SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF KINGS: TRIAL TERM PART 3
- X

MICHELLE BRADLEY,

Plaintiff,

INDEX NUMBER:
28940/2006

- against -

LUTHERAN MEDICAL CENTER and JOHN. T. MOON, MD,

Defendants.

- X

360 Adams Street
Brooklyn, New York 11201
October 21, 2009
PROCEEDINGS

BEFORE:

HONORABLE MICHELLE WESTON, Justice
(A jury of 6 and 2 alternates.)

APPEARANCES:

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&
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NANCY A. MESSANO
Official Court Reporter

MS. MOY: Yes.

MR. KOPFF: Yes, Your Honor.

THE COURT: Good morning.

Next witness, please, Counsel.

MR. KOREK: Good morning ladies and gentlemen. Good morning, Your Honor.

At this time, Your Honor, the plaintiff calls Dr. Michael Drew to the witness stand.

DR. MICHAEL DREW, a witness called on behalf of the Plaintiff, having been first duly sworn by the Court Clerk, was examined and testified under oath as follows:

COURT CLERK: Please state your name and address for the record.

THE WITNESS: Michael Drew. D-R-E-W, 70-10 Austin Street, Forest Hills, New York. That's my office address.

COURT CLERK: Thank you.

THE COURT: You may inquire.

MR. KOREK: Thank you.

DIRECT EXAMINATION

BY MR. KOREK:

Q Good morning, Doctor. I am going to ask you to keep your voice up loud enough so that our last jurors can hear you. If there is anything of course

you need me to repeat or rephrase please tell me and I will be happy to do so.

And it's important for our court reporter that you answer our questions verbally so she can take it down without having to look at you?

A Understood.

Q Okay, can you tell us are you a physician duly licensed to practice medicine in New York State?

A Yes, I am a surgeon. I have been practicing in New York since I had a license since 1976, roughly, and I have been practicing in New York since I finished my residency in 1981.

Q And, Doctor, in this case we heard that Michelle Bradley's surgery was an ambulatory surgery. Can you tell the members of the jury and court who is the director of ambulatory surgery at North Shore University Hospital, Long Island Jewish, Forest Hills?

A I serve as director of ambulatory surgery among other titles I have there.

Q We will get into that. Before we do can you tell the members of the jury and court something about your education.

Where did you go to college for example?

A I went to college at Lehigh University in

Bethlehem, Pennsylvania. After that I went to Georgetown University in Washington DC for four years. After which I did a surgical residency for five years at Mount Sinai Hospital in New York.

Q Let me just go a little slow. Georgetown, what did you do there?

A Georgetown was my medical school and we had four years of education afterwards and after that you pick a residency program or field of specialty that you want to go into. I chose surgery and then chose to do my residency at Mount Sinai Hospital in New York.

Q All right, and at Mount Sinai Hospital in New York can you tell us what years approximately you did your residency?

A I started my residency in 1976. It's a five year residency and I finished in 1981.

Q And did you serve as a chief resident as well?

A Yes.

Q And, in connection with your residency or chief residency did you receive any honors or awards?

A I did. When I finished my residency I was chosen by the attendings, the staff, the attending and physicians who trained us as the outstanding chief resident of my year.

Q And, Doctor, can you tell us what hospital that -- sorry, the hospital you are affiliated with now how long have you been so affiliated?

A Currently I have privileges at Mount Sinai Hospital. I have been on staff there continuously since 1981 and through my residency. For the first, oh, 15 years of my practice I did probably 75 percent of my work at Mount Sinai.

I also had an office in Forest Hills. Currently I don't practice actively at Mount Sinai and I am exclusively at North Shore Hospital in Forest Hills where I am one of the co-directors of surgery.

Q In fact I was going -- you took me to the next topic.

Tell the members of the jury and court some of the positions you hold in connection with the North Shore University Hospital?

A I am one the of co-directors of surgery and co-directors of bariatric surgery, weight loss surgery. For the last two years I have been president of the medical staff. I also chair what is called a performance improvement committee which is the major committee in the hospital that everybody reports to and that's where we keep tabs on the quality of everything that goes on in the hospital.

I also serve as the chairman of the operating room committee and I am on the surgical review surgical tissue review committee where we review all pathology. Everything that is taken out of a patient we look at to make sure that it matches what was suppose to be removed and what the preoperative diagnosis was.

Q Doctor, in connection for example with the performance improvement coordinating group of which you serve as the chairman and in connection with where you serve as chairman of the operating room committee have you become familiar with the standards of care with regard to surgical practice in 2005 as well as in the present?

A I have, yes.

Q Doctor, can you tell us in terms of your teaching appointments where it is that you have held such appointments?

A Well, I was -- since I finished my residency I have been on staff at Sinai I think I had a title of assistant clinical professor or clinical instructor in surgery at the Mount Sinai School of Medicine. And when I went -- I began at North Shore in 2001 I started as the director of the residency training program.

The residency program since has been -- the residents were no longer sent there by North Shore system. They use them at their tertiary centers. So now I am in charge of the training of the physicians assistants and the medical students that we get.

Q By the way was one of the residents that passed through your program Dr. Sasan Roayaie?

A Yes.

Q Doctor, did you receive any honors or awards in connection with your teaching?

A Yes. I was voted by the chief residents. They voted me the attending of the year in about six or seven years after I -- probably in 1987 or '88. Something like that. Which was a relatively nice award to get. That's from the chief residents. They are the ones who you impact the greatest.

Q Doctor, can you tell the members of the jury are you board certified?

A I am board certified which means I took a written exam and then an oral exam and you do that after you finish your residency. I finished at a time where we have to be recertified every ten years and so I was board certified for the first time in 1982. Then I recertified in '92 and again in 2002 and I am

due for recertification in 2012.

The recertification exam is just a written exam and thus far passed them all on my first shot.

Q Doctor, can you tell us in terms of your board certification and process was that a significant event during the time of your medical career?

A I think that, you know, what everybody aspires to if you finish. You can only be board certified, number one, by finishing an accredited residency program and getting the authorization from your chief that not only that you finished it but you completed it with everything that you needed to do in both ethical, moral and you had the surgical experience.

So, everybody, I mean that's what we aspire to. The American College of Surgery that's basically the highest board that we surgeons have and, you know, it's something that I think, you know, you would like to be part of, yes.

Q And, Doctor, can you tell the members of the jury and court what societies in terms of profession that you are a member of?

A I am the member of the American Society For Bariatric Surgery. There is a society for

laparoscopic endoscopy surgery. I think the American Society For Abdominal Surgery as well.

Q And, did, Doctor, can you tell the members of the jury and court some idea approximately how many patients you see per week both in and outside the hospital?

A I am a practicing surgeon as I have some administrative duties but basically 95 percent of my time is spent taking care of patients. I see in the office probably 50 to 60 patients a week. Obviously not all of them need surgery and I do about five to six hundred cases a year which I have been doing relatively steadily for the last twenty years at least. It varies by a few cases a year.

Q When you say cases, Doctor, as lawyers we think of a case and you think of a case another way. What is a case?

A A case constitutes an operation and out of the five or six hundred probably 60 percent of the cases I do are abdominal surgery, gallbladder, hernias, colon, small bowel, you know, intestinal work, weight loss surgery. Twenty percent or twenty-five percent is probably breast surgery and then, you know, what we in general surgery call the usual lumps and bumps, you know. Skin lesions and masses and things like that

that we deal with.

THE COURT: Lumps and bumps?

THE WITNESS: Lumps and bumps.

Q Doctor, if you can can you tell us approximately I know you mentioned but just give it to us again. How many years have you been doing surgery?

A I finished my residency in 1981 so that's 27, 28 years that I have been in private practice.

Q Are you familiar with procedure known as a cholecystectomy?

A I am.

Q The name for removing the gallbladder?

A Cholecystectomy is removal of the gallbladder, yes.

Q Tell members of the jury and court if you will approximately how many cholecystectomies you have done? You know, notice I didn't say laparoscopic. First cholecystectomies?

A I probably did two thousand cholecystectomies. First ten years of my practice there was no laparoscopic gallbladder removal as you probably heard. That's removing the gallbladder through a scope what we call minimally invasive surgery. That first started in New York in 1990 and 1991.

So, for the first, you know, again I always I would say I do 50 to 75 a year gallbladders conservatively so I probably did 500 opened initially and since then another one thousand five hundred laparoscopically, more or less. You know, as I say it could vary but it's that amount as opposed to a hundred or two hundred.

Q Okay. So, about two thousand total. About five hundred open and about one thousand five hundred laparoscopic cholecystectomies?

A Yeah, roughly. Even in the year of laparoscopic surgery we still do open gallbladders but now probably 95 percent of them are done laparoscopically.

Q Can you tell the members of the jury and court have you ever been asked to teach a course on the subject of laparoscopic cholecystectomies to surgeons and if so who asked you and did you accept the offer?

A Well, when I was at Mount Sinai the first person in New York and probably one of the major people in laparoscopic surgery was at Mount Sinai, Dr. Barry Salky. He was the first one to do laparoscopic surgery and the way it worked in those days since all of us who had finished were not trained in laparoscopic surgery we had to get trained in laparoscopy so the way

we did it is we went to the animal labs at the some of the surgical companies. I did it at Ethicon. They had the equipment at that time so you did an animal lab for two days where you learned how to do it and then you had to be proctored by somebody who was authorized to do it.

In my case it was Dr. Salky, he was the only one doing it and I think my partner and I became the second and third people to become qualified and then we proctored, you know, lots of people behind us. I think, you know, we had the claim as having done the first laparoscopic cholecystectomies in the borough of Queens in 1991. So, I know it's something I am quite familiar with.

Q Doctor, in fact how many residents, students, surgeons, do you think you have proctored in laparoscopic cholecystectomies over the years?

