CERTIFIED COPY

IN THE COURT OF COMMON PLEAS

LORAIN COUNTY, OHIO

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JAMES ARMSTRONG, etc.,	)	
	)	
Plaintiffs,	)	
	)	
vs.	)	No. 00CV126180
	)	
EMH REGIONAL HEALTHCARE, et al.,	)	
	)	
Defendants.	)	

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VIDEO CONFERENCE DEPOSITION OF

TIMOTHY C. LYONS, M.D.

Held at the Offices of

Medstream Telecommunications, Inc.

703 Second Street, Santa Rosa, California

Thursday, May 16, 2002, 4:00 o'clock p.m.

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APPEARANCES:

For the Plaintiff:	Friedman, Domiano & Smith Attorneys at Law 1370 Ontario Street Sixth Floor- Standard Building Cleveland, Ohio 44113 BY: THOMAS E. CONWAY, ESQ. DONNA TAYLOR-KOLIS, ESQ.
For the Defendant Briccio A. Celerio, M.D.:	Weston, Hurd, Fallon, Paisley & Howley Attorneys at Law 2500 Terminal Tower 50 Public Square Cleveland, Ohio 44113-2241 BY: RONALD A. RISPO, ESQ.
For the Defendant Dr. Bartulica:	Buckingham, Doolittle Attorneys at Law 4518 Fulton Drive N.W. P.O. Box 35548 Canton, Ohio 44735-5548 BY: MARK FRASURE, ESQ.
Reported by:	Denise Veirs, CSR License No. 5537

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MR. CONWAY: Let the record reflect that we are taking the deposition of Dr. Timothy Lyons by video conferencing. I assume all the parties here, no one has any objection to the way we're taking the depo, correct?

MR. RISPO: I believe we stipulated to that.

MR. CONWAY: That's fine. I do want to get the court reporter's name and phone number, though.

THE REPORTER: My name is Denise Veirs. I'm with Verbatim Reporting Service, 141 Stony Circle, Suite 240, in Santa Rosa. Phone number is area code (707) 575-1819.

MR. CONWAY: Okay, all right. Denise, what city are you in, just out of curiosity?

THE REPORTER: Santa Rosa.

MR. CONWAY: Would you please swear in the witness.

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TIMOTHY C LYONS, M D ,

called as a witness by the Defendant in the first duly sworn by the Certified Shorthand Reporter, was thereupon examined and interrogated as is hereinafter set forth.

EXAMINATION

BY MR CONWAY:

Q Hi, Doctor. My name is Tom Conway I'm going to be taking your deposition this morning I represent the Armstrong family along with Donna Kolis, another attorney who's here in Cleveland as well You understand that?

A. Yes

Q You've been retained by Ron Lispo, who represents Dr. Calerio, as an expert witness in this case, correct?

A. Correct

Q Doctor, this is going to be my only opportunity to speak with you. I'm going to ask you questions regarding your opinion and regarding other circumstances Please do not answer any question that you don't understand, okay?

A. Okay.

Q If you don't understand a question, make sure that you somehow indicate that to me I'll be glad to

rephrase, repeat, restate the question to make sure that you do understand it, okay?

A. Yes.

Q. If you do answer a question, I'm going to assume and rely upon the fact that you understood it. Is that fair?

A. Yes.

Q. If you need a break at any time, let us know. And if at any time you want to supplement, delete, change an answer that you've previously given during the deposition, feel free to do so. Let us know, you can go on the record at that time and supplement whatever previously given answer you feel is necessary to do so, okay?

A. Okay.

Q. And you understand that you are under oath. This deposition has the same effect as if you were in front of a jury giving your testimony. You understand that?

A. I understand.

Q. Final thing is, obviously give a verbal response to my questions whether it's yes, no or whatever explanation you want to give. Don't use "uh-huh" or nods of the head, okay, so the court reporter can get it down all right.

A. Okay.

Q. Doctor, do you have a f le with you on t .is case?

A. I do.

Q. Would you tell us for the record what constitutes your file in this case?

A. I have Amherst Hospital records from Nancy Armstrong. I have the deposition of Dr. William S. Richardson. I have the deposition of Dr. Kenneth George Smithson. I have the deposition of Dr. Celerio. I have letters enclosed from Dr. David Burkons, Dr. Richard Watts, Dr. Andrew London. I think he's a doctor. Doesn't say M.D. Dr. Smithson. Two letters from Dr. Smithson and Dr. Mendelsohn. In addition to that, I have my -- a copy of my own, a report to Mr. Rispo as well as another copy of my letter. Some correspondences from Mr. Rispo's office talking about dates and times for the potential trial and deposition. I have a certificate of death of Nancy J. Armstrong, including a copy of the autopsy report. I have office records of Dr. William Richardson. I have records from Dr. Paul Bartulica, and I have a deposition of Dr. Bartulica as well.

Q. Doctor, were you sent any depositions by any of the Amherst nurses?

A. No, I wasn't.

Q. Did you ever ask to review any deposition of any Amherst nurses?

A. No, but I wasn't aware any of them were deposed.

Q. Doctor, what I'd like you to do, and we can mark this here in the deposition, is any correspondence between you and Mr. Rispo, if you would separate that and we can mark that as an exhibit, okay?

A. Okay.

Q. And in fact, if you could give that to the court reporter, we'll just mark that as Exhibit No. 4, and each individual page, if it's okay with the court reporter; can just be a letter, okay, 4-A, 4-B, whatever, okay?

How many pages of correspondence are there between you and Mr. Rispo?

A. Let's see. I count 14 and included -- and also in that is the First Claim for Relief. That's attached to one of the letters, and also attached to one of the letters is a copy of my own report to Mr. Rispo.

Q. Okay. So we'll have at least 14, 15, 16 documents, correct?

A. Correct.

Q. That will constitute your correspondence file;

is that right?

A. Yes.

Q. Doctor, did you do any type of literature search in connection with your review of this case?

A. No.

Q. Did you go on the internet and do any type of research on any of the medical issues involved in this case?

A. No.

Q. And I take it you didn't look at any hard copy medical literature in your review of this case, correct?

A. No, correct, I did not.

Q. Doctor, looking at your C.V., I notice that in between 1994 and the year 2000 you were Chief of the Division of Cardiothoracic Anesthesiology at University Hospitals; is that correct?

A. Correct.

Q. And then I see that beginning in year 2000 to present, obviously this is an older C.V., it has you as Associate Chief of the Cardiothoracic Intensive Care Unit; is that correct?

A. Correct.

Q. All right. Why did you stop being the Chief of the Division of Cardiothoracic Anesthesiology in the year 2000?

A. I resigned that position so I could be a co-chief of the intensive care unit. A ong with that, had an improvement in my schedule, shall we say, where I worked less hours.

Q. Okay. Were you asked to resign that position as chief?

A. No.

Q. What year did you leave University Hospitals?

A. I left last year, 2000 -- 2001.

Q. What was the reason for leaving University Hospitals?

A. I took a job in Northern California.

Q. With what hospital?

A. I'm the Chief of Anesthesia for St. Helena Hospital.

Q. How many beds is St. Helena?

A. About 200.

Q. Is that a community hospital?

A. I would describe it as a community hospital, yeah.

Q. Have you ever had any type of disciplinary action taken against your license or against you by any type of licensing board?

A. No.

Q. Have you ever had any type of disciplinary

action taken against you by any professional group?

A. No.

Q. Have you ever been sued for medical malpractice?

A. I've been named in two cases which have subsequently been dismissed.

Q. Was that while you were at University Hospitals?

A. Correct.

Q. Have you ever testified as an expert witness before?

A. Yes.

Q. How many times?

A. I'm going to estimate four to five times.

Q. On behalf of hospitals and physicians; is that correct?

A. Correct.

Q. You've never testified on behalf of a patient; is that correct?

A. No.

Q. That's correct?

A. That's correct.

Q. All right. How do you know Mr. Rispo?

A. I met Mr. Rispo -- this case was originally given to a partner of mine at University who was an

anesthesiologist but he largely practices pain therapy. He took a look at this case and decided it was something more appropriate for an anesthesia intensivist like myself. He asked me, my partner, if I would take a look at this case. That's how I met Mr. Rispo.

Q. Who is your partner?

A. My partner's name is -- my former partner's name is Mark Boswell, B-o-s-w-e-l-l.

Q. Have you ever done defense expert work for Mr. Rispo's law firm, Weston Hurd, including any of the medical malpractice attorneys, himself, Deidre Henry?

A. No. I don't know all the attorneys there, but I don't believe I've ever worked with them before.

Q. What firms have you done defense work for?

A. I did a case for Reminger & Reminger.

Q. What attorney?

A. I'm thinking John Jackson? Is that an attorney?

Q. No, he's with another firm, but have you worked for John?

A. Oh, yeah, he's with -- I can't remember the name of that firm. I did work with John. The name of the attorney that I worked with at Reminger & Reminger, I don't recall, but I do know he was out of the Akron office and he's since left, but I can't recall his name.

Other attorneys I've worked with, there has been a couple in the Cincinnati-Dayton area. One is named John Haviland, and I worked with him on one case. That's all I can recall right now.

Q. How much do you charge per hour to review cases? Better yet, how much are you charging per hour for your work in this case for Mr. Rispo?

A. To review the case, I charge $250 an hour. For depositions, $400 an hour.

Q. Do you anticipate testifying live at the June 5th, 2002 trial?

A. I don't know. I actually just found out about that today. So I'll have to talk to Mr. Rispo about that later. I'll have to look at my schedule.

Q. How much would you charge to come to Cleveland to testify live?

A. I haven't thought about that yet. I've never testified in a live court hearing, especially not having to fly across the country. So I haven't really put much thought to that yet.

Q. How many hours of work did you put into this case, Doctor?

A. Originally when I looked over the case -- I'm going to have to estimate now because I don't remember what my original time was on it. But I think originally

I looked at it for about eight hours. I probably put about another eight hours into reviewing everything, including some new things I received prior to this deposition.

Q. What new things did you receive prior to the deposition?

A. It wasn't immediately prior but some -- the original things I looked through were depositions of Dr. Celerio -- I don't believe I had Dr. Smithson nor Dr. Richardson's deposition when I looked through the information the first time. I received them sometime in the interim and I reviewed them when Ron contacted me again for this deposition.

Q. In reviewing Dr. Richardson's depo, did that lead you to change your opinion on anything, Doctor?

A. No.

Q. Doctor, you're a member of the American Society of Anesthesiologists; is that correct?

A. Correct.

Q. Are you familiar with the American Society of Anesthesiology Standards, Guidelines and Statements?

A. I probably can't quote them verbatim, but I'm familiar with the spirit behind them.

Q. Doctor, at some point have you taken the time to actually read those standards, guidelines and

statements?

A. I likely have at some point in my career, yes.

Q. Did you find them to be reasonable and prudent standards governing the actions of anesthesiologists?

A. Yes.

Q. All right. Is there anything in those standards or guidelines that you disagree with?

A. Well, since I don't have them in front of me, I couldn't say for sure, but thinking back, I don't believe there was anything that I disagree with.

Q. Doctor, would you agree that individual anesthesiologists should order tests within their judgement, the results of which may influence decisions regarding risks and management of the anesthesia and surgery?

A. Yes.

Q. Do you agree that relevant abnormalities during the taking of a pre-surgical testing should be noted and action taken if appropriate?

A. Yes.

Q. Do you agree that minimal patient care should include an appropriate pre-anesthesia evaluation and examination by an anesthesiologist prior to anesthesia and surgery, and in the event that non-physician personnel are utilized in the process, the

anesthesiologist must verify the information and repeat and record essential key elements of the evaluation. Do you agree with that?

A. I agree with that.

Q. Do you agree that an anesthesiologist has the obligation to order appropriate preoperative studies and employ appropriate consultations as medically indicated?

A. Yes, I agree with that.

Q. Do you agree that an anesthesia plan developed by the anesthesiologist should be discussed with and accepted by a patient?

A. Yes.

Q. Do you agree with the standard that an anesthesiologist shall be responsible for determining the medical status of the patient, developing a plan of anesthesia care and acquainting the patient or the responsible adult with the proposed plan?

A. Yes. Could I amend my -- I'm sorry. Could I amend my answer to the previous question about the patient accepting the anesthetic?

Q. Sure.

A. I was involved in a case recently where the patient was not of sound mind and there was a court order to operate for emergency purposes. She didn't accept the anesthesia plan, so with those type of

exceptions in mind, I agree with the statement.

Q. You don't have any reason to believe that Nancy Armstrong was not of sound mind on August 7 of 1999, do you?

A. No.

Q. Okay. Would you agree that the development of an appropriate plan of anesthesia care is based upon, one, reviewing the medical record, two, interviewing and examining the patient to, A, discuss the medical history, previous anesthetic experiences and drug therapy, B, assess those aspects of the physical conditions that might affect decisions regarding perioperative risks and management; and three, obtaining and/or reviewing tests and consultations necessary to the conduct of anesthesia? Do you agree with that?

A. I agree with that.

Q. Do you agree that the anesthesiologist has an obligation to properly perform and document all information relevant to the use of anesthesia in the patient's chart?

A. Yes, I agree with that.

Q. Do you believe the anesthesiologist has an obligation to record his impressions in the patient's chart preoperatively?

A. Yes.

Q. Doctor, what area of anesthesiology are you concentrating in right now, your practice?

A. Right now my practice has changed. I'm the Chief of Anesthesia so I do all types of anesthesia, limited amounts of pediatrics and obstetrics, but otherwise just about everything.

