IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

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JESSE HATFIELD, et al.
Plaintiffs,
vs. Case No. 502766
PARMA COMMUNITY GENERAL
HOSPITAL, et al.,
Defendants.

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DEPOSITION OF VINCENT J. BERTIN, M.D.
Wednesday, December 17, 2003

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Deposition of VINCENT J. BERTIN, M.D., a Defendant herein, called by the Plaintiffs for examination under the statute, taken before me, Karen M. Patterson, a Registered Merit Reporter and Notary Public in and for the State of Ohio, pursuant to notice of counsel, at the offices of Vincent J. Bertin, M.D., 18660 Bagley Road, Building II, Suite 201, Cleveland, Ohio, on the day and date set forth above, at 2:20 o'clock p.m.

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APPEARANCES:

On behalf of the Plaintiffs:
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On behalf of the Defendant Parma Community General Hospital:
Weston, Hurd, Fallon, Paisley & Howley, by
DANIEL A. RICHARDS, ESQ.
2500 Terminal Tower
50 Public Square
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On behalf of the Defendant Vincent J. Bertin, M.D.:
Reminger & Reminger Co., L.P.A., by
MARILENA DISILVIO, ESQ.
1400 Midland Building
101 West Prospect Avenue
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VINCENT J. BERTIN, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF VINCENT J. BERTIN, M.D.

BY MS TRESL:

Q. Dr. Bertin, we met earlier; Jackie Tresl, attorney for Mr. and Mrs. Hatfield. Have you ever had your deposition taken before, sir?

A. Yes.

Q. Can you tell me in how many instances?

A. No.

Q. Have you had your deposition taken more than twice?

A. Yes.

Q. Have you had your deposition taken in medical malpractice cases?

A. Yes.

Q. Have you been named as a defendant in those medical malpractice cases?

A. Yes.

MS. DISILVIO: Objection. And, Jackie, just so I don't keep interrupting you,

may I have a continuing objection to any questioning regarding prior medical malpractice lawsuits?

MS. TRESL: Not a problem.

Q. Have you been named as a defendant in a medical malpractice case more than five times?

A. Yes.

Q. And you don't want to share with me any of the names of the parties involved in any of those cases; is that correct?

A. Yes.

Q. Were you found liable in any of the cases in which you were a defendant?

MS. DISILVIO: Objection to being found liable. If you know what that means, doctor, you may answer.

A. I don't know what liable means in a case like that.

Q. Were you found to be negligent in the suit in which you were brought as a defendant?

MS. DISILVIO: Let me interrupt for a minute. By that, do you mean has there ever been a jury verdict rendered against him?

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MS. TRESL: Or a settlement or in any way has anyone said as a defendant you violated the standard of care, that you were negligent in your care.

MS. DISILVIO: Objection. He's not going to answer that. Settlements do not imply liability by any stretch of the imagination. Oftentimes settlements are entered into as a business decision.

So, to the extent that that question asks for information which is deemed confidential in terms of settlement agreements, I'll object. If you want to know if a jury has ever returned a verdict against him, you can certainly ask him that question.

Q. Has a jury ever returned a verdict against you, Dr. Bertin?

A. No.

Q. When was the last time you were named as a defendant, what year?

A. Other than this case?

Q. Correct.

A. 2002.

Q. Prior to that?

A. 1999.

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Q. Prior to that?

A. I don't recall.

Q. Have you ever served as an expert in any lawsuits where you were asked to give an opinion on the standard of care?

A. Not at trial, but I have reviewed cases, yes.

Q. About how many cases have you reviewed?

A. Probably seven or eight.

Q. Plaintiff and defendant, or patient?

A. Both sides.

Q. More one than the other?

A. More defendant.

Q. And were any of the cases that you served as an expert on related at all to the facts surrounding Mr. Hatfield?

A. No.

Q. So you've never testified relative to compartment syndrome?

A. No.

Q. Have you ever testified relative to an injury caused by trauma, let's say venipuncture?

A. No.

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Q. Since you've had your deposition taken many times, I will just short and sweet set out the guidelines. If I ask you questions you don't understand, please tell me that you don't understand it.

A. Okay.

Q. If you answer my question, I will assume you understand it, okay? That's a yes?

A. Yes.

Q. I need you to answer yes or no rather than nod or shake your head so that Karen can put it down on the record.

A. Yes.

Q. I ask that you let me finish my question before you answer, and I will give you the same courtesy, to let you finish your answer before I ask my next question. Okay?

A. Yes.

Q. For the record, can you tell us your name and address, please.

A. A. Vincent Bertin, 18660 Bagley Medical Arts II, Number 201, Middleburg Heights, Ohio.

Q. You are a vascular surgeon; is that correct?

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A. Correct.

