MC GINNIS & ASSOCIATES, INC.
COLUMBUS, OHIO (614) 431-1344

IN THE COURT OF COMMON PLEAS

WASHINGTON COUNTY, OHIO

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Laine Kirkpatrick, et al.

Plaintiffs,

vs.

Case No. 96-PT-62

George Tokodi, D.O., et al.,

Defendants.

- - -

Deposition of William D. Barker, M.D., the Witness herein, called by the Plaintiffs, for examination under the applicable Rules of Civil Procedure, taken before me, Cynthia L. Cunningham, Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel, at the offices of Jacobson, Maynard, Tuschman & Kalur Co., L.P.A., NBD Bank Building, 175 South Third Street, Columbus, Ohio, on Tuesday, March 18, 1997, at 3:10 o'clock p.m. and concluding on the same day.

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APPEARANCES:

ON BEHALF OF THE PLAINTIFFS:

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ON BEHALF OF THE DEFENDANTS:

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Monday, March 18, 1997

Afternoon Session

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that the deposition of William D. Barker, M.D., the Witness herein, called by the Plaintiffs under the statute, may be taken at this time by the notary by agreement of counsel; that said deposition may be reduced to writing in stenotype by the Notary, whose notes may thereafter be transcribed out of the presence of the witness; that proof of the official character and qualification of the notary is waived; that the witness may sign the transcript of his deposition before a Notary other than the notary taking his deposition; said deposition to have the same force and effect as though the witness had signed the transcript of his deposition before the Notary taking it.

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I N D E X

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WILLIAM D. BARKER, M.D.

Of lawful age, being by me first duly sworn, to testify to the truth, the whole truth and nothing but the truth, as hereinafter certified, testified as follows:

EXAMINATION

BY MR. SLAGLE:

Q. Dr. Barker?

A. Yes, sir.

Q. My name's Attorney Larry Slagle, and I represent Laine Kirkpatrick, and we're taking your deposition today by agreement of the parties. I'll be asking you a number of questions. And since we're doing this by phone, if anything is garbled at any time or you don't understand a question, make sure you have me repeat it, okay?

A. I'll do that.

Q. And you've had your deposition taken before, I gather?

A. Yes, I have.

Q. So I'm sure you're aware that you have to keep your responses verbal?

A. Yes, sir.

Q. All right. Just for the record, would you state your full name and business address.

A. William D. Barker, Suite 412, 3535 Olentangy River Road, Columbus, Ohio 43214.

Q. Now, Doctor, I've been forwarded a resume by Mr. Jeffers,

a curriculum vitae, and I don't know that there's -- I guess there's a date on it of 5-96. Is that your most recent curriculum vitae?

A. That's correct.

Q. Do you have happen to have a copy of it there with you?

A. Yes, I do.

MR. SLAGLE: Can I have the court reporter mark that as Exhibit 1.

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Thereupon, Exhibit No. 1 was marked for purposes of identification.

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BY MR. SLAGLE:

Q. Do you have more than one version of your resume?

A. No, I do not.

Q. Now, I've looked at your resume, and I see that you've listed a couple of papers that you published; is that correct?

A. Just one was published in 1976, so that was 20 years ago, as we speak. The other two were papers that were read at regional meetings.

Q. Okay. Was there anything that was put in writing on the other two papers?

A. Yes, those would be -- would have been documents -- Those would have been papers that were developed but just not submitted for publication, so they would have been in writing,

yes.

Q. Do you happen to have those at your office; do you know?

A. I doubt that. Maybe way back in some files -- Well, let's see, the '75 was when I was finishing residency. I wouldn't have that at all. The '86 paper, maybe in some dark storage box someplace, but that's not something I would typically keep current. So I don't even know where I would look, to tell you the truth, on that.

Q. In looking at those, they don't appear to be in any way related to the issues of this matter; would that be an accurate statement?

A. I'd agree with that.

Q. Do you have any other writings?

Perhaps you might have one currently under submission or worked on?

A. Professional writings, I trust?

Q. Yes.

A. Correct, I do not.

Q. When you say "professional writings" in the sense of your business of orthopedic surgery?

A. Yes, sir.

Q. Are you also a novelist by chance?

A. No, but I just thought I'd clarify that point.

Q. Now, you are board-certified, riqht?

A. Yes, sir.

Q. And when did you become board-certified?
A. In 1976.
Q. Did you make that on your first attempt?
A. Yes, sir.
Q. Are you required in Ohio to have that updated?
A. Well, that's -- there's a little glitch in the question. The board-certification in orthopedics is national, and so I'll modify your question to suggest that it's -- to suggest the thought am I required to recertify nationally.
Q. Correct.
A. The answer to that is that I am not current. Program graduates are. There was a point in time, I believe, in about the mid '80s, the mid 1980s at which the American Board of Orthopedic Surgery made the election to recertify after a particular date.

And those of us who had been certified prior to that date were grandfathered in, so to speak, not requiring recertification. So I do not have a requirement to recertify.
Q. Okay. Can I ask you who you would consider to be on a national basis an authority in the area of orthopedic surgery specifically dealing with postoperative infections and treatment thereof?

MR. JEFFERS: Objection. Go ahead.

THE WITNESS: The only name that would really come to mind would be Robert Fitzgerald who is probably written as

much as anybody about operative -- operative-based infections, if you will.

And his primary interest has been in joint implant infections. He is the guy who I think has written the most in the last probably decade. He originated at the Mayo Clinic, and I believe is a head of the program not at the Mayo now but one of the other academic institutions. I'm not sure where he's located. He would be the one name I could come up with.

BY MR. SLAGLE:

Q. Did you happen to study under Dr. Fitzgerald or just someone you've read?

A. I did not study under him. I've read his papers and have been at a course or two over the last score of years where he has been in attendance as a lecturer.

Q. You've stated that you've been to over the years courses involving orthopedic surgery. And did any of those relate specifically to postoperative infections and treatments thereof?

A. Well, the course -- I've never been actually to a course that was dedicated in entirety to infections. For example, a typical course might be a couple of days to three days or four days in length. I've never attended a course and actually don't have knowledge that such a course has been offered. There may well have been. I'm just out of the loop on that.

There are, however, at the various courses that one might

attend, topics that will deal with infections problems depending on what the type of course you're attending.

For example, if you're at a joint implant course, total hip, total knee course and someone like Bob Fitzgerald happens to be on the panel, then one of the topics for discussion, one of the lectures at some point during the two or four days would probably be discussion of infection control, how to deal with postoperative infections.

And similarly, if one were perhaps at an athletic knee course, one might encounter a topic about what one does after infection with a ligament reconstruction procedure, that sort of thing. So there usually would be finite topics within the course at large if that's not too verbose.

Q. No, that was good. Do you happen to have in your office any course materials that you've attended dealing with postoperative infections and treatment thereof?

A. Well, the -- any course materials would be buried again in banker's boxes, and those are either in my basement or in the basement of my Dublin office in files. So the answer, I guess, is a half yes.

Q. Well, for instance, in my practice, if there are areas I like to keep covered, I'll pull that material out and put it in a special binder, for instance, and set it aside. Do you have anything like that set aside, for instance, dealing with postoperative infections and treatments thereof?

A. No, but you and I think alike. I'm using those white clear plastic binders, and I can put little labels down the side and it's pretty cool. The topics are the hot topics: osteoporosis, which is of great interest in today's environment, and thromboembolic disease.

So I have a couple of those in my basement at home very similar to your strategy where you clip those little articles and throw them in a binder and some day access those, but I've never done that for infections per se.

Q. As a member of the American Academy of Orthopedic Surgeons, do you receive their regular journals?

A. The journal that is produced by the Academy but actually is a subscription, we have to purchase. It's not an automatic mailing as a result of being a fellow in good standing, but there's a journal that's only about three years old that I do receive.

And then the only other publication that would be a sort of periodical would be the annual periodical that is called the -- it's a review of current topics review, and that's an annual journal. So I do subscribe to both of those.

Q. I'm sorry, do you know the titles of those journals?

A. One, I think, is simply the Journal of the American Academy of Orthopedic Surgeons and the other is Current Concepts Review, I believe.

Q. Are there any journals that you regularly refer to at any

time in your own practice when you treat your own patients?
A. Well, the journal -- the journals that are most germane to my current practice are the Journal of Sports Medicine, which I occasionally refer to, and then there's a journal that relates to hip and knee replacement that's called Journal of Arthroplasty, and I would refer to that on occasion. I subscribe to both of those and refer to it on occasion.
Q. Now, I gather you spend -- How much of your time do you say you spend in active clinical practice and/or surgery?
A. About 99 percent. Well, there's administrative office time, but I gather you're asking in terms of the actual practice. I basically work is what I basically do.
Q. Do you happen to know any medical textbooks that deal with infections, postoperative infections?
A. Well, again, similar to the concept of continuing education courses, the majority of textbooks that are -- that are available to us would perhaps have -- if appropriate and if germane would have a section that would deal with infections within the overall textbook.

But, for example, if you have a textbook that's basically talking about a total knee arthroplasty, for example, then there would be a section typically in that that would relate to infection management.

I don't have any -- any textbooks on my shelf or textbooks in the library that I would access on -- that would

be dedicated purely to infection management in orthopedic patients or musculoskeletal patients.

Q. What about a textbook, however, in your specialty of orthopedic surgery that would have a chapter on infection?

A. Yes, that's what I'm indicating, that most all textbooks when you're dealing with the surgical art of the musculoskeletal system will have an area or a chapter or a couple of chapters relating to infection management with respect to the topic of the textbook itself.

Q. What would be a primary textbook in that case?

MR. JEFFERS: Objection. Go ahead.

THE WITNESS: Oh, I suppose you could pick almost any -- any of the standard texts. For example, the classic textbook of orthopedics historically is Campbell's Orthopedic Text, and that would have probably as much information on infection management about the various possible regional infections that you could have. Every text that's out there, I think, is going to have some information.

BY MR. SLAGLE:

Q. Okay. Would you consider then Campbell's to be authoritative?

MR. JEFFERS: Objection.

THE WITNESS: Well, it's -- I'm not sure how you define "authoritative." It's a source of information for care of the musculoskeletal system and the care of infection with

respect to some of those infections that might -- that you might encounter.