Q. And I imagine a lot of the surgeries that you're involved in are non-cardiac surgery; would that be correct?

A. A lot of them are, yes.

Q. Are you familiar with the 1996 guidelines for perioperative cardiovascular evaluation for non-cardiac surgery, a report issued by the American College of Cardiology in association with the American Heart Association Task Force?

A. I'm familiar with the fact that that document exists. Again, I couldn't quote it verbatim.

Q. Have you ever read that document, Doctor?

A. It seems to me I have, but I can't swear to that.

Q. Would you agree that this document, which I believe is approximately 62 pages, is a reasonable and prudent standard set forth by the American College of Cardiology and American Heart Association?

A. Since I don't recall its content, I couldn't

agree with that.

Q. Do you find papers issued by the American College of Cardiology to be reliable in your practice of medicine, Doctor?

A. I don't come across many articles by the American College of Cardiology in my practice.

Q. Do you know approximately how long ago you would have had the opportunity to read that document which I just asked you questions about?

A. I have no idea.

Q. You had an opportunity to read over Dr. Celerio's deposition, correct, Doctor?

A. I did.

Q. First of all, do you know Dr. Celerio?

A. No.

Q. Did you ever meet him when you were in Cleveland?

A. Never.

Q. Dr. Bartulica, "Bartulica," did you ever know him?

A. No, I don't know him either, "Bartulica" or "Bartulica."

Q. We'11 use "Bartulica."

A. Okay.

Q. Were you ever an expert witness for him in any

of his prior medical malpractice cases?

A. I don't believe so.

MR. FRASURE: Objection.

BY MR. CONWAY:

Q. For Dr. Celerio?

A. I don't believe so.

Q. Did you know Dr. Richardson when you were in Cleveland?

A. I don't believe so.

Q. Do you know Dr. London, Andrew London, one of the plaintiff's experts?

A. I don't believe I know him either.

Q. Have you ever heard of Dr. London?

A. No.

Q. Dr. Smithson, have you ever heard of him?

A. No.

Q. Dr. Brandon, have you ever heard of that doctor?

A. No.

Q. Were you ever given a report, an expert report by a Dr. Brandon to review?

A. The No.

Q. Dr. Watts, do you know Dr. Watts?

A. I don't know Dr. Watts.

Q. Doctor, are you board certified in

anesthesiology?

A. Yes.

Q. What's the significance of being board certified, Doctor?

A. The American Board of Anesthesiology at the end of your training gives a test, first a written and then an oral exam, and upon completion of that you're board certified. What that essentially means is you're qualified by the ABA to be a consultant in anesthesiology.

Q. Is that a desirable objective to work for --

A. Yes.

Q. -- by an anesthesiologist?

A. Yes.

Q. What does being board eligible mean?

A. Board eligible means, it means that one has completed the appropriate training and is still eligible to take the exams but has not yet taken or has not yet passed them.

Q. All right. You're obviously aware that Dr. Celerio is not board certified in anesthesiology, correct?

A. I'm aware of that, yes.

Q. Are you also aware that he's not even board eligible?

A. I wasn't aware of that.

Q. You've read through Dr. Celerio's deposition how many times, Doctor?

A. I read through it completely once and then I skimmed through it again a couple of days ago, so I would say twice, one and a half times.

Q. You're aware that Dr. Celerio under oath had criticism of Dr. Bartulica's care and treatment in this case; you're aware of that, correct?

A. I don't recall that but -- you could probably point it out to me.

Q. Why don't we start at page 23. Do you have the deposition in front of you?

A. I have it right here.

Q. All right. Do you agree with Dr. Celerio's sworn testimony at page 23, line 7: "Well, my only criticism is that I was not given enough information by the attending physician about Mrs. Armstrong's condition"?

A. I read that, yes.

Q. Do you agree with Dr. Celerio's criticism?

A. Well, I'm reading on, and it says by -- the next question seems to ask, "By the attending physician, you mean Dr. Bartulica, that he didn't give you enough information?" He says, "No." I didn't know if he was

answering he didn't give him enough information, or no, he just doesn't agree with that statement. I was a little confused by his testimony here.

MS. KOLIS: Courtesy page for Mark --

MR. CONWAY: Yeah, page 23.

Q. Let's go down to page 23, line 15, where the question was asked of Dr. Celerio, "Tell me what information you now know that Dr. Bartulica didn't give you that you needed to know?" And he goes on to list four different areas of information that, according to Dr. Celerio, he should have been given by Dr. Bartulica.

A. Okay.

Q. Are you familiar with that from your review of the deposition, Doctor?

A. Well, I am now.

Q. All right. I think the four areas that Dr. Celerio criticized Dr. Bartulica were, and starting on page 23, line 18, "I didn't know that she was under a care of a Dr. Bordoy before she went to Dr. Bartulica." Line 22, "I was not aware that this patient had any heart problem." Line 25, "I was not aware of the medication which she was taking before she went to Dr. Bartulica." And finally at the top of page 24, "I was not aware about the small brain tumor that the patient has."

A. I see those things.

Q. Do you agree with Dr. Celerio's criticism of Dr. Bartulica's failure to provide him with those pieces of information?

MR. FRASURE: Objection, characterization. This is Mark Frasier speaking. Go ahead.

THE WITNESS: I guess I can deal with those one at a time, those criticisms.

BY MR. CONWAY:

Q. My question isn't about the criticisms, it's Dr. Celerio in his depo had certain criticisms of Dr. Bartulica. Do you or do you not agree with Dr. Celerio's criticisms of Dr. Bartulica?

A. Maybe I'm not understanding your question, but he has more than one criticism.

Q. Correct.

A, I agree that he has criticisms.

Q. You agree that he has four?

A. I agree that he has four here, yes.

Q. Do you agree with Dr. Celerio's criticisms of Dr. Bartulica?

A. Well, that's a difficult question to answer. His criticisms are that Dr. Bartulica should have provided him with information, and if Dr. Bartulica had that information, I believe he should have. But if he

did not have that information, then I don't agree with the criticism.

Q. Did Dr. Bartulica, from your review of the records, have information from Bordoy's chart regarding prior cardiac issues?

A. I don't recall.

Q. That would be fairly significant, wouldn't it, Doctor, if Dr. Bartulica had information from Dr. Bordoy's chart about a prior cardiac condition or concerns?

A. If it was a significant concern, certainly.

Q. Were you aware, Doctor, that in Dr. Bartulica's chart he has notes from Dr. Bordoy that state that this patient should have surgery, if this patient should have surgery, she should have a cardiology consult and an echocardiogram. Were you aware of that information, Doctor?

A. No, I wasn't aware of that.

Q. Didn't you review the medical chart **of** Dr. Bartulica?

A. I did. I have his office notes here. I did not see that in the office notes.

Q. Okay. Would you agree then at the bottom, as Dr. Celerio articulates, that it was Dr. Bartulica's obligation to tell Dr. Celerio the content of the prior

medical history from Dr. Bordoy's chart if Dr. Bartulica possessed it?

A. If it was significant information, sure.

Q. At page 25, line 8, do you agree with Dr. Celerio's comment or his opinion in response to a question at line 8, "You were saying you were critical of Dr. Bartulica for not revealing to you the information contained in Mrs. Armstrong's prior obstetrical medical chart, right?" And Dr. Celerio's answer is, "Yes." Do you agree with Dr. Celerio's position?

A. Again, if that information was significant to the care of the patient, yes, he should have passed it on to Dr. Celerio.

Q. Right. Obviously, Dr. Celerio has made a determination during this deposition that it was important because he's critical of Dr. Bartulica for that, correct?

A. That's his determination.

Q. Okay. Well, he's the anesthesiologist that was actually involved in this particular case, correct?

A. Right. But because -- sorry.

Q. Would you agree, Doctor, that the anesthesiologist who's actually involved in the case is in a better position to evaluate the significance of

certain information?

A. Yes

Q Would you agree with Dr. Calerio that in this particular case Mrs Armstrong should have had a good workup before she was put under anesthesia?

A. In retrospect, I agree with that

Q Do you agree with Dr. Calerio that she should have had a cardiology consult prior to going under surgery on August 7, 1999?

A. I can only answer that in retrospect, but given what they had to look at preoperatively, no, I don't believe that was necessary

Q Do you know why at the top of page 27 Dr. Calerio indicated that he would not have done this case had he known the different pieces of information that he's criticizing Dr. Bartulica for not providing him?

A. I'm sorry could you repeat that question?

MR CONWAY: Could the court reporter repeat it please.

(Whereupon, the reporter read the record)

MR RISPO: I'm going to object to the form of the question. This is Risdo speaking I don't know that Dr. Lyons would know what Dr. Calerio had in his mind when he was testifying

THE WITNESS: The reason that I'm pausing here is I'm trying to read through this and determine if that's what he actually said. He said he would not do the case if he had different information; however, I'm not sure by this that he's saying he wouldn't do the case if he had the information that Bartulica had. Since I don't know the information Bartulica had, I can't answer yes to that question.

BY MR. CONWAY:

Q. Shouldn't you know what information Dr. Bartulica had from reading his deposition as well as reviewing his chart?

A. Well, I didn't memorize it.

Q. Do you agree with Dr. Celerio's comment at page 27, line 12, that in answering the question, had you understood or appreciated that Ms. Armstrong had an enlarged heart, he would have not gone forward with the surgery? Strike that.

Do you see line 8 through 15 on page 27, Doctor?

A. Yes.

Q. Do you agree with Dr. Celerio's opinion that had he known that Mrs. Armstrong had an enlarged heart, he would not have gone forward with the surgery?

A. Do I agree with the fact that he wouldn't have

gone through with the surgery or do I agree with the assessment that he shouldn't have gone through with the surgery?

Q. The assessment.

A. No, I don't agree with that.

Q. It's your testimony that an individual with an enlarged heart such as Mrs. Armstrong had would not prevent you from going forward with this surgery?

A. Not necessarily.

Q. Well, what does that mean, Doctor, in this particular case? Would you have gone forward with the surgery or not?

A. An enlarged heart --

Q. Hypothetically speaking.

A. Certainly. An enlarged heart alone is not sufficient grounds to cancel or uphold her surgery. I think you have to correlate tests like a chest X-ray, an EKG with the clinical presentation of the patient and other components of their history. So an enlarged heart by chest X-ray alone is not a reason to delay the case.

Q. Do you think a reasonable and prudent anesthesiologist should know whether his patient has an enlarged heart prior to putting that patient under general anesthetic?

A. It might be useful information, yes.

Q. Do you believe that the standard of care requires a reasonable and prudent anesthesiologist to know whether or not his patient has an enlarged heart prior *to* that anesthesiologist putting the patient under general anesthesia?

A. If the information about the enlarged heart is available to him, yes, I agree.

Q. Were you aware, Doctor, that an X-ray was taken of Mrs. Armstrong which revealed that she had an enlarged heart?

A. I am aware of that, yes.

Q. And that X-ray was taken, I believe, on August the 5th, two days before surgery; were you aware of that fact?

A. I am aware of that, yes.

Q. Were you aware of the fact that the final radiology report reporting that she had an enlarged heart was dictated and transcribed on August 6 of 1999?

A. I did come across that in review, yes.

Q. Don't you believe that a reasonable and prudent anesthesiologist should have known in this particular case that Mrs. Armstrong had an enlarged heart?

A. No.

MR. RISPO: Objection, there's no evidence

that that final interpretation ever reached the chart before surgery.

BY MR. CONWAY:

Q. Doctor, do you agree that a person who has an enlarged heart is at greater risk for death in surgery than a person without an enlarged heart?

A. No.

Q. Dr. Celerio testified that he was not aware that Mrs. Armstrong had any heart problems prior to surgery. Is that your recollection of his testimony?

A. Yes, it is.

Q. Based on your review of the records, would a reasonable and prudent anesthesiologist know that Mrs. Armstrong had heart problems?

A. No.

Q. Do you have any evidence that Dr. Celerio made any effort whatsoever to look at the actual chest X-ray which showed Mrs. Armstrong's enlarged heart?

A. No.

Q. Do you have any evidence that Dr. Celerio made any effort whatsoever to look at the August 6, 1999 chest X-ray report which reported an enlarged heart?

A. No.

Q. And it's your testimony that the standard of care for an anesthesiologist does not require a

reasonable and prudent anesthesiologist to do either one of those things?

A. I agree that it's reasonable to get information about the chest X-ray; however, my understanding is in this case he did have what's called a wet reading of that chest X-ray. And the evaluation of the wet reading is adequate in my mind.

Q. What did the wet reading indicate, Doctor, if you recall?

A. I believe it indicated a right lower lobe infiltrate versus atelectasis.

Q. Is that situation significant to warrant further investigation by an anesthesiologist prior to putting a patient under general anesthesia?

A. That depends on how the patient is clinically.

Q. In this particular case, didn't the standard of care, Doctor, require the anesthesiologist, Dr. Celerio, to further investigate the information that was found on the wet read of the August 5th X-ray?

A. No.

Q. Why not?

A. Mrs. Armstrong came to him in no distress other than her abdominal pain, with normal respirations, with no fever, no white counts, normal respiratory rates. She had what is described as infiltrate versus

atelectasis in the right base of her lung. I don't believe that given that clinical situation with a person that's oxygenating normally, breathing normally, in no respiratory distress, without evidence of infection, anything further needed to be done with that wet reading.

