluation or having adequate information available to him and not seeking that information before she went to surgery.

Q Did you have an opinion in May of 2001?

A I really wasn't looking at it at that point from that point of view. I was really looking at it from the surgeon's point of view did he breach the standard of care? And as I read further into it and this pre-op and post-op assessment sheet caused me to come to that opinion as well.

Q Now, Doctor, you did read all the records that were provided to you, didn't you?

A Yes, I did, but I was concentrating on the surgical aspect of this from the point of view should she have been taken to surgery without adequate pre-operative assessment.

Q So you didn't think it was important to mention your opinions with respect to the anesthesia care at that time.

MS. TAYLOR-KOLIS: I'm going to object to whether he thought it was important or not.

Specifically the letter that I sent him, which is available to you to read, is assess the conduct of the OB/GYN but go ahead.

BY MR. RISPO:

Q Doctor, you're not an anesthesiologist, right?

A You had asked that before, no, I am not.

Q Okay. So what basis do you have for your opinions that Dr. Celerio breached the standard of care?

A Based on training and experience and being a surgeon and interactions for the last 26 years with anesthesiologists, I've seen what routine and prudent care is.

Q Doctor, do you have any opinions as to the care provided by Dr. Celerio in the manner of

administering anesthesia?

A I have no opinion one way or the other, I'm not an anesthesiologist.

Q Do you have an opinion whether he breached the standard of care in administering the type of anesthesia that he administered?

A No, I do not.

Q Do you have any opinion whether he breached the standard of care in selection of the drugs?

A No.

Q Or in the conduct of a resuscitation.

A No.

Q Doctor, when you rendered your opinion in May of 2001, two separate reports, you didn't know that the patient had primary amyloidosis --

A Correct.

Q -- is that right? And you didn't understand what the cause of her death was.

A I don't know if that's totally true.

Q What was your opinion as to her cause of

her death in May of 2001?

A Cardiopulmonary arrest.

Q Caused by what?

A One would believe an arrhythmia brought on by lack of oxygen which could be related to multifactors. There's no way I can know or anyone can know exactly what it was at that point.

Q Well, now that we do know, provided the information from the pathology study, do you have any reason to change your opinion?

A No, I do not.

Q You wouldn't amend or change or supplement your opinion in any way.

A No, I would not.

Q Even though you know that now the primary cause of her death was her primary amyloidosis.

A Based on the compromise that she was in she had amyloidosis but did the amyloidosis kill her or did the compromised state throw her into the arrest that was brought on by amyloidosis?

You don't know which came first, was it

the amyloidosis primarily or was she in such a state of compromise that if she had decreased oxygenation from possibly these pulmonary effects or not having -- being on correct drugs or being properly evaluated within the week before surgery throw her into that compromised state before the amyloidosis.

I'm speaking from a common sense point of view right now, there is no way to know that.

Q Okay. Doctor, I just have one or two more questions.

A Certainly.

Q I'd like you to focus on this, though, because it's very important to me and Dr. Celerio.

Let's assume that the patient was, in fact, removed from the operating room, surgery was canceled, she was worked up, let's assume that the atelectasis cleared, she was given antibiotics or whatever was necessary, let's assume that she had the same results that she did have in her cardiac workup and she was cleared for surgery and she went back to surgery, do you have any basis to give us an opinion

as a matter of reasonable medical certainty whether she would have survived the surgery if it were performed two months later?

A No, I really can't.

Q It's just it's equally likely she could have died from the surgery two months later.

A I don't know whether that's the case or not. You're trying to give me the words of equally likely, I can't give you an opinion on that.

I can tell you she would not have been in a compromised state and her chances of survival should be higher.

MR. RISPO: Thank you, Doctor, I have no further questions.

THE WITNESS: Thank you.

MR. WILT: I have nothing further.

MR. RISPO: One finality formality, Doctor, you have the right to review the transcript and/or view the tape before it's used for any purpose.

We don't care, but we have to ask you on the record what is your preference?

MS. TAYLOR-KOLIS: You should read.

THE WITNESS: I will read, and I just don't want the tape at Blockbuster.

MR. RISPO: Okay. We will guarantee that for you.

THE WITNESS: Thank you.

