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IN THE CIRCUIT COURT OF JEFFERSON COUNTY, ALABAMA
STATE OF GEORGIA

KELLY LEO and MARK LEO, Plaintiffs, vs. VISION FIRST EYE CENTER, INC. DR. MARK D. MCCLINTOCK; DR. MARK G. BEARMAN; VISION ALLIANCE OF MID-AMERICA, LLC; and JEFFREY M. FINE, et al Defendants.	)	Civil Action No.: 2005-5243

The deposition of JONATHAN M. WOOLFSON, M.D., taken on behalf of the Plaintiff; the reading and signing of the deposition being waived; taken before DionDre' Thomas, Registered Professional Reporter, commencing at 9:50 a.m. on this the 4th day of March, 2009 at 800 Mount Vernon Highway, Atlanta, Georgia.

C O N T E N T S

E X A M I N A T I O N

E X H I B I T S

(Original exhibit attached to original transcript.)

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APPEARANCES OF COUNSEL:

On Behalf of the Plaintiff:

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On Behalf of the Defendant:

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Also present: James Roberts

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P R O C E E D I N G S

JONATHAN WOOLFSON, M.D.,

having been first duly sworn, was examined and testified as follows:

(Exhibit 38 was marked for identification.)

CROSS-EXAMINATION

BY MR. BURNS:

Q. Doctor, I'll show you Exhibit 38 that is the Notice of Deposition that requires you to bring certain documents with you and I understand you had a miscommunication with your attorney and you don't have any documents?

A. Correct. I don't have anything outside of the record. The only document I have is the record and the deposition.

Q. You didn't make any notes or comments in your copies?

A. There are no notes, comments or summaries.

Q. Where is your copy of those documents?

A. I think I have got those at home. And I can get a copy of them to you. But all it is is a copy of the original medical records.

Q. How many doctors practice with you?

A. There are three other surgeons that work with us.

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Q. How many lasik procedures have you done?
A. I don't remember the exact number but it's in the range of 70,000.
Q. How many have you supervised?
A. Again, I don't know the exact number I have supervised but I have helped out many dozens of surgeries.
Q. If you can give me your best judgment. If you have done 70,000 I don't know if you supervised 10,000 or 50?
A. What do you mean supervising?
Q. When we got here this morning Debbie said you were supervising a surgeon doing a procedure?
A. I don't know the exact number but maybe several hundred maybe. I don't keep track of those numbers at all.
Q. Now, one of your partners is Dr. Andrew Shatz?
A. Correct.
Q. He is the director of referral ophthalmology.
What is referral ophthalmology?
A. In our practice we split the practice in refractive and non refractive. He is the director of what we call non refractive. Even though the

nomenclature is different in that he does a lot of intraocular lens work and that is refractive.

Essentially I do the lasering. I do most of the lasering and they some of the lasering. I do most of lasering. They do most of the non laser work. When I say laser I mean the excimer laser because there are other kinds of laser work that would include treatment for diabetes and those kind of thing.

Q. So the work you do is refractive?

A. Correct.

Q. How big is your referral ophthalmology department? How many people are in that?

A. What do you mean people?

Q. Well, Dr. Shatz is the director are there a number of people under him?

A. There are three surgeons in the referral ophthalmology division.

Q. There are now?

A. Yes.

Q. Would that be Dr. Shatz, Dr. Patel and Dr. Salmenson?

A. Correct.

Q. Anybody else?

A. They use some optometrist as well.

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Q. And is that Dr. Spetalnick?
A. He doesn't really work with him that much but Dr. Truong does a little work with him.
Q. Are those all of the doctors that practice with you?
A. Those are the doctors employed by us, yeah.
Q. All right. Are you the only shareholder of Woolfson Eye Institute?
A. Yes.
Q. What is the average patient volume per day?
A. I'm not sure I go into that because some days it maybe one or two patients and others it may be 30 patients for surgery. And the clinic same thing. It may be a very low volume or --
I'm not sure, are you talking referral ophthalmology or the laser side?
Q. I'm talking about the laser side.
A. The same thing we may see a few patients a day or a lot of patients in the clinic. The same is true for the surgery.
Q. Who else in the practice does excimer laser work other than you?
A. Dr. Patel and Dr. Shatz both do excimer laser work.
Q. What percentage of their work is excimer

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laser?
A. Dr. Shatz that's a very small percentage probably less than one percent of his work. Dr. Patel I don't know. I'm guessing but it's less than 10 percent of what he does.
Q. What percentage of your work is excimer laser?
A. Virtually all of it.
Q. Do you perform procedures, excimer laser procedures onsite?
A. Onsite?
Q. Yes.
A. Yes.
Q. Do you have your own laser machine, or do you use a rental machine?
A. We have our own machines.
Q. What machine do you have?
A. We have the Vixs.
Q. What model?
A. S4.
Q. Have you had any other kind of Vixs machines?
A. Sure.
Q. Which models?
A. All of them.

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Q. How long have you used the Vixs machine?
A. We started right after its introduction in 1996.
Q. Does the Vixs have a screen that is viewable to you as a surgeon so that you can review the prescription that was put in by a technician?
A. Yes.
Q. Has it always?
A. Yes.
Q. Have you or any of your doctors in your practice ever been sued?
A. Yes.
Q. Who has been sued?
A. I have.
Q. Anybody else?
A. Not that I know of.
Q. How many times have you been sued?
A. Four times.
Q. For what?
A. You know two of them are ongoing so I'm not sure how much I can talk about those. And one of them was a patient who claimed the laser had given her psychiatric problems. Another patient was -- I can't remember what the issue was but they were both dropped by the patients before deposition or anything

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were taken.
Q. Did any of the lawsuits that are currently pending or that were dropped did they involve you performing the wrong prescription on the patient?
A. No.
Q. Did they involve adverse side effects like starburst and halos and double vision or anything of that nature?
A. I think in the broad category that could be considered yes in that the patients were not happy with their vision.
Q. Is that with the pending cases too?
A. Yes.
Q. That would be true in all four of the cases?
A. Again, I think that the questions -- why don't you give it back to me again. When you ask are they unhappy with their vision that is why they sue, they are unhappy with their vision.
Q. In all four cases did the patients have starburst, halos, double vision, dry eye, flap complication?
A. Is that either or I'm not sure.
Q. Tell me what the problems were say in the two ongoing cases.
Do you know the name of that patient?

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MR. STOTT: Let me just caution him going on the record about an ongoing case without his attorney.

THE WITNESS: The ongoing cases I can't comment on.

MR. BURNS: They are public record.

MR. STOTT: If you know what the Plaintiff is claiming there damage to be I'm okay with you saying here is what they are claiming but as far as what your response is or what happened without your attorney is -- I can't advise you as your attorney on those cases but I can tell you if one of my clients were sitting in a deposition I would not want him to answer that.

THE WITNESS: The two pending cases are both from cases ten years ago. The issues were irregular healing and the Plaintiffs claims involved the fact that they thought they were not good candidates to begin with. That's on the record.

BY MR. BURNS:

Q. What are the names of the Plaintiffs in the two cases pending?

A. Holman and Carter.

Q. Do they live in Atlanta?

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A. No.
Q. Where are they from?
A. South Carolina.
Q. Both of them?
A. Yes.
Q. How long have those cases been pending?
A. Several years.
Q. The other two cases that were filed against you were they filed in Atlanta?
A. No.
Q. Where were they?
A. Tennessee.
Q. Both of them?
A. Yes.
Q. Tracing your practice since you graduated from medical school where have you practiced obviously Tennessee and South Carolina?
A. From medical school or the end of my eye training?
Q. The end of your eye training.
A. I first started working in Georgia. I was here for six months and then I went up to South Carolina. I started there in June of 1996.
Q. Where in South Carolina?
A. Greenville, South Carolina.

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Q. All right.
A. And I worked with a company called TLC. I worked with them in South Carolina and Georgia. Then I broke with TLC or we parted ways. I can't remember the exact dates somewhere around 2001 or 2002, and I opened up my own clinics in the region.
Q. When you say you opened up your own clinics in the region where are you talking about?
A. We have clinics in Georgia, Tennessee, South Carolina, North Carolina; and also I operate in Birmingham, Alabama.
Q. What brought you back to or what brought you to Atlanta?
A. There was some personal reasons and some professional reasons.
Q. What were the professional reasons?
A. We had a clinic here in Atlanta and most of my work is referral based so most of my patients come to me referred from other eye doctors, who either can't or don't want to do certain surgical cases.
Q. What were your personal reasons for coming to Atlanta?
A. I had friends here.
Q. You went to school at Emory?
A. Yeah. I had roots in Atlanta.

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Q. What is the lifetime assurance policy?
A. The lifetime assurance policy gives patients the ability to get additional laser treatment for the rest after their lives if it makes good medical sense and if they want it. And if they fall into certain parameters preoperatively. So it does not apply to all patients but it applies to most patients. The vast majority. I'm not sure of the exact percentage but well over 90 percent.
Q. What kind of enhancements do they receive?
A. They get additional excimer laser treatment to try to improve their vision and to try to make them happier. Again, only if we think it makes good medical sense and if they fall within certain parameters.
Q. And what are those parameters?
A. Generally we like a patient to be 20/40 or worse before we do it.
Q. I want to talk for a minute about your practice in Birmingham.
Do you know Dr. Bearman?
A. I do not know Dr. Bearman.
Q. Never met him?
A. Never met him. Never spoken to him.
Q. What is the name of your clinic in

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Birmingham?
A. I work with Shaffer Eye.
Q. When you say you work with Shaffer Eye what do you mean by that?
A. I don't own any part of that clinic there. They refer surgical cases over and I do the surgery.
Q. Do they get a percentage of your fee?
A. There is a financial arrangement where some of the money comes to me and some of the money goes to them.
Q. Is that disclosed to the patient?
A. I believe it is disclosed because I'm actually using their space.
Q. Do you do the procedures here in Atlanta or you go to Birmingham?
A. Go to Birmingham.
Q. With these lifetime enhancements are there risks involved with additional lasik surgery?
A. Yes. There is a risk with all surgery you do.
Q. Are the risk increased as the number of surgeries multiply?
MR. STOTT: Object to the form.
THE WITNESS: I'm not sure I understand what you mean multiply.

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BY MR. BURNS:
Q. Like you do more of them. The more times you operate on the eye does it increase the opportunity for the patient to have starburst and halo and dry eye and that kind of thing?
MR. STOTT: Object to the form.
THE WITNESS: I think there are different risk when you do an enhancement and the risks are different compared to the primary procedure.
BY MR. BURNS:
Q. What are the risk of an enhancement that are different from a primary procedure?
A. The risk are higher for epithelial in-growth and that would be the biggest one that we worry about.
Q. Why does the risk of epithelial in-growth increase with an enhancement?
A. The first time you do a surgery on a virgin eye when you make the flap the surgical epithelial are cut usually with a blade mostly with a laser but that flap is made with a very sharp edge. And when the laser is then applied to change the shape of the cornea the flap is reapplied. And the edge, the surface has a clean edge, and there is only a minimal amount of surface epithelial damage. And that heals

up in twelve hours or so for the vast majority of the patient.

Q. What percentage?

A. I'm not aware of those studies. But the majority are healed up and most are healed up by the next morning.

Q. What do you tell your patients when you give informed consent with laser surgery with regard to the flap healing?

A. With what aspect? We have an eight page consent page. I can go through everything of that if you would like.

Q. My question was about the flap healing what do you tell your patients the risks are on a first time laser in connection with the flap?

A. There is a risk of irregular flap.

Q. What do you tell them the likelihood of it is?

A. Less than one percent chance of having an irregular flap.

Q. When you go back for enhancements how is that risk increased from less than one percent to what percent?

A. The risk of having an irregular flap is less because the flap has already been made.

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Q. What is the risk of epithelial cell growth? How is that affected by multiple procedures?

A. As I was saying in the primary procedure the surface epithelial cells have a sharp edge and those heal up overnight. When we do an enhancement procedure, especially if we lift the flap and you do an enhancement, then the surface cells get disrupted more than during the primary procedure. When the flap is reapplied there is more roughening on the surface cells, and there is more healing that the surface cells have to do, and that increases the chance of some of those cells healing on the surface like they are supposed to but continuing to grow under the flap. That is what epithelial in-growth is.

Q. And Kelly Leo is experiencing that isn't she?

A. The medical record reflect Kelly Leo has epithelial flap, yes.

Q. Is there a cure for that?

A. Epithelial in-growth is usually successfully treated by lifting the flap and taking the cells out and then reapplying the flap.

Q. Has that worked for Kelly?

A. I have not evaluated her in person and I

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haven't been following her for this time.
Q. How many times has she had epithelial cells removed?
A. I would have to recheck the chart for that if you want the exact details of that.
Q. What is your judgment as you sit here?
MR. STOTT: Object to the form.
THE WITNESS: She has had epithelial in-growth return and she has had it removed.
BY MR. BURNS:
Q. How many times is my question.
A. I don't know how many times but we can go through the medical record if you want the details of that.
Q. With each time the epithelial cells are removed does that increase the likelihood that there will be more epithelial in-growth?
A. I'm not sure that is really true. I think it really depends very specifically on each individual patient because having epithelial cells grow under the flap is very unique to every patient that it happens to.
Q. You have had it happen to your patients haven't you?
A. Yes.