So I'm not sure what "authoritative" actually means, but I mean, it's where -- it's where valuable information is preserved and to have access to. So I don't want to hang myself, but not -- I don't want to call it authoritative if I don't mean what you mean by authoritative.

BY MR. SLAGLE:

Q. We can get that later. Have you yourself ever been a plaintiff or a defendant in a lawsuit?

A. I've been a defendant but not a plaintiff.

Q. How have you been a defendant if I might ask?

A. I missed the first part.

Q. How have you been a defendant? In what type of case?

A. Oh, I see. There were two unhappy patients who filed a lawsuit not together but independent.

Q. That was a medical negligence case?

A. Yes.

Q. Allegedly?

A. Yes; yes, sir.

Q. Did either one of those involve a question of infection?

A. No, sir.

Q. Can you tell me what court they would be filed in?

Were they both filed in Columbus?

A. The most recent was filed in Franklin County or Columbus,

I'm not sure how that all works, but it was a case that was filed, I believe, in 1987 or 1988 or so. That was a carpal tunnel release patient who was unhappy and who required repeat surgery.

The former, the initial case that was filed in 1979 or 1980 was filed in federai court as that patient resided in Kentucky. And my understanding was the patient residing in Kentucky and myself being located in Ohio forced that jurisdiction.

Q. Currently, your practice is in orthopedic surgery; is that correct?

A. That's correct.

Q. Have you testified as a medical expert prior to this occasion?

A. Yes.

Q. And can you tell me how often?

A. I probably have testified annually €or a dozen years.

Q. How many times per year?

A. Once.

Q. One time per year?

A. That would be a reasonable guess.

Q. Can you tell me which side of the fence you were testifying for, if you know?

A. I've testified on both sides.

Q. Do you have a breakdown?

A. Oh, it's probably been two cases for the defense and one for the plaintiff.
Q. Two to one defendant versus plaintiff?
A. That would be a good estimate.
Q. Have any of those cases in the past where you've testified involved an issue of postoperative infections?
A. Not postoperative infections, no.
Q. You hesitated, so one of them or more may have involved infections?
A. That's correct.
Q. And what type of case was it?
A. The case that I was defense expert was a case that was resolved last year. It was filed, I believe, up in Cuyahoga County. I think that's where the trial was. And involved a patient who developed -- who had developed an endocarditis.
And the allegation was that the -- that the patient had an ankle infection that caused the endocarditis which results in open heart surgery and valve replacement so that the plaintiff was blaming the orthopedic surgeon for his ultimate heart surgery requirement.
Q. Was that in any way involving initial infection itself or management thereof?
MR. JEFFERS: Did what, Larry?
BY MR. SLAGLE:
Q. That lawsuit.

A. I think that's what the lawsuit was about. The plaintiff was claiming that there was an infection in the ankle that spread to the heart and was then the source of the patient's cardiac difficulties.

But there was no -- There was no evidence, as it turned out, of ankle infection, but that didn't dissuade plaintiff from pressing the case. And so there was no ankle infection, but it was a question of a musculoskeletal infection involved. So that's why I was a little -- I even paused a little bit.

Q. Do you happen to know the case caption or the attorneys involved?

A. 1 know -- Well, the attorneys, the defense firm is Reminger up in Cleveland, Reminger and Reminger, and that's the firm name. I suppose you're going to ask me if I know the defendant --

MR. JEFFERS: Plaintiff.

THE WITNESS: Defendant was Ian Alexander who's up at the Crystal Clinic in Akron and plaintiff, I don't know the name. And plaintiff's attorneys, I don't know.

BY MR. SLAGLE:

Q. Have you been involved in any other expert witnessing involving infections?

A. Let me think about that for about 15 seconds here. I'll try to run through my brain here.

(Pause.)

A. To the best of my recollection, I just have not testified in those situations.
Q. Have any of the times you reviewed cases required your testimony in court itself?
A. Well, when I answered your former question with respect to how often I have testified, the parenthetical, I guess, information is that that implied or I was inferring that that was actual court testimony. So that would be either appearance in court or, for example, video court testimony. So the actual trial testimony may be perhaps annually.
Q. Regarding just review, how often in the past 12 years -- Since you set that limit initially, in the last 12 years how often have you reviewed testimony where your testimony may not have been required?
A. I've probably looked -- in the last dozen years, probably have looked at three cases a year.
Q. In any of those, have you given testimony by way of deposition and discovery as opposed to testifying in court?
A. Yes, I would have done some discovery, I think, on a few occasions and then the case would have been dropped or written a report of -- an opinion report, then the case was, you know, dropped or settled or whatever, as you know how that goes.
Q. Did any of those involve infection-related issues?
A. I don't believe so.
Q. Can you tell me the breakdown between plaintiff and

defendant in terms of sides in those other ones we discussed?
A. I think it's probably still the same, two to one defense versus plaintiff. It might be three to one defense through plaintiff. I always lean toward defendant because I'm a little sympathetic, of course, being on this side of the fence, it being a couple of times....
Q. How about testifying for your own patients, have you ever testified for them in any litigation being called as a treating physician, for instance?
A. Yes, of course.
Q. How often would you say you would be called as the witness for your own clients?
A. Gee, that would be probably in 20 years of practice, I've probably been a witness on a patient behalf less than ten times, I would say, maybe a dozen.
Q. Do you know how Mr. Jeffers got you in this case by any chance?
A. How he learned that I might be interested in looking at the case, for example?
Q. Yes.
A. Well, I'm not a foreigner to the law firm that he represents, as I was previously an insured with P.I.E. and, as I indicated before, I've had those two malpractice cases. P.I.E. was the insurance company for both those. And the Jacobson law firm defended me in both of those.

So aside from those two lawsuits where I got to know a couple of the attorneys at this firm, I've also taken part over the years in probably three or four of their claim review meetings during which they look at the various cases that are brought against the P.I.E. insureds,

MR. JEFFERS: Just so we don't go too long, the question was how I got your name. Was that your question, Larry?

MR. SLAGLE: Yeah. I was going to ask him the rest anyway.

BY MR. SLAGLE:

Q. Three or four claim review meetings, is that at the request of the firm or as a P.I.E. insured are you attending those meetings?

MR. JEFFERS: I think he's talking about the past, Larry.

MR. SLAGLE: Oh, in the past.

BY MR. SLAGLE:

Q. Was that as a P.I.E. insured or were you requested by the law firm to attend those claim review meetings?

A. Well, I think it's both. I think the law firm -- I think the law firm requests P.I.E. insureds to attend their meetings. I don't think -- or I think they don't ask non-P.I.E. insureds, but I don't know what their policy is. I never actually thought to ask that.

Q. What's the purpose of those claim review meetings?

MR. JEFFERS: Objection. I'm going to instruct him not to answer that, Larry.

MR. SLAGLE: On what grounds, Mike?

MR. JEFFERS: They're part of quality review.

BY MR. SLAGLE:

Q. Are they part of the quality review, Doctor?

MR. JEFFERS: Go ahead and answer the question.

THE WITNESS: I'm not sure what quality review means, so I don't know how to answer.

BY MR. SLAGLE:

Q. I think that's why I was asking what the purpose of the meeting was.

THE WITNESS: Is the question to me?

MR. JEFFERS: Yes.

BY MR. SLAGLE:

Q. Yes.

A. Well, the purpose of the meeting is to evaluate, I think, the -- as I had indicated before, the claims that are brought against P.I.E. insureds to have the case or claim discussed with peers who are P.I.E. insureds for the purpose of educating everyone around about the situation, that is to say, to discuss the issues with reference to that claim. I'm not sure --

Q. I gather that would be you'd review a number of different

matters, round table it, for instance?
A. I guess that's a fair assessment.
Q. Are you listed in any periodicals or publications as a doctor that would be available for medical review?
A. In your Ohio -- I think the Columbus Bar -- I think the Columbus Bar document -- Is it the Columbus Bar or Ohio Bar? I think it's Columbus Bar or Ohio Bar, one of those two, I've listed myself as a malpractice expert.
Q. Now, is that for defendants or plaintiffs or is it for all comers?
A. I've indicated my preference that I prefer to look at defense issues, but I would consider plaintiff cases.
Q. Now, have you ever attended any seminars which address the topic of being an expert witness in court?
A. No, sir.
Q. Obviously if you spend 99 percent of your time in the practice, you don't have any other business pursuits, I would gather?
A. Well, that's where that -- that's where the question is a little -- I'm not sure how the question was phrased. I mean, I guess -- Do you want to rephrase the original question?
Q. Do you own any interest in any other companies or corporations?
MR. JEFFERS: Objection just to relevancy, but go ahead.

THE WITNESS: Public companies, I guess -- Corporations or -- I have -- I run my own real estate situation. I own my office in Dublin, Ohio, and that is -- and I do that as an individual. And so that requires a certain amount of effort at bookkeeping. And so I don't know whether you're going to define that as a business or not. I lease that property back to myself. So that takes a little bit of time.

I've got a couple of investment properties similarly so, and that takes a little bit of time, but -- So I'm not sure exactly what you're -- how you want me to break my time down.

BY MR. SLAGLE:

Q. You don't have any interests in laboratories or any other medical providers or things like that?

A. No, sir.

Q. Can you tell me how you first became involved in this specific matter regarding Laine Kirkpatrick?

A. I had a -- I believe I had a phone call from Jacobson, Maynard and I believe --

MR. JEFFERS: It was me, Larry.

THE WITNESS: -- and it was to inquire if I would have an interest in looking at the case. So I think that Mike called as opposed to rote.

BY MR. SLAGLE:

Q. Can you tell me when that was?
A. I may have that available. Let me look. I've got a little binder here that I've got. I met with Mike on 10-25-96 for the initial time. I keep just a little log of the time. And so I met with him on 10-25-96.

By deduction, I can tell you it was some time before 10-25-96, but I do not have a written notation *as* to when he actually made that phone call.

Q. You say you have a binder there?
A. Yes, I do.
Q. What's within that binder?
A. Just a little of the information that I've assembled. I have, for example, in plastic sleeves the deposition copies of Dr. Rosenzweig and Dr. Markowitz and Dr. Tokodi.

Then I have a copy of a note to Mr. Jeffers that states that an invoice was enclosed. And I have just a little log then of the time I've spent -- that I had spent on the case; just very simple things.