A You know, there is, you know, we deal within a year with the time I was actively teaching there were, you know, 15 or 20 surgical residents who were doing laparoscopic surgery a year and at that time I was the younger and very energetic and I probably, you know, took them through their first gall -- almost every resident for a long time did their first few gallbladders with me. So, I have trained a lot of

people and I have seen it done.

Q Doctor, can you tell us in terms of post graduate courses if you have taken advantage of those in some of the areas in which you have done that?

A Well, I have taken, you know, laparoscopy is one of my focuses of surgery and I have taken as new procedures became available we all learned to do them ideally in the lab when you are at a place in Mount Sinai and you have somebody doing the cases you have the luxury of going in and watching them and they can teach you. But, in order to get certified you at least have to demonstrate some hands-on skills and ability and so we took a lot of courses.

Laparoscopic colon courses and Hiatal hernia and hernia, laparoscopic bands for obesity so I think I have kept up relatively steadily during my years in practice.

Q And, Doctor, have you been asked to serve as an expert in court at trial before?

A Yes. I have been doing review of law cases for medical cases for about -- I think I did my first one in 1997 or '98. So, about ten or eleven years I review cases.

Q And approximately how many times do you think you have appeared in court like you are today?

A I think over that ten year period it's or eleven year period maybe ten or eleven, you know, times, you know, in court as opposed to 50 or 60.

Q And, Doctor, on each and every occasion you have come to court have you been in qualified as an expert in general surgery?

A Yes.

Q Doctor, have you -- if you would tell the jury and court have you ever before -- sorry. Have you ever testified at the request of my firm?

A I have not.

Q Have you ever in fact heard of my firm before hearing about Michelle Bradley?

A No.

Q And, Doctor, where would you be if not here today?

A I had patients in a hospital which I hope to see later, not too much later.

Q I will keep my mouth closed on that one.

What rate are you being paid in order for you to be here?

A $350 an hour.

Q And, Doctor, have you in fact lectured in the field of general surgery and if you can give us a general idea?

A I have lectured. I have given lectures. As I say it is not -- my teaching is basically confined to the surgical residents who came through our program, the medical students we see. So, we would give them, you know, lectures. Both, you know, sitting down and speaking to them for 45 minutes and then you are all teaching as you are making rounds and in the operating room.

Q Doctor, I want to now draw your attention to Michelle Bradley and before doing so I want to ask you to take a look at certain exhibits which I think we have here in front of the courtroom. They are numbers 43, 27, 28, 32, 30, and 31 and I will ask you with the Court's permission to kind of take a look at those at the witness stand?

MR. KOREK: Judge, can I approach? I can probably pull them.

COURT OFFICER: 28, 32, 30?

And 31.

MR. KOREK: Yeah, thank you.

Q Doctor, have you seen smaller versions of those before?

A I have.

Q And, with regard to these exhibits did there come a time when you also met with a medical

artist?

A Yes.

Q And did the medical artist sit down and speak with you and get your thoughts about what the illustration should look like?

A Yes. He asked me what it looked like and I told him, you know, what I thought it would look like schematically, yes.

Q And do you think each of these exhibits are a fair and accurate representation of the human anatomy and would they be helpful in assisting you to describe to the jury what it is you are here to talk about today?

A I think they are all, you know, they are all diagrams, obviously. It is not, you know -- it is not exactly the way it appears in a human being but for purpose of understanding what we are doing and what we are looking at I think they serve its purpose, yes.

Q And you agree they are fair and accurate representations in that sense?

A Yes, I do.

MR. KOREK: Your Honor, I would ask these be moved into evidence.

MR. KOPFF: I am not going to object, Judge.

THE COURT: Mark them in evidence.

(So marked.)

COURT OFFICER: Which one you want up first?

MR. KOREK: I will let the doctor choose. You can just leave them there. Thank you.

COURT OFFICER: All right.

MR. KOREK: May I proceed, Your Honor?

THE COURT: Yes.

Q So, Doctor, I am going to ask you a number of questions calling for opinions. I will ask you to give the opinions only if you can do so within a reasonable degree of medical probability?

A Okay.

Q For some reason you can't do that tell me and I will go onto another question.

Also I would like you when asked questions to talk about things perspectively rather than in hindsight. So, in other words use --

THE COURT: Counsel, just ask the question.

MR. KOREK: Yes, Judge.

Q Is that okay?

A Yes.

Q And, Doctor, can you tell us using the diagrams that have been marked as exhibits 43, 27, 28, 32, 30, 31 in any order that you like can you describe for us what is a laparoscopic cholecystectomy?

A Okay.

MR. KOREK: Your Honor, may I ask the doctor to step down in order to do that?

THE COURT: Yes.

A Just starting here this is the way the patient's lying on the table. The liver is in the right -- this is right -- and this is the patient's right, the head is up here, right side left side, up, down. The gallbladder -- the liver is here and gallbladder is here and these are -- you heard the term trocars. These are the instruments we put in.

We put one in the belly button, one usually right in the middle right under the sternum, the breast bone and then two out here. And that's how we expose the gallbladder when we get in and look at it.

What you are seeing here this is some of the intestine you see and this is the liver. When you get in and now you are looking at it this is what the gallbladder looks like. It sits underneath the liver and you use these instruments to lift it up and -- to look at the anatomy, okay. This is the stomach. This is what is called the duodenum or duodenum. This is the small intestine, the bile duct -- liver has bile ducts.

What happens is the liver makes bile, you probably heard yesterday, and bile goes from the liver into these bile ducts and then goes into the gallbladder where the bile is stored. When we eat the gallbladder gets a signal, hormones from our intestine, that we are eating and we need help digesting and gallbladder squeezes out the bladder and helps in digestion.

So, bile goes out here and into the cystic, what is called the cystic duct and it joins the bile duct. These -- this is the left hepatic duct and this is the right and they join to make the common hepatic. Then the cystic duct joins it and where it joins it it becomes a common bile duct and then the common bile duct goes and empties into the intestine into the duodenum. This is what is called the ampulla and you will see this will have a role in how we have -- how we are able to look at the bile duct if we need to.

What happens is when we want to take out the gallbladder --

Q If you could for the record tell us the sticker number on the left hand corner?

A This is number 27.

Q Exhibit 27, plate number 1. If you could

just for this board tell us the same thing. What is the exhibit number?

A Okay. This is number 28. And again here you see a magnified view.

Q Doctor, if you can go a little slower because some of the terms are new?

A Sure. This is a magnified view of what we are seeing. Here is the gallbladder that we saw. Here is the cystic duct. These are the two hepatic ducts coming down and this is where the cystic duct joins it, okay. There is a vessel or cystic artery that comes in and supplies blood. It's been shown to be transected here, cut, which we do when we remove the gallbladder. You have to remove the blood supply so it doesn't bleed. And here you just see it enlarged.

The cystic artery has been divided and clamped and this is the cystic duct.

Now, when we do a gallbladder what we want to do is take out the gallbladder and a portion of the cystic duct. You have to take out cystic duct otherwise it doesn't come out, it's attached to it. So what we would generally do is identify -- you have to know where the cystic duct meets the common bile duct and what you would do is you would put a clip here or two because that's remaining in place so you want to

make sure it doesn't leak. So, most of us use two clips. Some people even use three clips but you put clips here, one here and you cut between there and then the gallbladder is freed and the gallbladder is -- you are able to remove the gallbladder in that way.

I think we have a diagram. This is number 32 and here you see what has happened here is the cystic duct has been cut right over here again. Hepatic ducts. Common bile duct. The cystic duct has been cut here and cut here and now the gallbladder is taken out from underneath the liver. This arrow shows where the gallbladder was sitting. This was attached to that. So, we cut the cystic duct and then we take out the gallbladder that way and as I say the critical thing is to know that this is the cystic duct.

Q Doctor, you can leave that up and I have other questions. You can return to the stand, return to the stand with the Court's permission?

A Okay.

Q Doctor, I want you to assume Dr. Moon, John T Moon was asked these questions and gave these answers in the courtroom to this jury under oath:

"QUESTION: In more simple terms, Doctor --"

MR. KOPFF: Page?

MR. KOREK: Sorry, page 171.

Q

"QUESTION: In more simple terms, Doctor, aren't we both saying or wouldn't you agree that a surgeon should know what he cuts before he cuts it?

"ANSWER: I can't answer it that way.

"QUESTION: Doctor, is it your opinion that a surgeon doesn't have to know what he is cutting before he cuts it? Is that your opinion?

"ANSWER: I can't answer it that way either.

"QUESTION: Do you think it would be better practice for the surgeon to know what he is cutting before he cuts it?

"ANSWER: I can't answer it that way either.

"QUESTION: Doctor, do you consider misidentifying the common" -- sorry -- "the cystic duct for common bile duct to be a medical mistake?

"ANSWER: I can't answer it that way."

Then I want you to assume that we asked Dr. Du, I asked Dr. Du at page 361 following questions:

MR. KOPFF: I move to strike this.

MR. KOREK: Well, I have a question coming based on this hypothetical.

THE COURT: Well, ask the hypothetical, Counsel.

MR. KOREK: Sure.

Q I want you to assume, Doctor, that Dr. Du testified that he agreed that in fact the surgeon has to know what he is cutting before he cuts it.

Can you tell us whether you agree that a surgeon has to know what he is cutting before he cuts it or disagree?

A I would strongly agree. It's one of the hallmarks of surgery. We cut nothing until we know what it is. I mean that's a basic principal of surgery. It deals with lots of structures, anything you are dealing with. There are lots of blood vessels. There are pieces of intestine. We don't cut anything until we are sure what it is.

Q And, Doctor --

THE COURT: Strike the reading of Dr. Moon's testimony. You have an exception. Continue.

Q Doctor, I want you to a -- I want to ask you whether you agree with this statement which was given in testimony by Dr. Du and I will read you the statement and tell us if you agree with it?