Q. Are you board certified?

A. Yes.

Q. Since when did you get your board certification?

A. Board certified in general surgery in 1987 and vascular surgery in 1990.

Q. Then it looks like you were recertified both in '95 and '97; is that correct?

A. Recertified a little later than that, '98 or '99.

Q. In vascular surgery?

A. In both.

Q. I notice here that 1995 through 1997 you were chief of vascular surgery, and it looks like now you are staff surgeon and director of vascular laboratory. Can you tell me the different duties and responsibilities relative to that sort of difference in title?

A. Yes. Basically, I've been chief of surgery at Southwest -- I don't know if it's even on that CV -- I've been chief of surgery at Southwest Hospital for three or four years. I've been chief of vascular surgery at Southwest

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Hospital and Parma Hospital probably about -- between three and four years at each institution.

What it is, basically, is a political position. You get elected by your department peers, and when you no longer want to do that position, then you don't try to be elected again.

Q. In '97, you didn't want to be the chief of vascular surgery at Parma Community any longer; is that correct?

A. Correct.

Q. You are currently staff surgeon at Southwest General; yes?

A. Yes.

Q. And staff surgeon, director of vascular laboratory at Parma Community; yes?

A. Correct.

Q. Are you still staff surgeon at Deaconess? I'm going to guess the answer is no.

A. Fortunately.

Q. Because Deaconess is no longer there. You were until last month?

A. I was until the final death nell, yes.

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Q. Anywhere else that's not reflected on here?

A. No.

Q. This is current, as far as you can tell?

A. That's correct.

MS. DISILVIO: With the exception of the title that he gave as it relates to chief of surgery at Southwest, which I think Dr. Bertin said was not on that CV.

MS. TRESL: Correct.

Q. So because you're a staff surgeon and a vascular surgeon then, do you do both general surgery and vascular surgery?

A. No. My practice is totally confined to vascular surgery.

Q. Tell me a little bit about your practice, what kind of patients you see.

A. A whole realm of peripheral vascular patients.

Q. You go in to do emergency procedures?

A. Yes.

Q. When?

A. When necessary.

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Q. Do you do a lot of vascular studies, or do you send someone to a vascular lab for that, or is that all incorporated together?

A. Well, vascular labs are set up in -- some are in the hospital, some are in your office. I have capability to do it in both places.

Q. How commonly do you perform fasciotomies? Is that a common procedure or uncommon procedure in your day-to-day practice?

A. Relatively uncommon.

Q. And why is that, sir?

A. It's mainly because I don't have a lot of trauma patients in my -- I'm not at a trauma center, per se. You see the fasciotomy type procedures more in trauma centers, let's put it that way.

Q. How many, let's say, forearm fasciotomies have you performed, say, in the last two years?

A. Superficial?

MS. DISILVIO: If you know.

A. Superficial forearm fasciotomy.

Q. I think you did both superficial and deep in this case. So why don't we say you can

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do one or the other or both, however you would like to break it down.

A. I might have to look back and see, but probably two or three.

Q. In the last two or three years?

A. Probably.

Q. It does not look like you do any active teaching right now.

A. Correct.

Q. Do you do any in-servicing of residents or interns in your daily practice when you're making rounds at the hospital?

A. No. I don't practice at a teaching hospital.

Q. Nobody sends students over if it's not a teaching hospital then?

A. Pretty much, no.

Q. Are you part of a practice group?

A. I'm a solo practitioner.

Q. What's the name of the corporation?

A. Southwest Vascular, Inc.

Q. You are the statutory agent of that?

A. Correct.

Q. How long has Southwest Vascular, Inc. been incorporated?

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A. Since, I believe, 1989.
Q. If you want to take a vacation, do you have someone that you call to step into your shoes?
A. Correct, yes. We have coverage arrangements.
Q. With other vascular surgeons?
A. Correct.
Q. Other sole practitioners?
A. Right.
Q. For today's deposition, what did you review?
A. Basically the medical record, my office notes.
Q. Your office notes. Do I have a copy of your office notes? I don't believe I do. Do I have a copy of your office notes?
MS. DISILVIO: I think you should. I think I sent them.
MS. TRESL: May I see what they look like and then I will know whether I have them or not.
MS. DISILVIO: You can take the binder. That's my binder.
Q. It will be so much quicker if he

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points them out to me.
A. Right there.
Q. I've never seen these.
A. This section.
MS. TRESL: To the extent there might be something in here I need to question the doctor about, may I reserve my rights?
MS. DISILVIO: Sure. I would just direct you to any notes -- there are progress notes, obviously, that predate the time of the alleged negligence in this case which are, in all likelihood, entirely irrelevant to any claim but pertain to Mr. Hatfield's underlying vascular disease. You should be able to quickly discern progress notes from August of 2002 and thereafter, which may or may not pertain to the allegations in this case. My suggestion is, since there's not very many progress notes from August of 2002 and thereafter, maybe we take a break and give you the opportunity to look at them so that you can inquire now.
MS. TRESL: Have you seen these either?
MR. RICHARDS: No.
MS. TRESL: Can you make us two

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sets, two copies. I would like a little bit before, too. I don't want to start right at the incident. I would like to at least go back.
MS. DISILVIO: I'll be happy to have her copy them.
MS. TRESL: Off the record.
(Discussion off the record.)
MS. TRESL: Back on record, please.
Q. When we stopped, I asked you what you had reviewed for today's deposition. You said his medical chart, which included your office records and hospital records; is that correct?
A. Correct.
Q. Did you review any policies and procedures?
A. No.
Q. Did you review any medical literature --
A. No.
Q. If you would let me finish my question.
-- relative to this case? Have you spoken to Dr. Chang in preparation for today's deposition?