Q. What was given to you other than the depositions of Dr. Rosenzweig, Dr. Markowitz and Dr. Tokodi for you to review?
A. Well, I have some hospital records from the Selby Hospital, Marietta Memorial Hospital, Doctors Hospital in Massillon and then some office records from Drs. Tokodi and Ada --

MR. JEFFERS: There's Chiu, Miller, Moretta, Sports Med, Physical Therapy. Then there's also some from Timken, also -- I'm not sure --

BY MR. SLAGLE:

Q. Are those complete records?

MR. JEFFERS: They are what were sent to us. So I can't tell if they're a complete record, but they're as much as we've received.

MR. SLAGLE: Can we have those marked as exhibits?

MR. JEFFERS: The records?

MR. SLAGLE: Yes.

MR. JEFFERS: Sure. You want them as a group as 2?

MR. SLAGLE: I don't know how they're broken down, if they're broken down by the individual hospital or doctors' offices. They probably should be marked individually.

MR. JEFFERS: There's tabbing. There's all sorts of tabbing. These things, I'm guessing, are about maybe six inches, four to six inches. That's two inches from the --

MR. SLAGLE: Is it in a notebook type?

MR. JEFFERS: One's in a notebook. The other one has spiral rings -- I don't know what they are -- metal spiral rings, let's say.

MR. SLAGLE: Do you know if they're the complete records of Doctors Hospital and Selby, for instance?

MR. JEFFERS: All I can say, I believe they are,

Larry. I gave him everything we have, let's put it that way, from the medical records from there.

MR. SLAGLE: So --

MR. JEFFERS: It's whatever you have is, I believe, what we gave them. I can't tell you for sure because I don't know exactly what you have.

MR. SLAGLE: For the record, could you just list them then by the tab indication?

MR. JEFFERS: Sure. These were what we got from Tyson. Tyson gave them to us at that one deposition. Timken Mercy, ER visit, 12-9-90; Selby ER visit, 1-14-93; Marietta Memorial, ER visit, 4-9-93; ER visit, 10-3-93 --

MR. SLAGLE: Don't go too fast.

MR. JEFFERS: She's getting it. Selby, OP surgery, 11-29-93; OP surgery, 11-22-94; OP surgery, 11-30-94; admission, 12-6-94 through 12-12-94; Doctors Hospital, admission, 12-16-94 to 12-24-94; Marietta ER visit, 7-12-95; Timken Mercy, admission, 8-8-95 through 8-9-95; Marietta, ER visit, 9-25-95.

And office records of Dr. Tokodi, Dr. Ada, Dr. Chiu, Dr. Miller, Dr. Moretta, Sports Med and then Physical Therapy 10-25-93 through 8-15-95.

BY MR. SLAGLE:

Q. Are those all the documents you've reviewed in preparation €or this deposition and the opinions you gave

Mr. Jeffers?
A. That's correct.
Q. Have you reviewed any other memorandum, notes, videotapes, texts, audiotapes or other materials?
A. No, sir.
Q. Now, can you tell us what the terms of your agreement with Mr. Jeffers is regarding your hourly rate?
A. I don't think we have an agreement.
MR. JEFFERS: $250.
THE WITNESS: Oh, for today's deposition or for -- I'm not sure what the question is.
BY MR. SLAGLE:
Q. What are you charging for today's deposition?
A. Oh, $250 per hour.
Q. Is that your typical charge in depositions?
A. Well, I'm saving you some time so you don't have to ask the judge to knock it down, so -- I'm just having fun with you. I know if I say 500, you'll take it to the judge and knock it down to $250, so I'll save you the trouble and say it's $250. I basically usually charge $500, perhaps $750 an hour for depositions.
Q. Is that the charge that you'll be giving to Mr. Jeffers if you testify in this case?
A. For my, for example, trial testimony?
Q. Right.

A. Probably $500 an hour.
Q. Would you tell me how many hours you've spent to the present time working on this case?
A. I have spent about, according to my little log here, up through 1-14-96, I have spent 3.25 hours. In the last couple of days, I have refreshed my memory on the records and have spent an additional two hours looking over records.
Q. And to whom will you send your bill, Mr. Jeffers?
A. Which bills? For today's deposition or for the work I've done for him?
Q. Yes, for the time you spent to review, not for the deposition.
A. I would send those to Mr. Jeffers.
Q. And you've not been paid for anything up-to-date, correct?
A. Have I been paid for anything to date?
Q. Yes, on this case.
A. Yes, I have.
Q. Okay. What were you paid for and how was it billed out?
A. Well, I was paid for certain of the work that I did through 1-14-96.
Q. What was the hourly rate at which you were paid at?
A. I don't have that information handy. I don't have the log. I keep that at home.
Q. You don't have a billing statement in your file then?

A. That's correct; in this file that's in my three ring binder with me today, that's correct. I do have an invoice statement on file at home.
Q. Did you know Dr. Tokodi before reviewing this?
A. No, sir.
Q. Has anyone other than Mr. Jeffers contacted you about this case in any manner?
A. No, sir.
Q. Did you receive any correspondence from Mr. Jeffers?
A. Just I think confirmatory letter that perhaps of the date that we were meeting and/or the date of the deposition, only that kind of thing.
Q. Can you tell us if you took any notes?
A. Took some notes.
Q. And what do your notes -- Are they written out separately or in the margins of the medical records? How are they done?
A. No, the notes are in a couple of little sheets of papers that I have with me in the binder.
MR. SLAGLE: Can we have those marked as an exhibit, Miss Court Reporter.

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Thereupon, Exhibit No. 2 was marked for purposes of identification.

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BY MR. SLAGLE:

Q. Did you have any dictation made in this matter?
A. No.
Q. Did you prepare a report at any time?
A. No.
Q. Have you reviewed any summaries of medical records?
A. No.
Q. Have you reviewed any summaries of any kind?
A. No.
Q. Can you tell me when you arrived at your opinions in this case?
A. Well, I think by the time I had -- by the time I had read through Dr. Tokodi's deposition, which I read on the 14th of January according to my time log, I had formulated the majority of the opinion -- of the opinion and, of course, that still is -- that opinion is not rock solid as we speak.
Q. That opinion is not?
A. Well, every day and every minute that goes by, I'm open to other information as -- to help form an opinion. So one never stops forming an opinion, in my view. That's the way I work. I'm open to new information at all times.
Q. Okay. Can I ask you, Doctor, when we're done with this deposition and we have discussed your opinions at this time, that if anything and any other information comes in that makes you believe you're going to change your opinion or alter it in any way, that you'll advise Mr. Jeffers who will advise me so

then I will take a follow-up deposition?
A. Certainly.
Q. How did you express your opinion in this matter to Mr. Jeffers if you did not write a report?
A. Verbally.
Q. Did you request any other information or other documents in what had first been supplied to you?
A. I think Mr. Jeffers has understood from the beginning that the ultimate access to the original -- the original records is something that I would always enjoy.

And so at some point if this should actually go to trial, that I will want to have an opportunity to review the original hospital records particularly because sometimes the copies are inadequate or lacking in entirety. So I always hold that as a sort of reserve clause, and I think he understands that.

Q. That would be true virtually of any doctor of reviewing, though there's a possibility the original records may reflect information that could not be picked up on a copy?
A. That's correct.
Q. Is it your experience that sometimes original records could not -- are not always the complete record as well?

MR. JEFFERS: Objection. Go ahead.

THE WITNESS: Well, I guess I've never been aware of a situation where -- I guess I haven't been aware of that. I'm not --

BY MR. SLAGLE:

Q. What's your concern then about the copies being inadequate?

A. Well, that the -- that the -- I don't know who made those copies, and I don't know how compulsive they were about making them. So I wouldn't bet the farm on the fact that I have an accurate representation of the record.

I have what's available, and there's -- one has to start from somewhere, but you're talking about 500 pages or 400 pages of materials here, whatever it is. So you can have misfilings as one collates them. You can have sheets of paper that were -- or pieces of records that were not copied accurately, were missed completely, that sort of thing. So I wouldn't ever want to indicate that I have viewed as of this date the entire medical record about this case.

Q. Do you feel you have all the information that you would want on which you base your expert opinion in this case at this time?

A. Well, I think that I can give you an opinion and I can -- and as I say, I'm always open to change the opinion based on information. I don't write this in stone.

And if new information becomes available that would prove me to be incorrect, then I'm the first guy that would say this additional information proves me to be incorrect in terms of my opinion, and I am be the first guy to say and alert you and

Mr. Jeffers that that would be the case.
Q. Okay, thanks.
A. Yeah.
Q. Now, Doctor, can you then enumerate for me the opinions that you've come to in this case?
A. Yes.
Q. And what are they?
A. Well, the central question is whether -- as I understand it with regard to my role here, was to create an opinion as to whether I felt Dr. Tokodi had fallen below the standard of care, as I understand he's the defendant in the lawsuit. And so that's the first opinion is to that question.

And then the ancillary opinions would be to try to shed light on the whole affair to help everybody to understand it. So those are the opinions I've reached.
Q. What are those opinions?
A. I believe Dr. Tokodi -- I'm sorry, I have trouble with his name, it's a tongue twister of a name -- Dr. Tokodi did not fall below the standard of care as required of orthopedic surgeons in the community or nationwide, and that it is unclear as to precisely what the nature of the -- of Mr. Kirkpatrick's knee difficulties was.
Q. And what do you mean it's unclear as to what his knee difficulties were?
A. Well, I don't think that there's been -- that an accurate

diagnosis has ever been established in terms of the events of the hospitalization at the two hospitals where all of the activity ensued subsequent to the outpatient surgery.

Q. And what is it that you feel is unclear?

A. Well, I don't know what the origin of his -- of his effusion, swelling, temperature, repeat surgical interventions was. I'm not sure of the exact etiology, and I don't think --

Q. You're not sure of it in the sense of what's causing it or why it was caused?

A. Well, both. I don't think anybody knows that answer.

Q. Would you dispute that he had an infection?

A. It's plausible, but I wouldn't -- No one knows that. No one knows he had an infection.

Q. What else would it have been if not an infection?

A. A synovitis.

Q. What is synovitis?

A. It's an inflammatory process of the synovium which is the joint lining.

Q. What would be required for you to make a diagnosis of synovitis?

A. Well, we know it's synovitis. We have a pathology report that says there's a synovitis. Now, the question is, what was it caused by? And I think that's the central question in the case, and I don't think anyone knows the answer.