MR. KOPFF: Page?

MR. KOREK: 363.

Q The question that was put to Dr. Du which I am asking if you agree with is this:

"QUESTION: Would you agree that if you cut

without first identifying the structure that you cut that that would be a departure from good and accepted practice?

"ANSWER: True."

Do you agree with that testimony of Dr. Du?

A Absolutely. That I think is as true a statement as you can have in surgery.

Q Doctor, do you have an opinion as to whether -- withdrawn.

I want you to assume that Doctor -- I want to ask you whether you agree with whether -- withdrawn.

I want to ask you whether you have an opinion as to whether this is a departure from good and accepted practice.

I will ask you to assume that Dr. Moon testified at page 167 that he misidentified the cystic duct for the common bile duct and that it was his testimony that the surgeon's responsibility that all of the anatomic structures be identified before they are transected and that Dr. Moon testified at page 169 that he agreed that a doctor should not under any circumstances transect any of the ducts until you know where you are anatomically before the transection takes place.

Do you agree with those statements, Doctor?

A I do.

Q And, Doctor, assuming that in fact Dr. Moon told us that he cut unintentionally the common bile duct when he meant to cut the cystic duct can you tell us whether you have an opinion as to whether that is a departure from good and accepted practice?

A I have an opinion on that. And I certainly believe that it was done unintentionally because nobody would do that intentionally obviously and it is a departure.

You know, you have to -- it is the hallmark of the operation. It is the critical point. You have to know which duct you are dealing with and which duct you are cutting and you can't proceed with the surgery until you've made that determination.

Q And, Doctor, do you have an opinion as to whether that departure was a cause of Ms. Bradley's injuries, namely the cutting of the common bile duct?

A I have an opinion and it was the reason for her injury.

Q I am going to come back to other questions concerning the surgery itself but before I do that I want to ask you to assume -- I want to ask you

questions with regard to Ms. Bradley leaving the hospital on the 8th.

I want you to assume that Nurse Luz Araneta testified that in 14 years as a nurse at Lutheran Medical Center she had never encountered a patient following laparoscopic cholecystectomy who had requested to be admitted to the hospital rather than go home because of post operative pain, all right. I want you to assume that's the testimony that the jury heard?

A Okay.

Q I want you to assume also that if we look at the hospital chart that on June 7, 2005, shortly following the surgery Ms. Bradley received morphine at 12:30 P.M., morphine again at 4:00 P.M., morphine again at 6:45 P.M., morphine again at 11:00 P.M. That she complained of pain and on Dr. Moon's order was admitted to the recovery room on the night of the 7th and stayed the 8th. That she was given morphine again at 2:30 A.M. She was given Toradol intravenous at 6:50 A.M. and had told the nurse that she is not ready to go home yet. That was Ms. Araneta. And in fact there was a note written by Dr. Moon for her to be admitted to the floor and there is a note showing that they were waiting for a bed, all right. Assuming that to be true?

A Okay.

Q Assume that at 7:55 A.M. her pain was reported to be two out of five and at 9:45 A.M. she was given one tab of Percocet. At 10:40 A.M. as this note called into admitting waiting for bed. At 11:40 it was reported that her pain was one out of five. That she was sitting upright in the recliner. That she feels better upright but feels pain in the shoulder when lying back and that she was out of bed to the bathroom and walking well.

Assume at 2:45 P.M. that her pain was two to three out of five and that at 2:55 P.M. she was given not one Percocet but now two Percocet tablets and that at 3:45 or four o'clock she was discharged from the hospital.

Do you have an opinion as to whether it was good and accepted practice for Ms. Bradley to be discharged from the hospital given the hypothetical facts I have asked you to assume?

MR. KOPFF: Can I have a sidebar, Judge, briefly?

THE COURT: Briefly.

(Discussion off the record.)

THE COURT: Repeat the question.

(Question read.)

MR. KOPFF: Objection to the form.

THE COURT: Overruled.

Q That means you can answer it?

A Okay. First, I don't think they were hypothetical facts but --

THE COURT: It's asked in a hypothetical form but you assume the facts as counsel gave to you to be true.

THE WITNESS: I understand. Sorry.

A Based on those facts I do have an opinion about the discharge and I think it was a deviation to send her home at that point.

Q Okay. And, Doctor, can you tell us was that a substantial factor in causing the delay in diagnosing her problem?

A I think it certainly contributed to a delay in diagnosing the problem. I think that this was a woman who showed a tremendous amount of pain disproportionate what you would have expected from somebody who had an uneventful gallbladder operation. I think Nurse Araneta correctly was correct in her assessment. You don't see people complaining of this type of pain after a gallbladder operation when there is not a problem.

People often stay or people will stay

after a gallbladder operation but it is usually for things like nausea, vomiting, they can't urinate. But, when you have pain like this I think it gives you pause to concern.

Here they were happy that the pain was getting better and it finally got better with a lot of medications. But, I think the unanswered question more importantly was why would somebody have this kind of pain requiring morphine? She was getting morphine at a time when 99 percent of the patients are home taking Tylenol or taking Tylenol 3 so --

Q Say that point again if you will. She was getting morphine at a time, 99 percent -- explain what you mean?

A I mean that she was requiring morphine at a time when most patients are home. Morphine is given, you know, intravenously or intramuscularly. Nobody goes home with morphine, and if you are requiring morphine at that point in the post operative period you have to at least think of why a patient would have that kind of pain and I don't think that was addressed.

The issue was yes, her pain got better and you would expect her pain to get better. She was given a lot of narcotics, a lot of pain

medication. But, I think the more important question was why she had the pain and nothing was ever done to consider that. They thought it was from her incisions.

Again, as the nurse stated who seen probably, you know, what she said in her 14-year career she is a recovery room nurse. She sees literally hundreds and thousands of patients. You know what the normal post operative incisional pain from a gallbladder is and it is not that significant. That's why people go home.

Q Doctor, in the high percentage of the patients that you treated what is your experience as to when patients go home after lap chole?

A They almost always go home the same day. You know, there are a few patients again who have unusual reaction to the anesthesia and who are nauseated. There are some people who -- older people who can't urinate so they require a catheter and they may stay in the hospital. There are some people it is done late in the day and you finish at nine o'clock at night so you are not going to send them home at 3:00 A.M. But again most 25-year old people who come in for an elective gallbladder do not require admission even overnight.

Q And while we are on it do you agree with Dr. Moon's first note which he wrote on the day of the surgery, the 7th, admitting her to the recovery room to stay overnight?

A Yeah, I think he felt the same way. This was not just pain, you know. This was not something -- this was unusual enough for him to consider admitting her to the hospital.

Q And do you agree with his note on the following day to admit her to the floor and note about waiting for a bed? Would you agree with that?

A I think that that again reflected his discomfort that this was not a typical, you know, course of a patient who had, you know -- he knows what he did in the operation. Sometimes we do an operation that there is a lot of blood loss, that there is a tremendous amount of inflammation. They can be more difficult and there the patients can be a little sore. But he knows what he did. This was a relatively straight forward, you know, uneventful gallbladder and he thought -- saw fit to admit her to the floor.

Q Doctor, I want to switch topics now for a moment.

At some point she goes to Lutheran Medical -- withdrawn.

I want you to assume that Michelle Bradley went home and was home until the night of the 12th. Went to Staten Island University Hospital and then on the 13th was admitted to Lutheran Medical Center and that on June 14th Dr. Moon saw her, Michelle Bradley, at Lutheran Medical Center and at 9:30 in the morning asked for an ERCP to be done and asked that it be done ASAP, as soon as possible. And that he considered the patient an urgent situation.

In fact the ERCP was done at 9:30 P.M.

Can you tell us, first of all, what your understanding of the ERCP is and why it was necessary and I think on this we have a diagram which again with the Court's permission I will ask you to use if it will be helpful. It's Exhibit 43. You can come down?

A This was the test that they asked -- that he asked to be done urgently that morning. ERCP, Endoscopic Retrograde Cholangiopancreatography. Fancy way in saying putting a scope down and you are looking at the -- cholangiole is the bile duct. Pancreatography is the pancreatic duct which is over here.

So, just to give you some background

when he asked for this test she had had a test done in Staten Island where they did what is called the HIDA scan. They gave her a medication in her veins which is absorbed by the body. Then goes to the liver and then the liver puts it out into the bile duct.

On that test it showed that that material was leaking out of the bile ducts. And, on that basis they knew she had some injury to her bile duct and on that basis she was transferred back to Lutheran because that's where the doctors took care of her and that was a reasonable thing to do.

And the next step to do is to try and further diagnose it because you don't know where in the bile duct that is leaking from and the ERCP may give you a chance to even treat the injury or the leak.

So, what it is is a scope is put down. It is done under anesthesia. You swallow a scope. If any of you ever had a scope in your stomach. Same thing. But it goes a little further. The scope goes all the way down to the stomach, into the duodenum and you can see the opening where the bile duct enters and then they can put a little wire and then inject dye so what you -- you can visualize this bile duct. You are injecting dye through this catheter here all the way around and it lights up. You can see on an x-ray

very clear picture of the bile duct.

And what they saw was that this bile duct was cut and nothing went beyond that. There was a little trickle beyond that thing but it was an abrupt cut off here. What you normally should see, okay, if you do an ERCP catheter should come up here. This duct should fill. You should see the cystic duct which was cut. You should see both hepatic ducts so you will get a very good view of the anatomy.

So, in this case there was a cut off right here. It went up a small way and then no dye went beyond that so that tells you that you have an injury to the bile duct. And as I say that's why she was transferred.