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Q. How many?
A. I don't know the exact number.
Q. Rough estimate?
A. On primary patients it's less than one percent. On enhancement patients it's higher.
Q. How high on enhancement patients?
A. I don't know the exact number. I would be guessing, five percent. When I say that it has happened I'm referring to the epithelial cells are there enough to need further intervention.
Q. Have you had to intervene on more than one occasion with any particular patient because of the epithelial cell regrowth?
A. Yes.
Q. How many times is the most that you have had to intervene with any one patient?
A. We have had one patient that has required like five or maybe six interventions.
Q. Do you anticipate intervening on that patient in the future?
A. We hope not.
Q. But do you anticipate you will have to?
A. I anticipate we will not.
Q. How old is that patient?
A. That patient is older. I can't remember his

exact age.
Q. Roughly?
A. In his sixties.
Q. That is not very old doctor.
A. I said older, which is referenced to older than the average patient.
Q. Does the enhancement increase the likelihood of any other adverse side affects such as starburst halos and those kinds of things?
A. It all depends on the specific for that individual patient.
Q. Thinking about Kelly Leo did the enhancements and follow-up surgeries that she has endured increase the likelihood she would experience starburst and halos and dry eye, blurred vision multiple objects?
MR. STOTT: Object to the form.
THE WITNESS: I think Kelly Leo started out with a very high prescription in terms of having had a lot of astigmatism and so the odds of her needing enhancement surgery was much higher than the average patient.
BY MR. BURNS:
Q. How high was it?
A. Again, it's difficult without having

actually examined her at the beginning. But we would give patients in that prescription range 30 to 40 percent chance for needing to come up for enhancement and possibly more than 50 percent. I actually tell all of those patients to expect a touch up surgery. I say just plan that in your future you will need a touch up surgery.

Q. Well, what was her risk of having starburst and halos and those side effects on top of that?

A. Her chances of having halos was higher than average just by the fact that she had a lot of astigmatism.

Q. How high was it?

A. I don't know. We don't give a specific number on that because the symptom is subjective in nature and difficult for us to or impossible for us to fully quantify. We want patients to know they are at an increased risk for glare after the surgery.

Q. When you say glare is that a generic term to include halos and starburst and ghost and double vision?

A. Correct. We use glare as a term to include those side effects.

Q. But each of those are different side effects aren't they? Halos is a different problem than

starburst?
A. They have different names and they describe different things for different patients.
Q. In the 70,000 or so lasik procedures that you have done how many times have you performed the wrong prescription?
A. I'm not aware that I have ever done that.
Q. Never?
A. I'm not aware that I have ever done that.
Q. What precaution do you take to prevent you or a surgeon in your practice from performing the wrong prescription?
A. We have multiple systems that we use and it has changed somewhat over the years. It's also different now in my own practice compared to when I was working with the TLC group.
Q. What are the multiple systems that you have in place to prevent you or your surgeons from performing the wrong prescription?
A. We use one form that contains the original measurement sheets and different refractions. And on that same form we have target prescription for what you want to put into the laser.
Q. How does that prevent the surgeon from performing the wrong surgery?

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A. There are different philosophies on what is safest. There is no good science that says what is better than the other. Another way of doing it which is the way we did at TLC was to have the prescription for each eye transcribed onto a separate sheet, and then establish treatment for that target per that specific eye on that sheet of paper and there would be a separate sheet for each eye.

Q. And the surgeon would compare the prescription he intended to do with what had been programmed into the computer the lasik machine?

A. It would work a variety of different ways. The surgeon -- some of the surgeons would compare the original measurement sheets to the treatment form for each specific eye. And then that would be handed over and implanted into the lasik.

I'm not aware of there being one set way of doing it. There are multiple ways of doing it and people have their own protocols.

Q. Do you always look at the screen after the prescription has been plugged in or put into the computer to confirm that it is the procedure that you're supposed to do before you operate on a patient's eye?

A. Yes.

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Q. Do all of the surgeons that work for you do that?

A. I don't know. I'm not in the room with them.

Q. That is good policy, isn't it?

A. That is my recommendation for them but there are other ways of doing it and I know of other surgeons who do it differently.

Q. What other methods are there within the standard of care that will allow the surgeon to be certain that he is doing the correct procedure on his patient other than looking at the screen before he activates the machine?

MR. STOTT: Object to the form.

THE WITNESS: As I said there are different protocols and people do things differently. Another way of doing it is either use the same original form and have the treatment form -- the treatment amount put on there and hand it over and have the technicians input that, or to confirm that its been transcribed the way you want it onto another separate form and have that separate form handed over to the rest of your team.

BY MR. BURNS:

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Q. You have read Dr. Horn's deposition?
A. Yes.
Q. And he testified that the standard of care require that the surgeon personally verify that the technician has put in the right prescription before the surgeon begin removing tissue.
You remember that don't you?
A. Yes.
Q. That is the way you do it, don't you?
A. Yes.
Q. And do you agree that is the standard of care?
A. No. I think there are different ways of doing it and everyone has their own protocol. And even by verifying what is in the computer with the sheet it can lead to the incorrect prescription put in.
Q. If you have the wrong prescription written on the sheet?
A. Correct.
Q. Tell me the ways you say that a surgeon can meet the standard of care to insure that the procedure he is doing is what is required for the patient.
And one you said that he can look at the

machine to make sure that the settings on the machine correspond with the appropriate prescription, correct?

MR. STOTT: Object to the form.

THE WITNESS: I'm saying that some surgeons will take or will look at the specific prescription that is on the laser, and they will compare that to the prescription that is written down in some format that they want.

BY MR. BURNS:

Q. Sure.

A. And that may be the original measurement sheets or it may be a transcribed sheet.

Q. But they are comparing, they are looking at the machine and saying, okay that is the prescription that is in the machine and that is consistent with the prescription I want to fill, correct?

A. Correct.

Q. Is there any way to do that, is there any way for the physician to ensure that he is doing the right procedure on the patient other than by looking at the screen to confirm that the proper prescription is in the machine before he does the surgery?

MR. STOTT: Object to the form.

THE WITNESS: I'm not sure exactly what you

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mean confirms the correct prescription because there can still be errors in any prescription that we have. Because if you check what is on the screen to a piece of paper the piece of paper may not be correct.

BY MR. BURNS:

Q. But you have never had that in your experience, correct?

A. Not that I can remember.

Q. You never had a situation where the paper was incorrect that you looked at --

A. Yes, I have.

Q. But not -- you caught the error before you went forward?

A. We caught the error before it went forward for different reasons. You can still have the incorrect prescription on that piece of paper, whatever the paper is.

Q. Whose fault is that if you have the wrong prescription that is the doctor's fault, isn't it?

MR. STOTT: Object to the form.

THE WITNESS: I'm not sure what you mean the doctor's fault.

BY MR. BURNS:

Q. Well, as the surgeon in charge of the

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operation isn't it your obligation to make sure that the prescription that you're going to fill on the patient is appropriate for that patient?

A. I mean you work as a complete team and you set up your protocols, and the surgeon will do his or her part. And it is reasonable to have your lasik technician to play a role in that as well.

Q. My question was, as a surgeon in charge of the operation isn't it your obligation to make sure that the prescription that you're going to fill is appropriate for that patient?

MR. STOTT: Object to the form.

THE WITNESS: Can you repeat that one more time?

BY MR. BURNS:

Q. As the surgeon in charge of the operation isn't it your obligation to make sure that the prescription that you're going to fill is appropriate for the patient?

MR. STOTT: Object to the form.

THE WITNESS: I think it's your obligation to set up a system that you believe works and for the surgeon to play their role in that.

BY MR. BURNS:

Q. Well, I have noticed that you have a pretty

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big presence on the internet. You have a big web page that tends to get a good a bit of traffic, don't you?

A. I'm not sure what you mean by a good bit of traffic.

Q. People look at it?

A. People look at our Web site, yes.

Q. And in that Web site do you say anything about it not being the doctor's responsibility to make sure that we do the right prescription on the patient?

A. I'm not aware of us saying that it's not the doctor's prescription -- responsibility.

Q. And you know that your obligation as an expert witness is to be fair to both sides, isn't it?

A. My obligation is to give you my opinion.

Q. Let's be truthful and fair to both sides?

MR. STOTT: Object to the form.

THE WITNESS: My understanding is that it's my obligation to give you an honest opinion of what I think is reasonable.

BY MR. BURNS:

Q. And there is nothing that you anticipate saying in this deposition that you would have any objection to your patient reading, is there?

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A. Not that I can think of, no.
Q. And you know that inputting errors have been reported in the literature, haven't they?
A. Correct.
Q. You have read about that?
A. Correct.
Q. And that is a problem that happens embarrassingly more often than you would like, isn't it?
A. I'm not sure I can comment on that.
Q. Well, are you familiar with advocacy groups of lasik patients who formed together and complain about problems associated with their lasik surgeries?
A. Yes.
Q. Are you a member of any such group?
A. No.
Q. Do you advise any groups?
A. No.
Q. Are you supportive of that effort?
MR. STOTT: Object to the form. What do you mean by supportive mentally, emotionally?
THE WITNESS: I don't understand your question.
BY MR. BURNS:
Q. In any way are you supportive of patient

advocacy groups whose mission it is to advocate safer lasik surgery?

A. I'm definitely in favor of advocating safer surgery.

Q. What have you done to further that goal?

A. What have we done internally or externally?

Q. Externally.

A. I'm not involved in any external advocacy groups but I have been involved with trying to do the best surgery we can.

Q. Internally?

A. Internally.

Q. And trying to do the best surgery you can involves confirming that the proper prescription is in the machine before you do the surgery, isn't it?

A. That's our protocol, but there are other protocols.

Q. But what protocol did Dr. Bearman follow?

A. Dr. Bearman followed a protocol where he decided on the prescription to be treated and checked that prescription beforehand and circled that prescription to highlight that is the one he wanted inputted, and then had the technician input that into the laser.

Q. Did he make any effort to confirm what the

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technician put into the laser was consistent with what the appropriate prescription was?

MR. STOTT: Object to the form.

THE WITNESS: He did not check the end-point prescription with the exact amount that he wanted in.

BY MR. BURNS:

Q. Do you have any criticism of that?

A. I think that is not the way that we do it, and -- but that is the way that his protocols are set up. And, you know, that's the way he set his up.

Q. Well, that doesn't make it right or safe, does it?

MR. STOTT: Object to the form.

THE WITNESS: Just the fact that anyone sets up any protocol doesn't make it right or safe.

BY MR. BURNS:

Q. You would agree that Dr. Bearman's protocol would be safer for the patient if Dr. Bearman would personally confirm that the prescription that the tech put in the machine was the prescription that was appropriate for the patient, wouldn't you?

A. If he was comparing the prescription in the laser with the correct form then that would be a different way of doing it, and maybe it may be safer.

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But again, any time you compare something in the laser you're not measuring -- you're not doing the measurements on that patient at that time so you have to compare it to something on paper. And whatever is on paper at that time may or may not be correct.

Q. It's garbage in and garbage out, isn't it?

A. I'm not sure exactly what you mean by that.

Q. If you have done improper measurements or calculations and that is what you put in the machine then you're going to get the wrong surgery performed, correct?

MR. STOTT: Object to the form.

THE WITNESS: If the prescription that is put in is not the correct prescription then you will not have obviously the desired effect.

BY MR. BURNS:

Q. Is that what happened here?

A. It's my understanding that the prescription that was input was not the correct prescription for that patient.

Q. In your expert opinion, did Dr. Bearman have any obligation to protect his patient from that type of error?

MR. STOTT: Object to the form.

THE WITNESS: Dr. Bearman set up his

protocol and had experience with that protocol and was operating within the standard of care for him as pertained to his protocols.

BY MR. BURNS:

Q. Well, this isn't a set up protocol he did it different on the first eight patients, didn't he?

A. His protocol was to set up the laser treatment and hand it off to the rest of his team who would input it into the laser.

Q. What -- did he do Kelly Leo's procedure different than he did the first eight?

A. There was some -- I mean, there was some differences that he had when he first started out with the laser system. And I don't have the chart in front of me to go through those details.

Q. Well, don't you understand that the first eight procedures Dr. Bearman did the calculations and give them to the tech and the first eight procedures came out fine?

A. I understand that -- it's my understanding that Kelly Leo's was the only one that day that was incorrect.

Q. Did you understand my question?

A. Give it to me again.

Q. Don't you understand that the first eight

procedures Dr. Bearman did the calculations and gave them to the tech and the first eight procedures came out fine?

MR. STOTT: Object to the form.

THE WITNESS: That is my understanding that there were no errors in those initial procedures.

BY MR. BURNS:

Q. Well, who did the calculations in the initial procedures as you understand it?

MR. STOTT: Can you tell me what you mean by the calculations are you talking about determining the prescription, or are you talking about --

BY MR. BURNS:

Q. You understand doctor don't you?

A. Actually I don't. Different clinics will do it differently. Some clinics will just put in a number and say this is what I want to treat and the technician wills do the calculations in terms of what is actually put into the laser. If a patient has a certain prescription let's say the patient is a minus six for the most part you don't put a minus six into the laser. You will put some number that is different depending on personal nomagrams or

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sometimes humility or technique and some surgeons may put in something that is a different number than minus six.

So when you say the calculations I don't know what you mean because there are calculations in terms of coming up with the number that you want to treat like the minus six is the end point result that you want. Most of the calculations involve what number do you want to put into the laser.

Q. The nomagram?

A. Yes nomagram.

Q. Is that the surgeons responsibility to verify that or is that the tech's?

MR. STOTT: Object to the form.

THE WITNESS: Again, it depends on how different protocols are set up. Some surgeons that operate will have technicians who are doing that all of the time. All right. And they will be the ones that do those calculations and input that data because they are more familiar with that. They may be doing that every day compared to the surgeon who is doing something else with most of his time. And, you know, he is only doing excimer laser a few times a month.

BY MR. BURNS:

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Q. How do you confirm that the right procedure is being done when you're performing surgery?
MR. STOTT: Object to the form.
THE WITNESS: How do I do it?
BY MR. BURNS:
Q. Yes.
A. As I said we have different systems but we only have one form, so that the prescription that has all of the measurements on it is the same form that has the calculations in terms of what to put into the laser --
Q. Who does those calculations?
A. -- in order to get the end result.
Q. Who does the calculations?
A. Either the doctor who is seeing the patient in the clinic and sometimes it will be the technician.
Q. Do you personally check the calculations if you do not do them yourself?
A. I don't check them on every patient no.
Q. You just assume that the technician would have done it correctly?
A. Yeah. I mean, we use the technicians and some of the other doctors that work in the clinic with me to do a variety of functions including doing

those calculations.
Q. Is it Dr. Woolfson's position and the position of Woolfson's clinic that if a technician makes a mistake and puts in the wrong prescription and you do the wrong procedure on the patient it's not your fault?
MR. STOTT: Object to the form it calls from a legal conclusion and it calls for a situation different than on the laser.
BY MR. BURNS:
Q. You can answer.
A. When you say is it your fault what were you talking about?
Q. Well, you're going to tell the patient I'm sorry you have had this bad result take it up with the technician.
MR. STOTT: Same objection.
THE WITNESS: As a clinic that employs the technician then I would be saying, you know, this error has been made and we are trying to fix the problem.
BY MR. BURNS:
Q. Well, are you telling your patient that the problem is between the patient and the technician, or are you, Dr. Woolfson, taking responsibility because

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you performed the wrong procedure?