Q. What were the possible causes of that synovitis?

A. Well, you have a patient who's had a hemarthrosis of a knee arthroscopy. Hemarthrosis can generate a reactive synovitis. You have instrumentation of a knee at surgery with instruments that are probably soaked in bactericidal agents. This can create a synovitis. You have the possibility that there's an infection which is always a possibility in a -- as a postoperative source of a synovitis.

Those are three possibilities that would result in a synovitis aside from other rarer forms of processes such as the inflammatory process and rheumatoid arthritis or autoimmune sorts of diseases. And those would be pretty low on the list.

But no one has an exact understanding. We don't think he had gout. We don't think he had gout or rheumatoid arthritis. But when it comes down to pinning down whether he did or did not have an infection, we don't have a culture and so we don't -- we don't really know the answer and nobody knows the answer.

Q. Can you tell me why a culture is required to identify specifically that this was an infection?

A. Well, a culture defines an infection. Unless one has a positive culture of a microorganism, be it viral or bacterial or other type of organism of which there are multitudes, then unless one has the definitive culture, then one cannot state with certainty that there was, in fact, an infection.

Q. What type of certainty are you requiring -- are you stating?
A. I just want to see a culture that's positive. I just want to see a culture that there was, in fact, an organism that grew out of this knee to be able to say that this was an infected knee, and we do not have that in this case.
Q. There is no culture at any time that indicates that?
A. Well, to the best of my knowledge, there is not in the records that I have reviewed. And that's why I indicated to you before that I will need at some point to look probably at the original chart to make sure that someplace hidden in the record there isn't a culture that was overlooked by somebody along the line.
Q. The Doctors Hospital diagnosis was septic arthritis of the right knee.
A. Is that a question?
Q. Do you have any dispute with that diagnosis?
A. Yes, I do.
Q. Why is that?
A. Septic arthritis is a diagnosis that relates to -- implies and indicates infection, and so sepsis implies infection. And so if they say septic arthritis, one can say that, but there's no proof of that. There's clinical -- There's some clinical evidence that would support that, but there's some clinical evidence that doesn't support that. So

just because somebody wrote that down does not make it so.
Q. What clinical evidence supports the diagnosis of infection?
A. A febrile patient who has a swollen, painful knee in the postoperative time frame would support an infection.
Q. What clinical evidence does not support an infection?
A. An aspiration of the knee done at two different facilities with a white blood count of 25,000 and a synovial analysis at the second institution that shows a mucin clot.
Q. And that analysis was at Doctors Hospital?
A. That's correct. The second synovial analysis at Doctors Hospital is the one I referred to with regard to the mucin clot.
Q. What does the mucin clot have to do with this?
A. Well, the mucin clot is one of the classic synovial fluid analyses. And very typically in an infection, a process caused by bacteria, the mucin clot would be very poor. So one sees a good quality mucin clot when allegedly the infection is well established.

According to some experts who would be testifying here, when one sees a good mucin clot present, then once has to be skeptical about the working diagnosis of sepsis.

And when one sees a white count in the 20,000 range, 25,000, 29,000, that's consistent between two hospitals over a period of a few days, then one has to be, I think, skeptical

of a diagnosis of bacterial infection as a source of the synovitis.

Q. Doesn't Dr. Tokodi diagnose this as an infection?

A. Again, his working or provisional diagnosis is infection and, of course, the answer is -- his working diagnosis, provisional diagnosis is infection, that's correct.

Q. Doesn't he treat this as an infection?

A. Yes, he does.

Q. And isn't that what he calls his preoperative and postoperative diagnosis on 12-9-94, infected right knee?

A. That's what the working and provisional diagnosis is, that's correct.

Q. And since he is an orthopedic surgeon, he understands what an infected right knee looks like when he goes in and does the surgery on him?

A. Repeat the question.

Q. Since he is an orthopedic surgeon, he should be able to tell what an infected right knee looks like when he does surgery on it?

A. Did you say "should"?

Q. Yes.

A. I don't think that's a -- I don't think an establishment of a diagnosis of infection is a matter of necessarily a visual confirmation.

Q. Can you tell me what the most common cause of septic

arthritis is?
A. Worldwide?
Q. Well, I prefer if you remain in the United States.
A. Probably in the United States, probably it would be staphylococcus bacteria.
Q. Can you tell me what the symptoms of infection of a joint normally are?
A. Typically the symptoms would include pain and swelling or a fluid on the knee, limitation of motion because of the pain, generally increased blood flow to the region creating a sense of warm to the touch. Those would be the primary symptoms that I have seen historically.
Q. Didn't Mr. Kirkpatrick have all those symptoms?
A. He had those symptoms.
Q. Okay. Can you tell me how they could have convinced you this was an infection?
What needed to be done that wasn't done or what was done that did not, in your mind, positively identify an infection?
A. Well, it's very simple. There's no culture-proven infection. And so if you show me a culture that was taken from the knee or show me a blood culture that was -- that might have related to infection within the knee, then I'll become a believer. But until you can show me a culture, I can't tell you with certainty that, in fact, there was an infection in this knee.

Q. Wasn't there a culture that indicated this was a positive -- a positive gram stain?
A. Well, the gram stain is a laboratory test that simply -- in which the laboratory technician smears a bit of the fluid on a slide and stains it and, yes, in fact, the gram stain showed a rare -- what they call rare positive cocci on the 12-6-94 -- I believe it was 94 -- aspiration that was done in the emergency room, but that does not an infection make. That could be erroneous
Q. How would you be able to identify whether it's erroneous or correct?
A. Well, that's where the culture would -- the culture that ultimately comes out from that smear is going to grow, the organism if, in fact, there's an organism to be grown.
If it's -- If the gram stain is a false positive, then that is to say there's no actual bacteria, even though the technician thought she saw bacteria, if there's no bacteria to be grown, then the culture will be negative and, in fact, that was the case here.
Q. Do you know cultures were negative or no result?
A. The culture was negative from the 12-6 aspiration. I believe the date is 12-6 when he came to the emergency room, so that was a negative culture.
Q. So what kind of culture was that?
A. It was a needle aspirate culture.

Q. Are there ways to do a culture which -- I think Dr. Markowitz indicated they could be anaerobic or aerobic?

MR. JEFFERS: Can I just break in real quick?

MR. SLAGLE: Sure.

MR. JEFFERS: You don't mind if the doctor is looking at the records as he's answering these questions, do you?

MR. SLAGLE: Not at all.

THE WITNESS: Well, the culture technique typically at most hospital labs would include a dual culture, one that is -- one is looking for so-called aerobic bacteria that grow in the presence of air, oxygen specifically, air-containing oxygen and one that -- one culture techniquing that tries to pick up those bacteria that do not like the presence of oxygen. And those are cultured by different technique.

So one culture that is sent to the lab would typically be grown in a couple of different types of media and conditions so that one would then end up with no -- when one has no growth would imply that there's no anaerobic as well as no aerobic material to be found; that is to say, no anaerobic and no aerobic material to be found.

BY MR. SLAGLE:

Q. Is it your opinion that without a culture showing growth of an organism, you can't make a diagnosis of infection?

A. That's correct.

Q. Under any circumstance?
A. That's correct.
Q. Now, in this case, he had a fairly high white blood count?
A. That's incorrect.
Q. That's incorrect?
A. I think that's incorrect.
Q. How would you consider his white blood count?
A. It's just -- His white blood count when he arrived at the emergency room at Selby was -- was a little above normal. It was only about 12,000, as I recall. I'm not looking at the record, but it was about 12,000.

MR. JEFFERS: Why don't you look at the record.

THE WITNESS: And that's not what I would consider high.

MR. JEFFERS: Let him check the record, Larry. He's going to look at it.

THE WITNESS: Here we go. I'm looking at the white blood count that was part of the portion of the complete blood count, the so-called cbc, and this was dated 6 December 1994. This was drawn at approximately 11:00 p.m. And the white count was consistent with my recent recollection there, it was 12,700, the high normal being 10,200.

So it is clearly above normal range, but I would not characterize it as high -- as very high. It's above normal,

but it's not very high.

BY MR. SLAGLE:

Q. Doctor, is it possible when you have -- Isn't it possible when you have cultures that you can have false negatives?

A. That's possible.

Q. And what are the cause of false negatives?

A. Well, I think that sometimes just the perhaps technique, the ability of the laboratory to grow the bacteria or organism, including Virus A acid-fast, that sort of thing. The laboratory is not 100 percent accurate with regard to that, so that would lead to false negatives.

Q. Is there anything in the records of Mr. Kirkpatrick's case that would indicate a possibility of a false negative?

A. Well, I don't think that there's anything specifically that indicates it. No one has -- No one -- False negative would be defined primarily if one, in fact, could prove at some point with certainty that, in fact, an infection existed, and that then -- then on that basis, one could look at a culture that had been reported out as negative and then define that culture as false negative in terms of the newer and updated information.

So that's the way I'll answer that question. I don't know that there's any other way to mark or to pick up a false negative culture. We have many, many cultures that were obtained, and it seems as though we never have a positive

culture to refute the negative ones.
Q. Wasn't he on antibiotic therapy much of the time these cultures were being taken and the agent organism was trying to be grown?
A. That's safe for the first culture in the emergency room, that's correct.
Q. And wouldn't they inhibit growth?
A. I don't know. It would depend on what the organism -- the alleged organism that is growing would be as to whether the antibiotic that was in use would inhibit its growth. As you know, each antibiotic will have its own particular set of organisms for which it's going to be effective and certain organisms for which it has absolutely no value in terms of combatting.
Q. Let me ask you this, Doctor, even if an infecting organism is not recovered, is there any way you could support a diagnosis of infection?
A. Well, you could you make a working diagnosis, a working provisional diagnosis of infection, but if -- so in that, and that's, in fact, what one would do if one has a clinical suspicion of infection, so that's what we do, you do what seems logical, and that's what was done in this case.
It seems logical that this fellow might be infected, and so you're forced at that point in time to rely on your clinical judgment to not have said, "Well, we'll ignore this

and not treat this as an infection" which would not be a very good idea. It wouldn't be in the patient's best interests.