Now, the reason you want to do this urgently and the reason Dr. Moon wanted to do it immediately as he should is because you have -- the only thing you know thus far is you are draining bile into the abdominal cavity and what happens is if for instance there may be a situation if there was a little hole in the duct or if this for instance -- you can have a situation that the clips can come off the cystic duct. So, that could be leaking bile. So, what you want to do is you want to be able to -- the ERCP will tell you that and then you may be able to put what is

called the stent in there and that's all the patient needs if it is that type of injury.

Ms. Bradley did not have the type of injury that could be treated by ERCP and that was -- that's why the delay in this case was doubly bad because not only couldn't it be treated but it continues to drain and nothing is being done about it.

Q All right. Doctor, if you would resume the stand.

Urgent patient -- Dr. Moon testifies that he wanted the ERCP done ASAP and it's ordered at 9:30 A.M. ASAP standing for As Soon As Possible, right?

A Right.

Q How long does it take to do an ERCP if it is ordered at 9:30 in the morning?

A Well, I think it is reasonable to allow a couple of hours, two hours, three hours. I mean I am going to give -- you know, the endoscopist who does this may or may not be doing something else. He may be in his office. He may not be available. But, again, in general, you know, assuming that you need a room for this and you need a doctor to do it I think two hours, or three hours is not an unreasonable amount of time.

You know, I wouldn't quibble over an hour or two but 12 hours I believe is unreasonable.

Q And then I want to ask you whether you think it was a departure from good and accepted practice for Ms. Bradley not to have been drained by Dr. Tack and before I ask you to do that I want you to assume the following facts that we received from the testimony to be true.

That Dr. Moon testified that Ms. Bradley was draining -- sorry, that Dr. Moon testified that the draining bile would be helpful to diminish or reduce pain. That he thought it was important, page 250, to have Dr. Tack perform a procedure on Michelle Bradley to draw some of the bile. -- to drain some of the bile.

That a consent form was signed by Michelle Bradley on June 15th to drain the bile.

That Dr. Moon specifically requested Dr. Tack who in his words at page 252 of the trial testimony he said was not an outside person but rather, quote, he was with Lutheran Medical Center. To do the procedure on -- to do the procedure to drain Michelle Bradley on June 15th. And Dr. Moon gave this testimony:

"QUESTION: In fact you had given specific

requisition to do the drain drainage, true?

"ANSWER: Yes.

"QUESTION: And in fact we agree that you were upset about it when you learned he didn't do it, true?

"ANSWER: Yes.

"QUESTION: So in October of 2007 when asked the question as to whether Dr. Tack's failure or refusal to do this drainage procedure was a departure from good and accepted practice there you answered not only that you were upset about it but it was a departure, true?

"ANSWER: Yes."

I want you to assume he gave those answers to those questions.

Do you agree with Dr. Moon in his October, 2007 testimony that it was departure for Dr. Tact not to follow the instructions from Dr. Moon to drain Ms. Bradley.

A I do.

MR. KOPFF: Objection.

THE COURT, well sustained as to form. Just ask the question.

MR. KOREK: All right.

Q Dr. Drew, do you have an opinion as to whether it was departure for Dr. Tact not to have drained Ms. Bradley as he was requested to do so by Dr.

Moon?

A I do have an opinion on that and my opinion --

Q What is the opinion?

A It is a significant departure. I mean Dr. Moon correctly, you know, as a surgeon who deals with this knew that one of the most important things would be to drain the bile. You have a situation that they have now proven because they have looked at the bile duct from the ERCP and from the HIDA scan so you have an open duct which is now draining bile into the patient's abdominal cavity.

Number one, it causes pain. But much more importantly it causes peritonitis. It causes inflammation. It causes an infection and the first thing you do when you have an injury like this is to drain it. I think when I was looking at the record one of the interesting things is when you read Dr. Roayaie's op note, okay, in the operative note himself he described that he is operating on a patient for a common duct injury and his next statement was she wasn't drained. It really flies in the face of what most people would do. If you can drain this, okay, it buys you time and at least you have a way for that bile to get out and the implications or the consequences of

that bile are minimized.

There are many times -- not many times but you can have an injury like this that you may recognize in the operating room and you may not feel comfortable operating on it yourself. What you would do is you would put in a drain so you have a way for that bile to get out. It goes from inside into a bag outside and that buys you time until you can get somebody who can deal with this effectively. But, if you don't drain it you are creating a situation where the patient is going to get sicker and sicker and it's going to make the subsequent operations much more difficult.

Q Doctor, knowing that she was operated on on the 17th do you have an opinion as to whether that departure caused additional pain to Ms. Bradley from the time it was ordered on the 15th and for the days that it wasn't done until the 17th?

A Yes --

MR. KOPFF: Objection.

THE COURT: What is the objection?

MR. KOPFF: To the form, Judge. Based on the time frame that he has given.

THE COURT: Come up.

(Discussion off the record).

THE COURT: Doctor, do you need the question repeated?

THE WITNESS: No.

THE COURT: You may answer the question.

A I think that the period of time between the failure to drain it and the time she ultimately underwent surgery to correct this certainly subjected her to a period of increased pain. Absolutely.

Q Doctor, did you agree with the decision to transfer Michelle Bradley from Lutheran Medical Center to tertiary care center like Mount Sinai?

A Yes.

Q And do you have any opinion as to when that should have been done?

A I think it should have been done, you know, as soon as you have this injury documented and I would say as soon as the ERCP was done you knew what the problem was that it was a transection of the bile duct and if you weren't -- if you felt yourself unable or not, you know, if you thought there were better people to do it that was the time to do it. You know, clearly I think the idea of transferring her to a place like Mount Sinai it was a good decision.

MR. KOREK: Your Honor, may I have use of exhibits 13 and 16 which have been previously marked or

--

Q Doctor, have you seen or are you familiar with Exhibit 13?

A Yes.

Q I want you to assume this is what Dr. Moon told us that he intended to make the cuts and he actually put a number for -- sorry, this is where he attempted to put the clip and make the cut. One, two and three represent the three clip that he intended to put on and where it says the word cut with a black line is where he intended to make the cut, all right?

A Yes.

Q I want you to also assume that he told us that he was aware in looking at Exhibit 16 that in fact the bile -- common bile duct was cut at the proximal portion and at the distal portion and that is reflected on Exhibit 16.

Have you seen that as well?

A I have.

Q Now, Doctor, can you tell us what the significance is of these diagrams as well as the testimony of Dr. Moon wherein he indicated that he should have only been making one cut?

A Can I come up?

Q Please with the Court's permission?

THE COURT: Yes.

Q And any of the diagrams that you think may help you illustrate the point please feel free to use them?

A Well, I think that the diagram already speaks for themselves and I think he, you know -- here this is -- here he outlined this is what we usually do. As I say you put the two clips on. Some people even use three. You make one cut and then when you cut this the gallbladder is now free. It's not attached any more to the bile ducts, okay. And then you start taking out the gallbladder from the liver bed.

We can assume that the artery was already cut, you know, beforehand. So, that is the way you do it.

What should have alerted him that there was a problem is that, you know, this is where he put the clip. He thought this -- you know, he thought -- sorry. Number one on his -- this is number one okay and number two. And number three is over here, okay. So, he misidentified it.

But, the thing that I think should have alerted him to a problem is that if you put a clip here and you put a clip here and you cut between them like you normally do you are not going to be able to

take the gallbladder out because it is still attached here. If you pull this up the clip is still on so the gallbladder won't come up. It's still attached. So, what you have to do -- what he had to do to do this injury he had to cut here and then he had to make a cut here and that's how you get that, you know, T shaped area that he was describing.

So, when you make two cuttings on a bile duct in this operation it gives you pause to concern, something that is not right and the only way he could have done this was to have made a second cut on the -- because this is what basically was, you know, in a schematic thing. It is more longer, but he had to cut here and he had to cut here. So -- and that's how you end up with a piece of the common bile duct missing.

So, that normally as I say it is very important to remember normally you clip, clip, cut and that's the last cut you make on a bile duct. So, to make a second cut on a bile duct should tell you that something is wrong.

Q When looking at the T section in Exhibit 30 right behind there was Exhibit 32, behind you?

A Okay.

Q I think it is 32?

A This is 31.

Q If you can go to 32?

A 32 is here.

Q So, if you could show the jurors what it should look like when the gallbladder comes out and what it did look like when this one came out?

A This is what we said it is suppose to look like. Clip, clip, cut, and then this comes out, okay. Over here. Here is what he ended up with. Clip, cut, clip, cut, and then take that out. And that -- so now you have this piece missing. As I say this is good to review. The ERCP showed the bile -- showed the dye coming up to here and then stopping. So, you knew that it is not in continuity. It is not any more attached to this part of the bile duct. So, that's when you knew you had a major problem on your hands because the bile doesn't go.

See, you can have done an ERCP for instance and the dye could have gone all the way up and then it could have been leaking out here. That's a much different thing to deal with. That's why you do an ERCP so the HIDA scan which tells you that stuff is dripping out is important. But the ERCP allows you to see the anatomy so that you can deal with it.

So that as I said the fact that he had to make two cuts to get this out is what should have alerted him to the fact that this was not business as usual.

Q And, in fact on that very point when you say it should have alerted him that it wasn't business as usual when should it have alerted him?

A In the operating room. As soon as -- when you cut -- when you make your first cut and now you are saying okay, now I am going to take the gallbladder out but the bile duct is not coming up because it is still attached to something that is what has to make you consider, you know, what -- I am not where I think I am. And I have to do something to sort of look. Let me look again.

Q While we are at it something that you have to do if you know you are having a problem intraoperatively, can you tell us what an intraoperative cholangiogram is and what is the significance?

A You know sometimes the surgeon is not sure, okay. And that's nothing that is not -- that is not an embarrassment. We always say it is better to be safe than sorry and you know we have given you diagrams where they are colored. I can tell you from

doing surgery there are no color codes in the human body so this looks fairly easy but it can be difficult and we find situations where we are just not sure.