MR. STOTT: Object to the form. Are you asking about a specific incident that happened, or you are speculating if it happened what would he do?

MR. BURNS: I'm asking for his philosophy.

MR. STOTT: I object speculation.

THE WITNESS: I'm not sure how I would respond if that were to happen. I generally would focus on trying to fix the problem.

BY MR. BURNS:

Q. And if you can't fix the problem?

MR. STOTT: Same objection.

THE WITNESS: You are asking me to speculate about what if and I'm not sure how I would respond in those circumstances.

BY MR. BURNS:

Q. Well, an expert is entitled to and I'm entitled to ask an expert hypothetical questions. And that is what I'm asking you is a hypothetical question.

If the Woolfson Eye clinic with you as the operating surgeon performed the wrong procedure on both eyes of a particular patient is it your position that that is the fault of the technician and not

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yours?

MR. STOTT: Object to the form incomplete and improper hypothetical.

THE WITNESS: Our position would be that Woolfson Eye Institute had made the error and we would do whatever we could to fix it. And we have moved forward there. If you're asking me if I would try to blame the technician, I'm not sure how it would end up, but most likely we would not try to blame the technician if that is what you're getting at.

BY MR. BURNS:

Q. Well, have you read about uncertified technicians operating laser machines in surgical suites?

A. I'm not intricately involved in that.

Q. Have you read about that?

A. I have heard that that happens, yes.

Q. And that is very dangerous, isn't it?

MR. STOTT: Object to the form.

THE WITNESS: That is not the accepted way of doing it.

BY MR. BURNS:

Q. And you don't know anything about the technician that is involved in this case, do you?

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A. I don't know any details about the technician.
Q. Don't have any basis to know if that technician was certified or not?
A. I don't know any details of that technician.
Q. Have you ever dealt with either of the companies that was involved in providing the laser machine to Dr. Bearman?
A. We have never used them to provide services for us.
Q. Well, before being involved in this lawsuit had you ever heard of Vision Lines of Mid America LLC?
A. I don't believe I had.
Q. Had you ever heard of Jeffrey Fine?
A. No.
Q. Cameron Mitchell?
A. No.
Q. Shawn Mayfield?
A. No.
Q. Do you know what LLC means?
A. Yes.
Q. What does that mean?
A. Limit liability corporation.
Q. Are you involved in any limit liability

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corporations?
A. Yes.
Q. You understand that in a limited liability corporation financial responsibility for the consequences of any error may fall simply on the LLC and no one individual?
MR. STOTT: Object to the form he is certainly not presented as a financial or business set-up expert.
THE WITNESS: I'm not aware of the legal implications of all of that.
BY MR. BURNS:
Q. Had you ever heard of Mobile Laser Systems Inc. before this lawsuit?
A. I actually had. I think I had heard that name before, yes.
Q. In what context?
A. I don't remember any detail.
Q. Do you know that that company is out of business?
A. No.
Q. Had you ever heard of anyone Flynn Clyburn?
A. Yes.
Q. Who is Flynn Clyburn?
A. Flynn Clyburn is someone who owned a mobile

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laser system and took it around to various doctors.
Q. Have you ever had any business dealings with him?
A. Yes.
Q. What business dealings have you had with Flynn Clyburn?
A. He used to work for me.
Q. From when to when?
A. He worked for me from '01 for a couple of years. I was not aware he was involved with these companies.
Q. What led to the two of you no longer working together?
A. He wanted to run his own mobile laser system company.
Q. So he worked for you from 2001 to 2003?
A. I don't remember the exact dates. In fact it was pretty earlier than that. It was probably a little earlier than that I don't remember.
Q. Your best judgment?
A. I think he probably went on his own in 2001 in that range. Again, I don't remember the exact dates and he was with me for a few years prior to that.
Q. How about Jason Gilbert do you know Jason

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Gilbert?
A. I had met Jason before yes.
Q. How did you meet Jason?
A. Jason had worked for another mobile company in the past.
Q. What is the name of the company?
A. I don't remember which one.
Q. Is Jason a certified lasik technician?
A. I don't know for sure. I believe he is but I don't know for sure.
Q. Do you know whether Flynn Clyburn is a certified Vixs technician?
A. I do not know whether he is or he isn't. It was my understanding when I knew him he was not.
Q. When is the last contact you had with Flynn Clyburn?
A. The last contact I had with Flynn Clyburn was pretty much when he left to run his own business. Again, I don't remember when that was but probably around 2001 in that range maybe later.
Q. Did you part under favorable terms?
A. No.
Q. Tell me about it.
A. Flynn Clyburn decided to run his own laser company and was working in the same geographic area

that we were already in so we had some overlap in terms of the areas that we were working. And we were considering what areas that we were going to work and what our business was going to be.

Q. Did he violate a non-compete agreement?

A. I don't believe so. There was never any issue of any legal action if that is what you're asking.

Q. There were hard feelings?

A. I think we both wished it would have worked out differently. There were personality conflicts with other employees at the time.

Q. Other employees of who?

A. Other employees of mine.

Q. What business were you operating then?

A. I was doing laser vision correction. Flynn was one of my employees and there was another employee that I was personally involved with that he had significant issues with. I was doing laser vision.

Q. What employee were you personally involved with? What do you mean?

A. There was one employee called Kelly Citron, who was my girlfriend at the time and had had significant history in the laser vision correction

world. And she was working with us and Flynn Clyburn had a significant conflict with her.
Q. What was the conflict?
A. I think it was a personality conflict. I'm not aware of any specific issue.
Q. Did you end up marrying your girlfriend?
A. No.
Q. Tell me about Jason Gilbert.
A. Jason was a technician working with one of the other mobile laser companies.
Q. Did he work for you?
A. He was never one of our employees. I'm not sure if he helped out on a temp basis for a minimal amount of time. He may have done that but I'm not sure about that.
Q. When Flynn Clyburn worked for you what company employed him?
A. At that time the company was called Custom Laser Eye.
Q. How many different laser eye companies have you owned or operated?
A. Just Custom Laser Eye which became Woolfson Eye Institute. It just changed the name it's essentially the same company.
Q. When did you change the name?

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A. Somewhere around 2004.
Q. What is Woolfson Enterprises?
A. That is just one of the other companies that we have.
Q. What does it do?
A. It functions mostly on an administrative level.
Q. What does it administer?
A. Woolfson Enterprises administer some of the HR and staffing issues intertwined with Woolfson Eye.
Q. What other business entities do you have ownership interest in?
A. I have different investment interest but nothing that I'm actively managing.
Q. Now, you describe the way that you do laser surgery and that you always look at the screen before you operate and is that so that you can ensure that you will perform the prescription that is appropriate for the patient?
MR. STOTT: Object to the form.
THE WITNESS: As I said before you can never ensure it 100 percent but is our protocol.
BY MR. BURNS:
Q. And that protocol has ensured 100 percent for 70000 operations, hasn't it?

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A. Well, we haven't always done it that way.
Q. Have you always looked at the screen?
A. No. We haven't always looked at the screen and looked at the primary data sheet. No.
Q. During what period of time did you perform surgery on patients without looking at the screen before you operated to make sure that you were filling the proper prescription?
A. We made the change to looking at the screen in the operating room with the primary data form around the time of -- was it 2001? End of 2001 is my best guess. But maybe off by a year or two.
Q. You added with the primary data form but in my question I'm only asking whether you have always verified by looking at the screen before you did the surgery?
A. I think when we first got started -- as I said we have done this in different ways over time and the protocols have changed. I believe when we first got started we transcribed the desired treatment for each eye onto a separate sheet with a separate sheet for each eye and then gave that over to the technician. And this is going back ten years now. I think at the beginning going back more than ten years now. I believe at the beginning we checked

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that sheet and not the laser itself.

Q. So you were -- it's been your practice some ten years or so in the past to operate on people without looking at the screen to confirm that what the tech put in the machine was the prescription that you wanted to perform?

A. No, I said going back ten years ago I can't remember exactly what we did. I remember that we did transcribe each treatment onto an individual form.

Q. Yes, sir, doctor. I'm really not interested in how you wrote down the prescription on the form. My focus is on whether you would look at the screen before you operated to make sure that the prescription that you were going to execute was appropriate for the patient?

A. That is what I'm saying is when we first got started I can't remember exactly. But I think when we first got started we focused on getting the transcription correct and not looking at the laser screen. And then we have had different protocol changes since then.

Q. Did you change the protocol to include looking at the laser screen some ten years ago or more in order to increase safety to your patient?

A. I can't remember exactly why we changed each

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protocol each time, but we have come up with a protocol now that I think works well. I can't remember why we made that decision exactly ten years ago.

Q. Now you hire your own technicians, don't you?

A. Yes.

Q. And do you make sure that they are Vixs certified before you put them to work on a Vixs machine?

A. Yes.

Q. How do you do that?

A. We have them go through the Vixs training and make sure and have the Vixs folks sign off on them and then we talk to the Vixs trainers themselves personally.

Q. Because you recognize that once you remove tissue from a patient's eye you can never put it back can you?

A. Once the tissue is removed you can't replace that tissue.

Q. You read in Dr. Horn deposition that it's a common statement for lasik surgeons that you can take away but you can never put back.

That is true isn't it?

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A. Once tissue is removed you can't put it back.

Q. Has your clinic ever used technician that you met for the first time on the morning of surgery?

A. In the laser room?

Q. Yes. I'm talking about excimer surgery. And we will be doing that all -- just to make things clear I'm only talking about the type of surgery that Kelly Leo had.

A. You're just talking about surgery not clinic stuff.

Q. Yeah. Just talking about surgery.

A. Okay. Would we use a technician we met the first day? That may have happened in the past.

Q. If I came in and said, you know, I'm a Vixs technician I would like to go to work for you.

Would you do any credentialing or just say great, come on?

A. I mean, we would want to make sure that you had the experience and certification that you're claiming to have.

Q. How would you do that?

A. We would check with whoever you're supposed to be credentialed with.

Q. With Vixs?

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A. We would check with Vixs also their certificates. In our usual system they will go through a process with the other technicians. But your earlier question was would you ever or have you ever. And if we were stuck in a bind then things would be different.

Q. But if you were stuck in a bind and I walked in and I said I'm a Vixs technician would you confirm in some way that I'm certified?

A. We would look to confirm you're certified yes.

Q. Does the standard of care require that in your opinion?

MR. STOTT: Object to the form. You're just talking about him coming in here while Dr. Woolfson already owns the laser and he walks off the street and he operates Dr. Woolfson's laser as opposed to him being with the service that owns the laser?

MR. BURNS: I think he understands my question.

MR. STOTT: Your expert has already testified that --

MR. BURNS: Another speaking objection where you're trying to coach the witness.

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You may answer.

MR. STOTT: This is for the record. We have given you what he is going to testify and he has not testified and has not been asked to look at or give an opinion on anything related to certification of technicians. Without the proper background of this case, since you expert has already testified it's not a standard of care violation, he has not been asked to look at that, I'm going to object you to asking him about areas outside of the area we have put him up as an expert on.

MR. BURNS: You can answer.

THE WITNESS: Can I have the question again please?

BY MR. BURNS:

Q. If I came in and said, you know, I'm a Vixs technician I would like to go to work for you. Would you do any credentialing? And I think you said yes, you would. And I asked you, how you would do that, and I said would the standard of care require that you confirm that I was certified before you put me to work?

MR. STOTT: Object to the form the reason stated and incomplete hypothetical.

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THE WITNESS: When you say standard of care what are you talking about?

BY MR. BURNS:

Q. Do you know what the standard of care?

A. Are you talking about the medical standard of care for the doctor or operating the laser?

Q. I'm talking about the medical standard of care for the doctor.

A. I don't think that the doctor is going to -- I mean, because there are two different things.

As a clinic overall we are handling both aspect of it. We are handling the technician aspect as well as the doctoring aspect of it. If you're asking what is the medical standard of care I don't believe that the doctors are going to get involved with the credentialing part of the laser.

Q. That's the clinic's responsibility?

MR. STOTT: Object to the form.

THE WITNESS: Again, when you talk about responsibility, if that is a legal issue in terms of who is legally responsible that is not something I can answer. That is something that the legal system would have to answer.

BY MR. BURNS:

Q. Yes, sir. But I'm asking you as an expert

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that has been hired by Dr. Bearman and his clinic to testify about the standard of care whether the standard of care requires that any effort be made by the doctor or the clinic to make sure that the technician is certified?

MR. STOTT: Objection.

THE WITNESS: I think the -- I mean, the standard of care resolves around what the doctor is doing and I don't think that the doctor is going to be responsible for the individual certification of the laser or making sure that the laser is -- that everything is perfect with the laser.

BY MR. BURNS:

Q. Yes. I'm not talking about the laser. I'm talking about the technician and the clinic and the doctor. And so if your patient read this deposition online they will understand that Dr. Woolfson says if we hire somebody the standard of care doesn't require that we confirm that they are certified to do the laser.

Is that what you're saying?

MR. STOTT: Again object to the form and all of the same objections.

THE WITNESS: Again, I'm perfectly

comfortable with my patients reading online in its entirety the fact we vet people out. The question you're asking me is who is responsible for making sure that the technicians are certified.

And my response to that is it's the same people who are responsible for making sure that the laser is running correctly and the actual surgeon himself doing the surgery that is not part of their responsibility.

BY MR. BURNS:

Q. And you read Dr. Horn's deposition and he testified that the standard of care required that he investigate the company that was providing the laser to make sure that it was a reputable company and that they had certified technicians.

You remember that testimony?

MR. STOTT: Objection. Misstates his testimony. Show him the testimony if you're going to ask him to remember something that is not in there.