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A. No.
Q. Were you aware that two of the nurses in this case were deposed last week?
MS. DISILVIO: Objection to any question that might ask about any discussions he has had with me. If you know anything about depositions, doctor, from any other source than me, you can let Ms. Tresl know.
A. No.
Q. Neither of the nurses told you that their deposition was going to be taken?
A. No.
Q. Have you spoken to either of the nurses that I spoke to last week since their deposition?
A. No.
Q. Do you know the names of the nurses that were involved in Mr. Hatfield's care during that period of time between August 6th and August 8th?
A. No.
Q. Do you have an independent memory of Mr. Hatfield relative to his stay in Parma in August of 2002?
A. I took care of Mr. Hatfield for 13

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years. Is the question you were asking --
Q. If I ask you specifically about what happened when he was there in August of 2002, do you remember, independent from what you wrote, what happened in your care of him? Or everything that you're telling me, will you be relying on your records for?
A. Basically, I would be relying on the records.
Q. It looks to me that you began caring for Mr. Hatfield in 1991, just from glancing at that.
A. Correct.
Q. Can you just tell me briefly how you happened to become his doctor in 1991?
A. Did you take that section in --
Q. I thought they would have given it back to you.
A. Here we go. He was referred to me initially February 5th, 1991. At that time, he had significant arterial occlusive disease of the lower extremity. What that basically means is blocked circulation in the pelvis and lower legs.
Q. And the abbreviation of IPVSC would

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stand for?
A. Inpatient vascular surgery consult.
Q. And PCH?
A. Parma Community Hospital.
Q. The last time that you saw Mr. Hatfield was when? Do you know that date?
A. I believe it was around January or February of 2003, I believe. No. Actually, probably it was October 25th, 2002 because he cancelled the appointment in January of 2003.
Q. Have you contacted him or his family in any way to reschedule, or do you know if he's gotten another vascular surgeon?
A. There was a request from another vascular surgeon across the street here, Dr. Rogers, for his records, so I assume that they obtained the services of another vascular surgeon.
Q. In just briefly glancing through the records, it looked to me primarily what you were seeing Mr. Hatfield for were lower extremity issues.
A. No. He also had carotid disease. If I recall, I did a carotid surgery on him at some point. I think I did a right carotid

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endarterectomy on him in 1997. And I also was the surgeon who performed his vascular access procedures on his left arm.
Q. On May 29 of 2002 when you say that -- I'm assuming that's the fistula -- the shunt is ready for puncture, that means that the fistula is being ready to be used for dialysis; is that correct?
A. Correct.
Q. At the time Mr. Hatfield was hospitalized in August, was that fistula accessible to -- well, let me ask you this way. Who is that A-V fistula opening accessible to in terms of when he's in the hospital? Is it only for dialysis, or is it for other things?
A. The fistula, per se, is only for dialysis unless there were a dire emergency situation where access was required.
Q. Is fistula the correct word or is shunt more appropriate?
A. They mean three different things.
Q. I want to be sure we're talking about the same thing. It's the thing under the arm where the needle for dialysis goes. What would be the best word to use here?

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A. In his case, graft would be the best. It's a forearm graft.
Q. That forearm graft, in his case, while they're doing dialysis, can they also be doing transfusions through it? Could they also be doing blood draws through it?
A. No. Those are reserved for dialysis purposes only unless there is an extremist case where access was required. If he had a cardiac arrest and we needed fast access, then you can probably use the access. Otherwise, no. It's used strictly for dialysis purposes.
Q. At the time he was in in August, that's what they were using in terms of the hemodialysis records?
A. Correct.
Q. It looks to me there were no problems with the fistula. The sort of weeping and seeping associated with it kind of simultaneously in August, is that normal?
A. That can happen after any dialysis session, yes.
Q. Explain to me briefly why that is.
A. Because you're taking a needle and sticking a needle into a tube, and that tube

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then, there's a hole in the tube, and that hole in the tube can leak once the needle comes back out. So when they're on the dialysis machine, the needle is in, the circulation to the machine is ongoing, and then there's another return needle that brings the circulation back. Those two openings in the graft, once you pull the needles back out at the end of the session, they can bleed. That's leaking.

Q. That didn't concern you when you saw that documented? You would expect that, and it subsides after awhile on its own?

A. Almost always.

Q. Sometimes pressure is needed, or not generally?

A. Well, remember, when they take the needles out after a dialysis session, they put pressure on.

Q. I see.

A. Then they usually release them from the unit. Sometimes they will ooze after that. Usually it always stops, though. Usually it doesn't take too much pressure to stop it.