So, what you can do is if you think you are dissecting it and you are starting the operation or even no matter where you are when you cut what you can do is okay, you know what, I think this is the cystic duct. I am going to put a little needle in. You can do that through the skin. I am going to put a little needle in and inject dye through that and I am going do an x-ray right in the operating room and then it shows all the bile ducts and you can tell where you are.

For instance, if you put it in here you need to see the liver. If by chance you are here and you put it in you will see that everything will go down, nothing will go up. So, that is -- that's one way we can decide to, you know, if we are not sure and as I say there is no shame in not being sure. These are -- these are difficult.

Q Doctor, do you have an opinion in this case as to whether the failure on the part of Dr. Moon to do intraoperative cholangiogram is departure from good and accepted practice?

A I think, you know, he felt he knew where

he was. I mean, you know, I have to sort of be -- at least think to yourself that maybe something is not right in order to do the cholangiogram. If you are going along and in your own mind everything is perfect you may not do a cholangiogram. Obviously things were not correct here and as I say that's only one issue. But again that second cut and the idea that you had to make another cut that has to register that, you know, what -- I am not where I am and let me do something to show where I am before I leave the operating room.

Q Well, Doctor, tell us if you agree with this statement of Dr. Moon on the subject of intraoperative cholangiogram. He was asked:

"QUESTION: Wouldn't you agree, Doctor, that if a surgeon had difficulty identifying the anatomic structures in 2005 that it would be a departure from good and accepted practice if the surgeon didn't do an intraoperative cholangiogram?

"ANSWER: No."

Do you agree with that statement?

A I don't. If you are having difficulty, it's one of the ways and it is -- you know, you have -- haven't yet crossed over the line where you have to -- because the next step if you are not sure is you have no choice but to open. So, the cholangiogram gives

you a way of non-invasively or without making a cut to figure out where you are. So, it is an easy thing to do and it should be used under those circumstances.

Q Doctor, what about converting to an open procedure? The jurors have heard a little bit about an open procedure. Can you tell us what is the significance of that?

A You know, every once in a while it will be a part of every consent where we -- every consent that we do laparoscopically we always ask for permission to convert it into an open procedure, the old fashion way because there are times when it is just too difficult. The gallbladder is too inflamed. You may have had previous surgery. There is bleeding. But there are occasional times where it just can't be done laparoscopically and you open it. And again there is no crime in that.

You know, the patient knows it is going to happen and again you know you are honest. We don't expect to happen. It is probably less than one or two percent but even in this case you always get consent for that because it is always a possibility and that's whether you are doing laparoscopic appendectomy or laparoscopic colon or laparoscopic hernia. You always have to have the ability to convert if you can't

do it.

Q And, Doctor, given what you told us about he should have know something --

THE COURT: Let the doctor resume his seat, please?

THE WITNESS: Sure, sorry.

Q Doctor, knowing what you told us about the fact that he should have known when he made the second cut that something was wrong can you tell us whether you have an opinion as to whether it was a departure from good and accepted practice for Dr. Moon not to have converted to an open procedure?

A I think that yes, I mean it is sort of a difficult question because he didn't know he did anything wrong. But, in my opinion when you made that second cut it had to -- should have raised, you know, a red flag to you that it is not the normal thing because there is no reason to make a second cut on a bile duct. And, you certainly know you are cutting across a bile duct because you can see it.

So, I think that that is one of my major criticisms that the injury occurred but it wasn't like there wasn't some signs here. Occasionally this injury occurs when everything is stuck together, you know, the gallbladder may be inflamed. We have drawn

a picture like that. Sometimes a gallbladder is sitting against the bile duct and it can be brutally difficult.

So, there are occasions where you injure a duct and you suspect it, you know. But, again, injuring the duct is one thing. You have to recognize it. That in my opinion that is what the deviation is. You cannot leave the operating room without recognizing it.

Q Doctor, do you have an opinion -- I want to talk to you for a moment about -- well, sorry. Is there any shame in converting to an open procedure?

A No, I think that, you know, it is one of the -- you know, early in the laparoscopic, you know, experience, people were reluctant to open because nobody wanted to get a reputation that they couldn't do it laparoscopically and we know from the surgical literature that most of the injuries we saw more bile duct injuries in the first two or three years of laparoscopic gallbladders than the surgeons had seen for 20 years before that and it was a function of people learning how to do the procedure and getting comfortable with the fact that it's not always possible to do.

So, there is no shame in it and as I

say I think the more experience people have and the more confident they are in their abilities the less reluctant they are to open because, you know, if you can't do it you can't do it.

You know, people, we have been taking out gallbladders for, you know, a hundred years and, you know, yes, you have a little bit bigger scar but you are alive and well and it is not that big a deal.

Q And the scar you are talking about is a four to six inch scar?

A Yes.

Q Doctor, what is a learning curve?

A A learning curve is the amount of cases that it's thought that a surgeon should do before they are truly proficient at the case. It is something that surgeons who do the case will, you know, have come -- the pioneers in the field if you will, you know, have done a bunch of cases and they will tell you that, you know, after I did 50 that is when I really understood what I was really looking at and seeing.

There are some cases for instance in bariatric surgery that the learning curve is thought to be 75 to a hundred cases. I elected not to do those cases because I, you know, what I think that is too long a learning curve. I will send those cases to

somebody else. I don't think it is fair for me to subject my patients to be the first 75 if it is going to be that many and that long.

But in gallbladders the learning curve is the amount of cases until you -- it is felt that you are proficient at it. It doesn't mean you can't have problems after that but that is what the learning curve means.

MR. KOREK: Your Honor, may we approach for a moment?

THE COURT: Yes.

(Discussion off the record).

THE COURT: Doctor, we are going to take a ten minute recess. Will you step down, please.

(Witness excused.)

THE COURT: Members of the jury, remember my admonition not to discuss the case with anyone. Take the jury out, please.

COURT OFFICER: All rise. Jury exiting.

(Whereupon the Jury exits the courtroom.)

(Recess had.)

COURT OFFICER: All rise. Jury entering.

(Whereupon the Jury enters the courtroom.)

COURT CLERK: Please be seated.

Counsels, waive reading of the roll?

MR. KOREK: Yes.

MR. KOPFF: Yes.

MS. MOY: Yes.

COURT CLERK: Doctor, you are still under oath.

Q Doctor, we left off talking about the learning curve. You explained a little bit about what it is. I want to ask you to assume that Dr. Moon testified at page 190:

"QUESTION: Doctor, would you agree that there is a learning curve involved in learning how to do these type of procedures?

"ANSWER: Yes.

"QUESTION: Would you agree that the results of laparoscopic cholecystectomy are greatly influenced by the skill and experience of the surgeon performing the procedure and reflects a steep learning curve? Would you agree with that?

"ANSWER: Yes?

Do you agree with those statements?

A I do.

Q I want you to assume that Dr. Moon further testified at page 193:

"QUESTION: Would you agree it is one of the most important variables?

"ANSWER: Yes.

"QUESTION: Would you agree that the physician's own learning curve, physicians own lettering curve is not a valid justification for the patient's injury?

"ANSWER: Yes."

Would you agree with that as well?

A Yes.

MR. KOPFF: Objection.

Q Doctor, can you --

THE COURT: Objection?

Sustained.

Q Doctor, would you --

THE COURT: Disregard that.

Q Do you think that the physician's learning curve should be a valid justification for the patient's injury?

MR. KOPFF: Objection.

THE COURT: Well, sustained as to form.

Q Doctor, do you have an opinion as to whether the physician's learning curve should be a justification for the patient's injury?

MR. KOPFF: Objection.

THE COURT: Well, sustained as to form.

MR. KOREK: I am just trying to figure out what I am doing wrong, Judge.

Q Do you have an opinion within a reasonable degree of medical probability as to whether a physician's learning curve should be a justification for the patient's injury?

MR. KOPFF: Objection.

THE COURT: Well, sustained as to form.

MR. KOREK: Your Honor, may we approach so I can get some help on it.

(Discussion off the record).

THE COURT: Next question.

Q Doctor, I want you to assume that Dr. Moon told us that he made an effort to identify the cystic duct, that he attempted to trace it from where the gallbladder itself began and that he himself thought that he was in the right place.

Knowing that to be what Dr. Moon testified to can you tell us do you have an opinion as to whether that is a satisfactory explanation? I didn't know, I thought I was in the right place?

A I have an opinion on that.

MR. KOPFF: Objection.

THE COURT: What is the objection?

MR. KOPFF: I think he is just going in the same direction that we just discussed.

THE COURT: No, I'll allow it.

Q If you can, Doctor?

A I think that just thinking that you are in the right place is not enough. I mean there are ways to know it more reasonably, more definitely and you have to know it more definitely and just because you think you are there in this case, you know, several, you know, surgical principals were violated and you can't -- I don't think he knew where he was. As I say I don't find that as justifiable defense to say well, I thought it was there. I mean, you know, if I go out and drive a car and I run a red light --

MR. KOPFF: Objection. Move to strike.

THE COURT: I will stop you there. Jury disregard that comment. The rest of the answer will stand.

Q Doctor, I want to actually be more specific. On exhibit -- sorry, 23 I had Dr. Moon agree with me before I wrote anything on this that in fact he agreed that he was not aware of these problems and that he had no problems with some other issues. I want to read to you what it is that he testified to?

THE COURT: Can you see that?

THE WITNESS: Yes.

Q Page 196 of the trial testimony. He said he was not aware of one structure adhering to another.

That he said he had no problems with the equipment. That he said he had no problems with excessive bleeding. He said he had no problems with acute inflammation. He said he had no problems with previous scarring. He said he had no variations in the cystic hepatic duct. In other words she wasn't born with anything that looked any different than the rest of us, and that he didn't incidentally contact an organ by using an instrument.