Now, if there was a change from the wet reading to the final copy, then that should have been relayed to the ordering doctor. I don't know who that is in this case, I imagine it's the surgeon. But to my knowledge, none of those changes were relayed, That is, the difference between the wet reading and the final reading are that they noted cardiomegaly. None of those things were related to the doctors that were taking care of her, and I think that the wet reading is sufficient.

Q. All right. Doctor, is it your testimony that there were no signs or symptoms of any type of cardiac problems being experienced by Mrs. Armstrong prior to her surgery; is that your testimony?

A. No.

Q. All right. Point in fact, Mrs. Armstrong was demonstrating signs and symptoms of cardiac problems prior to her surgery, correct?

A. Some of her symptoms, some of her subjective complaints could be consistent with cardiac problems or

other diagnoses.

Q. Let's start, what about the EKG which showed potentially an MI, that EKG being taken on August 7, 1999?

A. Was there a question? I'm sorry.

Q. Yeah. Are you familiar with --

A. Yes, I'm familiar with that.

Q. Okay. I'm sorry. There was an August 5th, 1999 EKG taken?

A. I have it in front of me.

Q. You're familiar with it?

A. Yes.

Q. You're familiar with that?

A. Yes.

Q. You're familiar, it says, "Consider anterior myocardial infarction,''correct?

A. Correct.

Q. Certainly this is evidence that Ms. Armstrong could be suffering from a serious cardiac problem, isn't it?

A. Could be.

Q. All right. You've read Dr. Bartulica's deposition in which a cardiac consult which read, "This EKG indicated that the age of the MI could not be determined," you're aware of that, correct?

A. Correct.

Q. That also is a very ominous piece of evidence, is it not?

A. It's an abnormal EKG.

Q. It says to consider a myocardial infarction in which the age of that infarction cannot be determined, correct?

A. Correct.

Q. The chest X-ray, Doctor, that also is evidence of Ms. Armstrong suffering from a cardiac condition or cardiac problems, correct?

A. Not necessarily.

Q. It can be, can't it?

A. It can be, yes.

Q. All right. People with enlarged hearts; that is, on chest X-rays, that is significant in that that could indicate a serious cardiac problem, correct?

A. It could.

MR. RISPO: Objection, again if you're talking about the cardiomegaly feature of the radiology report, the evidence is that that was not made available to Dr. Celerio at the time.

MS. KOLIS: I'm going to object because that's not the evidence; that's your interpretation of the evidence.

MR. CONWAY: You've answered the question, Doctor.

Q. Were you aware that Mrs. Armstrong had a family history of cardiac problems?

A. I did note that in one of her review systems, I believe.

Q. Is that a significant risk factor?

A. It could be depending on the nature of the heart problems.

Q. How about if one of her genetic relatives died of heart problems; would that be significant?

A. It depends on what age.

Q. Were you aware that Mrs. Armstrong was suffering from vascular problems including a femoral blood clot which required surgery in April of 1999?

A. I was aware of that, yes.

Q. All right. Is that also significant in that it could be related to a cardiac problem?

A. It could be possibly, but 1 think in this case the idea was that it was more related to her protein C deficiency and a hypercoagulable state.

Q. Is edema in a person's feet bilaterally associated with cardiac problems?

A. It can be.

Q. Were you aware of whether or not

Mrs. Armstrong was suffering from any bilateral edema in her feet prior to her surgery on August 7?

A. I believe her Amherst history and physical said she had some edema in her feet, but it was non-pitting edema, so she had some mild edema in her feet, yes.

Q. Could that be a sign of ventricular problems in the heart?

A. It can be, yes.

Q. Were you aware that she was suffering from or had a history of heart palpitations?

A. She had history of palpitations, yes.

Q. Of her heart?

A. Correct.

Q. That can be associated with serious heart problems, can it not?

A. It can, yes.

Q. What about varicosities; were you aware that Mrs. Armstrong was suffering from varicosities?

A. I don't recall that, but I'll take your word for it.

Q. Well, I mean, you don't recall it from the chart? I'm not making it up. Can that condition be associated with a cardiac condition?

A. I am not aware of varicosities having anything

to do with a cardiac condition.

Q. What about a history of shortness of breath; is that a fairly well-known sign and symptom of someone who's having heart problems?

A. Shortness of breath can be a symptom of heart disease, yes.

Q. How about fatigue?

A. Yes.

Q. Are you familiar with a drug called Redux?

A. I am familiar with that.

Q. And what do you know about Redux as it relates to being a risk factor or associated with heart problems?

A. Redux is a drug, weight-loss drug that was implicated in damage to heart valves. It's associated with some heart valve disease in patients who take it for a prolonged period.

Q. Were you aware of Mrs. Armstrong's history of chest pain?

A. Yes.

Q. That certainly can be a sign or symptom of a serious heart problem, can it not?

A. It can be, yes.

Q. All right. Were you aware of a recommendation by a prior treating doctor of Mrs. Armstrong that she

would need a cardiac consult for any type of surgery she was going to be involved in?

A. Well, I'm aware there was a recommendation prior to her vascular surgery which was a few months before, and I believe that evaluation was done.

Q. From your review of the record, I've listed twelve signs, symptoms or risk factors associated with cardiac problem. In your opinion, would you agree that Dr. Celerio was aware of all twelve of those or should have been aware of all twelve of those signs, symptoms or risk factors?

A. No.

MR. RISPO: One at a time, why don't you ask.

MR. CONWAY: Let me rephrase that. I'll strike that or rephrase it.

Q. Which one of these factors or conditions which Ms. Armstrong was suffering from or associated with did Dr. Celerio not know prior to putting Ms. Armstrong under with anesthesia?

A. Could you list those for me again?

Q. Well, was Dr. Celerio aware of the abnormal EKG?

A. Yes, he was.

MR. RISPO: I just want to avoid the double negative. Your previous question was which one did he

not know, now we're going into what he did know. So let s understand what he's answering now is what Dr. Celerio did know, not what he did not know.

BY MR. CONWAY:

Q. Dr. Celerio, in your opinion, knew about the abnormal EKG, correct?

A. Correct.

Q. He knew that a chest X-ray had been taken of the patient and did have a significant finding as revealed in a wet read, correct?

A. He was aware of the wet reading, correct.

Q. And he's aware that there was a significant finding in that wet reading, correct, regarding the right lower lobe?

A. It's questionable whether that's significant or not, but there was a finding, I'll agree with that.

Q. Doctor, as an anesthesiologist, is it reasonable and prudent to put an individual under general anesthesia if they're suffering from pneumonia?

A. No.

Q. Could the wet read from the August 5th, 1999 X-ray be consistent with someone suffering from pneumonia?

A. It's very unlikely.

Q. Why do you say that, Doctor?

A. Pneumonia generally has four components to its diagnosis. One is an abnormal chest X-ray, which she had. However, the other three are productive cough, a fever and a white blood cell count. She had one of the three. That abnormal chest X-ray, as you call it, could have been just about anything. It could have been an old scar, it could have been atelectasis.

Q. Could it have been endometriosis?

A. In her lung?

Q. Yeah.

A. I'm not aware that endometriosis goes to the lung, but I'm an expert on endometriosis so --

Q. What were the medical indications for that August 5th chest X-ray, Doctor; do you know?

A. I don't know.

Q. Dr. Celerio was aware of Mrs. Armstrong's family cardiac history, correct?

A. Correct.

Q. He was aware of her prior vascular problems, correct?

A. Correct.

Q. He was aware that she had edema in both feet, correct?

A. Correct.

Q. He was aware of her history of heart

palpitations, correct?

A. Correct.

Q. Her history of shortness of breath, correct?

A. She would describe it as occasional shortness of breath, but he was aware of that, I believe.

Q. Was there anything unusual about the way that Mrs. Armstrong had to sleep?

A. According to her review systems, preoperative pre-anesthesia review systems, she said she had to sleep upright.

Q. What's the significance of that to you, Doctor?

A. Well, that can mean, represent a symptom of heart failure, but it also can represent other things. It's also at odds with some statements she made or answers she gave later on, so what that exactly means is very confusing to me. For example, she does say she has a history of orthopnea or of having to sleep upright. However, a few moments later she denies having a history of nocturnal dyspnea. Those two things are conflicting.

I think a prudent anesthesiologist would review that with her and determine what her shortness of breath was, which I think she described as occasional shortness of breath.

Q. And would that reasonable and prudent

anesthesiologist document in the chart what his discussion with Mrs. Armstrong was exactly?

A. If I were the anesthesiologist, I would note that she has occasional shortness of breath.

Q. Would you document your discussions with Mrs. Armstrong regarding her positioning during sleeping and her shortness of breath in the chart?

A. I would document the conversation I had with her clarifying her shortness of breath, so if it were just occasional shortness of breath, then that's what I would document.

Q. Did Dr. Celerio ever document any type of conversation or investigation that he was involved in with the patient regarding any of her signs and symptoms from your review of the medical records?

A. I don't recall what he actually wrote down and what is on the anesthesia pre-op list. I could look at it here, I have it in front of me. I don't recall which was documented where offhand.

Q. Dr. Celerio was aware of Mrs. Armstrong's history of chest pain, correct?

A. I don't believe he was aware of that.

Q. Would you agree that an anesthesiologist has an independent duty to clear a patient for surgery?

A. Yes. He has an independent -- he or she has

an independent duty to determine whether or not they're suitable to undergo anesthesia, yes.

Q. Doctor, are you an expert in amyloidosis?

A. Definitely not.

Q. Mr. Rispo, the attorney who has retained you, has entered into a stipulation with the plaintiff in this case that Mrs. Armstrong would have had a life expectancy of four to five years. You don't have any reason to disagree with that life expectancy, do you, Doctor?

A. I have no idea what her life expectancy would have been, so I have no reason to disagree with that.

Q. Mrs. Armstrong could have been put under a different type of anesthetic in this particular case, couldn't she?

A. Yes.

Q. There could have been a decision in this particular case to operate under a local anesthetic, correct, as opposed to the general anesthetic she was put under?

A. She could have, but I wouldn't recommend it.

Q. Why not?

A. Well, generally local anesthetic for hysterectomy results in more discomfort and more stress for the patient. With the comfort foremost in our mind,

we seldom do things under local anesthesia, particularly major surgery such as this

Q If you have a patient Doctor, that you need to do major surgery such as this and that patient has a serious heart condition, it would be contraindicated to put that patient under general anesthetic, correct?

A. No, that's not correct

Q For this particular type of operation?

A. That's not correct.

MR RISPO: Are you assuming that he knew that she had amyloidosis?

MR CONWAY: No, I'm stating a serious heart condition. If he has a question, Ron he can ask me to clarify it.

MR RISPO: You have a duty to put to him a fair question. And the question that you put is as unfair as you could possibly put it

MR CONWAY: If you want to object -- if he can't answer the question, he can let me know.

THE WITNESS: I can answer.

BY MR CONWAY:

Q. Go ahead.

A. In general, I believe it's safer to go under a general anesthesia for a major surgery in a patient with serious heart problems

Q. If Dr. Celerio had not given Mrs. Armstrong a general anesthetic on August 7, 1999, she would not have died on August 7, 1999, correct?

A. I can't agree with that.

Q. You can't agree with that?

A. I cannot agree with that.

Q. Why not?

A. You'd have to tell me what other form of anesthesia she was getting. If she was going to be under local anesthesia, I cannot state that she wouldn't have died. If she received a spinal or epidural, she still likely would have had problems and perhaps died.

Q. How about if she had not been given any anesthesia on that day; she would not have died, correct?

A. No anesthesia and surgery or no surgery as well?

Q. Well, Doctor, I would hope that even out at that hospital, they would not operate on somebody without anesthesia, but let me rephrase the question then.

MS. KOLIS: That was good.

BY MR. CONWAY:

Q. Had the surgery been postponed on August 7, 1999 and thus Ms. Armstrong not given any anesthesia,

she would not have died on August 7, 1999, correct?

A. Probably not, no.

Q. All right. Giving her anesthesia on August 7, 1999 caused her death on that date, correct?

MR. RISPO: Objection.

THE WITNESS: The general anesthetic in that patient, Mrs. Armstrong, with amyloid heart disease resulted in her death.

BY MR. CONWAY:

Q. She would not have died, however, if the anesthesia had not been given to her, correct?

A. Correct.

Q. Can we agree, then, that the giving of anesthesia to her in the condition she was in on August 7, 1999 caused her death on that date?

A. Correct.

MR. RISPO: Objection again. I'm going to object and move to strike the last question and answer on the basis that it was broad and confusing as a question and ambiguous because it left out the fact that the patient had amyloidosis.

BY MR. CONWAY:

Q. On August 7, 1999, Mrs. Armstrong was suffering from a heart condition, correct, Doctor?

A. Correct.

Q. Dr. Celerio's administration of anesthetic to Mrs. Armstrong on August 7, 1999 while she was suffering from that heart condition caused her death, correct?

MR. RISPO: Absolutely ridiculous. We know, everybody knows --

MR. CONWAY: Wait a second.

MR. RISPO: -- that her cause of death was her underlying amyloidosis. Don't try and turn that around and suggest that anesthesia caused her death. That is wrong, the doctor will not answer it, we'll end this deposition if you can't ask a straight question.

MR. CONWAY: We haven't stipulated to the cause of death. Ron, let's do this -- I got an hour left of his time. We either finish it -- if you have objections --

MR. RISPO: Ask a fair question.

MR. CONWAY: I did ask --

MR. RISPO: You did not ask a fair question.

MR. CONWAY: He already answered it anyway.