THE WITNESS: I don't think it's -- I don't think the doctor is going to be responsible for going through all of the details of the lasik, what the lasik company is doing.

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BY MR. BURNS:
Q. Does he have any responsibility under the standard of care to make sure he is dealing with a reputable company with trained technicians?
MR. STOTT: Same objections.
THE WITNESS: I think that the surgeon has a responsibility to find some company and laser to work with that they can reasonably believe is competent to do what they are doing.
BY MR. BURNS:
Q. And you understand that the patient has no protection against an incompetent technician if that protection doesn't come from the doctor, does he?
MR. STOTT: Same objection.
THE WITNESS: I'm not sure what you mean by protection.
BY MR. BURNS:
Q. Well, if a patient of yours comes in here to Woolfson Eye clinic, that patient doesn't come in because of a particular technician.
They come in because of you, don't they?
MR. STOTT: Object to the form.
THE WITNESS: I think people come in for a variety of reasons.
BY MR. BURNS:

Q. And if the patient came in not knowing who the technicians were, their protection against incompetent technicians would come from you wouldn't it, if you were the surgeon going to perform their procedure?

MR. STOTT: Same objection.

THE WITNESS: I'm not sure what you mean by their protection would come from me.

BY MR. BURNS:

Q. Well, is the patient in any position to judge the competence of the technician?

A. I think it's difficult for the patient to make that evaluation.

Q. Does he have any basis to do it?

A. I don't know. I mean do they have any basis to do that? I mean, they could ask questions. So do they have any basis to I don't know.

Q. Have you ever had a patient come in and say before I let you do this I want to interview your technician?

A. Not interview no but we have had many patients that have asked are the technicians certified and is the laser certified and is the laser the best laser and ask technical questions. That happens on a routine basis.

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Q. And you answer those questions?
A. Yes.
Q. And you assure this patient that yes, the laser is certified, yes the technician is certified, don't you?
A. Yes.
Q. Have you ever employed a technician who is not certified?
A. Yes.
Q. To do laser surgery?
A. Not to run the laser but do the front office.
Q. But to run the laser, have you ever allowed an uncertified technician to run the laser?
A. No. The only techs that are allowed to run the laser are certified techs.
Q. You said that the doctor is not responsible for making sure that the tech is certified, correct?
A. Correct.
Q. Is the clinic responsible for making sure that the tech is certified?
MR. STOTT: Same objection.
THE WITNESS: Who is the clinic? I think whoever is providing the laser set up usually goes with the technician. And it's the

technician who is most familiar with that laser. And so whoever is providing that laser -- in our case it's the same clinic.

BY MR. BURNS:

Q. But you know --

A. In terms of legal responsibility I can't make that determination. I'm not here to testify about who is legally responsible that is the only decision I can make. All I can say is what is reasonable for a surgeon who is operating.

Q. According to you, would it be within the standard of care for a surgeon to schedule lasik surgery, call a company that he never had any dealings with, arrange for them to deliver a machine and a technician and begin to operate on people without asking any questions?

MR. STOTT: Object to the form.

THE WITNESS: I think it's the surgeon's responsibility to have a reasonable expectation that the company is going to do a good job. And that will vary on the specific details of that.

BY MR. BURNS:

Q. To meet that obligation the surgeon would have to or the clinic would have to do some investigation into the company that is providing the

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machine wouldn't they?
MR. STOTT: Object to the form.
THE WITNESS: Again, it would be determined by the specifics and their circumstances.
BY MR. BURNS:
Q. What are the variables?
A. Well, it would depend on how did they find out about that company? If they had heard about them before. Did they have a personal reference. Did they know anybody who had used them before. You know, had they been around before. Are they servicing many other doctors. Those are off the top of my head some of the things that would make it seem more reasonable to trust a company to do a good job.
Q. And Dr. Bearman didn't know any of that about Mobile Lasik System, Inc., did he?
A. I don't know what he knew at that time.
Q. Do you remember reading his deposition?
A. I read his deposition. I don't remember those details.
Q. But you would agree that the standard of care would require he make some inquiry if he was unfamiliar with Mobile Lasik System?
A. I didn't say that.
Q. Okay.

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A. I said he should feel reasonably comfortable using them and those reasons may vary.
Q. Have you ever used roll on roll off lasers?
A. Yes.
Q. When did you quit?
A. We actually haven't quit we still use them.
Q. When you use roll on roll off laser you have contacted a third party and they delivered a machine and a technician for you to use?
A. No. We have our own system. Our own set up.
Q. What do you mean by roll on roll off laser?
A. We have multiple locations and we have two lasers and we move the lasers around from one location to the next.
Q. Have you ever contracted a third party to provide roll on roll off laser services?
A. I do not remember exactly but I believe we may have used a third party to provide laser services for a brief period.
Q. Who was that third party?
A. I don't remember any details on that.
Q. Whose responsibility was it to make sure that the third party was competent?
MR. STOTT: Object to the form.

THE WITNESS: Again, I don't remember any details about the third party or how we chose them.

BY MR. BURNS:

Q. Did you make some effort to satisfy yourself that you had selected a competent laser provider and technician before you operated on your patients?

A. I don't believe that I personally made any investigations into who they were.

Q. Did you have someone on your staff do that?

A. Somebody on my staff had a reasonable sense of confidence that they were competent.

Q. And you have no idea who that person was just a secretary or somebody? That would suit you wouldn't it?

A. Again, this was several years ago so I don't remember the exact details.

Q. Who convert optometrist measurements into ophthalmic measurements for the surgeons in your practice?

A. I don't understand your question.

Q. There is a conversion isn't there from the optometrist, the way they measure, to the way you measure or calculate?

A. No.

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Q. There is not?
A. Not in our practice there is not.
Q. Have you had any prior dealings with any of the attorneys in this case?
A. Not that I know of.
Q. How were you hired? How were you selected do you know?
A. I have no idea.
Q. Nobody told you anything about it?
A. No.
Q. Do you know Dr. Wang?
A. I know Dr. Wang.
Q. Have you sent patients to him?
A. I don't think I have sent him a patient. I don't remember sending him a patient.
Q. How do you know Dr. Wang?
A. I met Dr. Wang at some of the meetings and he has a course that he gives and in the past he has asked me to come lecture.
Q. You have lectured for Dr. Wang?
A. Yes.
Q. How many times?
A. I believe it was once.
Q. On what topic?
A. It was some aspect of refractive surgery. I

don't remember the exact topic.
Q. Do you know Dr. Juan?
A. No.
Q. Have you referred a patient to other doctors for corrective surgery following a lasik procedure that you or someone in your practice did?
A. We have done a lot of cases and we may have sent some patients in the past. I'm not remembering any specific details. More specifically I'm sure we sent some patients at some point but I don't remember specific details.
Q. To whom?
A. I think the most likely, the most common would be sending patients to Canada at a time when technology had not been approved by the FDA and patients were sent for evaluation and possible treatment.
Q. Well, when you have a patient that has a bad outcome, do you send that patient to any particular doctor?
A. There is no specific doctor I send them to no.
Q. What doctors have you sent them to?
A. I remember we sent patients when I was working with TLC to different TLC centers to see if

they had different technology or could offer something that we couldn't.

Q. Can you identify any doctor that you have sent a patient with a bad outcome to?

A. I remember sending a patient to Dr. Mashunt in Toronto.

Q. Anyone else?

A. I remember sending -- I'm trying the remember specific doctors. There is a couple of doctors in town who we definitely have had second opinions from.

Q. Who are those doctors?

A. I had a second opinion from Dr. Kozarski, Dr. Hays.

Q. Were those for bad outcome patients?

A. They were definitely undesirable outcomes, yes.

Q. Who paid for the second opinions?

A. I don't remember to be honest.

Q. Do you know of any of your patients today who are vocally dissatisfied with the care they received from you?

A. Well, we have got some outstanding lawsuits so yeah.

Q. Anybody else?

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A. I'm sure there are patients that are dissatisfied to some degree. I can't think of any specific patients.

Q. How many cases have you been involved in as an expert witness?

A. I don't have the exact number. I think I have done deposition maybe half a dozen times or less.

Q. How many times have you reviewed cases of doctors?

A. I have reviewed cases another dozen times.

Q. So about 20 times perhaps you either gave a deposition or reviewed a case?

A. I would say less than that.

Q. What is your best judgment?

A. Less than that.

Q. Best judgment as to the number?

A. Twelve times maybe.

Q. And you have testify in eight cases, eight depositions?

A. No.

Q. How many depositions?

A. You mean outside of my own or including my own.

Q. Including your own.

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A. I can remember four or five.
Q. Including your own?
A. Correct.
Q. Tell me about those four or five.
A. Well, two of the cases that we talked about previously they were mine.
Q. All right. And the other two to three?
A. One was a case where the patient had residual prescription and some irregular astigmatism.
Q. What do you mean?
A. The cornea was shaped irregularly after surgery.
Q. Did you testify for the patient or the doctor?
A. For the doctor.
Q. What caused the cornea to be shaped irregularly?
A. We are not sure.
Q. Is that case ongoing?
A. No.
Q. What happened to it?
A. The case was found for the defendant.
Q. Who was the doctor, the defendant?
A. Dr. Miguel Santiago.
Q. Where did that case take place?

00070

A. Puerto Rico.
Q. What year was that case?
A. I don't remember. It was several years ago, three or four years.
Q. Did he go to trial?
A. Yes.
Q. Did you testify at trial?
A. Yes.
Q. In Puerto Rico?
A. Yes.
Q. Who was the lawyers involved?
A. I don't remember.
Q. Tell me about the next case where you testified.
A. It was a case several years ago in Atlanta and I don't remember all of the details of that case.
Q. Who was the doctor?
A. Dr. Kozarski.
Q. What did he allegedly do?
A. I don't remember the details of the case.
Q. Did it go to trial?
A. No.
Q. What happened to it?
A. I don't know.
Q. Did you give a deposition?

00071

A. Yes.
Q. The next case?
A. Those are the only specific ones I can remember.
Q. Have you ever testified on behalf of a patient?
A. No.
Q. Have you ever reviewed cases for Plaintiff's attorneys?
A. Yes.
Q. What attorneys?
A. I don't remember any of them.
Q. You can't identify any attorney for a patient you have ever worked for?
A. No. I don't have any relationship specifically with any attorney. I have been given cases from time to time to review and I have given them my opinion. I don't go looking for this work.
Q. I'm trying to identify --
A. No.
Q. -- any lawyer or any patient who have ever sent you a case and asked you to review it?
A. No.
Q. What is your hourly rate?
A. What is my hourly rate? I don't know.

MR. STOTT: I don't know either.
THE WITNESS: I can get it to you. I think it's 450 an hour but I'm not sure about that.
BY MR. BURNS:
Q. Have you ever seen what you think is medical malpractice performed by an eye surgeon?
A. Yes.
Q. When roughly? How many times have you seen what you think is medical malpractice?
A. I hadn't really thought about how many times. I think there have been a handful of times where there have been mistakes that fell below the standard of care.
Q. Have you ever talked to any of the patients about that?
A. I have answered their questions openly and honestly.
Q. Have you ever told the patient that the doctor fell below the standard of care?
A. I don't think I have used that terminology no.
Q. Have you ever told a patient that it was the doctor's fault that had the bad outcome?
A. Yes.
Q. What patients have you told that to?

00073

MR. STOTT: Don't mention names of your individual patients.

THE WITNESS: If a patient comes in and asks what their problem is and why they have got it I will answer that very openly and frankly.

BY MR. BURNS:

Q. Have you done any research in connection with this case?

A. No.

Q. Do you have any idea of how often the wrong prescription is filled on a patient during lasik surgery?

A. I don't know the exact number.

Q. What is your best judgment as to what percentage of time a patient undergoing lasik surgery has the wrong prescription performed on both eyes?

A. I don't know. I would be guessing.

Q. Is it unusual that the wrong prescription was performed on both of Kelly Leo's eyes?

MR. STOTT: Object to the form.

THE WITNESS: Again, I'm guessing, but I would say that is an unusual thing to happen.

BY MR. BURNS:

Q. What professional organizations are you a member of?

00074

A. American Academy of Ophthalmology, ASCRS.
Q. What is that?
A. American Society of Cataract Refractive Surgery.
Q. Any others?
A. SEEC, Society for Excellence in Eye Care.
Q. Any others?
A. I can't think of any off the top of my head.
Q. What role does the FDA play in refractive surgery?
A. I don't know the specifics of exactly what the FDA's role is but they are responsible for making sure that the devices that we invent work well and they set up parameters for how to use those devices.
Q. Do you know what an adverse incident report is?
A. I have a general understanding of that.
Q. What is your general understanding?
A. My general understanding is that if something happens that is significant and negative and unexpected.
Q. Something significant, negative and unexpected happens.
What is the doctor's obligation or the lasik surgeons obligation?

00075

MR. STOTT: Object to the form.
THE WITNESS: I don't know what you mean.
BY MR. BURNS:
Q. Do you have to tell the FDA?
A. I don't know what those rules are. I don't know.
Q. Have you ever notified the FDA of any adverse incident involving lasik surgery?
A. I'm not sure. The administrative side handles that. It's by our admin staff.
Q. Who in your administration notifies the FDA if you have an adverse incident?
A. I don't know.
Q. Up to this moment had you any suspicion that you were to suppose to notify the FDA of an adverse incident?
MR. STOTT: Object to the form.
THE WITNESS: I was aware that we do have to report certain things.
BY MR. BURNS:
Q. What things do you understand that you have to report to the FDA?
A. I don't know the details of what has to be reported to the FDA.
Q. Who have you assigned that responsibility to

00076

within the Woolfson Eye Institute?
A. I can find out who that is. We have someone in charge of operations and the admin side of that would be handled on that end.
Q. You don't know whose job that is, if anybody, at Woolfson Eye Institute?
A. I don't know who is responsible for reporting that to the FDA.
Q. Do you have something set up?
A. I believe we have something set up.
Q. Who set it up?
A. As I said it's set up on the admin side.
Q. Who set it up?
A. I don't handle the admin side.
Q. So you don't know who set it up?
A. I don't know who set up exactly what on the -- administrative side.
Q. Is it your understanding that the adverse admin report should have been filed in connection with Kelly Leo's case?
A. Again, I don't know the exact details of what need to be reported to the FDA or not.
Q. Do you read any professional journals?
A. Yes.
Q. Which ones?