Assuming those things to be true, Dr. Moon didn't have any problem with that, can you tell us what the significance is of the fact that he himself told us that he had no problems with any of those items?

A Well, I think that removes every potential reason why you would -- you would mistake the two structures and with those not in existence this is just, you know, an error of not recognizing the -- recognizing normal anatomy and I think that that is why I am here. That's a deviation in my opinion.

Q Deviation from good and accepted practice?

A Yes.

MR. KOREK: I have no other questions at this time. Thank you, Judge.

THE COURT: Counsel, do you wish to examine

this witness?

MR. KOPFF: Yes, with the Court's permission, please.

THE COURT: Yes, one moment. Attorneys approach one moment, please.

(Discussion off the record).

THE COURT: You may inquire.

MR. KOREK: Just by way of housekeeping I want to offer into evidence Exhibit 23. It is currently marked for I D. I know we had a discussion about it.

MR. KOPFF: Objection.

THE COURT: Objection is withdrawn, isn't it?

MR. KOPFF: Well, yes, Judge. We resolved it.

THE COURT: Okay, it's withdrawn. We resolved it previously.

CROSS-EXAMINATION

BY MR. KOPFF:

Q Good afternoon, sir?

A Good afternoon.

Q My name is Peter Kopff and I represent Dr. John Moon and the Lutheran Medical Center?

A Okay.

Q I am going to ask you a few questions. Let's start with your first departure. Let's assume that -- can --

MR. KOPFF: Can I have Exhibit 31 put up, please.

COURT OFFICER: No problem.

MR. KOPFF: Thank you.

Q Let's assume that hypothetically that Dr. Moon made the two cuts you described and at that point realizes I have a problem here. And, he says I am not equipped to handle this and he refers the patient to the same group at Mount Sinai but with more speed.

So, it is going to take a day let's say or day or two and the patient then would have had the same Roux En Y procedure that she would have underwent?

A She would have had the Roux En Y, yes.

Q And she would have had the same scars that she has today, correct?

MR. KOREK: Objection. I am not sure what the question is.

Q Well, all right, the procedure she would have had would have involved the same procedure she underwent which would involve essentially the same scars, true?

MR. KOREK: Judge, forgive me. It started off with a departure and then it went to a different question. So, I am trying to understand what the

question is. That's what my objection is. Is it withdrawn or --

THE COURT: Do you understand -- do you understand the question, Doctor?

A Ask me again. Sorry.

Q Okay. You and counsel had plenty of time to talk and go over what you were going to say, true?

A Before today?

Q Yes?

A Yes.

Q And now it is more spontaneous. You have to answer my questions. You don't know what questions I am going to ask?

A I don't think I do.

Q If you have a problem paying attention let me know or whatever and I will slow down?

A Okay.

Q Assume that my client, Dr. Moon, after he's made the two cuts that are mentioned and he has this T shape configuration attached to the gallbladder that he says oops, that would have been good if he could have noticed it at that time, true?

A Well, I think the departure is cutting it. Doing that injury is a departure.

Q Okay, you gave us a number of departures,

true?

A Yes.

Q And one of them you said when he has made this type of cut he should notice that, didn't you say -- and I am paraphrasing it. I am asking if he had noticed it at that time that then the patient still -- would have been accepted practice to refer the patient to a major center such as they did, correct? Can -- I know you are shaking your head. Can you give me a yes or no on that?

A It is not yes or no because my answer to you is you make the first cut, okay.

Q No, no, that's not my question. I am asking you to assume, Doctor --

A You want me to assume that he made both cuts?

Q Yes, I said that?

A Yes.

Q That he made two cuts.

MR. KOPFF: Can I approach, Judge.

Q I put the exhibit up here. It is not hard to see. He has the T shape cut. You know where we are?

A Of course I do. What I am telling you is my criticism is that you don't make the second cut.

Q That's not my question, Doctor?

A That's what you are asking me.

Q No, no?

A Go again.

THE COURT: Doctor, listen to the questions of counsel and assume the facts as he states them to you and if you don't understand the question just say so and I will have him rephrase it.

Q Did you hear my question, sir?

THE COURT: Just ask the question.

A Yes.

Q I assume once Dr. Moon realizes oh, I have this T shape configuration, if at that time he diagnosis it that would have been an earlier diagnosis, true?

A True.

Q And, it would have been acceptable then to refer the patient to Mount Sinai Medical Center as he did, correct?

A Correct.

Q You have no problem -- first of all you have no problem that this surgery was done, that the lap chole surgery was done, correct?

A Correct.

Q And you don't dispute that the patient

needed it, true?

A I do not dispute that, correct.

Q And the record shows that the patient was in five out of five pain before the surgery, true?

A True.

Q That's the highest pain you can get, true?

A True.

Q And for a moment to talk about Michelle Bradley's pain are you familiar with her sensitivity to pain having studied this case as you have?

A I have.

Q She -- when she had procedures that are routinely done under local anesthetic she has had general anesthetic, correct, time and again under every single one?

A You are talking about the Mount Sinai procedures?

Q Yes, sir?

A Yes.

Q She had numerous radiographic procedures and each time the average patient would have had them by local anesthesia and she required in the judgment of her physicians and her own desires general anesthesia, true?

A True.

Q Doesn't that tell us that she has a low tolerance for pain?

A It does.

Q Now, you said that it was a departure for someone. You didn't say who. It was a departure to discharge the patient, correct?

A Correct.

Q Because of her pain?

A Yes.

Q Because of her pain?

A Yes.

Q Now, are you aware that if you cut the bile duct that there is a period of time before the onset of pain from that? Can you agree yes or no? You are shaking your head?

A I am not agreeing with that.

Q Are you aware that Michelle has --

THE COURT: Well, wait a minute. The answer is no?

THE WITNESS: I don't agree with that.

Q Are you aware that Michelle has testified when her pain increased, sir? Have you studied --

A I don't recall that, no.

Q You are here. You have given an opinion today and --

A Yes.

Q And at the time you addressed the salient facts to this jury of this case you are not aware that Michelle ever had a time when her pain increased from when she left the hospital --

THE COURT: Ms. Bradley.

Q Sorry. Ms. Bradley that there was a time when her pain increased after she went home until she came back to Staten Island University Hospital, yes or no?

A There is a time that's why she went to Staten Island.

Q Okay. So, she went to Staten Island University Hospital what day, sir?

A The 13th -- the 12th.

Q And, so that is about how many days after the procedure?

A Fourth post operative day.

Q So on the fourth post operative day her pain increased?

A Increased enough that she went to the hospital. I think she said she was having pain all along.

Q Well, let me ask you. You agree that a patient and physician are a team. They have to work

together to get the best care. Do you agree with that?

A I will agree with that, yes.

Q And patient also has some responsibility, you agree?

A I would agree with that.

Q And if a patient -- a patient has a duty to communicate with a physician, correct?

A Correct.

Q Now, if I tell you that Michelle Bradley testified at her deposition on May 31, 2007, at page 109 line 2 through 4:

"QUESTION: Let's start with midday on the 11th. What happened then?

"ANSWER: The pain started to get worse."

You are unaware before this that actually on the 11th around noon her pain started to get worse?

A No, I -- I am aware that it got worse the day prior to her appearance at Staten Island. That's when she thought it was worsening.

Q Now, you can have pain from having surgery, correct?

A You can have incisional pain if that's what you are asking me, you know. Yes.

Q Are you a pain management expert, sir?

A I am not.

Q She was cleared to be discharged by a pain management expert. Are you aware of that?

A She was cleared by anesthesiologist who saw her but I don't know that it was related to the pain management.

Q Well, she -- and -- you are aware when you said there was a departure and you didn't say by whom that she was cleared to be discharged by several physicians who you have no reason to doubt assessed her pain and analyzed that her pain was decreasing, correct? Yes or no?

A Her pain was not decreasing. Her pain decreased at certain times and then it was waxing and waning.

Q Sir, she was on morphine, was she not?

A Yes.

Q Then she went to Percocet, correct?

A One tablet, yes.

Q Which indicates a decrease in the pain, true? That's a less potent analgesic, Percocet, than morphine, yes or no?

A Her pain was -- her pain was two when she was getting that. Two to three I believe when she got the Percocet. It was three --

Q And then she was discharged on Tylenol, correct?

A Tylenol.

Q Wasn't she discharged on Tylenol?

A She was given Percocet.

Q So, the testimony of Michelle Bradley is that her pain increased on the 11th around noon and you have said that the fact that she made calls and went to Staten Island University Hospital was because of an increase in the pain, correct?

A Correct.

Q And you acknowledge that there is anesthesiologist who evaluated her and signed off on discharging her at page 113 of the record knowing that she was awake, alert, stable, stable overnight, stable for discharge, home with escort. That was anesthesiologist, correct?

A Yes.

Q And the physician who is most skilled and experienced in assessing someone's pain is anesthesiologist in terms of the normal range of physicians in a hospital, true?

A I think what I have said was that there is no question --

Q Can you answer my question?

A Anesthesiologist may or may not depending on what his or her experience is.

Q Anesthesiologist --

MR. KOREK: Objection. All I ask is that Mr. Kopff allow the doctor to finish his answer.

MR. KOPFF: Well, you know, Judge, I asked him to answer yes or no which he hasn't done yet.

THE COURT: One moment. Well, did you finish your answer?

A There is no yes or no to the question you asked me.

Q Will you be able to answer any of my questions yes or no?

A I may. We can agree -- I said before I agree 100 percent that her pain was under control. What I also said was nobody had done anything --

Q Sir, it is cross examination?

A You just asked me the question.

THE COURT: One moment. I am going to strike the comment.

MR. KOPFF: Move to strike, Judge.

THE COURT: I will strike the Doctor's statement. I am going to strike your -- whatever it was. I am striking it. Jury disregard it all.