The upside -- The downside of not treating him is too great, whereas the risk of treating him is not great. So one would obviously treat on the basis of a working diagnosis of infection.

Q. I'm talking about a situation in which you cannot identify the infecting organism. Can you tell me if there are other signs that would support the diagnosis of infection?

A. In terms of a joint?

Q. Yes.

A. Well, the aforementioned signs would be supportive, but those are not exclusive to infection, of course, as you realize.

Q. What about isn't the white blood count indicative of infection?

A, I don't -- Well, it may be supportive, but it would also be supportive of another -- of any inflammatory process in the body.

Q. Well, these other inflammatory processes in the body which you discussed could cause the problems that they've identified in his right knee, what would correct those if they're not treated?

A. Well, I'm not sure what the question exactly is driving at here. I'm not sure I understand it.

Q. We know infection can be dealt with through antibiotics, correct?

MR. JEFFERS: Say that again, Larry, please.

BY MR. SLAGLE:

Q. Infection, for instance, can be covered by the use of antibiotics?

A. Certain infections can be dealt with by antibiotics, that's true.

Q. Well, because his joint problem was not infection, let's go through the other possible causes of his joint knee problems, and tell me how they would be corrected or if they're not corrected, are they still present.

A. Okay. So if he had a hemarthrosis post-op and had just had a violent synovitis as a result of the second time surgery and hemarthrosis, then time itself and aspiration and debridement would take care of that.

Q. Anything else that would help take care of that?

A. I think time and debridement and aspiration would probably help take care of that. Anti-inflammatory medicine might help take care of that. Immobilization would help take care of that. Maybe some ice, maybe crutch ambulatory, weight-bearing modification would take care of that. Time itself, along with those other modalities, would take care of that.

Q. How would you identify a hemarthrosis?

A. We know he had a hemarthrosis because that's what Dr. Tokodi said he found when he aspirated the knee the day before, I believe it was the day before he went to the emergency room, if my date is correct. So we know he had a hemarthrosis.

Hemarthrosis would be consistent with a -- would be virtually 100 percent of the time after a knee arthroscopy, so we know that patients have a hemarthrosis. And Dr. Tokodi aspirated that hemarthrosis in this patient.

Q. Hemarthrosis is just a swelling of the joint then?

A. It's an accumulation of blood within the joint that can be very -- can be very traumatic and very painful.

Q. And how do you know that that is what happened on December the 5th when Dr. Tokodi withdrew the fluid?

A. I believe the record indicates that when he aspirated the fluid, it was essentially bloody, and that's -- I think his impression was the patient had accumulation of blood within the knee which would not be an unusual situation after the arthroscopy.

So we know if you draw blood out of the knee, if you aspirate blood out after an arthroscopy, the diagnosis is hemarthrosis. That's the finding: You find blood.

Q. From where do you get that indication that it was essentially bloody fluid he withdrew from his knee?

A. Well, I'll have to look in the -- I think someplace in

the records, we have indication that there was a knee aspiration.

(Pause.)

A. I think my date might have been wrong. Let's see on that. Date of surgery was what date?

MR. JEFFERS: 11-30 and then 12-9.

THE WITNESS: 11-30?

MR. JEFFERS: Then 12-9.

THE WITNESS: I think that actually the date of surgery was 11-29 according to -- So in Dr. Tokodi's office notes, the date of surgery listed as 12 -- I don't know where the medical record -- The original medical record is helpful.

I will presume that I am -- that I am seeing a date of 12 -- No, I'm sorry, 1-29-93 as listed here in Dr. Tokodi's record which says, "Surgery, right knee," but because there's a punch hole through the copy, I can't tell you.

Then the next entry down is a note that says he was seen on 11-30-93, and that date's a date that's typewritten in as well as a handwritten note that would tend to correlate. He says, quote, "A lot of pain in his knee. He has considerable effusion. We took 80 cc's of fluid off his knee. He had complete relief of his symptoms. He will see us for regular appointment."

BY MR. SLAGLE:

Q. That was on November 30th?

A. That's what his record would indicate.
Q. Is that in Dr. Tokodi's office notes?
A. Let's see the date of this. This is '94. Okay, I'm sorry, this was, as I indicated, '93. Now we're coming up to speed. That was a '93. That's the date. He had his surgery about a year apart actually. So that was the '93 aspiration.

He saw him after surgery -- interestingly enough, saw him after surgery a day after surgery in 1993 and had an aspiration of his knee, took off 80 cc's of fluid. And I may have been confused there confusing some dates because I had it in my recollection that there was a visit to Dr. Tokodi prior to the emergency room visit at which time he aspirated some fluid.

And, in fact, the whole purpose, I believe, and the whole point of your expert, Dr. Markowitz, was that it was the very -- that very fluid that was aspirated that Dr. Markowitz was finding fault that he had discarded. And the fluid I'm talking about that Dr. Tokodi aspirated was the fluid about which Dr. Markowitz is so upset that Dr. Tokodi did not culture.

Q. Isn't that the fluid that was drawn off in the emergency room on 12-5-94?
A. Okay, that was probably the 12-5-94 fluid, I believe that's correct.
Q. In your medical opinion, is there any justification for

drawing fluid off a knee and discarding it without testing it?
A. Yes.
Q. And what would that justification be and under what circumstances?
A. Well, in the postoperative time frame because you occasionally will have -- you'll have accumulation of blood in the knee and if you evaluate the patient and they have a significant swelling, one method, a good strategy to reduce that accumulation of blood is to aspirate it, and that would typically give the patient relief of the pain.

The pain is from the distention of the blood, but it's also from the reaction of the joint lining layer, which is called synovium, to the blood. So there's a dual issue there. One can develop a synovitis from the accumulated blood, but also one has distention from the accumulated blood.

So I think it is not at all rare that an orthopedic surgeon within three or four days after a knee arthroscopy might aspirate a knee and not do what, as you suggest, test it which I infer would mean culture it.

I wouldn't typically culture material at three or four days after a knee arthroscopy unless I had a sense that there was an infectious process ongoing. And that would be statistically one chance in a thousand of arthroscopy pretty much across the board.

So one would anticipate that most swelling that one sees

in the few days after knee arthroscopy is not going to be infectious at all. The statistics don't bear it out.

Q. What would you need to sense that an infectious process is going on?

A. Well, that's the clinical judgment that you apply at your experience and training and then in your sense of the patient and knowing what your sense of the patient's pain threshold is, knowing the circumstance of the surgery primarily that would lead you to having that culture done.

Q. What symptoms would you look for that would give you a degree of suspicion that it might be infection?

A. Well, I think the infection question primarily becomes one of pain. Usually what one considers to be, let's say, my phrase would be inordinate pain out of proportion to what the examining physician might otherwise expect would be the clue in my mind to go ahead and worry about an infectious process.

Q. Well, don't the records indicate that Mr. Kirkpatrick was complaining of increased pain?

A. Well, that would be consistent with a hemarthrosis. That's why you would be seeing the patient in the first place, the very fact they're having pain. And you would look at the patient, and then you would decide on the basis of your clinical judgment whether you felt that that would be consistent with the hemarthrosis.

Then you would aspirate the knee, and you would think

that that would all tie out or that there would be more concern that there was infection, so you still get down the clinical judgment. You have to look at the patient's circumstance and you have to examine the knee, and that's how you -- and that's how you decide that. You don't automatically culture every knee you put a needle in, in my experience.

Q. Okay. Well, then let's discuss the circumstances and the findings that you would need to tell you that perhaps this might be an infection and you should culture it and take the appropriate steps.

A. I would think it would get down to what I would consider inordinate pain, and inordinate pain is a judgment call. If I look at a patient and I think it's out of proportion to what I would expect as an orthopedic surgeon €or the particular procedure that he had, because that's probably the only real -- there's no really typical external clue, you don't -- there's no sign -- there's no little sign that pops up and says there's infection here, at that point, it's clinical judgment involved, and you just have to make that clinical judgment.

Q. Would a fever indicate to you that there's perhaps infection?

A. It may or may not. Fever can work both ways. So the fever might indicate it, but you can also have a fever in

hemarthrosis alone and a knee surgery alone so it's not exclusive.

Fever can be consistent with the fact he's had an operation and an operation only and no other problems. It could also be consistent that there's a little infection. It can also be consistent with a hemarthrosis and no infection.

Q. What about if the knee were hot?

A. Well, the knee would be hot from having a knee arthroscopy. And a knee that had a recent injury is usually going to be hot, particularly one that has a hemarthrosis because there is an inflammatory process. So a hot, swollen knee two or three days after knee arthroscopy is consistent with knee arthroscopy.

Q. How soon after the surgery should that hemarthrosis appear?

A. It's there as soon as you're done with the case. Once you let the tourniquet down, if, in fact, a tourniquet is used -- and a tourniquet was used in this case, I believe -- every knee will acquire hemarthrosis; some less, some more.

Q. Will it get progressively worse or go away until it's aspirated or about the same?

A. Some hemarthroses sort of take off and increase in volume, and those are the people that would call and have bitter complaints of pain. And that's where you're faced with the decision whether they have an infection.

So all of us as orthopedists at one time or another have looked at a knee and we've operated on knees probably -- I know I have -- where there has been a hemarthrosis as the source of the pain and no evidence of infection. It's -- It happens.

Q. What type of pain medication do you prescribe to someone who's had an arthroscopic operation on the knee?

A. I typically prescribe one or another of the standard mid-range scheduled narcotics such as codeine or its variants. Codeine would be a typical medication. Maybe a little step above that would be a drug called Vicodin. A step above that would be Percocet, and those would be the three.

But also we often prescribe and tell folks as an ancillary drug or as their primary drug, to take the anti-inflammatory category of drugs because some folks will be quite comfortable on anti-inflammatories alone.

Q. What type of anti-inflammatory?

Ibuprofen, for instance?

A. Aleave, which is a Naprocin variant, or simple aspirin, sometimes that will do it.

Q. Wouldn't you expect those to take care of the hemarthrosis?

A. Well, the drug -- the joint will ultimately -- If left to its own devices, the joint ultimately has the capacity to take care of the hemarthrosis. It's just if you have a significant

hemarthrosis, if you had four ounces of blood in the knee and had enough swelling, then you would have a painful, unhappy knee, and that would be a knee already that you would have -- start to develop -- you could get into kind of a vicious pain cycle and a synovitis that would then tend to self-perpetuate.