A. I read journals that come out from Asterisk and iNet and different journals that come out.
Q. And do rely on those journals to provide accurate information for you in treating your patients?
A. I don't rely on any specific source for providing treatment information for my patients. There is no one specific source of journals or meetings or organizations.
Q. No, sir. I wasn't saying there is one single source.
But do you rely on the organizations that you're a member of to provide you with reliable information in treating your patients?
MR. STOTT: Object to the form.
THE WITNESS: Sure we look at the publications and specific studies and evaluate them.
BY MR. BURNS:
Q. Are there any authors that you view as authoritative in the area of lasik eye surgery?
A. There is no specific one author or a few authors that I would consider to be the authoritative bodies or individual.
Q. And I didn't say the authoritative, but just

are authoratives, people that you would say a writing by Dr. Wang I think that would be reliable information that we could rely on.

A. We don't rely on anything just based on who the author is no.

Q. Are there any books that you rely upon to provide information to help you treat your patients?

A. We look at the whole picture of information that is coming out and so a book is usually outdated by the time they come out. And so it's a mix of individual contacts with doctors and meetings, big meetings and small meetings and some publications. It's a mix of everything that helps us to determine what we are going to do.

Q. Have you ever written or blogged or done anything in connection with input on lasik surgery?

A. No.

Q. About patients having the wrong procedure performed on them?

A. No.

Q. Have you ever been to a seminar where they discussed patients having the wrong procedures performed on them?

A. Yes.

Q. What seminars?

A. I don't remember the specifics. It was many years ago. I don't think the seminars were specifically about that, it's just those things were mentioned, and the gist of it was to make sure you had a protocol that actually worked and to be careful.

Q. Have you ever heard anybody say that the standard of care does not require that the doctor do the right procedure on his patient?

A. Can you repeat that please?

Q. Have you ever heard anybody say that the standard of care does not require that the doctor do the correct procedure on his patient?

A. I have never heard anyone say that the standard of care does not require the correct procedure to be done.

Q. My question was?

A. You have a lot of negatives.

Q. Have you ever heard anyone say that the standard of care does not require that the doctor do the right procedure on his patient?

A. I never heard anyone say that the standard of care does not require doing the correct procedure.

Q. Have you ever heard anybody say that the standard of care requires that you do the correct

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procedure on your patient?
A. I don't remember ever hearing that.
Q. Have you ever heard any place that it's within the standard of care to do the wrong procedure on a patient?
A. I don't remember reading the standard of care requires X, Y, and Z. Most of the information that I get doesn't put it in the medical legal jargon so I'm just trying to think if I can remember anything that states it in that format of the standard of care is X, Y, Z. And in general, you know, that is just not a format that we present information.
Q. Well, have you ever heard in any format that it's okay for the doctor to do the wrong procedure on his patient?
A. I have not read that it's okay for the doctor to do the wrong procedure.
Q. Now, in this case you agree that Dr. Bearman performed the wrong prescription on both of Kelly's eyes didn't he?
MR. STOTT: Object to the form.
THE WITNESS: I agree that he performed the wrong prescription, correct.
BY MR. BURNS:

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Q. On both of her eyes?
A. I believe that is true. I need to check the chart and everything.
Q. You didn't bring that with you to check?
A. No.
Q. But you don't know whether he performed the wrong procedure?
A. I believe it was both eyes.
Q. Do you understand that Dr. Bearman did not check to be sure that the technician programmed the correct prescription into the lasering machine before he operated on Kelly Leo?
A. Could you repeat that please?
MR. STOTT: Object to the form.
BY MR. BURNS:
Q. Do you understand that Dr. Bearman did not check to be sure that the technician programmed the correct prescription into the lasering machine before he operated on Kelly Leo?
MR. STOTT: Same objection.
THE WITNESS: It's my understanding that he did not check the laser with the correct prescription before he did the laser.
BY MR. BURNS:
Q. Did he check the laser with regard to any

prescription?
A. I wasn't there so I don't know exactly what he checked.
Q. Well, based upon your review of his deposition did he look at the laser machine in an effort to determine whether the correct prescription had been put in?
A. It's my understanding that he had the technician input and check the data and that he did not check it himself.
Q. And you have no criticism of that whatsoever?
MR. STOTT: Object to the form.
THE WITNESS: I didn't say I had no criticism of that. We have a protocol that is different.
BY MR. BURNS:
Q. If you have criticism of that tell me what it is?
A. We have a different protocol.
Q. My question is, do you have any criticism at all of Dr. Bearman operating on Kelly Leo without even looking at the screen to attempt to confirm that the right prescription had been put in?
A. Well, as I said we have a different

protocol.

Q. Yes, sir. I didn't ask you whether you had a different protocol I asked you whether you had any criticism at all, of Dr. Bearman for operating on Kelly Leo without looking at the screen to attempt to confirm that the right prescription had been put in?

A. And as I was saying we have a different protocol and as such a different protocol may have provided a different outcome in this instance. And, you know, we --

Q. It's a yes or no question. Do you have criticism or not? I didn't ask you whether you have a protocol.

I asked whether you have any criticism of Dr. Bearman for operating on both of Kelly's eyes without looking at the machine to determine whether it had the correct precipitation or not?

MR. STOTT: Object to the form.

THE WITNESS: That is what I was trying to say.

BY MR. BURNS:

Q. It's yes or no. Do you have criticism or not?

MR. STOTT: Same objection.

THE WITNESS: Yeah. We have -- yes. We do

things differently and so I think while he operated within the standard of care we have as I said a different protocol and, you know, you say if there is any criticism. We have set up a protocol for reasons -- for our own reasons. And so we have chosen to do it that way and -- but again, having said that I think he acted within the standard of care.

BY MR. BURNS:

Q. You said yes you have criticism. Tell me what your criticism is of Dr. Bearman operating on both of Kelly's eyes without looking at the machine to determine that the prescription was correct?

A. As I said the criticism I have is that we have a different protocol and I think his protocol works out fine but it's just that ours are different.

Q. So you have no criticism then. You either have criticism or you don't. You say well, he has his protocol, and we have got ours. I have no criticism. I just want to get to the bottom of it doctor.

A. I have given you the bottom of it. You know, we have a different protocol.

Q. But that doesn't make his wrong, does it?

A. It does not make his wrong, correct.

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Q. Okay. Do you have any criticism of his protocol?
A. I think his protocol is forged within the standard of care.
Q. My question was, do you have any criticism of his protocol?
A. I think that -- I think our protocol is better in some ways, but our system of doing it is totally different in that we are -- we are one clinic and so we are operating a different way. If we were using a roll on roll off system then it would be different. So that is why I keep going back to having different protocols. Because our clinic is so different than the way he has his set up. Because we have all of the people involved all work for the same clinic.
BY MR. BURNS:
Q. My question doctor was, do you have any criticism of his protocol?
A. I think his protocol was adequate.
Q. So you have no criticism of his protocol?
A. You know I'm not in that situation. It's difficult for me to say because I'm not -- I'm not operating in his exact set up in that you have got to have technicians that -- if you're in his situation

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and you bring the laser in you have got to -- you're bringing the patient, you're bringing the laser and the technicians in that you can trust because you can't as a doctor you can't physically check everything.

Q. But you can look at the screen?

A. You can look at the screen.

Q. And he didn't do that, did he?

A. He did not.

Q. Do you have any criticism of his failure to look at the screen before he removed tissue from Kelly Leo's eyes?

MR. STOTT: Object to the form, asked and answered.

THE WITNESS: Again, I would set up protocols differently.

BY MR. BURNS:

Q. I didn't ask you if you would doctor. Please listen to my question.

Do you have any criticism of his failure to look at the screen before he removed tissue from Kelly Leo's eyes?

A. No. I think he had a protocol that was set up and had worked in the past and that's something that worked for him. It didn't in this

circumstance --
Q. Why not?
A. -- with all of the safety that we have.
Q. Isn't it true doctor that the reason it didn't work is there was an error in putting the prescription in the machine?
A. There was an error in the prescription in the machine.
Q. And if the doctor doesn't look every time there is an error in putting the prescription in the machine the doctor is going to do the wrong surgery, isn't he?
MR. STOTT: Object to the form.
THE WITNESS: I need you to repeat that.
BY MR. BURNS:
Q. If the doctor doesn't look at the screen every time there is an error in putting the prescription in the machine the doctor will do the wrong surgery, isn't that true?
MR. STOTT: Object to the form.
THE WITNESS: If there is an error in the machine and the doctor doesn't check it he will do the wrong treatment, correct.
BY MR. BURNS:
Q. Every single time?

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A. I would expect that.
Q. And is there any reason why the doctor shouldn't take a moment and confirm that the prescription that is in the machine is the appropriate prescription for the patient before he removes tissue from her eyes?
A. The doctor may not be aware of the nomagrams from that specific laser and as I said earlier the numbers of the prescription if you try to treat maybe or usually it will be different from the number that goes into the laser itself. And so the surgeon when they are looking at what is in the laser will actually -- it will be different. It will be something that is different than to what is in the chart to what your desired prescription is.
Q. Well, isn't that the surgeon's obligation know what the appropriate prescription in the machine is for the operation he wants to perform?
MR. STOTT: Object to the form.
THE WITNESS: Everybody has their own protocol but in this circumstance he was bringing someone else in to run the laser and for the laser to be functioning correctly.
BY MR. BURNS:
Q. Well, what is his obligation then if someone

else is running the laser what was Dr. Bearman's function just step on the pedal?

A. No.

Q. What?

A. His obligation is to have his pre-opt measurements done and to plug that into whatever his protocol is in the system and to perform the surgery as best he can.

Q. What is there in performing the surgery, if he doesn't have to look at the screen, all he does is step on the pedal, isn't it?

A. No.

Q. What does he have to do to perform the surgery?

A. On this.

Q. On this procedure for Kelly Leo what is it that he had to do?

A. He has to use a special instrument.

Q. The laser machine?

A. No.

Q. What special instrument?

A. He need to use a special keretome instrument to make a flap incision.

Q. How does he do that?

A. Again, it will vary under different

00090

protocols, but most people will have a technician set up the keretome, the flap maker, and then the surgeon will use that to make the flap.

Q. What does the surgeon do to make the flap?

A. He has got to apply a suction ring on the eye.

Q. What does he do to do that?

A. There is a physical ring that you place on the eye. Then you have got to apply the pressure so it's a suction pump associated with that, and that applies the pressure, which increases the pressure on the eye. And then the surgeon will need to keep the cornea hydrated and then activate the flap maker cutting device. Which in this case would have been an oscillating blade that would move back and forth. And after the flap is made then the surgeon's responsibility would be to deactivate the suction and to maintain the proper hydration of the eye, lift up the flap and then apply the laser.

After which time he has to reapply the flap in a perfect position and keep it smooth and give it back and get it together and get it dry and apply drugs. That is the basic steps, it doesn't cover everything.

Q. How long did the surgery take on Kelly's

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left eye?
A. I don't have the exact timetable and I wasn't there.
Q. Roughly?
A. My guess is that each eye probably took about five minutes.
Q. How long would it have taken for Dr. Bearman to have confirmed the -- that the correct prescription was in the machine?
A. I don't know exactly how he has things set up in the OR with the charts but.
Q. Do you remember reading his deposition where he said he could have done it in seconds?
A. I mean, just checking the actual prescription itself would just take a few seconds.
Q. Now you said Dr. Bearman had a protocol in his office.
Well, he never used that protocol before had he?
A. When I say he had a protocol he had a mechanism of figuring out what the prescription was he wanted and communicating that with the technicians and getting that applied to the laser.
Q. Didn't he use a different protocol on the first eight patients?

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A. He used a different protocol. Yes, he used a different protocol.
Q. So what was the justification for using a different protocol on Kelly Leo than the one he had used successfully on the first eight patients?
A. You would have to ask him.
Q. Do you have any basis for that?
A. I can't try to figure out why he changed or did things differently.
Q. You agree that the protocol he used on the first eight patients was safer on the patient than the protocol he used on Kelly Leo, don't you?
MR. STOTT: Object to the form.
THE WITNESS: it was different.
BY MR. BURNS:
Q. Was it safer?
A. It may have been safer.
Q. How do you explain the first eight patients not having a problem with that protocol but Dr. Bearman employing a new protocol and performing the wrong surgery on both of Kelly's eyes?
MR. STOTT: Can you tell me which protocol you're talking about?
THE WITNESS: We can't speculate as to why things happened one specific way for one

00093

patient.
BY MR. BURNS:
Q. Why can't we?
A. Because having an adverse outcome on the one patient is not indicative of -- that on its own is not indicative of one way being safer or another.
Q. Well, we know why we had the bad outcome with Kelly.
It's because the wrong prescription was filled on both of her eyes, correct?
A. Kelly had the wrong prescription.
Q. But the first eight had the right prescription on their eyes, didn't they?
A. It's my understanding that the first eight did just fine.
Q. What was the change that resulted in Kelly's prescription being wrong? What did Dr. Bearman change, if you know?
A. I don't know the exact details of what happened in the OR.
Q. You remember Dr. Bearman's testimony in this case?
A. I don't remember those details, no.
Q. Do you remember him testifying he did the calculations in the first eight and he allowed the

00094

technician to do the calculation in the ninth on Kelly's?

MR. STOTT: Object to the form.

THE WITNESS: I don't remember all of the details on that.

BY MR. BURNS:

Q. Were you intellectually curious why the first eight went fine and Kelly Leo's went bad?

A. I'm not sure how to answer this either. I did wonder why that happened, but I wasn't there to know exactly.

Q. You couldn't figure it out from reading his deposition?

A. Well, I could see what happened with the issue of him having the correct prescription in the chart that he had filled out and that he had actually done some of the calculations and circled it several times so he actually did do the correct calculations. Circled it as that is what he wanted to treat. And then had the technician input that. So I wasn't curious as to exactly where it happened because I think I followed the train of events to a great degree.