Q. Is it a general maxim that patients that are receiving hemodialysis are being

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heparinized?

A. Almost every patient during dialysis, okay, receives heparin.

Q. And that the anti-coagulable state that they're in continues then in between dialysis sessions?

A. No. No. Heparin has a half-life of an hour-and-a-half.

Q. Okay.

A. So you give a dose of heparin; within a three-hour time period, it's gone from the body.

Q. Subcutaneously also?

A. Subcu heparin has a -- you know, that's a different deal, but that has nothing to do with this. The kind of heparin used for dialysis purposes is IV heparin, and that has the half-life that I told you.

Q. Why don't we cut right to the chase.

A. Please do.

Q. The records that my colleague here and I have, let's start with, first of all, in some of your records -- now we're talking about your records primarily from August 6th until August 8th -- I believe you mentioned twice, and

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it may have been three times, that you believe that the hematoma that Mr. Hatfield had was as a result of aberrant needle sticks, and I believe you mentioned that it was 16 gauge.

Now, first of all, how did you determine that the hematoma was as a result of aberrant needle sticks?

A. I'm trying to find where I wrote that.

MS. DISILVIO: Dr. Bertin, please understand, at any point in time during the deposition you need to find a note, let us know, we'll take a break so that you can find the appropriate documentation.

Q. Here is one, and I can find another one.

MS. DISILVIO: What are you referring to?

A. To the operative note.

Q. Correct.

A. I got that.

Q. Then there's another reference. I'll find out while you're reviewing that. Give me just a minute then.

A. Okay. Status post, aberrant needle

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puncture. Basically what that meant, essentially, is that there was more blood formation in the arm than would be expected from just a vein draw. That's what that meant, aberrant.

MS. DISILVIO: You said more what in the arm?

(Record read.)

Q. It seems, though, that aberrant is describing a needle puncture rather than what you're seeing, that there's more blood than you would expect. So the aberrant does not refer to the needle puncture itself?

A. No. Because I wasn't there at the time of the needle puncture.

Q. So the aberrancy is what you saw when you came after the needle puncture, describes what you saw after the needle puncture?

A. I don't know why we are getting fixated on the word "aberrant." Basically, there's a needle puncture in the arm. And, you know, I don't know what else I can tell you.

Q. Well, when the word "needle puncture" is preceded by the word "aberrant,"

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there may be some significance to that. Perhaps there wasn't when you wrote it, which is why I'm asking you about it. I'm not fixating on it. It looks to me you're looking at a needle puncture and describing it as an aberrant needle puncture. I don't know what that means, if that meant that it was raggedy, if the skin was hanging, if it was crooked. It looks like it describes the puncture.

A. No. Aberrant, the term that I used here, had nothing to do with any of those you just mentioned.

Q. So what you meant by it was that what you saw when you came in to consult was that there was more blood there than you would have expected?

A. From a vein puncture, yes.

Q. From a vein puncture. Do you draw any conclusion from that when you see that?

MS. DISILVIO: From the blood or from his use of the terminology?

MS. TRESL: From what he meant when he described what he saw as aberrant.

A. My conclusion from that is that the artery probably was entered by the needle. That

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was my conclusion at that point.

Q. Could you sort of flesh out that idea a little bit more for me.

A. No.

Q. Was it speculation, or is it more likely than not that was what you thought it was the result of when you saw it? I mean, could it have also been lymph fluid, could it have been someone injected normal saline in there inadvertently? This is what I'm after.

MR. RICHARDS: Objection.

A. No. The patient had a blood draw. Nobody was putting an IV in. Blood draw, excess bleeding in that position could be arterial stick.

Q. What led you to the conclusion that it was connected to a blood draw as opposed to someone doing something else, starting an IV or attempting to start an IV?

A. I thought that was common. I mean, I didn't see the person do it. But from my review of the situation, there was no other reason for me to think that there was a -- it would be an unusual place to put an IV, let's put it that way.

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Q. But no one said -- and I don't want to put words --

A. I don't know one hundred percent whether there was an IV attempt placement there or whether it was a blood draw, to be perfectly honest. I don't know one hundred percent. I was not there when that person performed the act.

Q. I understand. But this note, this patient is a 78-year-old white male, status post aberrant needle puncture to the right antecubital fossa by the laboratory, that looks fairly definitive. What I'm trying to determine is if someone told you that or said, Dr. Bertin, we have this patient with a large arm, can you look at it; and you looked at it and put two and two together, if you remember.

A. I don't remember.

Q. So this may be your observation, but not based on facts that you were told?

A. I don't understand the whole line of questioning. I just don't.

Q. Well, with all due respect, sir --

A. I don't know how to answer it.

Q. -- you don't have to understand the

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line of questioning.

A. I can't answer something if I don't understand what the question is.

MS. DISILVIO: Why don't we take this opportunity to take a break. Jackie, you can review the records.