Q. Doctor, should an anesthesiologist be able to read a plain film chest X-ray and determine whether or not the X-ray shows an enlarged heart?

A. Yeah.

Q. Should an anesthesiologist be able to read a plain film chest X-ray and recognize pneumonia in an

individual's lungs?

A. That would depend on how subtle the finding.

Q. Have you seen the chest film, Doctor?

A. I have not.

Q. To your knowledge, did Dr. Celerio at any time, even after the death of Mrs. Armstrong in this case, ever look at the chest X-ray?

A. Not to my knowledge.

Q. Would you agree with Dr. Celerio's opinion at page 31, line 14 through 22, where he was asked a question, "Do you have an opinion, Doctor, that your lack of knowledge about the enlarged heart, once again from the radiologist, caused or contributed to Mrs. Armstrong dying on August 7, 1999?" And Dr. Celerio opined that he could conclude that that was the case. Do you agree with Dr. Celerio's opinion?

A. Well, in retrospect I can, yes.

Q. Doctor, would you agree with Dr. Celerio at page 32, line 4, that if Dr. Bartulica had information that Mrs. Armstrong had previously taken Redux, that it was below the standard of care of Dr. Bartulica, of him not to have given that information?

A. You're asking me if Dr. Bartulica should have let Dr. Celerio know whether the patient had previously been on Redux?

Q. Yes.

A. Not if ne had knowledge that it hadn't caused her any problems.

Q. So you disagree with Dr. Celerio's criticism as he has stated multiple times but specifically at the top of page 32?

A. I disagree with that.

Q. Okay. Do you agree with Dr. Celerio's medical judgment opined at the bottom of page 32 where he indicates that had he known of that 14-day use of Redux by Mrs. Armstrong, he would have called off the surgery to investigate further?

A. Do I agree with --

Q. His judgment.

A. His judgement that he should have canceled the case because of her history of Redux?

Q. Yeah, had he known of the 14-day use of Redux, he indicates he would have called off the surgery and investigated further. Do you believe that that would have been a reasonable and prudent course of conduct by Dr. Celerio?

A. No.

Q. You don't?

A. No.

Q. Okay. In your review of the records, Doctor,

are you aware that Mrs. Armstrong was suffering from a small brain tumor?

A. Yes.

Q. Do you have an opinion as to whether or not that small brain tumor played any role at all in her death?

A. I don't think that it did.

Q. Do you agree with Dr. Celerio that if Dr. Bartulica was aware of that tumor, he should have told him about it?

A. I agree that he should have told him, but I doubt it had any significance to the anesthesia.

Q. Would it have been below the standard of care for Dr. Bartulica not to tell Dr. Celerio about that small brain tumor?

A. Well, given that it -- it wouldn't have impacted in any way whatsoever the anesthesia delivered by Dr. Celerio, I don't believe so. He's not obligated to tell him every detail, no matter how minor, with regards to the patient.

Q. Do you think Dr. Celerio's opinion that had he known about that small brain tumor, that he would have canceled the surgery; do you agree that that would have been a reasonable and prudent thing to do?

A. No.

Q. You don't have any criticisms against any of the nurses at Amherst Hospital, do you?

A. No.

Q. Pursuant to the American Society of Anesthesiology, Dr. Lyons, does an anesthesiologist have a duty to inform the patient when that anesthesiologist becomes aware of an abnormal test?

A. Any abnormal test are you asking me?

Q. Well, let's deal with the abnormalities on Ms. Armstrong's chest X-ray. Didn't Dr. Celerio have an obligation to tell Mrs. Armstrong about those abnormalities on her chest X-ray as indicated in the wet read?

A. No.

Q. You don't believe that would have been important for Mrs. Armstrong to be aware of so that she could in fact give informed consent for the surgery?

A. I don't believe the findings on the wet read impact the anesthetic at all. I don't believe that those increase her risk at all.

Q. If you were Dr. Celerio, would you have told Mrs. Armstrong about those abnormal chest X-ray results?

A. On the wet reading, no, I would not have.

Q. Would you have told Mrs. Armstrong about the abnormalities on the EKG which indicate that she may

have suffered an MI age indeterminate; would you have told her that?

A. Yes, I would have discussed the EKG with her.

Q. Was that discussed with her in this case, Doctor?

A. I don't know.

Q. Would it be below the standard of care not to discuss that with Ms. Armstrong in this case?

A. It would be below the standard to not discuss her cardiac history.

Q. What about the specific test results of that abnormal EKG?

A. Specific --

Q. Right.

A. I don't believe he's obliged to discuss the specific results. I believe he's obliged to discuss the abnormal EKG, and as part of the listening and history from her, ask if she's had such a problem in the past, an abnormal EKG.

Q. Did Dr. Celerio -- is there any evidence that he at any time discussed with Ms. Armstrong her abnormal EKG?

A. It's not documented. I don't know.

Q. Would that be below the standard of care, then, not to discuss that with Ms. Armstrong?

A It would be below the standard of care to not review ner cardiac history.

Q. And we have no evidence -- well, let's go back. What about specifically the abnormal EKG, that's all I'm asking you about at this point, Doctor; would it be below the standard of care for an anesthesiologist, specifically Dr. Celerio, not to discuss the abnormal EKG with Mrs. Armstrong?

A. I believe that he should discuss that she has an abnormality in her EKG, yes.

Q. And if he doesn't do that, he would be below the standard of care, correct?

A. Well, as it pertains to her cardiac history, yes, if it wasn't part of the discussion.

Q. Would it have been reasonable and prudent to postpone this surgery, Doctor, and enlist a cardiac consult?

A. Not based on what the doctors knew on the morning of surgery.

Q. That would not have been reasonable or prudent, to have a cardiac consult in this case; is that your testimony?

A. Not based on what the physicians knew on the morning of surgery, no.

Q. What does an ASA-3 rating mean, Doctor?

A. ASA-3 rating -- an ASA rating is a rating that is meant to give sort of a general overview of the complexity of diseases that the patient has. An ASA-3 rating is a patient that has severe systemic disease that limits activity but is not incapacitated.

Q. What was the severe systemic disease that Mrs. Armstrong was suffering from which led Dr Celerio to give her an ASA-3 rating?

A. In Dr. Celerio's deposition, he gave her an ASA-3 rating because of the chest X-ray and EKG. However, I believe that's incorrect. The ASA rating --

Q. What do you believe her rating should have been?

A. I believe her rating should have been 3 but not on the basis of the chest X-ray and EKG.

Q. What would your basis for giving her a 3 be?

A. She has protein C deficiency and she had already demonstrated she had systemic emboli which causes her to lose blood supply to her leg. That's a severe systemic disease in my mind. That's why I would have given her a 3. The ASA rating is not based on chest X-ray or EKG findings alone. It's based on disease states.

Q. Doctor, would you agree that a person who has to sleep sitting up supported by pillows to breathe may

have a bi-ventricular dysfunction of some type?

A. They may.

Q. Will you concede that checking off a box such as Mrs. Armstrong did in her self-assessment in the respiratory category has within its differential the suggestion that a person has an underlying cardiac problem?

A. Correct.

Q. Were you aware that Mrs. Armstrong had had a prior cardiac catheterization?

A. I was aware of that.

Q. Is that another factor that an anesthesiologist preoperatively testing a patient should consider?

A. Yeah, the results of that would be helpful to an anesthesiologist.

Q. And when the cardiac catheterization was done, correct?

A. Correct.

Q. You indicate in your report that Dr. Richardson, quote, "cleared," quote, Mrs. Armstrong. I presume you mean for surgery?

A. Yes.

Q. What date did Dr. Richardson, in your opinion, Doctor, clear Mrs. Armstrong for surgery?

A. Well, that's not clear from the records. And that's a report that was written before I had read Dr. Richardson's testimony, his deposition, and that was based on statements made by Dr. Celerio and Dr. Bartulica, is that how we're saying that; in which they both reported that the patient had seen her primary physician, Dr. Richardson, and that he had given her the okay for surgery. It's not clear when he did that, and in fact now, reading Dr. Richardson's testimony, it's not clear if he did that. However, both the surgeon and the patient seemed to have relayed to the anesthesiologist that he did clear her, so in his mind she was, quote/unquote, "given the okay" for surgery.

Q. And you think or it's your opinion that Dr. Celerio was reasonable in relying upon this vague information that Dr. Richardson had cleared Mrs. Armstrong for surgery despite not knowing when that clearance allegedly occurred, correct?

A. I don't think I would describe the information as vague if it came from the patient's attending surgeon who had knowledge of that, of that, quote/unquote, "clearance." I think it's reasonable for him to rely on statements made by the surgeon and patient. Oftentimes that's all we have to go on in anesthesia. We have a snapshot of the patient; we get to see them

preoperatively for a short time. And the history we get from the patient is very important to assessing that. As part of that history, that both the patient and the surgeon contributed to, she was seen by her primary physician who gave her the okay for surgery. So yes, I believe he was reasonable.

Q. Doctor, Dr. Richardson adamantly denies that he cleared this patient for surgery, correct?

A. He did deny that, yes.

Q. If the jury -- well, strike that.

Are you making a judgment on Dr. Richardson's credibility in giving us your opinion here today?

A. On his credibility, no.

Q. Do you have any reason to disbelieve Dr. Richardson when he says he did not give surgical clearance for this patient?

A. Well, that's a complicated question because Dr. Richardson does admit that there was a conversation between he and the surgeon at which time they talked about the surgery and they discussed the patient's medications that needed to be altered preoperatively. During that time, Dr. Richardson was well aware she was going to surgery, and I think it would have been reasonable and prudent for him as her primary physician to bring up any issues that he had with the surgery or

any objections that he had at the time. In not doing so, I believe that constitutes clearance on his behalf. That to me says that he had no objections to her going to surgery at that time. And that is what was relayed to Dr. Celerio.

Q. Is there any evidence that Dr. Richardson did any type of examination, ordered any type of test to, quote, "clear" Mrs. Armstrong for surgery?

A. No.

Q. Would the standard of care require Dr. Bartulica to inquire of Dr. Richardson as to whether or not Dr. Richardson had done a physical examination or ordered any tests on Mrs. Armstrong?

A. I believe the standard of care dictates that he should talk to Dr. Richardson regarding the surgery, and in so doing determine whether or not he had any objections to her going to surgery. Dr. Richardson is the only one who is aware of the patient -- he's the one that's most aware of the patient and he can, with a simple conversation, give her the go-ahead for surgery without discussing anything further. If --

Q. Then if that's the case, why did Dr. -- why do anesthesiologists then, why are they required to do preoperative assessments if we can just rely upon hearsay that someone is cleared for surgery?

A. We do like to have some objective evidence in front of us. Oftentimes the patient -- time passes between the patient seeing their primary physician and the time of surgery. Oftentimes patients are on drugs that affect their metabolic state, so to have recent updated information is helpful to us. However, that part of the history is very important, that input from the primary physician is as important as anything.

Q. Have you ever had a case, Doctor, where a patient was cleared for surgery, let's say three or four days before surgery, and then the patient came in for immediate pre-surgery testing and started exhibiting symptoms, signs of a serious problem which was cleared or which there was no evidence of during the initial clearance by the other doctor? Have you ever had that type of situation?

A. Certainly.

Q. Okay, all right. So you've had situations whereby a person, when they were surgically cleared by some other consulting doctor, had a normal EKG, normal chest films, and when you became involved immediately preoperatively they had abnormal EKGs or abnormal chest films; you've had those situations?

A. Well, oftentimes we don't have access to what the primary physician had. I have been involved in

cases that patients have come to surgery after seeing their primary and then exhibited physical signs of a change, and the patient is able to tell us that. That's the great part about the history. The patient is able to tell us what has changed in their status since the last time they saw their physician. Oftentimes we don't have the chest X-ray and the EKG that the primary doctor reviewed.

Q. In this particular case, wouldn't it have been reasonable for Dr. -- well, strike that.

In this case, Mrs. Armstrong was not aware of what her chest film or her EKG showed, was she? We have no evidence that she was aware of the findings on either of those tests?

A. She was not aware of either of those things, correct.

Q. So how would she know whether or not tests that were done before changed if she doesn't even know the results of those tests that were taken on the 5th and the 6th?

A. She would have no way of knowing, but she would be able to tell you whether she felt any differently and had any new symptoms since that time.

Q. Would it have been reasonable for Dr. Celerio to go into the hospital recordkeeping system and find

out what Mrs. Armstrong's prior EKG showed?

A. If it was accessible, sure.

Q. Would that be a reasonable and prudent thing to do when comforted with an abnormal EKG immediately prior to a surgery?

A. Yes.

Q. Would it be below the standard of care not to do that?

A. Not to verify old EKGs?

Q. Not to investigate a recent abnormal EKG by going into a hospital record system and retrieving older EKGs to which a comparison could be made.

MR. RISPO: Let's establish for the record here, though, that the surgery was at Amherst Hospital and the prior EKGs were at Elyria.

BY MR. CONWAY:

Q. Doctor, let's assume that the anesthesiologist has access to the record system where the prior EKGs are, all right? If that's the case, would it be below the standard of care for the anesthesiologist not to go back, look at the old EKGs and compare them to the recent abnormal one which occurred immediately before a surgery?

A. Depending on the abnormality, yes.

Q. In this case, Doctor, considering the

abnormality that presented, wasn't it below the standard of care for Dr. Celerio not to go back and compare that EKG to prior EKGs which were taken of Mrs. Armstrong?