Now, ask your question, Counsel. Wait for

your answer. If you have a motion to make then make it.

Q Doctor, how many times have you testified in court?

A About ten times.

Q Of those ten times how many times were for plaintiffs that were suing either doctors or hospitals?

A Ten.

Q A hundred percent for the plaintiff, correct?

A Yes, yes.

Q Now, in addition to those times in court you have appeared and testified in depositions in cases in many states, correct?

A Correct.

Q How many depositions have you testified in where you are paid as an expert for a plaintiff in a medical malpractice case?

A I have done probably 50 or 60.

Q And you've reviewed approximately a case a month?

A I have reviewed twice -- usually I review -- I am going to say I probably review four or five a month now. I haven't been doing that all along of which I find probably less than half where there is a deviation. So, the other half I have not found a

case against a physician.

Q I just ask you how many cases you reviewed. That would be four or five a month for how many years?

A Yes.

I would say for the last three years at that pace. Maybe one to two or three for four or five years. Before that, something like that.

Q So, at least on average 50 cases a year you have reviewed, correct?

A Now, for the last three years, yes.

Q And how many for like the nine years before that?

A Probably I would call it an average of two a month, over that period of time.

Q Now, let me go back and ask the question. If you can answer it yes or no it may expedite things?

A Okay.

THE COURT: Counsel, just ask your question.

Q Assuming that Dr. Moon called in, recognized once there was this T cut on Exhibit 31 plate 4 B, once that existed and he wanted to refer the patient to Mount Sinai or another institution the same surgery would have been done, correct?

A Once the T cut had been made, yes. I

just want -- okay.

Q And the same surgery is done the same scars are made. It's a big procedure, correct?

A Yes.

Q Now, Doctor, an injury to a common bile duct is a known complication of a laparoscopic cholecystectomy, yes? Can you answer that yes or no?

A I can and it is yes.

Q And, complications -- you have had complications yourself in your career, correct?

A I have.

Q And, complications can have a range of morbidities, correct?

A Yes.

Q And, are you -- would you agree, are you aware that Michelle Bradley today has no ongoing complaints or treatment other than being observed?

A I would agree with that, yes.

Q So for the past two years or more, almost two and a half years she has been healed in terms of she has no ongoing complaints referable to her situation, the surgery?

A Based on the record that I saw absolutely.

Q And there is a range of complications that a patient can have, true?

A Yes.

Q And one reason that you can have an injury to the common bile duct, if you can answer this yes or no, is because the way that the jury sees these plates in evidence that is not the way it looks at surgery, true? You are nodding, but --

A That's true.

Q In other words, the different color codes, it is fine for court that we have these visuals but it doesn't look that way to a surgeon. It is hard to do the surgery than is presented in the visual, correct?

A Yes.

Q Now, Doctor, if a doctor is going to testify to a deviation wouldn't he be on weak ground if he is testifying to a deviation about a physician that has different specialty and training and experience and judgment than himself? Would you agree?

MR. KOREK: Objection.

THE COURT: Sustained.

Q Well, you in saying that there was a departure in discharging Michelle Bradley on June 8th, you have said that that was because of the amount of her pain. That was one of the factors, correct? Yes or no?

A One of the factors.

Q And, in medicine physicians all the time have to make judgments and they must understand the physical condition, must be aware of the complaints of the patient, and then they have to make a judgment about treatment and not all physicians make the same judgment based on the same facts, correct?

A Correct.

Q And sometimes they can be what is called an error of judgment and that is not negligence. If two physicians look at the same situation and make different judgments that is not negligence, do you agree?

A Not necessarily but it can be.

Q Today you are telling the jury that with hindsight looking back as you sit here today you are saying that there was a departure in discharging Michelle and do you stick to that even though you now know that her pain increased not on the 8th, nor the 9th, nor the 10th, but not until the 11th, three days later, sir?

A Yes, I am saying that. Absolutely I am saying that.

Q And you are saying that even though the surgical team evaluated Michelle --

THE COURT: Ms. Bradley.

Q Ms. Bradley, and the anesthesia attending evaluated her, correct?

A Yes.

Q And you don't doubt the surgical team when they made a judgment made the best judgment that they could given their experience, training, and they wanted the best for Michelle Bradley at that time, would you agree?

A I think with the proviso given their training, yes.

Q Well, you have a team in a teaching hospital. You are not going to challenge the fact that medicine needs teaching hospitals and best hospitals are teaching hospitals, true?

A I would agree that teaching hospitals have a large role in medicine, yes.

Q And in terms of training physicians we need physicians trained in America, true?

A Training. That doesn't mean we allow them to make decisions unsupervised. Training.

Q Okay, so you have a surgical team. I just want to know if you are attacking the system?

A Not one bit am I attacking the system. I am a product of that system.

Q Very good, okay.

So in addition to having the surgical team which made a judgment and you don't question that it was a good faith judgment on their part, true? You are not saying there was any malevolent motive?

A No. There was absolutely --

Q There is a difference in judgment in your view and their view, true? Yes or no?

A I don't think that is a straight yes or no answer.

Q Very good.

In addition to the surgical team there was anesthesiologist who assessed the patient and you don't put any bad motive to that anesthesiologist in how he did his care -- how he did his evaluation, true?

A He is not evaluating the patient from a surgical point of view. I said --

Q No?

A We don't have to -- there is no question that her pain was getting better. The anesthesiologist is not the one to decide why is this woman having pain. That's my whole point. Does -- she got better with pain? Absolutely. They gave her very good choice of drugs. But nobody looked at why was she having the pain.

Q Well, Doctor, that is your assumption. The anesthesiologist actually --

THE COURT: Strike the comment. Just ask the question.

Q There are anesthesiologists at almost every surgery, aren't there?

A Yes.

Q Do you, I think you said, is it five hundred surgeries a year or fifty --

A Five hundred to six hundred.

Q And, do you do any of those without anesthesiologists?

A Every one of them is done with anesthesiologist.

Q And you have made judgments and discharged patients and had complications that you failed to recognize, true?

A Yes.

Q You have even had a patient dye, true, sir?

A Yes.

Q That is -- that's a very bad complication, true?

A Yes. Can't have much worse.

MR. KOREK: At the appropriate time can we

discuss one of the issues at the appropriate time. I don't need to interrupt now.

THE COURT: Counsel, just remind me when we take a break.

MR. KOREK: Thank you.

Q Now, Doctor, would you agree that if the family delays notifying the physician about the pain the physician cannot be responsible for that portion of the pain? Would you agree?

A I think I would agree with that.

Q So, if the jury were to find if there is a one day delay or two day delay in the family notifying Lutheran Medical Center or Dr. Moon that part of the patient's pain is not the -- is not delayed by the physician who hasn't been told yet, correct?

MR. KOREK: Objection, Your Honor.

THE COURT: Well, one moment. There is an objection. What is the objection?

MR. KOPFF: I will withdraw it.

Q Now, Doctor, are you aware that there was an issue according to Dr. Moon that they had an ambulance ready for the patient to go to Mount Sinai and the family wanted a physician in Brooklyn? Are you aware of that?

A I know that, yes.

Q I want -- I am going to ask you a hypothetical. Assuming that the family, that an ambulance is ready to have the patient go to Mount Sinai to Dr. Schwartz's practice which is the same practice that actually handled it through Dr. Roayaie, true?

A Yes.

Q And there was a delay of one or two days because the family wanted to research other physicians in Brooklyn. Then the defendants would not be responsible for that delay, correct, if the family elected to delay to look for a different physician? Would you agree?

A I don't necessarily agree with that.

THE COURT: I am going to stop you a moment. All right, Counsel, you can continue.

Q Sir, have you ever seen the file of materials that the family compiled on this case?

A I don't think I have.

Q Okay. Are you aware that there was a Dr. Dale Distant, D-I-S-T-A-N-T, who was discussed as an alternative to the physicians at Mount Sinai Medical Center?

A Distant?

Q Yes?

A Yes, I am aware of that.

Q Now, so, you've heard what is called a second opinion, have you not?

A Yes.

Q Have you ever been asked to do a second opinion?

A Yes.

Q Are there times when doctors don't agree that sometimes you have a different opinion than the first opinion?

A Well, yes, that can happen, yes.

Q Now, I am going to suggest that the family as of June 15th had communication by e-mail with Dr. Distant's office and there was an issue that the family rejected Dr. Moon's offer to send the patient to Mount Sinai and there was an ensuing delay of a day or two, and if as I am suggesting the family, and they have a right to check and pick out the physician they want. You agree with that, true?

A Well, I do up until a point. You know, it is up to the doctors taking care of the patient to tell them you know what, I think you can do it but I think we need to do it in an hour. We need to do it in a day. We can take two weeks. You know, so, it is not just the family wants it so okay. I think that

the treating physician has to tell you the patient how urgent that you should accomplish this.

Q You are raising another issue. You said before that you thought that the patient and a physician were a team in the treatment, correct? Yes or no?

A The patient is getting their medical information from the doctor. They are a team but they are not equal. They don't have equal knowledge.

Q The only medical information is not from the doctor. They communicated with Dr. Distant. They contacted another surgeon, sir. You are not aware of that?

A I am very aware of it. According to Dr. Du, Dr. Du's deposition he --

MR. KOPFF: Judge, please.

THE COURT: I will stop you a moment. What is the question?

Q Let me see if I can get a square -- Doctor, if the jury has to --

THE COURT: Just ask the question, Counsel.

Q If the family decided to investigate other possibilities they didn't want to travel to Mount Sinai, they live in Staten Island and some members in Brooklyn. If they elect to look for other options and

that decision on their part caused the delay that part of the delay would not be the responsibility of the defendants. It would be the responsibility of the family, yes or no?

A No.

Q Now, Doctor, when the patient was at Staten Island University Hospital the patient could have been drained at that site, true?