So you can get into sort of a vicious cycle of pain, inability to use the knee, lack of motion, more pain, more inability to use the knee.

So you can fairly quickly, if you have a hemarthrosis, go to -- get into a vicious cycle problem, and that's one of the jeopardies of any joint surgery, particularly the knee. The knee tends to be one that can be a little fickle along those lines.

Q. Now, when you see someone in the emergency room, don't you normally document that?

A. You mean see them as a patient?

Q. Yes.

A. Normally at Riverside Hospital, that's the -- would be the normal strategy, that's correct. I don't think at Riverside Hospital where I practice primarily that it is possible to probably to see a patient without going through that formality.

Q. You don't think it is possible?

A. At Riverside, I don't think it's possible. I think that the -- that the protocol at Riverside suggests that the

patients be registered and, you know, formally entered into the system for -- And I think that that primarily has to do with billing.

Q. In that protocol, though, they do other -- they do the normal everyday we take your temperature, check your heartbeat, things like that?

A. Well, not so. Typically if I am, for example -- to clarify that for you, if I'm going to see you and I'm going take off your external fixation frame €or your broken wrist, I would call the -- I would call the cast technician.

We make arrangements to meet the patient, and typically, to the best of my recollection, and I might be in error here, but I think those patients who come in for those simple procedures, for an external fixation frame removal, for example, would not have vital signs taken. So I think every hospital would have its own -- Every hospital has its own protocol with regard to those issues.

Q. What about your protocol with regard to an office visit, what do you do regarding asking your patients and recording their vital signs or whatever else may be relevant to their case?

A. Well, we don't record vital signs in the office. If a patient comes to see me, we will basically -- they'll end up with -- if the secretary is there, they'll end up with an entry stamped "entered" on their patient file and then

typically a handwritten note or two by myself or my nurse, then typically a dictation by myself.

Even if I see a patient on a Sunday morning because they have a screw loose or a bolt that needs to be tightened or they're having pain after a knee arthroscopy, I might see them in my office and I wouldn't -- I might not write anything on the chart but dictate something at some point. Typically that would be my typical protocol.

Q. If you have a patient that is suspected of having an infection, would you have taken his temperature, for instance, in the office?

A. No, not -- No, I wouldn't.

Q. What about if you suspect an infection and you drew the fluid off his knee, would you have that tested?

A. If I suspected an infection?

Q. Yes.

A. Well, if I suspected an infection, then I'm -- then I would, in fact, obtain a culture of that material that we withdrew, yes, if I suspected it because that's the way one proves an infection is one cultures the material and either finds an organism or one doesn't.

And if one doesn't, then one can't prove the infection and they wouldn't know how to manage the patient in terms of antibiotic care in the long run.

Q. If someone was on Vicodin and continued to complain of

increasing knee pain, wouldn't that be a sign of perhaps an infectious process going on?

A. Well, if one is -- whether one is on a medication schedule or not, increasing pain is -- would -- is certainly consistent with an inflammatory process that's problematic and would be consistent with an infection.

Q. Even while he's in the hospital and having the fluid drained from his knee, would that be a hemarthrosis process which would require continual draining?

A. Are you saying would hemarthrosis require continual draining?

Q. Yes.

A. Well, if you have further accumulation of fluid, I think that that -- that's just a -- that would be a fact. If you had accumulation of fluid and you felt that it was in your patient's interest to diminish the volume in the knee, then to aspirate that would be reasonable to do, I suspect.

Q. Well, what is a Jackson Pratt?

A. It's a surgical drain.

Q. Would that take care of hemarthrosis.

A. I don't know that you could say -- Some people, I believe, put drains in joints in an effort to diminish blood accumulation after a procedure. I wouldn't ever say that it takes care of it.

It may help diminish the swelling, but I think that if

you look at postoperative drains in general, that a lot of orthopedists don't use those anymore or as much as they used to, but I don't think anyone has found them terribly effective, but that doesn't mean they're potentially not valuable. It gets down to a judgment case by individual case, what the circumstance is, what you're trying to achieve with the use of a drain.

Q. This hemarthrosis question concerns me, obviously. Are you saying that a knee will continue to develop this fluid on the knee just through hemarthrosis and fight continual drawing of the fluid off the knee?

A. You can have a little bleeding in the knee, and once the -- once you get a little bit of blood clotted in the knee, that can serve as a source to pull fluid in. It's kind of an osmotic pressure grading, I believe.

That's been my experience, that if you evacuate a knee of blood after surgery and you see that patient back in two days, that knee will be filled up again.

Q. How often do you have to see a patient to take care of a filling of fluid in the knee?

A. Well, if you had a patient who had persistent swelling, usually you wouldn't aspirate a knee more than maybe one time if you had accumulation of blood, but if you -- but I think the idea maybe here is that if you, in fact, are working on a provisional diagnosis of a -- if you're working on a

provisional diagnosis of infection, then to diminish the volume of fluid in the knee by aspiration is one of the therapeutic -- one of the therapeutic arms here.

And so you would -- if you're working on a provisional diagnosis of an infection, you aspirate the knee and that's probably to the betterment of the knee.

Q. Is that normally something you do for hemarthrosis?

A. You might aspirate it once. You might aspirate it a couple times.

Q. In Laine's case, weren't they continually aspirating his knee the entire time he was in the hospital for the six days?

A. I saw he had continual aspiration prior to his surgery.

Q. Then he had the Jackson Pratt on afterwards?

A. Well, that was a drain I think he put in at surgery, yes, and that's not -- that's just a drain that is -- allows drainage from within the knee to the exterior. But you're working on -- The provisional diagnosis here is and the working diagnosis is he has an infection.

Q. The provisional diagnosis at the hospital in Marietta -- is that at Selby, correct?

A. Well, yes.

Q. That's also the discharge diagnosis; is it not?

A. That's -- Well, let's see what the discharge summary says.

(Pause.)

A. Well, there is no discharge diagnosis.
Q. In terms of the hospitalization at Doctors Hospital, it's not a provisional diagnosis at Doctors Hospital, is it, of septic arthritis?
A. Well, unless you can show me a culture that's positive, I think that it is forever provisional or working because nobody --
Q. You have no opinions in this case regarding whether the treatment of the infection itself is proper or improper because you say there was never an infection; is that correct?
A. What did you just ask me now?
Q. So you have no opinion as to whether Dr. Tokodi treated improperly for an infection because in your opinion there's no infection?
A. Well, I think he properly treated the knee for a working diagnosis of an infection. That's what one is obligated to do. If one feels that there's a possibility or high possibility or probability of infection, then you're obligated to pursue that treatment; otherwise, we have -- we'll have plaintiff's attorneys coming after us saying, "Well, Doctor, why didn't you treat him for the infection?"
So you have to -- at some point, you have to say, "I think that the diagnosis is infection and I'm going to treat the patient on that basis." And then so you start off on that basis.

And then if your cultures don't prove that cut, then at some point, you have to say -- you have to scratch your head and say, "Well, my clinical impression was wrong, there was no infection."

Then you have to decide what the heck you're going to do, so it's a forward going process. We can't make these decisions in retrospect, as you're well aware.

Q. At the time of discharge from Selby Memorial, you feel at that time if Kirkpatrick had an ongoing infection, he should have been discharged on oral antibiotics?

A. I don't think it was inappropriate that he was discharged on the oral antibiotics.

Q. Would you discharge a patient who has -- is treating for an infection that still has a fever on the date of discharge and on the date of discharge, you've again aspirated his knee if you thought it was an infection?

A. Well, if I thought that the patient was, in fact, clinically much improved, then I might allow him to go home, again with the understanding that he was going to be seen back relatively soon in the hospital or in the office.

So I think you have to just go on the basis of what the clinical sense is. And I think there was an arrangement to see him back within about 48 hours or so and then, of course, to call in the meantime if there was any significant increase.

So you're still -- I think you're still trying to

formulate here at the time of discharge. He didn't have a culture. He's spending money right and left treating a provisional diagnosis. There's expenses involved. You've got a patient that wants to get out of the hospital probably. You're trying to get the problem solved. You don't have any positive cultures. You don't know if it's an infection.

So to put him on an oral antibiotic still consistent with the original working diagnosis and even if he's got a little fever, I don't find great fault with that. He's been on antibiotics. You're going to keep him on antibiotics for a while. The working diagnosis is infection. I'm simply saying we just don't know if there was an infection.

Q. Did you look at Kirkpatrick's deposition in this case?

A. No, sir.

Q. Sir, I'm sorry, I did not hear that.

A. No, I did not.

Q. Did you discount any of the facts or opinions that are stated by Dr. Markowitz or Dr. Rosenzweig other than the fact you don't feel there's an infection.

MR. JEFFERS: Objection. That's a little broad, but if you can answer it.

THE WITNESS: I don't -- I would have to -- I think that's -- I'm not going to answer that. It's too broad of a question. I just won't answer it.

BY MR. SLAGLE:

Q. Could you find any criticism of the opinions expressed by Dr. Markowitz?
A. Sure.
Q. And what would they be?
A. Well, his logic is circular.
Q. Why do you say that?
A. Well, he basically is saying that you -- that you go from -- you go from sort of a situation where he must have had an infection because that's what everybody said, and then you take it back to the beginning and say, "Well, why didn't you treat it for an infection a day earlier?''

And so he's starting at the end, he goes to the beginning, then he comes back around to the end again. I don't know if that's exact circular logic, but he wants it both ways. He wants the culture to be taken immediately, and he's findings fault with Dr. Tokodi for discharging some fluid from the knee on the 5th.

And in his alarm of how rapid the bugs are developing, there's millions and millions of them, according to his theory, and yet a simple day later, that very culture that by his own logic would say should be grossly positive, is, in fact, negative.

And so he wants us to get a culture, and yet he's unable to explain why the culture 24 hours later where if you got your calculator, the guy must have a billion bugs in his knee,

has no culture. So he's unable to explain the 12-6 negative culture, yet he's very upset there was no culture taken on 12-5.