A. I believe the standard of care would have been for him to attempt to do so. It's not always possible.

Q. Is there any evidence he even attempted to do so, Doctor?

A. I don't have any evidence, no.

Q. All right. Does the patient have a right, Doctor, to know what their current physical condition is prior to agreeing to go forward with a surgery?

A. Yes.

Q. That's the patient's right, to be informed and given an informed consent?

A. Correct.

Q. In this particular case, Doctor, since Mrs. Armstrong was not told about the abnormal EKG findings or the abnormal chest X-rays, she did not give informed consent to this particular surgery, did she?

A. Could you repeat that for me.

MR. CONWAY: If the court reporter could repeat it.

(Whereupon, the reporter read the record.)

THE WITNESS: First of all, with respect to the chest X-ray, I think I already stated that I felt it

had no bearing on her condition whatsoever. So I don't believe that it was necessary for her -- for them to discuss that with her. I do believe, as I mentioned before, that there should have been a discussion with respect to an abnormal EKG elicited in the history. However, what she deserved to know and what I believe they attempted to tell her, to the best of their ability, was whether or not she was in reasonable condition to undergo anesthesia that day.

BY MR. CONWAY:

Q. But we have no evidence of what was discussed with her from the medical records, do we?

A. We don't have any evidence of that, no.

MS. KOLIS: Celerio said he did not tell her that type of thing.

BY MR. CONWAY:

Q. Are you aware that Dr. Celerio testified he did not tell her about the abnormal EKG?

A. I am not aware of that.

Q. If he did testify to that under oath, he would have been below the standard of care, correct?

A. Are we talking about the EKG or the chest X-ray now?

Q. EKG.

A. Well, I believe that he should have discussed

abnormality in the EKG or the fact that she had an abnormal EKG.

Q. And if he did not do so, he was below the standard of care for an anesthesiologist, correct?

A. Yes.

MS. KOLIS: Can I make a safe assumption that you are not going to wish to examine the doctor? The only reason I'm asking is Mr. Rispo and I have recently been through an experience when the two-hour mark came, the screens went out. I only booked for exactly two hours.

MR. RISPO: I don't think I'll have any. I don't think it would happen at this facility.

MS. KOLIS: I just want to make sure. We're off the record, chatting about time.

(Whereupon, there was a discussion off the record.)

BY MR. CONWAY:

Q. Doctor, do you have any evidence that the chest X-ray or the final chest X-ray report of August 6, 1999 was not available to Dr. Celerio?

A. I don't have any evidence of that, no.

Q. Did the standard of care require any physician who was aware of Mrs. Armstrong's cardiomegaly to tell her about that condition prior to this surgery?

MR. RISPO: Object to that because it completely misrepresents the record here. It's clear the doctor did not know about her cardiomegaly and any questions based on that is unfair.

MR. CONWAY: I agree with you.

Q. Doctor, you're aware that Dr. Celerio was totally unaware of Mrs. Armstrong's enlarged heart or cardiomegaly, correct?

A. Yes.

Q. Assuming he became aware of that condition, the standard of care would have required him to tell her about that condition, correct?

A. Well, that depends at what point in time it occurred. If it came to him as information, he could relay that to her primary physician, then he would be responsible for relaying it to her. I guess the reason I'm answering that way is I don't know when Dr. Celerio became aware of it, if at all, and it wasn't his sole duty to let her know at any point in time that she had an abnormal chest X-ray. However, if that information came to him, he would be -- it would be reasonable for him to relay that at least to her primary physician.

Q. Would the standard of care require him to relay that information to at least the primary physician, in this case, Bartulica, the surgeon, if he

became aware of that?

A. If he became aware of it, sure.

Q. All right. And he'd be below the standard of care if he did not tell Dr. Bartulica if he became aware of it, correct?

A. Correct.

Q. Do you subscribe to the Journal of the American Society of Anesthesiology?

A. Yes.

Q. Do you find that to be a reasonable and reliable journal?

A. It depends on the article but in general, yes.

Q. Do you pay money for that journal subscription, Doctor?

A. It's part of the membership to the ASA, so indirectly I do, yes.

Q. Do you have an opinion whether or not Dr. Bartulica deviated from the standard of care in this case?

A. I don't believe he did.

Q. You know what the word "non-compliance" means?

A. Yes.

Q. Do you believe at any time that Mrs. Armstrong was non-compliant?

A. I'm assuming you're talking about compliance

with her prescribed medical therapy?

Q. Yes.

A. Well, I'd have to go over Dr. Bartulica's and Dr. Richardson's records a lot more thoroughly to determine that, but I don't have any reason to believe that right now.

Q. All right. And in assessing the facts and circumstances leading up to her death during the surgery on August 7, 1999, there's no evidence during that time period, within 60 days of her death, that she was in any way non-compliant; would you agree?

A. Not to my knowledge.

Q. All right. Doctor, you issued a report in this case, correct?

A. Correct.

Q. Was that your first draft?

A. I believe so.

Q. Did you make any other reports other than the one dated June 27, 2001?

A. No.

Q. You indicate at the top of the second page, the sentence, "The finding of the chest X-ray, while concerning," what do you mean by "while concerning"?

A. The indication was on the wet reading that there was a possible infiltrate there, and I think that

a prudent person reviewing her history would go back and look and make sure she didn't have the other signs I spoke of, of pneumonia, specifically fever, white blood cell counts, productive cough. So that's something that needed to be evaluated and could have easily been done so by looking at the patient's lab reports and talking with her.

Q. Have you ever had the opportunity, Doctor, when confronted with a chest X-ray which concerned you, or a wet reading of a chest X-ray which concerned you, to actually go and look at the X-ray; have you ever done that?

A. I have, yes.

Q. You indicate later in that paragraph that the abnormal EKG was the most significant piece of information that Dr. Celerio encountered in his evaluation of the patient.

A. That was the most abnormal finding, yes.

Q. And "Upon encountering this information, the most reasonable next step would be to delay the operation and refer the patient back to her internal medicine specialist for evaluation."

A. Right.

Q. You stand by that opinion, correct?

A. Yes.

Q. "However, in Armstrong's case, a recent evaluation had been performed by Dr. Richardson in which she was cleared for surgery." In looking through all of the medical records that were supplied to you, did you come across any lab test or examination that was ordered by Dr. Richardson to, quote, clear Mrs. Armstrong for this surgery?

A. No.

Q. Did you come across any lab tests or examinations that were ordered by Dr. Bartulica --

A. Well --

Q. -- to clear Nancy Armstrong for surgery?

A. Well, I think Dr. Bartulica was aware that she was going through pre-admission testing, so I suppose by scheduling the surgery he was indirectly responsible for those things being done.

Q. Okay. You indicate Dr. Celerio did have the final word and decision to anesthetize this patient, correct?

A. Correct.

Q. And as such, he has an independent duty to that patient to make sure that putting her under anesthetic is safe for her, correct?

A. To the best of his ability, correct.

Q. You don't have any idea when this clearance by

Dr. Richardson was supposedly given; is that correct, Doctor?

A. No.

Q. Would it make any difference to you if this, quote, "clearance," hypothetically speaking, was given a month before surgery or a week before surgery?

A. It wouldn't make any difference unless the patient relayed to me that she had a change in her symptomatology in the interim.

Q. If Dr. Celerio had any questions as to whether or not the patient had, in fact, been cleared by Dr. Richardson, the standard of care would require him to actually verify it himself, correct?

A. Yes.

Q. Are you saying that it is reasonable and prudent and the standard of care for Dr. Celerio to carte blanche, so to speak, rely upon Dr. Bartulica's representation that there had been clearance in this case?

A. Well, I do think -- I should amend my answer. I do think it's reasonable if there was a direct conversation between Dr. Bartulica and Dr. Richardson, and Dr. Bartulica relayed that to Dr. Celerio in its completeness, then I believe that that is a reasonable approach, yes.

Q. Of course, if you found in your review of the medical records and the depositions, if you found Dr. Richardson to be credible in his assertion that he did not give clearance in this case, Dr. Bartulica is below the standard of care, correct, Doctor?

MR. FRASURE: Objection.

THE WITNESS: May I answer now?

BY MR. CONWAY:

Q. Sure.

A. If I agreed -- I'm sorry. That question confused me a bit. Could we go over that again?

MR. CONWAY: She can read it again for you.

(Whereupon, the reporter read the record.)

THE WITNESS: Well, I think we talked before whether or not I had a problem with Dr. Richardson's credibility. I don't have a problem with his credibility. However, I do have a problem with his opinion as to whether or not he gave the go-ahead for surgery. And in this particular case, I believe by not objecting to the surgery when he had the conversation with Bartulica, he was giving the go-ahead.

BY MR. CONWAY:

Q. How would Dr. Richardson, if you could help me out, be in any position to know whether or not a surgery should go forward on Mrs. Armstrong if he hadn't

examined her or had any tests conducted to see whether or not she could withstand a surgery like that?

A. But he had examined her in the past and he had laboratory evals done in the past. He had seen her, he had examined her previously, and that's in his -- that's evident in his office records. There's no --

Q. But what was the last date he had examined or had any lab tests done on Mrs. Armstrong, from your review of the records?

A. From my memory, I believe he saw her approximately a month prior to surgery.

Q. Can a person's condition change within one month, Doctor?

A. Yes.

Q. A person with a serious heart condition, could that condition change within a month?

A. It could, and typically we see a change in symptoms as well.

Q. Are you familiar with the ACLS standards, Doctor?

A. I've reviewed them, yes.

Q. Are you ACLS certified?

A. No.

Q. Why not?

A. I'm board certified in critical care medicine.

Q. My question is why aren't you ACLS certified?

A. That's why I'm not ACLS certified.

Q. Do you think it's reasonable and prudent for an anesthesiologist who is not critical medicine certified to be certified in ACLS?

A. Yes.

Q. Should a person who's certified in ACLS be familiar with the ACLS standards?

A. Yes.

Q. Are you able to tell, Doctor, from your review of this record why Dr. Celerio who called the code in this particular case relinquished running the code to Dr. Trocio?

A. I believe Dr. Celerio stated that Dr. Trocio had more experience in resuscitation and it was prudent for him to relinquish control to him.

Q. What time did this code actually begin, Doctor?

A. Sometime between 12:02 and 12:10, I believe.

Q. Yeah. From your review of the records, what specific time is it your understanding that this code actually began?

A. Am I allowed to review this?

Q. Yes, certainly.

A. Oh, boy, lost the page.

According to the code record and anesthesia record, the code was called at 12:10, however there was some resuscitation being performed by Dr. Celerio prior to that.

Q. Doctor, have you ever been in the position of calling a code?

A. Absolutely.

Q. Would you agree that there was a delay by Dr. Celerio in calling this code?

A. I believe that there were some attempts by Dr. Celerio to resuscitate the patient prior to the code being called.

Q. What specific attempts do you believe Dr. Celerio made prior to calling the code?

A. Well, I think it's apparent from the anesthesia record that after induction the patient's blood pressure started to fall, and it's prudent at that point for him to recheck the blood pressure, which he did. It continued to fall. He turned off his anesthetic agents and put the patient on 100 percent oxygen and then began administering pressure agents, first a 25 milligram dosage of Ephedrine, followed by a 50 milligram dosage of Ephedrine. Those drugs don't work instantaneously, so there was some time in between waiting for those drugs to take effect.

Q. Are there drugs that might work a little bit quicker than the drugs Dr. Celerio chose to use?

A. Quicker, not necessarily. There are drugs that are more potent, however those drugs are seldom used as first-line drugs that raise low blood pressure when a patient is under anesthesia.

Q. Would you agree that Dr. Celerio put the patient under general anesthetic at 11:50?

A. Yes.

Q. Would you agree that at 11:50 the patient's blood pressure dropped to 80 over 35?

A. Yes.

Q. Would you agree that the patient's blood pressure never got better than 80 over 35 until 12:03?

A. I don't see it improving at 12:03. Is that not what you asked me?

Q. Right, it didn't. Between 11:55 when the patient's blood pressure was 80 over 35, it never improved at all up until 12:03, correct?

A. Correct.

Q. What was done during that eight-minute interval to resuscitate Mrs. Armstrong?

A. During that time, it appears that the volatile anesthetic agent that he was using was decreased.

Q. Anything else?

A. Well, I'm noticing here on the anesthesia record, this may be as a result of time discrepancy between the code sheet and the anesthesia record, but it appears that between 11:55 and 12:00 noon that the Ephedrine was administered at least by anesthesia record. So the anesthesia was decreased and the Ephedrine was given subsequent to that.

Q. And while that was being done, the patient's blood pressure did not improve, correct?

A. It did not improve.

Q. How long will a patient live who has a blood pressure of 80 over 35?

A. It depends on the patient and what their cardiac output is.

Q. How about a patient -- pardon?

A. Sometimes --

Q. How about a patient with this underlying cardiac problem, amyloidosis?

A. With this underlying cardiac problem, it's difficult to say.

Q. Then it indicates, at 12:03, what is done at that point?

A. Let's see. Well, it depends which record you refer to, but it appears there's another dose of Ephedrine given somewhere around 12:03 by the anesthesia

record. The discrepancy in the code record says the first dose of Ephedrine was given at about that time. So there's some discrepancy between the two records.

Q. And we have no way of knowing which is the more credible version, correct?

A. They both may be credible if they were referring to different clocks.

Q. What's done between 12:03 and 12:10 when the code is actually called?

A. According to the anesthesia record, an additional dose of Ephedrine is given.

Q. That's it?

A. Anesthetics were discontinued about that time.

Q. Why weren't the anesthetics discontinued almost immediately, Doctor?

A. Well, the first -- the first movement, the first change the anesthesiologist should make when the blood pressure falls post induction is decrease the amount of anesthesia, amount the patient is given. By turning it off, you risk the patient awakening. I think what Dr. Celerio did at this point was prudent. He decreased it, found the blood pressure fell further, and then he discontinued entirely.