(Recess had.)

(Record read.)

Q. In the same vein of questioning, if I can draw your attention to the consultation report that you dictated on 8-7 at 8:55.

A. Let me find that. Got it.

Q. First of all, before we discuss that, the operative note that we read before, what was the date on that, sir?

A. 8-8.

Q. And the date on this consultation report is?

A. 8-7.

Q. And if you could read for me the first line of the third paragraph there.

A. The right arm problem developed after venipuncture was performed by apparently a medical laboratory at Parma Community Hospital.

Q. If you could finish it, please.

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A. Where inadvertently the brachial artery most likely was stuck with a 16-gauge needle, and this resulted in extravasation of hematoma involving the right antecubital area extending into the right biceps and also into the right forearm.
Q. This was written 24 hours before you took Mr. Hatfield to the operating room. First, let me ask you, on what did you base your observation or your knowledge that this was a 16-gauge needle?
MS. DISILVIO: Objection. If you remember.
A. I have no knowledge because I never saw the actual performance of the --
Q. So you just --
A. I don't know if it's a 16-gauge needle or not. My only reason I would have thought --
MS. DISILVIO: Don't guess.
A. I really can't guess.
MS. DISILVIO: Nobody wants you to guess.
A. I can't guess with any degree of accuracy, I suppose.

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Q. So when you write something in the medical record and you document that as being what you're seeing and what you're acting on, do you generally document things which you don't know?
MS. DISILVIO: Wait a minute. Objection. I think what he told you is he doesn't remember how he got that information for that note and doesn't know today what size gauge was being used. I don't think that's the same question as to what he knew or what he wrote at the time of the events.
MS. TRESL: Just say you object, okay.
MS. DISILVIO: Let's not mischaracterize his testimony, and I will say I object. I'm going to protect the record in the appropriate manner for my client, and I will object when all I need to do is object. When I need to clarify the testimony, I'm going to clarify it.
MS. TRESL: Are you done?
MS. DISILVIO: Am I done?
MS. TRESL: Yes.
MS. DISILVIO: I certainly am.

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Q. Dr. Bertin, you put here that this brachial artery was most likely stuck with a 16-gauge needle.
A. Yes.
Q. You have no memory whatsoever how you determined, of all the gauge needles in the whole world that he could have been stuck with, you determined that most likely it was a 16-gauge needle?
MS. DISILVIO: Objection. If you remember.
A. The only way I could have thought, okay -- I just can't remember for sure why I put 16-gauge needle. But if you go to the blood lab and you get -- if the tech comes around to the floor and they're drawing blood in the patients and they put the blood into the bottle, the usual gauge needle that they use is either 18 or 16, and that's what I've been familiar with. When I've had blood drawn myself, someone comes around for -- you know, if you go to a lab and have blood drawn, check your cholesterol or whatever, that's usually what it is, a 16- or 18-gauge needle. That's why that came up. I personally did not see a 16-gauge needle go into

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Mr. Hatfield's arm.
Q. But as you sit here now telling me it could have been an 18-gauge just as easily, that's your understanding of the size that they use to draw blood at Parma Community; is that correct?
A. I don't know what they use on the floor, per se. All I know is from times that I've seen them, when I make rounds early in the morning and I see them draw blood, the appearance of that needle appears to be that size.
Q. This statement in your consultation report that, was likely stuck with a 16-gauge needle, is based on when you make rounds in the hospitals in the mornings and you observe the lab, going from room-to-room, the size needle that they generally use?
MS. DISILVIO: Objection. I think he told you in this case he doesn't recall what the information was that he used to arrive at this conclusion, and he is giving you the best --
MS. TRESL: Marilena --
MS. DISILVIO: I'm going to have her

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read back the answer because I'm not going to have you misconstrue this gentleman's testimony. Could you please read back the answer to the question which began with the answer "I don't recall."

(Record read.)

Q. The question is: At the time that you wrote that this was likely stuck by a 16-gauge needle, it's your understanding from making rounds in the hospital that Parma Community generally draws blood, or phlebotomists generally draw blood, using 16- or 18-gauge needles?

MR. RICHARDS: Objection.

MS. DISILVIO: You may answer.

A. To my knowledge, when blood is drawn from a routine venipuncture on the floor, that the needle used is 16- or 18-gauge. I'm not sure why the number 16 is actually there, to be perfectly honest. Whether I said 16, whether I dictated 18, I don't know.

Q. If I told you that the phlebotomists -- and just assume that what I'm telling you is correct -- do not use 16-gauge needles ever to draw blood, would that change

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your understanding of the 16-gauge needle that likely caused this?

MS. DISILVIO: Objection to the hypothetical.

A. No. The whole point is, whether it was a 16, 18, 20, it really doesn't matter. The whole point is that the artery was entered with the puncture. I can't tell by looking at the skin, if that's your question, I can't tell by looking at the skin if it was a 16-gauge, 18-gauge or 20. Nobody can. All I can say is the artery was punctured.