Then he's claiming that the plaintiffs, all of his travails in life are now because Dr. Tokodi discarded a vial of 50 cc's of fluid on 12-5-96. And I think it's just a bunch of horseshit, excuse my French.

Q. Doesn't Dr. Rosenzweig indicate the same?

A. Well, I don't recall -- It's been quite a while since I read his deposition. It was within the last -- I'm not sure exactly when I read that, but I think the sense was that, again, you have a plaintiff's guy and he's going to basically say the same.

But nobody's got a bug here, so I don't know -- I don't know if -- I don't think I could sit on a plaintiff side on this case and say that there was fault of Dr. Tokodi because I don't know how I can point a finger at him if there's no clear cut infection. I just don't understand it.

Q. You're saying no bugs, no infection, correct?

A. Well, no -- There's no bacterial infection that we know about. Maybe there's a viral infection here.

Q. Why would you say there might be a viral infection?

A. Well, I don't know. If there's an infectious process, maybe it's viral. I don't know. Nobody knows. That's the point, nobody knows.

Q. How would you identify a viral infection?
A. I suppose you have to do viral cultures. Do we do that? No, I don't think we do that.
Q. Why not?
A. I do not know. I suppose that's probably a pretty difficult thing to obtain. I don't think that we do viral cultures. I don't think we do routinely fungal cultures and acid-fast cultures.

And I don't think that those are in the initial time frame where one is thinking about what would be considered most probably a bacterial infection. I don't think those would be indicated. I don't think I've ever heard, by the way, of a viral culture, but I'm trying to open up the discussion here that nobody really understands what's going on with this knee.

Q. Well, I don't know that nobody understands. It still seems to me if you go back to Doctors Hospital, they seem to be pretty specific about what's going on.
A. Well, there again, they're working on a working diagnosis of infection, and that's fine. I have no fault -- I haven't found any fault with them, that they're working on that diagnosis. That's what I would be working on, too, probably.

But the issue here is how *is* it that your plaintiff's expert, Dr. Markowitz, is finding so much fault with Dr. Tokodi who is also working on a provisional diagnosis of

infection and he is now relating to Mr. Kirkpatrick, who's had an unfortunate problem, he's relatinq that to the fact that Dr. Tokodi threw out a vial of fluid?

It just doesn't make any -- There's no relationship to the logic or mislogic there. I just don't get it. I'm sorry. I'm either stupid or I don't get it or whatever.

Q. And you would disagree regarding Dr. Markowitz's impression that Laine should not probably have been released from the hospital on 12-12, and if so, it shouldn't have been on oral antibiotics either?

A. Well, certainly there's nobody that's ever proven that he had an infection. And even the Massillon doctors a few days later when they cultured his knee couldn't find an infection.

And your guy, Markowitz, up there saying he was on the wrong bacteria when he was discharged, well, if he's on the wrong bacteria, by God, you ought to have a bug that grows out. And where is it, Dr. Markowitz? Where's your bug?

If you're going to point a finger at our guy for throwing a vial of fluid away, you should come up with a big -- you should proceed forth with why it was just a bad antibiotic for which nobody has proven.

Q. When the doctors at Doctors Hospital did the surgery on him when he was admitted, what would you expect to find during the course of that surgery that would be indicative of infection; could you tell me?

A. Positive cultures.
Q. Well, when you're looking at it when you pull the stuff out, whatever you're debriding out of there, what should it look like?
A. Well, you should have not so much necessarily what it looks like, but when you have a synovitis, if you have a synovitis, that's what you would expect to see. Then the pathological diagnosis is consistent with the synovitis.

And so you have a synovitis, so what do you do? You do a synovectomy. You will take it out, debride it and send it to the path lab, and the path lab says, "There's synovitis." And that's exactly what they conclude on the basis of an acute inflammatory process and they have a synovitis.

And you have a synovitis at Doctors Hospital and documented by the pathologist, and you have a pathologist at Selby Hospital who documented it. So that's what you have. You have a synovitis. It's an angry joint. We just don't know why it's angry.
Q. When Dr. Moretta speaks of purulent material, p-u-r-u --
A. -- -u-l-e-n-t, purulent or purulence, either way.
Q. -- what does that signify to you?
A. Well, usually the implication when one uses the term, one is implying infection. When one hears it, one infers infection, but just because -- but that's a visual observation. And a visual observation does not infection

necessarily make.

For example, a gouty arthritis will have fluid that very much looks like pus if it's a dramatic, gouty arthritic problem. So one could say it's purulent, but that's an observation. But unless one had a culture positive to prove an infection, then one would find that the description of purulence was a description only and not documenting, in fact, there was infection. It takes a culture to prove an infection.

Q. So you would disagree then with the pathologist at Doctors Hospital when he said his diagnosis after that initial surgery, that there was synovium with acute and chronic inflammation consistent with septic arthritis of the right knee?

A. No, I don't agree because the word is consistent. There's no pathology that says it's septic arthritis. It's also consistent -- I suppose if you ask him under deposition would that be consistent with an acute and chronic inflammatory process from a vigorous allergic reaction to a knee, to a caustic agent, he might have to say yes. I think you have to ask him under inquiry. Consistent with does not mean exclusive for, as far as I'm concerned.

(Recess was taken.)

BY MR. SLAGLE:

Q. Do you know that Mr. Kirkpatrick developed reflex

sympatheticdystrophy?
A. That's my understanding.
Q. Now, would you have any disagreements that that type of difficulty can result from the events occurring in his case?
A. That's a good phrase, the events. I'm in 100 percent agreement with you on that.
Q. What events, in your opinion, would result in the reflex sympathetic dystrophy?
A. Well, in my experience, a reflex dystrophy could evolve from something as simple as a very minor trauma to a limb. And so the most minor trauma up to very major injuries to a limb could result in a reflex dystrophy.
Q. And in this case, can you identify what the trauma in his course of treatment would have resulted in the reflex sympathetic dystrophy?
A. Well, trauma would imply any injury. So surgery is an injury. It's a controlled injury, but surgery itself can trigger a reflex dystrophy. So one or more accumulative effects of the various procedures because he had several procedures, and it could well be that those were -- that those singularly or accumulatively were the triggering phenomena.
Q. You don't know which one or you would not be willing to hazard an opinion of which might have been the triggering phenomena?
A. I think that would be the determinate, yes.

Q. Have you -- I hate to ask this, but I have to, have your hospital privileges ever been revoked or suspended?
A. I'm not offended. No, sir.
Q. Has any state medical license been suspended or revoked?
A. I've got a bunch of nos for you.
Q. Have you ever applied for state licensure and been denied?
A. No, sir.
Q. Have you ever been in partnership with any other physician?
A. I was not in a partnership. I had a fellow named Dave Robie -- I should say have -- who has been a member of my corporation for about eight years, and we've had an expense-sharing relationship.

He developed or initiated his own corporation so that he is not a part of my corporation at this point, but we still maintain our expense-sharing relationship in a similar relationship, so there's been no change of our association or relationship save for the legal corporate structure.
Q. Can you tell me with which insurance company you currently carry your liability or malpractice coverage?
A. Yes, sir.

MR. JEFFERS: Objection. Go ahead.

THE WITNESS: Yes, sir, Ohio Hospital Insurance Company.

BY MR. SLAGLE:
Q. Ohio Hospital Insurance Company?
A. Yes, sir.
Q. And when did you start that coverage?
A. I believe it was either 1 August or 1 September 1996.
Q. At the time of the incident in this case, December of '94, who was your insurance carrier for malpractice coverage?
MR. JEFFERS: Objection.
THE WITNESS: P.I.E., Physicians Insurance Exchange.
BY MR. SLAGLE:
Q. Can you tell us if that has been the same insuring organization for Dr. Tokodi?
A. I don't know. I don't know if that's the case.
Q. Have you ever had your insurance coverage with any other carrier?
A. No, sir.
Q. Have you ever been denied liability insurance coverage?
A. No, sir.
Q. Have you yourself ever held a position within the insurance company?
A. No, sir.
Q. And you said you have been asked to serve to review cases or claims, correct?
A. Yes, sir.
Q. And what is that process when it happens?

A. It's a meeting in which one or more of the attorneys in the law firm of Jacobson, Maynard and particularly in this office, in the Columbus office, would present to a particular specialty group -- For example, when I come to review a claim, there would be two or three orthopedic surgeons at the claim review. So those attorneys would present to those individuals the various cases that had come up or had been filed or whatever or inquired about.

I'm not sure how legalese goes, but at that point, there would be a discussion about -- essentially about the merits of the case. I think it just helps with the intent of helping the attorneys who are charged with the defense of those claims, perhaps getting a better perspective, some of the information -- background information that they would need to help them do their job maybe in a more efficient fashion.

Q. Have you ever received any announcement notices or correspondence from your insurance carrier that you're serving as an expert witness in a medical malpractice case?

A. Have I received an announcement from the insurance company?

Q. Yes.

A. No, I don't -- No.

Q. Any instructions what to do if you were approached to be an expert witness?

A. No.

Q. How about have you read any articles or books regarding how to be an expert witness?
A. No, I'm just me.
Q. Do you feel the amount of your premiums that you pay for medical liability insurance are justified?
MR. JEFFERS: Objection.
THE WITNESS: Well, they're higher than I would like, but I do realize the expense of a claim brought and the significant expense that it takes to properly analyze and then, if required, to continue to defend it.
So I don't like paying the malpractice insurance but realize to a certain extent with where the money goes. So that's kind of a qualified yes, I guess.
BY MR. SLAGLE:
Q. Do you believe there's a medical malpractice insurance crisis?
MR. JEFFERS: Objection.
THE WITNESS: In 1997, I do not believe that's the case.
BY MR. SLAGLE:
Q. What occurred in 1997?
A. No, I say I don't think anything occurred in 1997, but as I sit here today, I don't believe that's the case. I believe a few years ago, there was mounting difficulties with rapidly escalating insurance premiums, and that's what I think

probably many of us in the profession would refer to as a, quote, crisis, end quote, because we were under tremendous financial burden to come up with ever increasing premiums so that some people even had to move their practice from one state to another. And in our lingo, I guess that would be called a crisis.

Q. Now, going back to Doctors Hospital, when Dr. Moretta did the initial surgery on 12-18, if this were a hemarthrosis, can you tell me what you would have expected him to find during that surgery regarding material relative to that smear?