Q. Well, what was the error that was made on Kelly Leo that was not made on the first eight?

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A. There was an error with the treatment of the astigmatism.
Q. What error?
A. The error of the astigmatism was the X was incorrect.
Q. What caused that error?
A. The numbers that the doctor had written down and that he crossed off with the technician did not correspond to the prescription that was in the laser.
Q. Why?
A. Again, I wasn't in the laser room to know exactly what happened but it appears that the technician put in the incorrect numbers.
Q. And the only intervention after the technician put in the incorrect numbers that would have prevented the wrong surgery from being performed on Kelly Leo would be for Dr. Bearman to confirm the prescription in the machine?
MR. STOTT: Object to the form.
THE WITNESS: If he had compared what was in the laser to the correct prescription then that would have prevented it.
BY MR. BURNS:
Q. That's the only thing, isn't it?
MR. STOTT: Same objection.

THE WITNESS: I can't speculate as to the only thing that could have prevented it but.

BY MR. BURNS:

Q. Could you think of anything else that would have prevented him from doing the wrong procedure other than confirming that the prescription is correct?

MR. STOTT: Object to the form.

THE WITNESS: Sure. Once the prescription is put into the laser it usually gets stored in the hard drive and it gets pulled up during the surgery time. And at that point the technician also should have been checking to make sure that that laser prescription that was in the laser corresponded to the prescription on the chart.

BY MR. BURNS:

Q. So the technician should have caught that?

A. The technician absolutely should have caught that.

Q. Did you see in the chart where it says out of range in connection to the prescription in the machine?

A. Yes.

Q. What does that mean?

00097

A. The laser has gone through different FDA and Vixs parameters in terms of the amount that it can treat. And so the laser will have certain things in terms of what it can treat and she had more astigmatism in one eye than the laser was able to treat.

Q. Well, that was based on the wrong prescription, wasn't it?

MR. STOTT: Object to the form.

THE WITNESS: That was based on the wrong prescription.

BY MR. BURNS:

Q. And when you get an out of range error message what is the surgeon supposed to do?

A. Well, it depends on what the out of range message is and what the specifics are in that case.

Q. In this case?

A. I believe he thought he had the correct prescription and he knew the astigmatism was high and so he went ahead with the treatment.

Q. That is Dr. Bearman you're talking about?

A. Yes.

Q. So he knew that he had the out of range, error?

A. I'm not sure what he was aware of at that

time. I was not in the OR.
MR. STOTT: When you get to a stop I need a restroom break.
MR. BURNS: Okay.
MR. STOTT: Is now good?
MR. BURNS: Yes. Go right ahead.
(A short break was taken.)
BY MR. BURNS:
Q. Doctor, did Custom Laser Eye ever provide lasers to other surgeons or other surgery facilities?
A. I don't Custom Laser Eye provided any.
Q. You don't think so?
A. Custom Laser Eye provided -- actually, I don't remember that. I think we had a few surgeons that we helped out but I don't think it was Custom Laser Eye. One of the other corporations was involved with that.
Q. What corporations have you owned an ownership interest in that rented laser machines to other doctors?
A. There is an LLC that we have Nanli, that is responsible for owning the lasers.
Q. Who owns Nanli?
A. I do.
Q. Any other owners besides you?

00099

A. No.
Q. How long has Nanli been in existence?
A. Again, it started more or less around 2001, 2002 in this range.
Q. How many employees does it have?
A. I think two full-time employees at this time.
Q. How many doctors do you provide laser machines for?
A. You mean right now?
Q. Yes, sir.
A. I'm not sure we are doing that. We are only helping out a couple of doctors and I don't think we are doing that right now.
Q. Are these machines you use in your practice?
A. Correct.
Q. And so if you have got a day when you don't need the machine if you can rent it to somebody else you do that?
A. Correct.
Q. And the two employees are they employees of the Woolfson Eye Institute?
A. They are employs of Nanli.
Q. Do they do any work for Woolfson Eye Institute?

00100

A. They may help in the clinic on some days at Woolfson Eye.
Q. What do they do for Nanli if you are not providing any machines to any doctors?
A. We move the lasers around to our different clinics and that is their job.
Q. So you have a contract -- so Woolfson Eye Institute clinic has a contract with Nanli for it to transport the laser machines to the appropriate clinic?
A. Correct.
Q. Does it also provide a technician?
A. I can't remember -- I don't believe that the technicians are hired by Nanli. I believe that the technicians are a direct employee of the different Woolfson Eye clinics.
Q. Who are the two employees?
A. Ben Sever and Tom Kirk with a K.
Q. Now we are in agreement that the surgery that Dr. Bearman did made Kelly Leo's vision worse?
A. She is definitely complaining of a lot more side effects. And yes her vision would be worse from that.
Q. Yes, sir. And I'm not talking about the side effects now I'm talking about her actual vision.

00101

Her vision was worse coming out than going in, wasn't it?

A. Her vision today without glasses is not worse than her vision beforehand without glasses.

Q. Her vision today is not any worse?

A. Again, I need to check the chart and if you want me to evaluate and go through the chart step by step we can do that. Her vision -- I don't remember her vision without glasses before surgery.

Q. We may have to do that doctor. I don't have the chart. But I do want to know whether you contend her vision was better or worse after Dr. Bearman performed the wrong prescription on both of her eyes and you don't know the answer to that.

A. Are you talking about with or without glasses.

Q. Without glasses was. We will do it both ways.

Was it worse without glasses?

A. Without glasses her vision today in terms of what she is reading on the chart I believe is better than her vision without glasses before surgery.

Q. Is that a result of the many enhancements Dr. Wang has done?

A. That is a combination of all of the

00102

treatments.
Q. When she walked out of the surgery, two days after the surgery was her vision without glasses better or worse than when she went in?
A. Again, we will need to go through the chart on that day by day.
Q. How about her vision with glasses is it better today than it was before the surgery?
A. I believe her vision today with glasses is worse than it was with glasses prior to surgery.
Q. How much worse?
A. Again, we can read the numbers off the chart and I don't have that.
Q. Does it make a dramatic difference in her ability to see?
A. She is having significant problems with her vision.
Q. Is Nanli involved in providing lasers for surgeries that result in Medicare payments to Nanli?
A. No, not that I know of.
Q. What makes you say that?
A. Because I'm not aware of the lasik being covered by medicare. So I'm not --
Q. You said that she has got side effects. What side effects are you aware of that

00103

Kelly Leo is experiencing as a result of this surgery?

A. She is having some glare and halos.

Q. All right. Tell me what -- and glare I think you said earlier is the generic term that involves a number of other issues?

A. Yes.

Q. What are halos?

A. Halos are descriptive terms given by patient to describe often a ring around light most commonly seen in dark when there is a bright light.

Q. What causes halos?

A. We don't know.

Q. No idea?

A. We know that there are different risk factors but we don't know exactly what causes glare on halo.

Q. What are the risk factors on halos?

A. Anyone who starts out with a high prescription or who starts out with a lot of astigmatism or starts out with really big pupils, patients with light blue or light green eyes, are more sensitive. Or patients that start out with glare preoperatively all of these we know are conditions that will make it more likely to have

glare afterward.
Q. And you discuss those risk factors with your patients before you obtain consent for lasik surgery?
A. Yes.
Q. What are starburst?
A. Starburst fall under the general glare issue and occurs mostly at night in darker conditions. When there is a bright light patients may see streaks of light emanating from that bright source of light.
Q. What causes it?
A. The same issues we talked about for halos are all the same issues for glare.
Q. You're talking about those are risk factors. I'm trying to determine what is it about the surgery that causes the patient to have starburst?
A. We don't know exactly what causes starburst. We know that those are risk factors and patients with those risk factors are more likely have glare even if everything go perfect with the surgery. So we don't know what causes the glare.
Q. What is night vision?
A. It's a term to describe how well you see at night.
Q. Are the problems with night vision that Kelly is experiencing?

00105

A. She is having some issues at night yes.
Q. What are those issues?
A. I don't have the chart in front of me so I can't go through all of the details with that.
Q. What are the risk factors for problems with night vision follow lasik surgery?
A. The same risk factors as we talked about with glare.
Q. Is Kelly having a problem with dry eye?
A. Kelly has had some problems with dry eye, yes.
Q. What is dry eye?
A. Dry eye is a condition where the patient may have some surface epithelial changes caused by the eye not getting the proper amount or proper type of lubrication.
Q. Is the increase of dry eye increased with multiple enhancements?
A. Long term I'm not sure that is really true. Long term I would say the risk of dry eye would go back to whatever the baseline is.
Q. What is the baseline risk?
A. Some patients will have the dry eye but it's usually worse over the first several weeks to several months. And a small percentage of patients will end

00106

up having long term dry eye.
Q. What percentage have long term dry eye?
A. We don't know the exact percent with long term dry eye.
Q. What is your best judgment?
A. Less than five percent.
Q. Kelly has long term dry eye, doesn't she?
A. I haven't examined Kelly to comment on that.
Q. Based upon your review of her deposition and the depositions in this case you don't have enough information?
A. I would have to recheck the chart for each symptom that you're looking for here. I do recall issues of dry eye have come up after the surgery.
Q. What is the baseline risk for patients to have permanent night vision problems?
A. Can you repeat that.
Q. What is the baseline risk for a patient having permanent night vision problems following lasik surgery?
A. What do you mean baseline risk?
Q. Well, taking all --
What percentage of them are going to have permanent night vision problems?
A. Overall that risk is low it's less than five

percent. In her case with the fact that she started out with a lot of astigmatism prior to surgery her risk for that would be high.

Q. How high was her risk?

A. I don't know the exact percentage.

Q. Your best judgment.

A. If I had to guess I would say her risk was in the five percent range maybe a little bit higher.

Q. I thought you said that taking all comers the risk was five percent?

A. I said less than five percent overall. You're asking me to guess I'm giving you numbers and I'm just guessing.

Q. Don't you communicate with your patients about the likelihood that they are going to have these adverse side effects even if everything goes right with the surgery?

A. We communicate with our patients.

Q. What risk do you tell them that they will have with permanent night vision problem?

A. We tell them it's less than five percent.

Q. And how about starburst what do you tell them?

A. Again less than five percent.

Q. Halos?

00108

A. Same thing. Less than five percent.
Q. And if there is a patient like Kelly that has some of the risk factors that you describe what do you tell her?
A. We tell her that the risk is higher. We don't know exactly what those risks are and we don't like to put a specific number on them.
Q. Have you read any of the literature about the percentage of patients who have these symptoms of halo and starburst and dry eye and night vision problems following lasik surgery?
A. Yes.
Q. And what percentages are you familiar with?
A. I can't remember the specifics. I know a lot of different studies give very different amounts for the different parameters that you mentioned, and there is a big difference also for different lasik systems. So there is a big variation based on how you define the symptom.
Q. What is the variation range from?
A. I would have to look up the literature if you're asking me for a specific.
Q. Have you seen as high as 20 percent of most lasik surgery have problem with halos and starburst?
A. I don't remember that specific number.

00109

Q. Does that number shock you?
A. That seems high but again it's when the measurements are taken it and exactly who is measuring them and what it is that they are measuring in terms of the parameters. I would be shocked to find out 21 percent of my patient has long term halo glare or dry eye.
Q. What percentage of your patients have long term problem with halo glare or dry eye?
A. I think less than five percent.
Q. Is it something about the way you performed the procedure that minimize the risk those side effect?
A. I don't know.
Q. On your web page do you discuss the risk of halo, starburst, dry eye?
A. I'm not sure of what specifics we go into on the web page.
Q. Is there a reason you wouldn't discuss those?
A. I'm not sure of the format.
Q. My question is, is there any reason why you wouldn't disclose those risk on your web page?
A. I'm not sure. I hadn't thought about if there is a reason we wouldn't do something like that.

00110

But I can review what is on the web and see if that is on there.

Q. Certainly you want your patients to know the risk that post surgery they will have halos, starburst, dry eye and these other problems, don't you?

A. Yes.

MR. BURNS: Do you have Dr. Bearman's deposition testimony?

MR. STOTT: I only have what he brought.

BY MR. BURNS:

Q. Do you agree that the standard of care require that the surgeon operate on the proper eye?

A. Yes.

Q. Do you agree that the standard of care that the surgeon perform the appropriate procedure?

MR. STOTT: Object to the form.

THE WITNESS: I'm not sure what you mean by appropriate procedure.

BY MR. BURNS:

Q. That he follow the prescription.

A. I think that the standard of care for the surgeon is to set up protocols that are reasonable to make sure that the laser, instruments and everything is done correctly which would include the

00111

prescription.
Q. Okay. If you look at Dr. Bearman deposition on page 150. Beginning at Line 4 the question was: Do you agree that the standard of care requires that you do the appropriate procedure?
And his answer would you read that answer out loud?
A. I would agree that the standard of care is to do the appropriate procedure on the appropriate eye.
Q. Do you agree with him?
A. Yes.
Q. Then the next question: And do you agree that in his case you did not do the appropriate procedure?
Would you read his answer?
A. I would agree in this case that we treated the wrong prescription.
Q. Do you agree with that?
A. I do agree that they did the wrong prescription in this case.
Q. And is that the wrong procedure to do the wrong prescription isn't that equivalent to the wrong procedure?
MR. STOTT: Object to the form.

00112

THE WITNESS: I'm not sure how you want to define prescription and procedure in the legal setting. I can't comment on how you're defining prescription and procedure.

BY MR. BURNS:

Q. Does the standard of care require that the surgeon do the right prescription?

MR. STOTT: Objection; asked and answered several times.

THE WITNESS: I think the standard of care requires that the surgeon set up the appropriate protocols that involve making sure he has a reasonable belief that the laser system instrumentation and everything is done correctly.

BY MR. BURNS:

Q. Look at page 151 beginning at Line 20. Question: And do you agree that the standard of care requires that the surgeon perform the correct prescription on the patient?

Read Dr. Bearman's answer please.

MR. STOTT: Objection to stating out of context.

THE WITNESS: He says: Sure. Sure.