A Yes.

Q But was not drained at that site, true?

A Was not. They didn't complete the workup.

Q And, when the patient went to Mount Sinai Medical Center what day did the patient arrive there?

A Patient arrived at about eight o'clock on the -- I think 16th, 8:00 P.M. or 8:30 at night.

Q And patient could have been drained at that time, correct?

A Well, at that point --

Q Yes or no?

A Anything could be done but there is no sense in doing it when you are going to operate the next day.

Q So one day delay is no problem, true?

A 12 hours -- no, not when you are going to

do the surgery. The drainage is to get you to the point of surgery.

Q Okay. And would you agree that the decision as to when to drain we know your position on it. But --

THE COURT: Just ask the question. Strike that.

Q If there is an interventional radiologist that has to make this decision do you agree that that physician has different training and considerations than you as a surgeon, yes or no?

A It is not the decision of the interventional radiologist. The interventional radiologist is allowed to give his or her opinion that I can do it, I can't do it, it is not safe. But, he or she is not allowed to say I won't do it because the patient is leaving. That -- it was Dr. Moon who is the surgeon, his decision is to get the drainage and the interventionalist has every right to say I can't do it. It's too dangerous. The patient is too this or -- but to decide not to do it that's not the role of the interventionalist.

Q Sir, the patient that died --

MR. KOREK: Your Honor, may we approach?

THE COURT: Yes. Yes.

(Discussion off the record.)

THE COURT: There was an objection. Sustained. You have an exception, Counsel.

MR. KOPFF: Thank you, Judge.

THE COURT: You will be given an opportunity to amplify the record outside the presence of the jury.

MR. KOREK: Objection, Your Honor. I don't know if it is for my benefit or the jury's but I heard these remarks and I would appreciate it if you talk lower --

THE COURT: Well, approach because I have nothing to rule on. I didn't hear the comments.

MR. KOREK: Sure.

(Discussion off the record).

THE COURT: Anything else, Counsel?

MR. KOPFF: No. Thank you very much, Judge.

THE COURT: Any redirect?

MR. KOREK: Judge, Mr. Kopff read from page 109. I wanted to read the page before or pages before.

MR. KOPFF: Can I have a second to see.

MR. KOREK: Sure. I was going to read from 102.

MR. KOPFF: 102?

MR. KOREK: Yes.

MR. KOPFF: I object. If I read something out

of context, but that's not -- I object.

MR. KOREK: That's precisely why I want to read it.

THE COURT: I have to see what it is we are objecting to.

(Discussion off the record).

REDIRECT EXAMINATION

BY MR. KOREK:

Q Doctor, Mr. Kopff read from pages 109 line 2. I wanted to read some of the testimony that appears before that at page 101 continuing --

THE COURT: Counsel state what you are reading from.

MR. KOREK: Sure.

Q I am reading from the same deposition or examination before trial of Ms. Bradley. My question is were you aware of this testimony? This is what Ms. Bradley testified to again in her deposition of May 31, 2007. So this is at page 101:

"QUESTION: Let's talk about that evening. By the time evening time rolled around and evening time I mean six, seven, eight o'clock, what level of pain were you in by say seven o' clock in the evening?

"ANSWER: Still about a six.

"QUESTION: Again what was your ability to move

around?

"ANSWER: I couldn't move at all.

"QUESTION: So where were you staying at the time?

"ANSWER: I was on the couch the whole time on the couch, recliner.

"QUESTION: The whole time?

"ANSWER: Yes.

"QUESTION: What were you doing while you were anchored to that couch?

"ANSWER: Nothing. Just laying there.

"QUESTION: Were you able to watch TV at all?

"ANSWER: No, I couldn't even concentrate. I was in so much pain.

"QUESTION: Had they given you any pain medication upon your release from the hospital?

"ANSWER: I think they did. I don't remember what it was. I remember it was not working.

"QUESTION: Did you take it?

"ANSWER: Yes.

"QUESTION: When did you first take the pain medication that you had been given at the hospital?

"ANSWER: A few hours after I got home.

"QUESTION: What effect if any did taking that pain medication have on that pain you were experiencing?

"ANSWER: No effect.

"QUESTION: Let's go a little deeper into the evening. Now it's ten, eleven o'clock in the evening. Describe for me the level of pain you were in at ten, eleven o'clock in the evening?

"ANSWER: It was getting a little bit worse so maybe it was a little bit above six. Maybe a seven.

"QUESTION: Did you do anything about the pain that you were in?

"ANSWER: I kept taking the pain pills.

"QUESTION: Were they having any effect?

"ANSWER: No, none.

"QUESTION: So at this point in time at least by ten o'clock P.M. you had not contacted or did anyone on your behalf?

"ANSWER: No.

"QUESTION: That evening passes. Let's talk about that night. Were you able to sleep that night?

"ANSWER: On and off not for very long period of time.

"QUESTION: Again what was the level of pain throughout that evening?

"ANSWER: Same. About six, seven.

"QUESTION: Six, seven?

"ANSWER: Yes.

"QUESTION: Let's talk about the following morning, just arbitrarily. Let's say eight o'clock in the morning, okay?

"ANSWER: Okay.

"QUESTION: Describe the state of your health and pain level at eight o'clock in the morning?

"ANSWER: I was on and off in and out of sleep.

"QUESTION: This would be on the morning of the 9th, right?

"ANSWER: Yes.

"QUESTION: So June 9th at about eight o'clock A.M. what was your pain level?

"ANSWER: It was still the same.

"QUESTION: Six to seven?

"ANSWER: Yes.

"QUESTION: Were you able to walk at all?

"ANSWER: It was very hard. I needed help.

"QUESTION: When you say you needed help in what form did you need help?

"ANSWER: My mother had to help me sit up and she had to -- I had to hold her to walk to the bathroom.

"QUESTION: Were you able to wash yourself?

"ANSWER: Yes.

"QUESTION: Were you able to go to the bathroom on your own?

"ANSWER: Yes.

"QUESTION: Were you able to dress yourself by yourself?

"ANSWER: No. No, I couldn't bend totally so she had to help me put my pants on.

"QUESTION: A little, a little later in the day let's say midday, noon?

"ANSWER: Ah-ha.

"QUESTION: What was the state of your pain?

"ANSWER: The same, still six, seven.

"QUESTION: Still having the same difficulties you just described?

"ANSWER: Yes.

"QUESTION: Let's go to the evening. It's now the evening. Let's say again let's just pick an arbitrary 7:00 P.M. What was the state of your pain at 7:00 P.M.?

"ANSWER: The same.

"QUESTION: Pain level six to seven?

"ANSWER: Yes.

"QUESTION: What about physical difficulties and by that what I am going to say is, you know, walking, doing the things that one would normally associate with daily life, what were your difficulties?

"ANSWER: Everything. I couldn't get off the

couch. I couldn't walk around. I just didn't want to be moved. I was in so much pain. I didn't want to be moved off that couch.

"QUESTION: Were you taking your pain medications?

"ANSWER: Yes.

"QUESTION: At regular intervals?

"ANSWER: Yes.

"QUESTION: As prescribed?

"ANSWER: Yes.

"QUESTION: What was the effect if any they were having?

"ANSWER: Nothing.

"QUESTION: In other words no positive effect?

"ANSWER: No.

"QUESTION: It's now ten o'clock, eleven o'clock at night, bedtime, what state are you in?

"ANSWER: Exactly the same.

"QUESTION: Same thing?

"ANSWER: Exactly the same thing for the next day and a half.

"QUESTION: So, it's basically the exact same thing for day and a half. That brings us to the 11th, correct?

"ANSWER: Okay."

And what Mr. Kopff read.

"QUESTION: Let's start with midday on the 11th. What happened then?

"ANSWER: The pain started to get worse."

Thank you, Your Honor.

Do you recall having heard that testimony as well?

A I read it. I didn't recall it before but I do now.

MR. KOREK: Thank you. Nothing else.

RECROSS-EXAMINATION

BY MR. KOPFF:

Q Doctor, when the patient was discharged on June 8th the pain score was noted to be one at 4:00 P.M., correct?

A Yes.

Q So, that's on a five scale. One is low for pain, right?

A Yes.

Q And you are aware that the nurse called home in June --

MR. KOREK: Your Honor, I would object to that as beyond --

THE COURT: Wait a minute.

MR. KOREK: Beyond the scope.

MR. KOPFF: He just read from all this time period. He read that's what -- he went three days and read. That's what this testimony was. That's why I want to go into. It's exactly what he read.

THE COURT: Sustained.

MR. KOPFF: Judge, I read on the 11th. Then he read the three days before and now I just want to ask a question on --

THE COURT: Sustained. You have an exception.

MR. KOPFF: Okay.

THE COURT: Nothing else?

MR. KOPFF: Well --

THE COURT: I mean nothing else other than what I ruled on? Do you have another question?

MR. KOPFF: Well, I wanted to question about the nurse calling --

THE COURT: No, sustained. That's sustained.

MR. KOPFF: Can I question about the questions that were asked about pain by the nurse?

THE COURT: Come up.

(Discussion off the record).

THE COURT: Any other topic other than the topic we discussed at sidebar?

MR. KOPFF: No, Your Honor.

MR. KOREK: Nothing else, Judge.

THE COURT: Doctor, thank you. You are excused.

(Witness excused.)

THE COURT: Come back up, Counselors, to discuss scheduling.

(Discussion off the record).

THE COURT: It's lunch time. We are going to adjourn until 2:30. Remember my admonition not to discuss with anybody the case. Don't read or listen to any discussion about the case and don't try to look anything up in connection with the case. Anyone attempts to influence you, say anything to you about the case notify court personnel. Enjoy your lunch. 2:30.

(Whereupon the Jury exits the courtroom.)

(Luncheon recess had.)