A. You would find from a continuing ongoing hemarthrosis that had provoked an inflammatory response, you would have found some accumulated blood that had been clotted. You would have found some inflammatory tissue that would be referred to as a synovium. And you would find some perhaps debris about the knee, so-called fibrinous material that would be the coalescence of the protein in the blood.

So those are the kinds of things -- And you would see an inflamed, a reddened, erythematous -- our term for red -- membrane that would be probably more voluminous than it would normally be. So that's what you would find, I think.

Q. Is that what Dr. Moretta found during his surgery?

A. Well, we have the operative report, and that's the purpose, of course, of the operative report, so that he's able to record what his findings were.

Q. I gather you, of course, disagree with Dr. Moretta's opinion that he suffered a septic arthritis as a complication following the surgery by Dr. George Tokodi?
A. And that would be -- I believe I've seen a letter. Is that your referencing a letter of opinion of where that statement's contained? Is that what I'm being asked? I would like to review that real quickly if I could.
(Pause.)
MR. JEFFERS: Larry, are you referring to that letter that he sent to you?
MR. SLAGLE: I'm referring to the May letter of May 23, 1995.
MR. JEFFERS: Okay.
THE WITNESS: Well, I disagree with the phrase septic arthritis because we, in fact, do not know that to be the case. That still remains a provisional diagnosis. And so if he would like to modify that and say that the provisional or working diagnosis of septic arthritis was a complication, that might be the case, but he says it was septic, and I disagree because I don't know it was septic. I don't know how he knows it's septic if there's not an organism to be found.
BY MR. SLAGLE:
Q. So you would not accept his clinical judgment, hands-on experience and experience of going through the operation with Laine, the four plus months of treatment as being sufficient

for him to reach a clinical judgment this is septic arthritis?
A. Well, the diagnosis -- I'll go back to the original -- our original discussion, the diagnosis of a septic arthritis to be certain requires an organism to be identified, and so it has nothing to do with his inability or ability in the operating room or his inability to judge things clinically.

It has to do with is there an organism. And so if his clinical judgment is that there was a septic arthritis, that's what he was working with, and we simply do not know if it was an infection.

Q. Have you ever had a patient with infections?
A. Yes.
Q. Have you had a patient with infections that resulted from surgery?
A. Yes.
Q. Every one of those cases, has that infection been documented through the cultures?
A, By definition, that's how one documents an infection, by culture.
Q. So the only way you can have an infection, in your opinion, is if it's documented by culture?
A. Well, I don't like the form of the question in that if -- if you say I have a cold tonight, then I can have an infection, but I may not be able to document that readily by culture.

So I mean the only way you can say with certainty there was an infectious process was to be able to identify the organism. It's just scientific --

Q. How about to a reasonable medical certainty?

A. Well, that's not the way you make decisions. I mean, I don't know. I don't know that there was an infection. I don't think there's reasonable medical certainty there was an infection. That's the point of contention here. I disagree that there's a reasonable certainty because if I agreed there was reasonable certainty, I wouldn't have agreed to fight this cause here with Mr. Jeffers.

Q. So if you had concluded by a reasonable degree of medical certainty that there was an infection, then you're saying you would not have testified as an expert in this case?

MR. JEFFERS: Objection.

THE WITNESS: I didn't really say that specifically. No, if I could document an infection, then we would deal with the -- then we would look at the other aspects of things and try to understand if there was, in fact -- If, in fact, a documented infection was there, a failure of the system to treat that, we would have to look at that with a whole fresh look and find out if there was a problem at that point.

It's just that if there's no infection that's documented, then for somebody to point a finger at Dr. Tokodi and say that he blew it because it's obvious to everybody in

the world that there's an infection to me doesn't make any sense.

BY MR. SLAGLE:

Q. I'm just trying to clarify this point.

A. Sure.

Q. In your opinion, as long as there's not a culture identifying the infecting organism, there's no infection, correct?

A. There's no proof of infection. We -- There's no proof of infection.

Q. Well --

A. There may have been infection here. I don't know. There may have been infection. I can't say because there is not a -- I can't say there was an infection or there wasn't an infection. We simply can't say.

My word two years after the fact don't take the -- If there was an infection, my thoughts or comments don't take the infection away. On the other hand, two years after the case if there was not an infection, your expert up in Wisconsin or wherever he was does not make it so. So it's a two-way street. We can't make something that isn't real. It's it either was infected or it wasn't.

Q. If you can't prove an infection, you can't go further and render an opinion about rendering treatment of that infection?

A. You can render opinions regarding whether it was

plausible or prudent to treat it as though it were infection until one can come to further conclusions about the situation because those are -- because in my mind, they're independent issues.

Q. If there's an infection, let's concede that fact, let's assume there's an infection, would you consider it prudent for a doctor to discard the --

MR. JEFFERS: When are we assuming there's infection? From the start?

BY MR. SLAGLE:

Q. Yeah, let's assume there's an infection first on 12-5-95 -- '94, would you think it's prudent for a doctor at that point to discard the material drawn from the knee?

MR. JEFFERS: Objection. *Go* ahead.

THE WITNESS: Well, if everybody is in the loop and if he assumes it and he assumes it, he would not throw it out. If he assumes --

BY MR. SLAGLE:

Q. Let's assume there's an infection on 12-5-94.

A. On 12-5-94.

Q. Is it prudent for the doctor to throw the material drawn from the knee out?

MR. JEFFERS: You're saying the doctor knows there's an infection?

BY MR. SLAGLE:

Q. Let's assume he has a suspicion there's an infection.

MR. JEFFERS: Objection. Go ahead.

THE WITNESS: Well, he -- I think if he assumed there was a suspicion, he wouldn't throw it out. So the very fact he throws it out implies that he doesn't think it's infected because I don't think any prudent physician would discard material that's going to help a patient and help him manage the patient's situation.

BY MR. SLAGLE:

Q. So if a doctor then assumes there's an infection, a prudent physician should not throw the material out?

MR. JEFFERS: Objection.

THE WITNESS: If he -- If he is suspicious or assumes an infection, then it would be prudent to not throw the material out, that's correct.

BY MR. SLAGLE:

Q. In your practice, have you consulted with infectious disease experts when you had a concern about treatment?

MR. JEFFERS: Ever?

MR. SLAGLE: Yes, ever.

THE WITNESS: Routinely, I would if I have an infection problem. Essentially routinely, that is to say essentially 100 percent of the time, if I have an infection problem, I will ask the infectious disease staff to assist or actually make an antibiotic selection as well as -- as well as

the delivery protocols. That's their bailiwick, and they -- they certainly know more about the choice of antibiotics than I, so I would routinely if I have a clinical infection resort to their skills.

BY MR. SLAGLE:

Q. What would you consider an infection problem then if you would resort to their skills?

A. What would I consider an infection problem?

Q. Right.

A. Well, a culture positive proven infection.

Q. So if you did not have a positive culture, you would not consult with an infectious disease specialist?

A. Well, that's correct because it takes a positive culture to prove an infection in my practice. And then I wouldn't bother somebody -- I wouldn't bother an infectious disease individual to -- with a non-infectious disease problem.

Q. So, in your experience, you never had an infectious disease consultation when you had a negative culture?

A. Not in my experience, no.

Q. Well, Doctor, I think I'm done for now. Have you understood all of my questions?

A. Oh, yes.

Q. Given your answers to the best of your ability to be true and correct?

A. Absolutely.

Q. You told me everything you recall in this case?
A. I believe so.
Q. You did have an occasion to look at documentation in the file to refresh your recollection?
A. Oh, absolutely. We looked at a few dates and numbers and things to bring us up-to-date, absolutely, correct.
Q. Up to this point, there's nothing in your testimony you wish to change or to add to?
MR. JEFFERS: Larry, let me just say one thing, since we're doing this by phone, as you realize, I'm going to have him read this deposition to make sure that all the questions did come out clearly and so he did understand them. I think we've given that consideration to both Dr. Markowitz and Dr. Rosenzweig, and I would ask for a similar consideration in this case.
MR. SLAGLE: Oh, I don't have any problem with that.
MR. JEFFERS: Okay.
BY MR. SLAGLE:
Q. So there's nothing you wish to change or add to at this point?
A. That's correct.
MR. JEFFERS: Along with what I just said?
MR. SLAGLE: Yes.
MR. JEFFERS: Thanks, Larry.
BY MR. SLAGLE:

Q. You did have the full Doctors Hospital record, correct?
A. Well, I have copies of records that would seem to be comprehensive, but I can't tell you that they're an accurate record of the entire document not having seen the original.
Q. You have been given Dr. Moretta's records as well?
A. Copies of records, that's correct.
Q. If Dr. Moretta were to testify that based on his observations that there's no doubt in his mind that there is an septic arthritis, would that in any way change any of your opinions?
A. No, sir.
Q. If you have any additional opinions or changes in your opinions, will you immediately notify defense counsel?
A. I'll do that.
MR. SLAGLE: Thank you very much, Doctor.
THE WITNESS: You bet, sir.
MR. JEFFERS: Larry, is 30 days okay?
MR. SLAGLE: Thirty days?
MR. JEFFERS: To review.
MR. SLAGLE: Oh, geez, I think we need to shorten it.
MR. JEFFERS: Twenty-one days?
MR. SLAGLE: How about two weeks?
THE WITNESS: I can read it quickly once I get it.
MR. JEFFERS: He said he can do it in two weeks,

Larry.

(Discussion held off the record.)

- - -

Thereupon, Exhibit Nos. 3 through 7 were marked for purposes of identification.

- - -

(Signature not waived.)

- - -

(Thereupon, the deposition was concluded at 5:30 o'clock p.m. on Tuesday, March 18, 1997.)

- - -

A F F I D A V I T

- - -

STATE OF OHIO,)
) SS:
COUNTY OF _____,)

William D. Barker, M.D., having been duly sworn and cautioned, deposes and says that:

I have read the transcript of my deposition taken on Tuesday, March 18, 1997, and made all necessary changes and/or corrections as noted on the attached correction sheet, if any.

_____
William D. Barker, M.D.

Sworn to before me and subscribed in my presence this ____ day of _____, 1996.

_____
Notary Public

My Commission Expires:_____

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