MR. RISPO: All right. Thank you, Doctor.

THE WITNESS: Thank you.

MR. RISPO: Take care, Donna.

MS. TAYLOR-KOLIS: Okay.

MR. RISPO: Marianne. Marianne, would you go ahead and write it up and arrange for filing with our Common Pleas court.

THE REPORTER: Yes.

(Video conferencing deposition concluded at 12:02 p.m.)

State of Maryland

City of Baltimore, to wit:

I, MARIANNE R. HEWITT, a Notary Public of the State of Maryland, County of Baltimore, do hereby certify that the within-named witness personally appeared before me at the time and place herein set out, and after having been duly affirmed by me, according to law, was examined by counsel.

I further certify that the examination was recorded stenographically by me and this transcript is a true record of the proceedings.

I further certify that I am not of counsel to any of the parties, nor in any way interested in the outcome of the action.

As witness my hand and notarial seal this 20th day of May, 2002.

MARIANNE R. HEWITT
Notary Public

My Commission Expires:

June 21, 2003

CERTIFICATE OF DEPONENT

I hereby certify that I have read and examined the foregoing transcript, and the same is a true and accurate record of the testimony given by me.

Any additions or corrections that I feel are necessary, I will attach on a separate sheet of paper to the original transcript.

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Dr. Andrew M. London

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Video Conferencing Deposition of

Dr. Andrew M. London

May 9, 2002

Andrew M. London

6 Old Lyme Rd.
Lutherville, MD. 21093

Date of Birth: June 5,1947

Place of Birth: Baltimore, Maryland

Education:

College:	University of Pennsylvania	1965-1969
Medical School:	University of Maryland	1970-1974

Post Doctoral Training:

Internship:	Johns Hopkins Hospital	1974-1975
Residency:	Johns Hopkins Hospital	1975-1978
Fellowship:	Union Memorial Hospital Pelvic Surgery	1978-1979

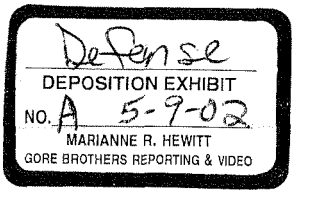
Certification:

Diplomat, American Board of Obstetrics and Gynecology 1980

Licensed: Maryland 1976

Appointments:

Instructor: Johns Hopkins School of Medicine Obstetrics and Gynecology	1978-present
Clinical Assistant Professor: University of Maryland School of Medicine Obstetrics and Gynecology	1982-present



Hospital Appointments:

The John s Hopkins Hospital Baltimore, Maryland 21205	1978-present
The Union Memorial Hospital Baltimore, Maryland 21218	1978-present
University of Maryland Hospital Baltimore, Maryland 21201	1980-present
St. Joseph Hospital Towson, Maryland 21204	1983-present

Administrative Experience:

Director of Resident Education-The Union Memorial Hospital Baltimore, Maryland	1978-1982
Director of Cervical Clinic-The Union Memorial Hospital Baltimore, Maryland	1978-1984
Editor, Gynecologic Laser Society Newsletter	1979-1982

Practice:

The Union Memorial Hospital- Calvert Women's Health	1997-present
Marek, London & Adashek, PA	1982-1997
Solo Private Practice	1978-1982

Organizations:

American College of Obstetrics and Gynecology -Fellow	1980-present
American Fertility Society	1984-present
North American Menopause Society	1994-present
Gynecologic Laser Society	1985-1995
American Laser Society	1985-1995
Maryland Ob-Gyn Society	1980-present

Publications:

1. London, AM and Burkman, R: Tubo-ovarian Abscess with Associated Rupture and Fistula Formation into the urinary bladder: A Report of Two Cases.
Am.J. OB-GYN 135:1113, 1979

2. Utian et. al and the Esclim Study Group: Efficacy and safety of low, standard and high doses of an Estradiol transdermal system (Esclim) compared with placebo on vasomotor symptoms in highly symptomatic menopausal patients. Am J. Obstet.Gynecol,181:71-79, 1999

Representative Chapters and Books

Contributor-Menopause and the Perimenopause in *The Baby Boomers Body Book.* Peck, Brian, Sourcebooks Inc. 2001

Patents:

The London Curette – Cooper Surgical Shelton, Connectuit 2000

Instrumentation:

Milan-London Smoke evacuator- Narco-Pillilng Company 1982

Andrew M. London
6 Old Lyme Rd.
Lutherville, MD 21093

Donna Taylor-Kolis Co. L.P.A.
Attorneys at Law
Third Floor-Standard Building
1370 Ontario Street
Cleveland, Ohio 441 13-1791

May 8,2000

Re: Nancy Armstrong

Dear Ms. Taylor-Kolis,

Thank you for allowing me to review the medical records of Mrs Armstrong. This is a very disturbing case as this tragic outcome appears to have been avoidable.

The records indicate that Mrs. Armstrong went for presurgical testing on August 5,1999 and that time was found to have an abnormal chest x-ray. The x-ray showed infiltrates and a pneumonia that suggested that this be followed to "resolution". Dr. Bartulica was told of this result the same day and did not feel that this finding warranted canceling her surgery. She also had an abnormal ECG with evidence of a myocardial infarction. In spite of this abnormal findings, the plan was to proceed with the surgery on August 7,1999. To compound the situation, the anesthesia preoperative evaluation did not pick up on this finding and allowed the procedure to take place. The outcome was dire.

It is my strong feeling that both Dr. Bartulica and the anesthesia personnel deviated from the accepted methods ofmedical care that allowed the operation to proceed and not cancel and reevaluate Mrs. Armstrong and operate when her pneumonia was resolved. Given the Chest x-ray findings,it is likely she suffered the outcome that she did.

I have reviewed the the following records:

The Coroners report of Lorain County of Ohio
Records of Amherst Hospital
Office notes of Dr. Bartulica
Laboratory evaluations
Records of Dr. Stan Richardson
Records from St. John Westshore

Thank you for allowing me to evaluate the records of Mrs Armstrong. If I may be of further assistance, please do not hesitate to contact me.

Sincerely,

Andrew M. London

Andrew M. London
6 Old Lyme Rd.
Lutherville, MD 21093

May 29, 2001

Donna Taylor-Kolis CO. L.P.A.
Attorneys at Law
Third Floor-Standard Building
1370 Ontario Street
Cleveland, Ohio 44113-1791

Re: **Armstrong v. Bartulica**

Dear Mrs. Taylor-Kolis,

I have reviewed the records of Nancy Armstrong. These include the office records of Dr. Bartulica as well as pre-surgical testing, laboratory results, the operative report and the autopsy report. I have also had a chance to review the deposition of Dr. Bartulica. Based the review of the above records, I find that there is negligence and a breech in the standard of care given to Mrs. Armstrong in allowing her surgery to proceed in the face of unresolved abnormal laboratory results-specifically an abnormal EKG and chest x-ray.

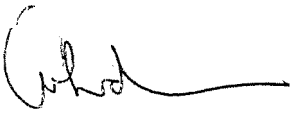
The bases of my conclusions are based on the records and Dr. Bartulicas' deposition. In particular, there was deviation from the evaluation of the abnormal chest x-ray, which was reported to him as abnormal pre-operatively by pre-surgical testing and mandated an investigation to be sure that there was no pathology that would jeopardize her during a surgical procedure. The surgery was not an emergency and could have been put off until evaluation and resolution of the infiltrate and effusion was completed. It was also within the standard of care for Dr. Bartulica to be aware of the EKG and with the abnormality present, it would have been imperative to have the EKG evaluated by a cardiologist and cleared for surgery in that there was a question of a myocardial infarction.

I did not have the records from her previous physician at the time of the review. Based on the deposition, there was a recommendation that Nancy Armstrong have an

echocardiogram because of exposure to Redux. This was not done and may not have been the responsibility to Dr. Bartulica to do, but he did have the responsibility to have a cardiologist or internist determine if the evaluation was necessary.
I feel that had these evaluations been done before the surgery, that she would have been treated appropriately and would have survived her surgical procedure. It is my medical opinion that the above deviations were a direct and proximate cause of the death of Nancy Armstrong.

Thank you for asking me to review the records of Mrs. Armstrong. If I may be of further assistance, please do not hesitate to contact me.

Sincerely,



Andrew M. London