Q. So why put 16-gauge needle into your consultation report?

A. I don't know. I don't know.

Q. Am I correct in saying that the 7th is the first day that you saw Mr. Hatfield?

A. Correct.

Q. At the time that you observed this hematoma, did you inquire into, if you remember, how the injury occurred?

A. Inquired to whom?

Q. Nursing, Dr. Chang, nursing supervisor, phlebotomy department.

A. I don't recall talking to anybody

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specifically, but I believe there are notes in the chart that said it was from the laboratory.

Q. Can you point me to those notes?

A. No. I mean, I don't know where. I would have to -- at some point during that -- when I came to see him, during the consultation, the laboratory drawing the blood was what I assumed had occurred.

Q. The answer to my question was that you had seen somewhere in the record where it was referred to, and I would like to take the time, if I could ask you, to please find that.

MS. DISILVIO: Let's go off the record.

A. I don't know if I saw it in the record or if it was hearsay from the nursing staff on the floor. I don't know. It really didn't -- at that point, it was -- it didn't matter, from my standpoint.

Q. Rather than having Karen read the record again --

MS. DISILVIO: Is what you're asking is for us to take a moment, take a break, and for Dr. Bertin to go through the chart and find reference to the blood draw?

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MS. TRESL: Well, I believe, in answer to my question of how he came to that determination, I believe he said, and we can have Karen read it, that he believed he saw somewhere a reference in the chart that it was caused from a blood stick, which was partially what helped him to formulate his opinion.

Then I believe you said you aren't sure now whether you read it or it was something that you had heard on the floor.

MS. DISILVIO: Karen, why don't we go back and let's read the record.

(Record read.)

MS. DISILVIO: The answer, Jackie, so it's clear, is I believe it's from the record. He did not say it was from the record. If you would like us at this juncture --

MS. TRESL: I would.

MS. DISILVIO: Then what I ask is that we take a break and have Dr. Bertin go through the chart.

MS. TRESL: That's fine with me.

(Discussion off the record.)

Q. When we left, Dr. Bertin, you were going to find for us in the medical record where

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the reference to the lab stick is.
A. Well, the only thing we find in the record is the report on the nursing note that said that the patient had bloody drainage, right antecubital fossa area. And that's where we have that.
Q. This would be what time?
A. This was at 6:00 in the morning, 5:20.
Q. 5:20.
A. That's when the nursing note is placed in the chart.
Q. So based on that reference, that's where you drew the conclusion that this was as a result of lab work that was drawn?
A. No. That's where it's placed in the chart. My conclusion came from being in practice 25 years, knowing that in this particular area, a patient who is a renal failure patient, that this most likely represented an area of a blood draw. I mean, I don't know any other way I can say that. This area represented, most likely, a blood draw.
Q. Right. But the reference is not just to an area of a blood draw; it's also

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reference to aberrancy and also reference to the size of the needle. So we're talking about the totality of the note, not just the fact that you observed this in the antecubital.
MS. DISILVIO: Is there a question?
MS. TRESL: No. I'm clarifying because he was attempting to clarify for me.
MS. DISILVIO: No. He was answering the question.
Q. Do you know, based on your observations with the antecubital and needle stick, was there an incident report filed, if you know?
MR. RICHARDS: Objection.
A. No. I do not know.
Q. As you sit here today, you have no recollection of doing any independent investigation about that stick; is that correct?
A. Correct.
Q. Could you tell, from your observation then or your note now, if the area was stuck more than one time?
MS. DISILVIO: Based on his note and observation or also his surgery?
MS. TRESL: His note and his

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observation.
A. No. Based on the note and observation, no.
Q. So it would look, from your consultation report, that it was from your observation at the bedside before you took Mr. Hatfield into surgery, it looked to you that it was a single puncture; is that correct?
A. Correct.
Q. And then once you went into --
A. No. Let me put it this way. I would assume it's a single puncture, because when you go to draw blood, you go in once, draw the blood, come back out.
Q. And in your operative note, you say aberrant needle punctures.
A. Correct.
Q. So tell me what changed from your consult note to your OR note that caused you to pluralize that.
A. Well, give me one second to review the operative note.
At the time of the surgery, I found the laceration of a branch of the brachial artery; I found a hematoma in the brachialis

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muscle area; I also found a laceration of the basilic vein.
The laceration of the basilic vein was at an area different from the laceration of the brachial artery. So for a needle to possibly hit -- it's conceivable one needle stick could have done all of the three things there, but it's probably not likely. My feeling is that there was probably -- you know, if you're going to draw blood, you jab. If you miss, you jab again. That was my observation from being there at surgery at the time that that's what went on.
Q. The second area where you thought may have been a second stick, is it possible, and I know you said it's possible, would that area theoretically, depending on anatomy, have been behind the area of the stick, or is it over to the side that it would almost have to be a second needle?
MR. RICHARDS: Objection.
Q. Could you just draw me a little diagram?
A. Let's just cut to the chase here. Look at this here. See this, this is the