Q. How long did it take him to reach the decision to discontinue it after the patient's blood pressure had

hit 90 over 35?

A. It appears it was discontinued shortly or within five minutes of the blood pressure being 80 over 55

Q What was done at 12:10. Doctor from your reading of your records?

A The code was called at 12:10 according to this

Q So from 11:55 to 12:10. that's 15 minutes. the patient's blood pressure never improved from 90 over 35. correct?

A Correct

Q There was no effort to give any type of medication stronger than Epinephrine, correct?

A. Correct

Q Then what happens at 12:10. octor?

A. 12:10. the code is called and they begin CPR

Q Who actually begins the CPR?

A. It's not clear.

Q Doctor. do you believe it's possible that at the time the code was ended at 1:02. that Mrs Armstrong was still alive?

A. I don't have any evidence of that In fact. given the EKG tracing done at 12:56. I would think t at's very unlikely

Q. So you're relying upon an EKG tracing, correct?

A. I'm using that as evidence. That's the only objective thing that I have from that period of time. But if you show me this EKG at 12:56 and a patient that's undergoing code for an hour, I would think it's unlikely they would survive even a short time longer.

Q. Would you agree between 11:55 and 12:10, during that 15 minutes, a gross amount of hypoperfusion to the heart took place?

A. I don't know if that's true or not.

Q. Why don't you know whether that's true or not?

A. Well, she maintains a relatively normal heart rate according to this until 12:05, so there's no real way to determine if there's hypoperfusion or not. Certainly as her heart rate begins to fall, you would suspect that as a result of hypoperfusion.

Q. Let's say when it gets to 80 over 35, would that be an indication of hypoperfusion?

A. Not necessarily.

Q. Can it be, Doctor?

A. It can.

Would you mind if I took a break for a minute?

MR. CONWAY: Sure. No, I don't mind, go ahead.

(Whereupon, a brief recess was taken.)

BY MR. CONWAY:

Q. Doctor, in this particular case, what in your opinion would have been necessary, what circumstances would have had to exist for it to have been proper to get a cardiac consult prior to her surgery?

MR. RISPO: Object to the generality of the question. Answer if you can.

THE WITNESS: That's a very general question. But in this case, I think it would have been reasonable to do so if she had had a change in her clinical appearance or her symptoms since the last time she was seen by her primary doctor. For example, if she came to me and said, "I saw my doctor a month ago and he gave me the A-okay, but since then I can't breathe and I'm having crushing chest pain and this is new for me," and then in that situation I would definitely refer the patient to a cardiac consult prior to surgery.

If she came to me and said, "I've been evaluated by my doctor and he said A-okay and I've been fine since then," then I think it would be prudent to not refer the patient for a consult.

BY MR. CONWAY:

Q. How about if you find out that there has been a change in EKGs over time?

A. If there was a significant change in the EKG, then yes, I would hold the surgery up, if I could, and have that further evaluated.

Q. Doctor, where is there any evidence that Nancy Armstrong told Dr. Celerio that she was cleared for surgery?

MR. RISPO: In the record?

MR. CONWAY: Yeah, anywhere. I'm just curious.

THE WITNESS: I thought that was in Dr. Celerio's deposition, but I don't know exactly where that is.

BY MR. CONWAY:

Q. Is there anything in the medical records that documents that Mrs. Armstrong at any point told Dr. Celerio that she had been cleared by Dr. Richardson for this surgery?

A. No, he documents nothing about that.

Q. What evidence are you relying upon in your assertion that Mrs. Armstrong told Dr. Celerio that Dr. Richardson had cleared her for surgery?

MR. RISPO: I think he was answering your hypothetical.

THE WITNESS: Well, my answer to that is I believe he had mentioned that in his deposition. I

might be wrong. I might have been referring to his conversation with Bartulica. I am aware that he had a conversation with Dr. Bartulica regarding the clearance, and I thought that Celerio had mentioned it in his deposition, but I might be incorrect about that. I'd have to search through the whole deposition to find it. I didn't make a notation of it.

BY MR. CONWAY:

Q. Should Dr. Celerio have asked Mrs. Armstrong about the nature of her shortness of breath, specifically how long she had had shortness of breath or whether it was continuous or not?

A. Yes.

Q. Should he have documented her responses in the chart?

A. If she reported that they were significant symptoms, yes. If they were negative, oftentimes we don't document that. For example, if she says, "I get short of breath but it hardly ever bothers me," then it's oftentimes the negatives aren't documented, the negative response. So if she said, "Yes, I have significant shortness of breath and these are the conditions under which it occurs," and it was concerning to him, then he was obligated to document that. If she made nothing of it, commonly we omit the negatives. We

can't list everything that's possibly not wrong with the patient.

Q. Even though the patient in this particular case indicated herself that she was suffering from shortness of breath?

A. She indicated that she was suffering from shortness of breath occasionally and she attributed it herself to anxiety.

Q. Doctor, should Dr. Celerio have asked Mrs. Armstrong about the nature of her heart palpitations?

A. I'm sorry, could you repeat that? I lost it.

Q. Yes. Should Dr. Celerio have asked Mrs. Armstrong about the nature of her heart palpitations?

A. No.

Q. He had no duty to inquire into those?

A. He needed to inquire with the patient. Heart palpitations along with a lot of Mrs. Armstrong's symptoms are very common, and I think that someone doing a review of systems on that patient should inquire with the patient of the nature. What type of palpitations -- I'm sorry, did you ask me that?

Q. Yeah, that's my question. Does he have the duty, does Dr. Celerio have the duty to inquire of

Mrs. Armstrong the circumstances surrounding her heart palpitations prior to putting her under anesthetic?

A. Oh, yes, yeah. I'm sorry, I misunderstood you.

Q. He would also have the obligation to chart those responses if they were in fact positives, I guess would be your way of putting it, correct?

A. Correct.

Q. Do you agree with Dr. Celerio's opinion that he was probably partially responsible for what happened to Mrs. Armstrong?

A. I'm sorry, could I go back to that last response? I wanted to add something to that.

Q. No problem.

A. Yes, he did have the responsibility to document the positives. And in that regard, I think the positives are that if by history those palpitations turned out to be something more than palpitations -- everyone on the planet has palpitations. However, when they're associated with symptoms, for example, passing out, they become of concern to medical personnel. So only in that regard do I think he should have documented that, if she had other symptoms with palpitations.

Q. Or other symptoms associated with cardiac disease or cardiac condition, correct?

A. If the patient knew about that, yeah, correct.

Q. Okay. Now, do you agree with Dr. Celerio's assessment that he was probably partially responsible for what happened to Mrs. Armstrong?

A. Well, in that he was one of the health care professionals taking care of her, and given that she had this undiagnosed, unknown heart condition which was more severe than anyone imagined, I suppose he plays a role in that. He was there administering anesthesia. However, I don't believe his administration of anesthesia was below the standard of care, nor do I believe him proceeding with the surgery was below the standard of care given what he knew preoperatively about that patient.

Q. Do you agree with his assessment that he, referring to Dr. Celerio, that Dr. Celerio himself said he should have known about her medical conditions before the surgery?

A. Well, I think Dr. Celerio wished he would have known about them. However, I don't agree with the statement that he should have known about them given what he had before him.

Q. Do you think Dr. Celerio had the obligation to pick up the phone and call the cardiology group who had interpreted the EKG to talk with one of the

cardiologists there about their interpretation of the EKG?

A. Do I think he had a responsibility to phone them?

Q. Yeah, or talk with them.

A. Well, the reason that I'm hesitating is that the interpretation of the EKG by the computer is fairly clear. So given the information that he had or that he believed he had from Dr. Richardson and the patient saying she had no history of heart problems, I believe he was within the standard of care by not calling them.

Q. Doctor, have you ever come across patients who have had abnormal EKGs and have no idea that they're having any type of heart problems?

A. Yes. In fact most abnormal EKGs don't represent any type of heart problem.

Q. Can people have abnormal EKGs and not know that they're actually suffering from a heart problem?

A. Yes.

Q. Can people have MI's, myocardial infarctions, without knowing it?

A. Yes, but they usually are aware of symptoms that go along with those conditions.

Q. Such as shortness of breath, chest tightness, things of that nature, correct?

A. Correct.

Q. Okay. Doctor, would you have started CPR prior to 12:12 if you had been the anesthesiologist rendering care and treatment to Mrs. Armstrong?

A. The reason again I'm hesitating on this is I can't tell by the documentation present whether she had a palpable pulse at that time. I would have started CPR at such time that her pulse was no longer palpable, and that occurs at different pressures depending on the patient.

Q. Do you have an opinion as to whether or not, and if so when, Mrs. Armstrong suffered a cardiac arrest?

A. No, I can't tell exactly because the documentation with regards to the code is not well done.

Q. All right. Doctor, should the documentation regarding the code be done to a sufficient degree that people can look at it and determine what occurred?

A. If possible, yeah. But if you've ever attended a code, you realize it can be chaotic and the person recording may be passing medications and doing a number of tasks. So oftentimes I find as an intensivist, the code sheets are not complete because the scenario is so tense and so many different things are needed from the person that may be documenting.

Q. In this particular case, is there any evidence that Dr. Bartulica became involved at all in the resuscitative efforts?

A. No, and I believe he said he didn't in his deposition.

Q. Doctor, in what ways -- I'd like -- I got your report here of June 27, 2001. Are there any opinions that you hold that are not contained in this report?

A. That's a big question.

Q. Well, Doctor, you've been an expert witness before, correct?

A. Correct.

Q. You've written expert reports before, correct?

A. Correct.

Q. And you realize the reason expert reports are written is to notify the other side what your basic opinions are in the case, correct?

A. Correct.

Q. And I assume that's what you set out to do when you made this report June 27th?

A. I did.

Q. So I'm assuming that all of your opinions that you hold in this particular case are contained in your June 27th report, and if I'm not correct, let me know.

A. Well, I think we've already gone over some of

the opinions that I have that I developed based on information received afterwards. For example, you and I discussed Dr. Richardson and whether or not he provided clearance for the patient. That was something that I formed an opinion on after writing this report. So to answer your question, I would say yes, I guess I'd have to have some opinions that aren't included in this report. That would be one of them.

Q. And it's your opinion that Dr. Richardson did provide surgical clearance in this case; is that your opinion under oath, Doctor?

A. Well, my opinion is that he had a discussion with Dr. Bartulica and he didn't voice any objection. And if he had objections to the surgery, then he should have voiced them. By not doing so, yes, I believe he did give the A-okay for surgery.

Q. Does that relieve Dr. Bartulica -- assuming that's true, does that relieve Dr. Bartulica and Dr. Celerio from independently assessing this patient preoperatively?

A. No, but as part of that independent assessment, they must include Dr. Richardson's opinion. That's very important.

Q. And of course, if the doctor, say Dr. Celerio hypothetically, had no reasonable basis to rely upon

this alleged circumstance of Dr. Richardson -- strike that.

What other opinions do you have, Doctor, that aren't contained in your report?

A. I can't think of any right now.

I would like to make an amendment to something I said earlier when the time is appropriate.

Q. Go ahead. What do you have to say?

A. Well, you asked me if the fact that anesthesia was administered caused Mrs. Armstrong's death. And I tried to answer that her death was caused by anesthesia with amyloid heart disease. I don't think I answered that true to what I believe. I think I misspoke. I should have said I believe that the cause of her death was amyloid heart disease. However, I wouldn't deny the fact that her receiving general anesthesia played a role in that death.

Q. Once again, Doctor, you will agree that had Dr. Celerio not administered anesthesia to Nancy Armstrong on August 7, 1999, she would not have died on August 7, 1999, correct?

A. Correct.

MS. KOLIS: Doctor, while Tom is looking through --

MR. RISPO: I do object to double-teaming. If

you have questions

MS. KOLI you want me to write them down on a piece of paper?

MR. RISPO: Yes.

MS. KOLIS: Be prepared to stay a little bit longer because Ron wants me to write out the questions.

MR. FRASURE: Can I ask my three or four?

MS. KOLIS: No, because we're not done, obviously.

MR. CONWAY: Write them out and hand them to me.

MS. KOLIS: (Proffers document.

BY MR. CONWAY:

Q. Doctor, are you aware of how much time Dr. Celerio spent with Nancy Armstrong, total time?

A. No.

Q. Are you aware of at what time Dr. Celerio first saw Nancy Armstrong?

A. I believe that Dr. Celerio estimates that time in his deposition, but I couldn't say for sure the exact time.

Q. How much time do you customarily spend with a patient such as Nancy Armstrong prior to a surgery where you're going to be the anesthesiologist?

A. A patient such as Nancy Armstrong?

Q. With her exact medical circumstances as known to Dr. Celerio?

A. I'd say in the range of 15 to 20 minutes.

Q. What would you be talking to your patient about during that 20 minutes?

A. I would go over her review of systems, I would ask about other diseases such that she had in the past, I would ask her what surgery she's had in the past, I would ask her about her allergies, and I would ask her if she had anything else pertinent to her medical history that I hadn't covered.