BY MR. BURNS:

00113

Q. Do you disagree with him?
A. Yeah. I'm not sure how he is defining stuff but I have already answered what I think is reasonable.
Q. I didn't understand what you said.
A. I said I have already answered what I think is the reasonable standard of care, and so I'm not sure how he is defining or reading a question or, you know, what he is thinking at that time. What I can answer is what I think is reasonable at this time.
Q. You disagree with Dr. Bearman. You say that the standard of care does not require that the surgeon do the correct prescription on the patient; is that right?
A. That is not what I said.
Q. You said all he had to do is a procedure, a protocol that is reasonable, isn't it?
A. I think that would be a reasonable standard of care.
Q. That is what you say the standard is. Long as you have a protocol that is reasonable it doesn't matter how many times you do the wrong procedure on the patient or the wrong prescription it's within the standard of care?
MR. STOTT: Object to the form.

00114

THE WITNESS: No.
BY MR. BURNS:
Q. Well, I thought that is what you said that as long as you have a reasonable protocol you have met the standard of care even if you performed the wrong prescription on the patient.
Did I miss something?
MR. STOTT: Objection; misstates prior testimony.
THE WITNESS: Earlier you said it doesn't matter how many times you treat with the incorrect prescription as long as the protocol is reasonable and I would take exception to that.
BY MR. BURNS:
Q. How many times do you have to do the wrong prescription before the protocol would not be reasonable?
A. I'm not sure it would depend on the circumstances. It would have to be you know if you're evaluating your outcomes in terms of how patients are doing it would depend on what kind of problems were coming up and how often and how bad.
Q. Okay. So you don't know how many times Dr. Bearman could perform the wrong procedure on patients

00115

and still be operating within the standard of care, correct?

MR. STOTT: Object to the form.

THE WITNESS: I would imagine that he would evaluate his protocols.

BY MR. BURNS:

Q. I'm not asking what he would have done. I'm asking what you're saying. You're the expert testifying that the standard of care does not require that the surgeon perform the correct prescription, correct, that is your position?

A. I think the standard of care is for him to set up his protocols.

Q. And regardless of whether the protocol results in him doing the wrong prescription on his patient, according to you, he is still within the standard of care?

A. I think he acts within the standard of care.

Q. And how many patients is he allowed to do the wrong prescription upon before you say he is falling below the standard of care?

MR. STOTT: Same objection.

THE WITNESS: I would imagine again he would have to evaluate --

BY MR. BURNS:

00116

Q. I'm asking you about what you would evaluate, doctor. I'm asking you.
A. I would imagine he would have to evaluate the type of problems that were coming up, how bad they were, how often, and see what he could do within his protocols to make that better.
Q. My question was: And how many patients is he allowed to do the wrong prescription on before you say he has fallen below the standard of care?
MR. STOTT: Objection; asked and answered.
BY MR. BURNS:
Q. I'm looking for a number.
MR. STOTT: He just told you the number depends on what the circumstances. You can't force a number out of him if he has already answered that way a number of times.
MR. BURNS: He can answer.
THE WITNESS: The things depend on what the circumstances are.
BY MR. BURNS:
Q. What are the circumstances that allow him to perform the wrong prescription on both eyes of a patient that tell you that that is a reasonable protocol?
A. You have to ask that again.

00117

Q. Well, you said depends on the circumstances. My question is, what are the circumstances that allows him to perform the wrong prescription on both eyes of Kelly Leo and for you to say he still has a reasonable protocol?

A. I'm not sure I understand your question in terms of what are the circumstances. You have to restate that a little better.

Q. What is your basis for saying that he had a reasonable protocol when he performed the wrong procedure on both of Kelly Leo's eyes?

MR. STOTT: Object to the form.

THE WITNESS: I know that that is a protocol that many other surgeons have used and it's just my opinion that a lot of surgeons do it that way as being the standard of care. And in anything that we do there is going to be some risk of complications and even risk of having incorrect prescription no matter what we do.

BY MR. BURNS:

Q. What surgeons do you know who do not look at the Vixs screen before operating to make sure they are doing the right prescription?

A. I haven't taken a poll of surgeons to see who does what.

00118

Q. Has any surgeon, have you ever heard of any surgeon other than Dr. Bearman who didn't look at the screen to confirm he had the right prescription before he operated?

A. Sure I have heard that before.

Q. Who?

A. I don't know of any specific name but those issues have come up at meetings in terms of different protocols of setting things up and different ways things could go wrong.

Q. Has any doctor ever stood up at a meeting and said, I don't believe it's appropriate to look at the screen to make sure you have the right prescription before you operate on a patient?

A. I don't remember hearing that.

Q. Have you ever read that?

A. I don't remember reading that.

Q. Are you going to make that announcement the next time you're given an opportunity to speak. I have served as an expert witness and I want you all to know I don't think the standard of care requires that you look at the screen to confirm that it's the right prescription?

MR. STOTT: Object to the form.

THE WITNESS: Repeat that please.

00119

BY MR. BURNS:

Q. Are you going to make that announcement the next time you speak that you have served as an expert witness and you want the surgeons to know that the standard of care does not require that they look at the screen to make sure they have got the right prescription?

A. No, I will not be making that announce.

Q. Have you ever heard anybody say anything close to that?

A. I have heard people at meetings say they set things up very closely to the way Dr. Bearman set up his protocol.

Q. Does that include not looking at the screen before doing the surgery?

A. I have heard some surgeons not doing that as, well as even surgeons who do look at the screen and still have the same outcome.

Q. That would be because they had a mistake on the paper they used to put the information into the machine, wouldn't it?

A. There was a mistake somewhere.

Q. The mistake would have to be duplicated wouldn't it? If they were comparing the machine to the paper then the paper would have to be wrong?

00120

A. There could be multiple places for errors.
Q. Do you agree with Dr. Bearman that if he had gone forward with what he knew to be an incompetent technician he would have fallen below the standard of care?
MR. STOTT: Object to the form.
THE WITNESS: Repeat the question.
BY MR. BURNS:
Q. Do you agree with Dr. Bearman that if he had gone forward with what he recognized as an incompetent technician that he fell below the standard of care?
MR. STOTT: Same objection.
THE WITNESS: I would agree if he knowingly used an incompetent technician that would be below the standard of care.
BY MR. BURNS:
Q. Do you agree with him he had a duty to make inquiries to determine whether the technician is competent?
MR. STOTT: Object to form misstates testimony. If you want to ask him questions beyond what is going to testify at least give him the honest testimony that was given. Don't go lie to him about what somebody said --

00121

MR. BURNS: Look nobody is lying to anybody get a grip.
MR. STOTT: Don't misstate testimony to try to get him to agree with it. You have already said your expert testified to that when he clearly said the opposite. And I can read it to you on page 117 to 119 of this deposition where your expert clearly said there is no need to make any. So you have already misstated the testimony from one witness.
MR. BURNS: No. I haven't and you're interrupting.
MR. STOTT: Well, I'm going to read it into the record.
MR. BURNS: Look I'm taking this deposition. You do what you want to when we are done.
MR. STOTT: I'm going to read it into the record.
MR. BURNS: You don't have a right to just read things into the record at this deposition.
MR. STOTT: Why not when you just said you didn't misstated testimony which you misstated, I think, I have a right to defend myself when you say that I'm wrong about that.
BY MR. BURNS:

00122

Q. On page 145 beginning on Line 8. Are you with me doctor?
A. We are coming across it.
Q. The question was: And as a consequence of your obligation to determine whether the technician was competent, you had the right to make inquiries of the technician, didn't you?
MR. STOTT: Object to the form mistakes the context, and is different than the question that was asked.
BY MR. BURNS:
Q. The answer?
A. You want me to read the answer?
Q. Yes.
A. The answer on page 145 Line 15 says: I believe so.
Q. You agree with that, don't you?
A. And as a consequence of your obligation to determine whether the technician was competent, you had the right to make inquiries of the technician, didn't you?
As I previously stated I think he had a -- had some obligation to make sure that he had a reasonable expectation that the laser system was functioning right and that the people providing the

lasers that there was some reasonable expectations there. I did not say that the surgeon was responsible for evaluating the individual technicians that that laser company was providing.

Q. I understand that's your testimony.
Have you read concerns in the medical literature about flap complications?

A. Repeat the question.

Q. Have you read concerns in the medical literature about flap complications?

A. Yes. I have read medical literature concerning flap problems.

Q. What do you recall having read?

A. There have been multiple articles on flap issues. I don't know specifically what you're talking about.

Q. Have you read about surgeons who have quit using -- performing lasik because of the flap complication?

A. I'm aware of surgeons who have quit doing lasiks yes.

Q. Because of flap complication?

A. I'm not sure why they stopped doing lasik there could be multiple reasons.

Q. Well, do you know of any surgeons who have

quit doing lasiks because of complications including flap complications?

A. I'm aware of some surgeons who at some point may have quit making flaps, but I don't know the specific terms. I don't know where everyone stands today on that and I don't know what all of the specific reasons are.

Q. What is epilasik?

A. There are different ways. Epilasik is a way of applying the laser to a more surface area of the cornea.

Q. And does that provide a degree of safety?

A. I think there are different procedures that have got different risk associated with it.

Q. What is the safety that is associated with epilasik?

A. The safety of the epilasik is that you're not cutting a deep flap into the tissue so that one aspect of it makes it a little safer.

Q. What is the danger of it?

A. There are -- you're more likely to have surface irregularities on the surface cells that may have increased risk of infection with the epilasik.

Q. Are you familiar with a publication called Eye World?

00125

A. Yes.
Q. What is Eye World?
A. It's one of the journals in the eye community.
Q. Who publishes it?
A. I don't know.
Q. Do you review it from time to time?
A. I don't routinely review it.
Q. Is it peer reviewed, do you know?
A. I believe it's partially peer reviewed. There is a kind of fuzzy line there.
Q. Are you aware of a move toward surface ambulation?
A. Yes.
Q. And is safety the reason for that?
A. Safety is one of the reasons for that yes.
Q. Are there long term studies of lasik patients?
A. Yes.
Q. How long?
A. Original lasik patients were done over 20 years ago.
Q. What are the long term studies showing?
A. The long term studies are showing lasiks is stable and have good results.

00126

Q. Are you familiar with studies that find cornea ectasia?
A. Yes.
Q. What is that?
A. Ectasia is an irregular healing pattern and thinning of the cornea.
Q. And what is the consequence of the patient?
A. The patient can have permanent corneal vision problems that are difficult to treat.
Q. Is that a condition found in long term studies of lasik?
A. They have found some lasik patients have ectasia post operatively.
Q. What percentage of the long term lasik patients have ectasia?
A. I don't know.
Q. Your best judgment?
A. My best judgment less than one percent.
Q. Is that what you tell your patients when you are discussing the long term risk?
A. If someone came in and asked me what the long term risk of ectasia were I would probably less than one percent.
Q. Do you voluntarily tell them, or do they have to ask you?

A. We mention ectasia as a risk factor. We don't throw specific percentages on every risk associated with it lasik.

Q. What are buttonholes?

A. Buttonhole is a condition that arises when a flap is made and there is an irregularity in the flap that is made such that there is a portion of the that actually does not cut through and underlining tissue protrudes through the flap.

Q. Is that a serious condition?

A. Any complication could be a serious complication.

Q. Is that one of the complications that has been uncovered in long term follow-up?

A. I'm not sure I understand the question.

Q. Is it long term follow-up that has led to the discovery of buttonhole?

A. No.

Q. That is seen immediately post surgery?

A. You will see it during surgery.

Q. What is keratoectasia?

A. I believe that is the same as ectasia we were talking about earlier. Keratoectasia then?

Q. Yes.

A. I believe it's the same as ectasia for the

function and what we are talking about.
Q. Have you ever warned a patient there is a risk that the wrong prescription will be performed on them?
A. I don't remember ever telling a patient that.
Q. Is that a risk that the patient assumes when they go in for lasik surgery that the doctor will perform the wrong prescription?
MR. STOTT: Object to the form.
THE WITNESS: I think that is one of the many risks that can could happen during surgery.
BY MR. BURNS:
Q. But is it one that the patient assumes?
MR. STOTT: Same objection.
THE WITNESS: I'm not sure what you mean assumes in the legal sense but it's a risk that can they are going to have, yes.
BY MR. BURNS:
Q. Well, there are some risk that can even if the surgery is performed perfectly you may have a bad outcome you understand that don't you, or do you?
A. Yes.
Q. And the risk that can the surgeon will perform the wrong prescription is not a risk that the

00129

patient is expected to assume when they go in for lasik surgery or are they according to you?

MR. STOTT: Same objection.

THE WITNESS: Again I don't know when you use the word assume I don't know what the legal definition is and how to apply that to your question.

BY MR. BURNS:

Q. Well, you have to deal with informed consent, don't you?

A. Yes.

Q. And when you deal with informed consent you tell the patient what the known risk are of the surgery, don't you?

A. Yes.

Q. And in doing that you tell them that even if the surgery is done properly you can have this risk, don't you?

A. Yes.

Q. And if the wrong prescription is performed the surgery is not done properly?

A. You didn't get the correct outcome.

Q. Was the surgery done properly if you performed the wrong prescription on the patient?

A. If you performed the wrong prescription

00130

on the patient somewhere something broke down and something was done incorrectly.

Q. What percentage of your patients have dry eye following surgery?

A. You mean long term or short term?

Q. Short term.

A. I don't know what that exact percentage is but I tell every patient to expect some dry eye after surgery.

Q. Do you receive ophthalmology the journal?

A. Yes.

Q. Do you agree with the statement that side effects such as dry eye, nighttime starburst and reduced contrast sensitivity occur relatively frequently following lasik surgery?