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basilic vein (indicating). This is where you would normally do a venipuncture.
Q. Okay.
A. If you put a needle through this, you go right to here (indicating). Let me find it for you. Right there. If you go through that, next thing you'll hit, brachial artery, it will be right here, okay. You can feel it with your finger, but that's where it is. So if the needle is going in like that, it can go right in, hit the artery. Normally it goes right into the vein. If it goes deeper, it's the artery. I mean, I don't know what else to tell you. That's exactly the spot. This is where the hematoma was, right here.
Q. But based on that, it looks to me like one single needle easily could have gone through both.
A. Possibly. It's possible. It's possible. One needle could have done, if you take it and you went like this (indicating) and you went -- well, the areas of the injury were separated about this far (indicating). It's possible if you came in at a particular angle that you could have done that with one stick,

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but not likely. I still say there was more than one jab.
Q. By your operative note towards the bottom, there was a branch vessel that had been lacerated by a previous venipuncture and the basilic vein has been lacerated. What does that mean, previous venipuncture?
A. Remember, when we're dictating operative notes, it's not like this -- it's like perfect -- you get some corrections and things like that. The transcriptionist may put a word in different than what you said. Sometimes you may say something different than what you really meant. There can be -- how should I say it -- syntax errors, if you will.
Q. So the word "previous" is a syntax error?
A. Yeah. "Previous" just means by a venipuncture. Again, my assumption through this whole thing, okay, is that this represented to me a venipuncture that was done. I have no other reason to think, from putting together my 25 years in practice and the type of situation like this, that this was a venipuncture.
Q. But the operative note looks like

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we're talking about two venipunctures at least, and it looks like one is earlier than the second.
A. No. No. That's not what that meant. That's not what that meant by this.
Q. In this case, what do you mean by --
A. There was a branch vessel in the brachial artery lacerated -- but that's why I'm there. I'm doing the surgery because there's a hematoma here. Do you understand? I think they're getting caught up on a word there that doesn't mean a lot.
Q. So "previous" means you were in there because of the previous venipuncture that brought you to where you're at right now and not, rather, that there was a venipuncture before the --
A. No. I am there. There has been a laceration of the branch of the brachial artery, and I am there because there was a venipuncture that --
Q. Done previously --
A. Yes.
Q. -- that caused this?
A. Yes, done previously, exactly.

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MR. RICHARDS: Objection.
Q. Since we're on the operative report, describe to me, when you went in there, what you saw apart from just having me read the words.
A. This was 18 months ago.
Q. I understand.
A. Have you ever done any surgery?
Q. Never. What is meant by deep hematoma? Then I'll ask you my questions in here. What does that mean, deep?
A. Let me go back to this again. Is it okay?
Q. Yes. Although a picture would be great.
A. I don't have one of the upper extremity, though.
Q. You can draw it.
A. I can't draw that great. But, again, this is a good example. Here is the area of concern. Hematoma means there is like a swelling right in this area like this (indicating). What was the other question?
Q. Deep.
A. Deep means -- remember, when I opened up this arm, because he had a hematoma

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here, I make what we call a lazy S incision. The reason I do the lazy S is because it heals better. If you make one vertical incision here, it doesn't heal as great. The lazy S heals because there's a flexibility here. I go like that, make a lazy S. When I open this up here, you could imagine, there's nerve, artery, vein, and there's muscle here. He had a fair blood collection back here in the muscle down deep to here. Here is your biceps tendon here. Right down here he had blood collection and then he had superficial blood collection all right in this area.

Q. You describe the nerve and the muscle as viable.

A. That means the color. The color, appearance of the nerve and the muscle itself is what you would expect normally. See, nerves have kind of a very whitish-yellow tinge to it, and that's the way this nerve looked.

The muscle is a -- a viable muscle has a pink appearance, okay. This particular muscle was still pink and, obviously, viable. Muscle that dies has a black appearance, like gangrene. That's a good way to look at it.

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When it's black, or brownish -- that would be probably even a better description, brownish -- then that's a bad muscle. He had no evidence of that.

Q. So your use of the word "viable" then does not mean functionality as much as it means color and appearance?

A. Right.

Q. What can you assume when you see viable muscle and nerve tissue when you're in there?

A. That it hasn't died.

Q. Do you have any opinion as to how this wrist drop was caused?

MR. RICHARDS: Objection.

A. No. I mean, there's a couple ways it could happen. But do I know exactly in his particular instance why he has that? No.

Q. Tell me the couple of ways it could have happened.

MR. RICHARDS: Same objection.

A. Could be needle trauma, could be some compression trauma. Those would be probably the two.

Q. If it was needle trauma, how in this particular case would the wrist drop have resulted from needle trauma?

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A. It's hard to tell.

MR. RICHARDS: Same objection. Continuing objection to this line.