Q. Doctor, in this case, would you have looked at Nancy Armstrong's chest X-ray?

A. With having a wet reading, no, I don't think I would have.

Q. Would you have looked at the final radiology report that was transcribed on August 6?

A. Having a wet reading, no, I wouldn't, I wouldn't look for the final.

Q. Would you have attempted to get prior EKGs of Nancy Armstrong to compare with the abnormal one that was taken right before surgery?

A. Yes, I would have made an attempt to look at other EKGs.

Q. Would you have called the cardiology group who

read that EKG and talked with a cardiologist regarding that EKG?

A. If that was feasible. I would have made an attempt to do that.

Q. What do you mean by feasible?

A. Well, this is a lady that was having surgery -- I would have made an attempt to do that, that's my answer.

Q. Are you aware that the nurses were concerned enough about the chest X-ray results to point it out to Dr. Celerio prior to surgery?

A. Yes, I'm aware of that.

Q. Does that lay in favor of requiring Dr. Celerio to actually look at the chest X-ray?

A. No.

Q. Or -- pardon?

A. No.

Q. This wasn't an emergency surgery, was it, Doctor?

A. I would describe it as an urgent surgery. No, it wasn't an emergency.

Q. Nancy Armstrong would not have died had she not had that surgery on August 7, 1999, correct?

A. I believe she still would have died, but not undergoing induction of anesthesia, she probably

wouldn't have died that day.

Q. I apologize b caus that wasn't what m r question was meant to be. Her condition that she was suffering from that Dr. Bartulica decided to do surgery on was not life-threatening; that's the endometriosis, correct?

A. It was not life-threatening.

Q. And that condition, as a pain management specialist, you're aware can be treated with painkillers; is that correct?

A. Yes, except she failed painkillers. There are conditions severe enough where the pain is not adequately relieved with pain medicines, narcotics in this case, and oftentimes that prompts an urgent surgery. Failure to control pain is a very serious topic and that's something that we take seriously, and that was a cause for her to go to surgery on Saturday rather than Monday.

Q. Do you have any comments on the appropriateness of the specific anesthetic agents that were used by Dr. Celerio in this particular case?

A. I think that they were appropriate given what he knew about the patient.

Q. Were there other anesthetic agents that could have been used in this case that would have had a

different effect on Mrs. Armstrong's heart?

A. Yes, there are other agents that could have been used.

Q. Have you ever had cases, Doctor, where you've decided to use certain anesthetic agents because of a concern over one of your patient's heart conditions?

A. Yes, it's generally when I'm aware of a patient's serious heart condition I'll choose an anesthetic agent that's perhaps more gentle on the heart if I know that condition exists.

Q. The anesthetic agent that was used by Dr. Celerio was what, Doctor?

A. For induction he used Propofol, also known as Diprivan.

Q. That's not a gentle agent, is it?

A. It's average. It's not the most gentle.

Q. What agent would you use in a case like this?

A. Given what I knew, or if I knew -- I'm sorry; I'd have to ask you to clarify your question. Given what Dr. Celerio knew that morning?

Q. No. If you suspected, you, Doctor, suspected that a patient had heart problems or a heart condition, what type of anesthetic would you use?

A. You would have to be more specific with that. What kind of heart problems and how severe are they? If

I suspected they had severe heart problems, I would use a different induction agent.

Q. Which one would you use, Doctor, or can you tell me?

A. I would use a drug called Etomidate. That's E-t-o-m-i-d-a-t-e.

Q. What's the characteristics of that drug?

A. That's a sedative hypnotic drug that accomplishes the same thing as Propofol, though it's a littler gentler on the blood pressure and the heart.

Q. Would it also take a little longer for the patient to be brought out from under anesthetic than Propofol?

A. Not with just an induction dose. That would make no difference.

Q. Is there any drawback from using that type of drug, the one you just mentioned?

A. Etomidate?

Q. Yeah.

A. There are some side effects of Etomidate that are unpleasant.

Q. Such as?

A. Patients who go to sleep with Etomidate, they often have myopalmus, which sort of simulates a seizure. Oftentimes they have some muscle achiness after that.

Etomidate is associated in some cases with adrenal insufficiency and adrenal crisis afterwards, and in general patients are probably less clear after surgery. They come out of it equally quickly, but they may be less clear after surgery from Etomidate rather than Propofol.

MR. CONWAY: Mark, why don't you go ahead.

EXAMINATION

BY MR. FRASURE:

Q. Doctor, my name is Mark Frasure. About two minutes worth of questions. I represent Dr. Bartulica.

A. Yes, sir. Could you move your microphone a little closer. I can barely hear you.

Q. My name is Mark Frasure. Just a few questions for you.

A. Sure.

Q. Could you summarize your medical training after your graduation from medical school, your medical experience?

A. After graduation from medical school, I did an internship in internal medicine. It's called a preliminary year, just one year of internal medicine. I did three years of anesthesia residency and one year of critical care. It's difficult to explain, but actually the first year -- first six months of critical care and

the last six months of anesthesia overlapped. That was allowable by the American Board of Anesthesia at the time. So an anesthesia residency after the internship, a critical care fellowship, followed by a fellowship in cardiothoracic anesthesiology.

Q. When did you complete all of that training, then?

A. Summer of '94.

Q. You went where then?

A. I went into practice at University Hospitals of Cleveland.

Q. And you remained there until this past summer?

A. Until this past December.

Q. And what were your duties there for those six years or so, six or seven years at University Hospitals in Cleveland?

A. I was an anesthesia intensivist; I put patients in the operating room, put them under anesthesia, I also ran part of the time the cardiothoracic intensive care unit.

Q. You're board certified in anesthesiology?

A. Correct.

Q. Are you boarded also in critical care medicine?

A. Correct.

Q. You're licensed to practice medicine there in California, I presume?

A. Correct.

Q. Do you still hold your license in Ohio?

A. Yes.

Q. What percentage of your professional time do you devote to the active clinical practice of medicine, roughly?

A. Ninety-five percent.

MR. FRASURE: That's all I have. Thank you.

FURTHER EXAMINATION

BY MR. CONWAY:

Q. Doctor, where did you go to medical school?

A. Northeastern Ohio Universities, College of Medicine.

Q. Where is that located, Doctor?

A. Rootstown, Ohio.

Q. Where is that located; where is that by?

A. It's about an hour south of Cleveland. It's next to Kent.

Q. And you graduated from medical school in 1989?

A. Correct.

Q. Where was your undergraduate degree?

A. Youngstown State University.

Q. Doctor, have you published anything in your

career as a --

A. I have my name in a couple of papers. I think they're in my C.V.

Q. Anything else other than a paper published in 1998 and another one in 1998?

A. No, I don't believe so.

Q. You weren't the primary author in those papers, were you?

A. No.

Q. In fact, all of these have, looks like about five or six other doctors involved in preparing those papers, correct?

A. Correct.

Q. What was your part in actually publishing these papers?

A. I think for both of the papers that you have there, I participated in the anesthetics of the patient that were written up. In addition to that, I believe I reviewed the data that was accumulated by the lead author prior to publication, and I believe I reviewed the abstract and the statistical analysis prior to publication.

Q. One of them deals with early extubation of elderly coronary bypass surgery patients, correct?

A. Correct.

Q. And other one deals with the extubation of coronary artery bypass surgery patients on intra-aortic balloon pump, correct?

A. Correct.

Q. Anything else published during your career as a physician?

A. I believe we had an abstract published, and that may be listed there as well. The abstract was published in the proceedings of a meeting, a critical care meeting. I'm not sure if that's listed in my C.V. or not.

Q. Go ahead, I'm sorry.

A. It has to do with a drug called Vasopressin.

Q. Has no relation to any of the issues in this case, correct?

A. No.

Q. Doctor, any other reasons that you want to cite under oath as to why you left University Hospitals to go to a 200-bed hospital in Northern California?

A. Better job.

Q. How many bed hospital was University Hospitals?

A. I don't know how many adult beds they have. I think the total number of beds is somewhere around a thousand.

MR. CONWAY: I don't believe I have anything else.

MR. RISPO: Anything else, Mark?

MR. FRASURE: No.

MR. RISPO: I guess we're concluded. Thank you very much for your time.

MS. KOLIS: Denise, this is Attorney Kolis, who retained you to do this job. I need an expedited transcript.

THE REPORTER: Who all wants a copy?

MR. FRASURE: I do. Mark Frasure.

MR. RISPO: I do also, Denise. Ron Rispo.

MR. CONWAY: We need to put one other thing on the record with regards to the doctor.

Doctor, you have the right to review this transcript and sign it, and that's totally up to you. Let the court reporter let us know what your pleasure is. I advise that you do read it over.

THE WITNESS: Yes, I'll read it.

MR. CONWAY: Okay.

(Whereupon, Plaintiff's Exhibit No. 4 was marked for identification.)

(Whereupon, the deposition was concluded at 6:35 o'clock p.m.)

CERTIFICATE OF WITNESS

- - - -

I, TIMOTHY C. LYONS, M.D., hereby declare under penalty of perjury that **I** have read the foregoing deposition testimony; and that the same is a true and correct transcription of my said testimony except as I have corrected pursuant to my rights under Section 2025 (q)(1) of the California Code of Civil Procedure.

_____
Signature

_____
Date

STATE OF CALIFORNIA)
) ss.
County of Sonoma)

I, Denise Veirs, holding CSR License Number 5537, a Certified Shorthand Reporter, licensed by the State of California, hereby certify that, pursuant to Notice to take the foregoing deposition, said witness was by me duly sworn to tell the truth, the whole truth and nothing but the truth in the within-entitled cause; that said deposition was taken at the time and place stated herein; that the testimony of the said witness was recorded by me by stenotypy, and that said deposition was under my direction thereafter reduced to computer transcript and, when completed, was available to said witness for signature before any Notary Public.

I further certify that I am not of counsel or attorney for either of the parties to said deposition, nor in any way interested in the outcome of the cause named in the caption.

IN WITNESS WHEREOF, I have hereunto set my hand this 20th day of May, 2002.

Denise Veirs
Certified Shorthand Reporter

WESTON HURD

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Ronald A. Rispo
216.687.3217
RRispo@westonhurd.com

September 19, 2001

Timothy Lyons, M.D.
2405 Overlook Road
Cleveland Hts., OH 44106

Re: ***Nancy J. Armstrong v. Briccio A. Celerio, M.D. and C & K Anesthesia, Inc.***
Our File: 23617

Dear Dr. Lyons:

Please find enclosed herewith the following additional documents for your information and file:

1. Transcript of the deposition of the plaintiffs expert, Dr. Kenneth Smithson, D.O., which I took for discovery purposes on September 5, 2001.

Please review this deposition transcript and be familiar with it prior to your depositions in this case and/or trial appearances.

Thank you again for your willingness to participate in the legal process.

Yours truly,

Ronald A. Rispo

RAR/aml
Enclosure
J:\RAR\ARMSTRON\Lyons, s19.wpd

Dr Lyons
EXHIBIT NO. 4
5/16/02
DENISE VEIRS

WESTON HURD
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NAME:	TIMOTHY LYONS, M.D.
FACSIMILE PHONE NUMBER:	707/967-5803

SENDER: MARY LOW SHUMATE **EXTENSION; 3232**

DATE: May 8,2002 **TIME:** 3:30 p.m.

OUR FILE NUMBER: 23617 **JOB NUMBER:** 091

TOTAL NUMBER OF PACES INCLUDING COVER SHEET: 4

[] THE ORIGINAL OF THE TRANSMITTED DOCUMENT WILL BE SENT BY ORDINARY MAIL
[xx] THIS WILL BE THE ONLY FORM OF DELIVERY OF THE TRANSMITTED DOCUMENT

COMMENTS: Dear Dr. Lyons:

Attached is a copy of your 6/27/01 report. In addition, Mr Rispo has asked that I confirm that you have copies of the following materials that were previously sent:

1. Medical records for Ms. Armstrong.
2. Transcript of depo of William Richardson, M D.
3. Transcript of depo of Kenneth Smithson, D.O.
4 Report of David Burkons, M.D.
5. Report of Richard Watts, M.D.
6 Report of Andrew London, M.D.
7. Report of Kenneth Smithson, D.O.

We will be in touch with you to confirm your deposition date. In the meantime, please contact me at 216/687-3232 should you have any questions.

Mary Lou Shumate, R.N

4B

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SCHOOL OF MEDICINE

DEPARTMENT OF ANESTHESIOLOGY
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TELEPHONE. (216)844-7340
FAX: (216) 844-3781

June 27,2001

Ronald A Rispo, Esq
Weston Hurd
Fallon Paisley & Howley L L.P.
2500 Terminal Tower
50 Public Square
Cleveland, Ohio 441 13-2241

Dear Mr Rispo,

I have reviewed the medical records of Nancy J Armstrong as well as the depositions of Drs. Celerio and Bartulica and the office records of Dr Richardson In addition, I have reviewed the correspondences from Drs. Smithson, London and Mendelsohn. This is an unfortunate case of a young woman who died while under anesthesia secondary to a rare, undiagnosed cardiac condition Although this is a tragic loss, I believe Dr Celerio was within the standard of care with respect to the practice of anesthesiology

Mrs Armstrong presented to Amherst Hospital on August 5, 1999 with a chief complaint of pelvic pain The admission history and physical documents no history of heart disease or subjective complaint of dyspnea, as well as no leg edema, and clear lungs (no rales or rhonchi) with exception of decreased breath sounds in the right base The preoperative anesthesia checklist is positive for dyspnea on exertion, leg swelling and orthopnea but negative for chest pain, paroxysmal nocturnal dyspnea and history of congestive heart failure At the time of the admission nursing assessment, the patient was normotensive and afebrile with a respiratory rate of 20 The initial nursing assessment also documents that the patient has a history of occasional shortness of breath, but denies a history of cardiovascular problems. It also notes that the patient has no edema

Other pertinent objective information that was available to Dr Celerio include:, a 'wet' reading chest x-ray noting a right lower lobe process, an abnormal EKG showing poor R-wave progression and a normal white blood cell count.