A. I think in the immediate post opt period yes most people will get dry eye and glare to some degree.

Q. Are you familiar with research that says lasik eyes have a 48 percent reduction in corneal biomechanical strength?

A. I'm aware of some of the general research with that but not the specific study that you're referring to.

Q. Well, what is the risk of corneal

biomechanical strength reduction, if you know?
A. The risk would be irregular healing.
Q. Any other risk?
A. That would be the biggest one I would be concerned about.
Q. And how would that manifest itself the irregular healing?
A. You can get the irregular shaped eyes. Irregular shaped cornea could cause vision problems.
Q. Have you ever heard science of refractive surgery?
A. I don't think so.
Q. What machine was Dr. Bearman using when he did this operation?
A. I believe he was using the Vixs machine.
Q. Which number?
A. I would have to recheck the chart.
Q. Does it matter to you which number he was using?
A. It matters just in that the laser was in the realm of being up to date for that time period.
Q. Well, if he was using the Vixs S2 or the S3 either one would be acceptable to you?
A. I think the patient would have good results with either one, yes.

00132

Q. And in either one it's simple for the surgeon to see the screen to verify the prescription, correct?
A. Yes.
Q. You agree that Kelly Leo has very significant vision problems?
MR. STOTT: Objection to the form.
THE WITNESS: Again, I'm not sure how you want to define very significant vision problems but she certainly has vision problems.
BY MR. BURNS:
Q. Well, if you had been her surgeon you would be very upset about this outcome, wouldn't you?
A. I would have been upset with this outcome.
Q. Have you ever had an outcome this bad?
A. It's difficult to compare bad outcome.
Q. Can you think of an outcome you have had that is as bad as Kelly Leo?
A. Again, I'm not in the patient's shoes, I can't judge for them which is really bad. But we have certainly had bad outcomes, yes.
Q. So you think you have had outcomes as bad as Kelly Leo?
A. I said I don't know. This is not a good outcome but we have had outcomes unfortunately that

00133

were not perfect.
Q. But in none of the bad outcomes that you had did you perform the wrong procedure on both of the patient's eyes?
A. Not that I know of.
Q. You think you may have and not known?
A. No. I have no knowledge at all about having done something like that.
Q. If you had done that you would know it wouldn't you?
A. I would hope so yes.
Q. Dr. Bearman could have caught the error in the programming of the lasik had he looked at the screen couldn't he?
A. It's possible that he could have caught the error if he looked at the screen and compared it to the correct information.
Q. What constitutes lasik success?
A. We define success by making the patient happy.
Q. Okay. So if the patient has got dry eye or halo or starburst and is not happy then that is a failure?
A. It's not success, correct. It's different than falling below the standard of care though.

Q. Do you know what the Ambulatory Code is?
A. No.
Q. What is the first principle of the Hippocratic Oath?
A. My understanding is first do no harm.
Q. Did Dr. Bearman violate that standard?
MR. STOTT: Object to the form.
THE WITNESS: I would not put myself to be an expert in first off discussion of the Hippocratic Oath.
BY MR. BURNS:
Q. He did harm to Kelly Leo, didn't he?
A. Kelly Leo is not doing well and whether he did the harm is not -- again, that is a legal definition that I can't go to.
Q. What do you mean?
A. Well, he was the surgeon, and he had a whole team of people working with him.
Q. You said he had a whole team. The person who made the mistake in putting the information into the machine was the technician, wasn't it?
A. I believe it was the technician that made the mistake.
Q. And Dr. Bearman was the only person in a position to catch that mistake wasn't he before he

00135

operated?
A. No.
Q. Who else?
A. It could have been multiple people --
Q. Who?
A. -- including the technician and whoever was checking it.
Q. Who else was checking it other than the surgeon?
A. Well the technician was supposed to be checking it.
Q. Anyone else?
A. I wasn't there in the operating room to see if there was anyone else around.
Q. Have you heard the term captain of the ship?
A. I have heard it used loosely. I don't know what that means.
Q. You don't know what that means as far as a surgeon's responsibility in the operation of a surgery?
A. I have an overall understanding.
Q. Tell me your overall understanding of a captain of the ship, doctor.
MR. STOTT: Object to the form.
THE WITNESS: My overall understanding is

that the captain of the ship refers to someone being responsible for everyone underneath him.

BY MR. BURNS:

Q. In surgery who is the captain of the ship?

MR. STOTT: Object to the form calls for a legal conclusion.

THE WITNESS: I'm not sure again that is what this proceeding is all about.

BY MR. BURNS:

Q. Isn't that something you were taught in medical school doctor that the surgeon is the captain of the ship in a surgical suite?

A. We were not taught that way at Emory. We were taught that you have a team of people working and you rely on the whole team.

Q. What was the FDA approved range for treating high astigmatism with Vixs laser?

A. I don't remember the time frame of when things were changed with the FDA and specific times.

Q. Have you ever used the Vixs laser outside of the approved range by the FDA?

A. I think we have gone outside of the approved range what the FDA parameters were.

Q. Before doing that did you obtain consent from your client?

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A. We generally would get consent from our client.
Q. Generally or always?
A. I believe we have always got consent from the patient.
Q. That is a risk the patient ought to know?
A. In our clinic we tell the patient what the FDA parameters are.
Q. What safeguard do the FDA provide for the patient?
A. I don't understand the question.
Q. Isn't it true that the FDA has studied lasik surgery under certain circumstances so they can help estimate the risk?
MR. STOTT: They may have evaluated some things. And as I'm sitting here and thinking about it I can't say that we always get the patient's consents. We get a general consent from them but every time we are outside of the specific parameters I can't say that we have them document and sign that.
BY MR. BURNS:
Q. Do you talk to them about it whether they sign it or not.
A. I'm trying to think about that because there

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are a lot of different parameters that come out and the FDA may have certain things that they haven't either looked at or we know to be different. And I can't say that we have talked to every patient every time we have gone outside of FDA parameters. In fact I'm pretty sure we have not talked to them every time.

Q. Was that an error or did you do that on purpose, I just won't tell the patient?

A. I think it depends on what it is. There are some things that the FDA has not looked at that the medical community feels is okay to go ahead with.

Q. I mean, so you don't you know have to talk to the patient about that you just go ahead and do it if you feel good about it?

A. It depends on the specific circumstance.

Q. When you're going out of range that the FDA has approved is what I'm asking?

A. Was there a question.

Q. Yes. Is that something you discuss with your patient?

A. Again it depends what the exact situation is but I can't say we have spoken to patients about going outside of the FDA parameters every time.

Q. Why not?

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A. Again, it depends on what is the exact circumstances are.

Q. What are the circumstances that cause you not to discuss it with the patient if you're going outside of the FDA approved range?

A. It may be a pretty well established understanding within the medical community that doing something is perfectly okay even though the FDA has not approved it for that.

COURT REPORTER: Could we have a break?

(A short break was taken.)

BY MR. BURNS:

Q. I want you to look if you would doctor at Exhibit 13.

What is that please sir?

A. Exhibit 13 in the top right corner of page 139 it shows what looks like a laser treatment form for Kelly Leo on the left eye.

Q. Do you see where the form indicates that this treatment exceeds the limits approved for refractive use.

Do you see that?

A. Yes.

Q. And how did the treatment exceed the limit approved for refractive use, what about it was wrong?

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MR. STOTT: Object to the form.
THE WITNESS: Repeat the question.
BY MR. BURNS:
Q. What about the treatment exceeded the limits approved for refractive use?
A. The parameter that would have been exceeded would have been the amount of astigmatism.
Q. And that is the negative 4.46?
A. Correct.
Q. What is the limit?
A. I don't remember what the limit was at that time.
Q. Do you know what it is now?
A. I believe it's 6 -- we treat up to 6.
Q. So it's gone up?
A. Yes. Over time the amount of the treatment on the left side and on the astigmatism has increased over time. That is why I don't remember what the maximum amount was at that specific time.
Q. We see the treatment started at 2:42:32 p.m. and ended at 2:43:36 p.m.
So it took a little over a second?
MR. STOTT: Object to the form a second.
BY MR. BURNS:
Q. Is that right?

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A. No.
Q. How long did it take?
A. It looks like it has taken a little over a minute and four seconds.
Q. A minute and four seconds. Is that consistent with your experience?
A. That seems reasonable.
Q. That would be the same for the other eye?
A. Do you want me to look at another page?
Q. It's 14.
A. Looking at Plaintiff Exhibit 14, page 227 and the treatment starting at 2:36:48 ending 2:37:36 so a little less than a minute and the prescription is a little less.
Q. What is marking the eyes, what does that mean?
A. To mark the eyes we put a ink mark somewhere on the cornea to help with the alignment of the lasik.
Q. Did Dr. Bearman do that here?
A. It's not marked on his form.
Q. Do you do that?
A. We do mark our patients.
Q. Why?
A. Marking the patient can help with the

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accuracy of the treatment. It's an enhance for the patient.

Q. It would have been appropriate for Kelly Leo who is a high astigmatism patient?

A. We are looking at this six years ago so at that point and time I'm not sure how well that was.

Q. You're not sure what?

A. I'm not sure how well accepted it was at that point and time you know back in September of 2003. I'm not testifying it was the standard of care in 2003.

Q. You don't know one way or the other?

A. Correct. I don't think there was a lot of emphasis placed on that at that time.

Q. What benefit does a patient get of having the eyes marked?

A. We don't know for sure.

Q. What is the presumed benefit? Why do you do it?

A. The markings is to help with the alignment.

Q. To make the surgery safer?

A. I'm not sure if it's safer but it may help her a little bit with accuracy of the treatment.

Q. You disagree with Dr. Forman's testimony that a physician should never put his foot on the

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petal of the laser prior to reviewing the data on the screen you're saying he is wrong about that?

A. I'm saying he has done a different protocol that's all.

Q. He is not talking about a protocol he is making a statement that a physician should never put his foot on the petal of the laser machine prior to viewing the data on the screen, you disagree with that?

A. I would have to read the context that he wrote that in.

Q. Did you read that deposition?

A. I read his deposition.

Q. The question was asked by Joe page 237 Line 4: Okay. And again, we can boil all of that down by saying he should have verified what was input in the laser before he touched the petal?

Answer: Right and that won't change.

And you say he is wrong about that, correct?

A. I'm saying as a blanket statement he is wrong about that.

Q. Now, you said that Dr. Bearman had a protocol and that that is why he was within the standard of care.

Was it the same protocol that was followed

on all nine patients or a different protocol?
MR. STOTT: Object to the form.
THE WITNESS: When I'm talking about protocol I'm talking about he would set up his mechanism of figuring out a prescription and then have a reasonable mechanism of making sure that was put correctly into the laser.
BY MR. BURNS:
Q. Did he have the same protocol on all nine patients?
A. He used overall the same protocol but he ended up -- yeah his protocol it was essentially the same.
Q. Describe for me what you say his protocol was that was the same on all nine patients?
A. He made a decision as to what prescription needed to be put into the laser and communicated that to the technician running the laser and instructed the technician to input that prescription.
Q. All right. So it's your opinion that he did not look at the prescription as it was put into the machine on the first eight patients either?
A. I wasn't not operating room to know but my understanding is that the technician would have inputted the prescription into the machine.

Q. But my question is, did Dr. Bearman look at the machine to confirm that the prescription was put in correctly on the first eight?

MR. STOTT: On the computer screen you mean.

THE WITNESS: I wasn't there.

BY MR. BURNS:

Q. Is that part of the protocol that you're talking about?

A. The main part of the protocol is how he would make the decision about what prescription needs to go into the laser and setting up the system for that to take place.

Q. Is it your opinion that that protocol was the same on Kelly as the prior eight patients?

A. I think his overall protocol was followed through the same way.

Q. How was the protocol different? You said the overall protocol was followed through how was the protocol different on the protocol used on Kelly?

A. I wasn't in the laser room but there was obviously an issue with getting the prescription in and there was a decision made to have the prescription in the laser in the plus format as opposed to the minus format.

Q. Who made the calculation in the first eight

procedures?
A. The doctor would have made the decision as to what prescription he wanted put in and made his calculations based on the measurements he made before.
Q. Who made the calculations with regard to Kelly?
A. He made those same decisions as to what he wanted put into the laser.
Q. Who made the calculations?
MR. STOTT: Which calculations?
THE WITNESS: Dr. Bearman made the decision as to what he wanted to put into the laser what he wanted to treat and communicated that to the technician.
BY MR. BURNS:
Q. Do you understand that Dr. Bearman made the calculation on the fist eight patients and gave them to the technician but he allowed the technician to make the calculations on Kelly Leo?
MR. STOTT: Object to the form.
THE WITNESS: I think there was a difference in them changing the format of how the laser would accept the data.
BY MR. BURNS:

Q. How was the format on how the laser accepted data changed?

A. The astigmatism treatment can be accepted in both a minus and a plus format and from my understanding the doctor was in the habit of transposing his clinic results which were in the plus format and changing those into the minus format for all of the patients. And then with the new laser system they decided that they could accept -- the technician were more used to dealing with whatever prescription it was and so they would accept it in the plus format. That was the major shift that occurred from patient number 8 to number 9. And that was the biggest change.

So it wasn't a change in the overall protocol for how things were done it was more of a change of how they were going to -- how the input data was put into the actual laser itself.

Q. Is it your understanding Dr. Bearman still follows that protocol?

A. I don't know what protocols he follows now.

Q. Do you think he still doesn't look at the screen to confirm the prescription is right?

A. I don't know what protocol he is following.

MR. BURNS: Why don't we take a break?

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(A short break was taken.)
(The deposition was concluded at 1:46 p.m.)

C E R T I F I C A TE.

G E O R G I A:
FULTON COUNTY:

I hereby certify that the foregoing deposition was reported, as stated in the caption, and the questions and answers thereto were reduced to the written page under my direction; that the foregoing pages 1 through 149 represent a true and correct transcript of the evidence given. I further certify that I am not in any way financially interested in the result of said case.

Pursuant to Rules and Regulations of the Board of Court Reporting of the Judicial Council of Georgia, I make the following disclosure:

I am a Georgia Certified Court Reporter. I am here as an independent contractor for Huseby, Inc.

I was contacted by the offices of Huseby, Inc. to provide court reporting services for this deposition. I will not be taking this deposition under any contract that is prohibited by O.C.G.A

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15-14-7 (a) or (b).

I have no written contract to provide reporting services with any party to the case, any counsel in the case, or any reporter or reporting agency from whom a referral might have been made to cover this deposition. I will charge my usual and customary rates to all parties in the case.

This, the 17th day of March, 2008.

DIONDRE C. THOMAS, RPR, CCR-B-2433