On the morning of August 7, 1999, I believe that Dr. Celerio was faced with a normotensive, non-tachypneic patient for an urgent procedure with a vague history of shortness of breath and leg edema, an abnormal ERG and chest x-ray, but no active cardiopulmonary symptoms In my opinion, the history and physical findings alone

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would not have been sufficient reason to delay this urgent case. The finding of the chest x-ray, while concerning, would also not be grounds to delay this case, especially in light of a normal white blood cell count and lack of fever It is my opinion that the abnormal EKG was the most significant piece of information that Dr Celerio encountered in his evaluation of this patient, Upon encountering this information, the most reasonable next step would be to delay the operation and refer the patient back to her internal medicine specialist for evaluation.

However, in Mrs. Armstrong's case, a recent evaluation had been performed by Dr. Richardson in which she was 'cleared' for surgery This information was communicated to Dr. Celerio by both the patient and her surgeon, Dr. Bartulica. Dr. Celerio did have the final word in decision to anesthetize this patient, however, in order to make this determination he was obligated to consider information from many sources. Not only is it his duty to consider the objective and subjective evidence before him, but also *the information and opinions relayed by other physicians, particularly the patient's own primary* care provider. Oftentimes this is the most useful information available. In this case, the 'snapshot' that Dr. Celerio had of Mrs. Armstrong included an evaluation by her primary physician, a physician that had seen her numerous times in the past and was more familiar with her medical condition than any other health care provider Based on Dr. Richardson's recommendation and the subjective and objective evidence before him, Dr. Celerio proceeded with the anesthetic as I believe any reasonable anesthesiologist would have.

Approximately 15 minutes after induction, Mrs. Armstrong experienced a significant fall in her blood pressure Dr Celerio responded appropriately by administering a moderate dose of ephedrine. When this patients blood pressure failed to respond to the initial dose of pressor, Dr Celerio was again appropriate in giving another larger dose of ephedrine and discontinuing the anesthetic agents. At approximately 12:10 a code was called and Dr. Celerio began CPR Upon arrival of the code team, Dr. Celerio relinquished the code leader position to Dr Trocio It is not uncommon for a physician who is mote experienced in resuscitation to takeover the code leader position from a physician with less experience in this area This is reasonable provided the code team is aware of the change Ultimately, the resuscitation was unsuccessful and the patient was pronounced dead at approximately 1:02pm.

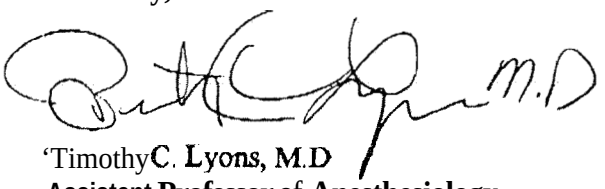
There *are* some time discrepancies between the anesthesia record the nursing pi-ogress notes and the code sheet However, I believe that it *is* clear from the depositions of Drs. Celerio and Bartulica that Dr Celerio was vigilant and engaged in resuscitation of this patient in a continuous manner from the time of her deterioration,

Surprisingly, the post-mortem examination revealed "marked vascular and stromal amyloid deposition throughout the heart " It is clear from the office records of Dr Richardson that this condition had remained undiagnosed despite two cardiac evaluations in the four months preceding surgery. In addition, these office records also reflect that Mrs. Armstrong's vague complaints of dyspnea and her abnormal EKG were also present in the month prior to surgery Indeed, it is now clear that she suffered from amyloid

heart disease, which was unknown to her anesthesiologist, internist, and surgeon as well as the patient, herself. I believe this rare disease was the direct and proximate cause of death while under anesthesia

In summary, it is my *expert* opinion that Mrs Armstrong expired under anesthesia secondary to cardiac failure from amyloid heart disease that could not have been anticipated from the patient's history and physical condition. In addition, I believe that ,Dt Celerio's efforts did not deviate from the standard of care.

:Sincerely,



'TimothyC. Lyons, M.D
.Assistant Professor of Anesthesiology
Co-Chief, Cardiothoracic Intensive Care Unit
Department of Anesthesiology
University Hospitals of Cleveland
Case Western Reserve University

Email: tlyons4062@aol.com

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Ronald A Rispo
2166873217
RRispo@westonhurd com

June 11,2001

Timothy Lyons, M.D.
2405 Overlook Road
Cleveland Hts., OH 44106

Re: ***Nancy J. Armstrong v. Briccio A. Celerio, M.D. and C & K Anesthesia, Inc.***
Our File: 23617

Dear Dr. Lyons:

Please find enclosed herewith copies of the following documents for your review and file:

1. Expert witness report dated May 29, 2001 from Dr. Andrew M. London, who addresses the issues as they relate to the surgeon, Dr. Bartulica.

2. Expert witness report dated May 31, 2001, from Kenneth G. Smithson, D.O., Ph.D., who addresses the issues of anesthesiology as it relates to our client, Dr. Celerio.

We will need your final report and opinions no later than June 25th. We need to exchange the reports with opposing counsel by June 30th in order to comply with the court's case management order, and to be certain that you will be able to qualify and testify as an expert on behalf of the defense at trial.

Accordingly, if there is any reason why you cannot get your final report to me before June 25th, I would appreciate it if you would call me or my probate paralegal, Mary Lou Shumate, as soon as possible so that we might make a motion for extension of time, if we can demonstrate good cause.

Thank you in advance for your time and analysis. Please give me a call to discuss the case if you have any questions before you write your report.

Yours truly,

Ronald A. Rispo

RAR/dss
Enclosures

cc: Nary Lou Shumate, RN/Paralegal
(w/encls)
J:\RAR\ARMSTRONL\LYONS J11

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Ronald A. Rispo
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May 2,2001

Mark Boswell, M.D.
2545 Norfolk Road
Cleveland Heights, OH 44106

Re: *Nancy J. **Armstrong** v. Briccio **A.** Celerio, **M.D.** **and C & K Anesthesia, Inc.***
Our File: 23617

Dear Dr. Boswell:

Please find enclosed herewith the following additional materials for your review and consideration in connection with the preparation of your report and review of this case:

1. Transcript of the deposition of Briccio Celerio, M.D., which was taken on April 10, 2001.

After you've had an opportunity to review the transcript of Dr. Celerio's deposition, I would appreciate it if you would provide us your report as soon as possible. Our deadline for production of reports is June 1, 2001.

Best regards,

Ronald A. Rispo

RAR/dss
Enclosure
J:\RAR\ARMSTRON\BOSWELL M02

Dr. Celerio was the anesthesiologist assigned to the case and assessed the patient prior to surgery. Shortly after surgery began on 8/7/99, dark venous blood was noted at the incision site. The patient became cyanotic, developed bradycardia and hypotension, and arrested. She was unable to be resuscitated.

The autopsy listed the cause of death as probable cardiac arrhythmia secondary to massive cardiomegaly with pericardial effusion and associated pleural effusion as a result of chronic systemic hypertension.

Plaintiffs are claiming that Dr. Celerio fell below the accepted standard of care in his treatment of Ms. Armstrong. I have enclosed the following materials for your review:

1. Copy of the complaint;

2. Records from William Richardson, M.D.

3. Records from Paul Bartulica, M.D.

4. Records from Arnherst Hospital;

5. Transcript of the deposition of Dr. Bartulica;

6. Report of co-defense expert, Geoffrey Mendelsohn, M.D.;

7. Copy of the autopsy report.

Following your initial review of these materials, please contact Mr. Rispo at 216/687-3217. If Mr. Rispo is not available, please feel free to contact me at 216/687-3232.

Also please forward a copy of your current curriculum vitae to my attention at your earliest convenience.

Thank you for your assistance, and we look forward to speaking with you.

Very truly yours,

Mary Lou Shumate RN

Mary Lou Shumate
Nurse Paralegal

MLS/gdm
Enclosures
cc: Ronald **A.** Rispo, Esq.

J:\MLS\RISPO\BOSWELL LTR

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Ronald A. Rispo
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August 31,2001

Timothy Lyons, M.D.
2405 Overlook Road
Cleveland Hts., OH 44106

Re: ***Nancy J. Armstrong v. Briccio A. Celerio, M.D. and C & K Anesthesia, Inc.***
Our File: 23617

Dear Dr. Lyons:

Enclosed herewith please find a copy of the following documents for your information and file:

1. Report by David Burkons, M.D., dated August 24, 2001.
2. Report by Richard Watts, dated August 26,2001.

As you will see, Dr. Burkons is an OB/GYN surgeon and his report has been submitted on behalf of the eo-defendant, Paul Bartulica, M.D.

Please review and become familiar with his report prior to your deposition.

Although your deposition has not yet been scheduled, I anticipate that it would take place in the month of October.

Finally, please be reminded that this case is scheduled for trial on November 14, 2001. I anticipate that we would be looking for your to testify on the third or fourth day of trial. Please advise what would be the best schedule for you during that week.

Thank you in advance for your cooperation and participation in this case.

Yours truly,

Ronald A. Rispo

RAR/dss
Enclosure

cc: Mary Lou Shumate, RN/Paralegal
(w/encl)

J:\RAR\ARMSTRON\Lyons, August 23.wpd

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Ronald A. Rispo
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November 2,2001

Timothy Lyons, M.D.
2405 Overlook Road
Cleveland Hts., OH 44106

Re: ***Nancy J. Armstrong v. Briccio A. Celerio, M.D. and C & K Anesthesia, Inc.***
Our File: 23617

Dear Dr. Lyons:

I just attended a final pretrial conference on this matter on November 1st.

As I had anticipated, the plaintiff has asked the court to reschedule the case for trial at a later date because she is not prepared to go forward at this time.

Accordingly, the court has rescheduled the case for Wednesday, June 5,2002.

I am sorry for any inconvenience this might have caused you. However, you may disregard the November 14th trial date, and schedule any appointments which you wish to schedule this month without concern for this trial date.

Please mark your calendar, however, for Friday, June 7,2002 for your live testimony.

If there is any reason why you would not be available on June 7,2002, please advise me promptly. I anticipate being in contact with you in the not too distant future with a view to scheduling your discovery deposition, assuming that the plaintiffs attorney wants to request that opportunity.

In the meantime, thank you for your courtesies, patience and understanding. Sometimes we have no control over what will occur on a judge's calendar. I look forward to your continued participation and assistance in this case.

Yours truly,

Ronald A. Rispo

RAR/dss
J:\RAR\ARMSTRON\Lyons, Nov. 2.wpd

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October 16, 2001

Timothy Lyons, M.D.
2405 Qverlook Road
Cleveland Hts., OH 44106

Re: ***Nancy J. Armstrong v. Briccio A. Celerio, M.D. and C & K Anesthesia, Inc.***
Our File: 23617

Dear Dr. Lyons:

Please find enclosed herewith the following additional materials for your review in connection with the trial of this matter:

1. Transcript of the deposition of the William S. Richardson, M.D., the primary care pliysician.

Please review the transcript and be familiar with it prior to your deposition and/or trial appearance.

Thank you in advance for your cooperation.

Yours truly,

Ronald A. Rispo

RAR/dss
Enclosure
J:\RAR\ARMSTRON\Lyons, Oct.16.wpd

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FACSIMILE COVER SHEET

URGENT!

Deliver Upon Receipt To:

NAME	TIMOTHY LYONS, MD
FIRM:	
FACSIMILE PHONE NUMBER:	(707)967-5803
MAIN PHONE NUMBER:	

SENDER: RONALD A. RISPO EXTENSION: 216/241-6602

DATE: Thursday, May 16, 2002 3:54:54 PM

OUR FILE NUMBER: 23617

COMMENTS:

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Ronald A. Rispo
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RRispo@westonhurd.com

May 16, 2002

Timothy Lyons, M.D. By Fax #707/967-5803

Re: ***Nancy J. Armstrong v. Briccio A. Celerio, M.D. and C & K Anesthesia, Inc.***
Our File: 23617

Dear Dr. Lyons:

This will simply be a reminder letter to you that this case is scheduled for **trial, commencing on June 5,2002.**

Assuming the case goes forward upon the appointed date, and we have every reason to believe that it will, plaintiffs case and the co-defendant case will have to proceed first. I expect their cases will take up the first three days of trial. This would mean that it would not be time for us to present our evidence until Monday, June 10th.

Accordingly, I am writing at this time to request that you or your secretary advise me what would be the best arrangement for you in terms of time and date, and whether you would like me to make any hotel or airline reservations for you.

We would much prefer to have your attend as a witness live at the time of trial. However, it for any reason it is impossible for you to appear, then we would propose to take your videotape deposition for use in evidence at trial. If it becomes necessary to take your deposition, then we would want to do so on Saturday, June 8th.

Please advise me or my secretary of your schedule and availability.

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Once again on behalf of Dr. Celerio, I want to thank you for your willingness to participate in these proceedings as a witness on behalf of Dr. Celerio.

Best regards,

Ronald **A.** Rispo

RAR/dss

cc: Mary Lou Shumate, RN/Paralegal
Dreama S. Smith, Secretary to RAR

J:\RAR\ARMSTRON\Lyons, May 16.wpd