A. If it bruises the nerve at all, that could be probably the most likely, I would think, a bruising of the nerve.

Q. Would you see bruising of the nerve when you were in there?

A. You can't tell. This is going out at a microscopic type level.

Q. So a viable nerve then wouldn't speak to whether or not it was a bruised nerve?

A. Correct.

Q. And compression trauma, describe how that would have occurred.

A. Compression trauma is not likely because, in this particular area, the most significant compression would be on the median nerve more than the radial nerve, which would be the problem with a wrist drop. So I think I'll scratch that compression phenomenon.

Q. So, in your opinion, the most likely cause of this was trauma from the venipuncture?

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MR. RICHARDS: Objection.

A. My guess is, because the nerve was not lacerated --

Q. Right.

A. -- my guess is bruising of the nerve. It makes the most sense. I don't think anybody knows for sure. Maybe God knows.

Q. If the nerve was bruised, how was it bruised if it wasn't lacerated?

A. You have a piece of spaghetti coming along like this (indicating). If you go down and you bang the piece of spaghetti but don't cut it, there could be some trauma to the spaghetti, but it's still intact. Does that make sense to you?

Q. And that trauma would be enough to cause permanent wrist drop?

A. It's hard to tell what goes on at a microscopic level within a nerve.

Q. More likely than not, that would be enough to cause permanent wrist drop?

MR. RICHARDS: Objection.

A. I can't say that. I would say it's possible.

Q. You've enumerated that that's the

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only thing that's possible when you stand back and look at this case.
MR. RICHARDS: Objection.
Q. Because we've scratched compression trauma. Is there any other theory other than the nerve was bruised as the puncture was made?
A. That would be my -- that would be my theory. Maybe a nerve specialist might have a different theory. Maybe a neurosurgeon may have a different theory. I don't know.
Q. Have you ever had a case where a nerve was bruised and resulted in permanent disability like this?
A. Have I particularly had a case or do I know of a case?
Q. Particularly where you've worked, surgically intervened in a case.
A. In this area of the body?
Q. Any area of the body.
A. Where penetrating things can cause a nerve problem? Sure.
Q. Give me an example.
A. Sure. Aortic balloon pump. You put those in through the femoral artery. Sometimes there will be oozing. Sometimes from the trauma

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of the balloon pump going in right adjacent to the nerve, you get bruised up. When we do carotid surgery, if there's a nerve -- a good example is the nerve that comes right underneath the chin. If we just stretch it a little bit, just stretch it, it will be bruised up. And patients get a little droop in the face which usually resolves itself in about six to eight weeks. Sometimes, sometimes, depending on the severity of the bruising of the nerve, it can last longer.
Q. Is this the first instance that you know of where the bruising caused permanent disability?
MR. RICHARDS: Objection.
A. I don't know in this instance if the bruising caused permanent disability.
Q. Take my word that he continues to have permanent wrist drop. Assume for this deposition that he does have permanent wrist drop. Have you ever seen a scenario where a bruised nerve, as it heals, and I think you said six to eight weeks, where the injury was permanent, resulting in permanent disability?
A. Well, in fact, in my experience,

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when nerves have been injured, a lot of times most neurosurgeons even would wait two to three years before they decide whether you have permanent versus nonpermanent nerve injury.
Q. Can you --
A. So my guess is, to answer that question, probably at least three, four years.
Q. Can you point me to any literature that you rely on that a nerve being bruised like that can result in permanent disability?
A. No.
Q. This is based on your practice and what you've seen --
A. Yes.
Q. -- as a vascular surgeon?
A. Correct.
Q. So, more likely than not, not to beat this dead horse, the cause of Mr. Hatfield's permanent wrist drop, assuming that he continues to have permanent wrist drop, is that the venipuncture traumatized and bruised his radial nerve; is that correct?
MR. RICHARDS: Objection.
MS. DISILVIO: Objection.
Q. The radial nerve is what we're

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talking about; correct?
A. For wrist drop.
Q. Yes.
A. It would be radial nerve, correct.
Q. That's the most likely cause of his permanent wrist drop?
A. I think it's a possible cause.
Q. I believe I asked you if there was any other causes, and I believe you said no.
MR. RICHARDS: Objection.
MS. DISILVIO: And he also deferred to a neurosurgeon and/or a neurologist. So with that in mind, you may answer.
A. Yes. I mean, I would be -- that's the answer.
Q. So that's it, when you look at this injury, you would say in your practice that it was the result of trauma to the radial nerve caused by the venipuncture?
A. No. I think this patient had trauma to the radial nerve. Whether it was caused by the venipuncture, per se, it's a possibility.
Q. What else could have caused it?
MS. DISILVIO: Objection. If you know.

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MR. RICHARDS: Same objection.
A. That would definitely be it.
Q. That's what I thought you were saying. So, as we're sitting here today, more likely than not, as a vascular surgeon who practices, you would say that Mr. Hatfield's permanent wrist drop was as a result of --
A. I question Mr. Hatfield's permanent wrist drop because I do not know that Mr. Hatfield has a permanent wrist drop.
Q. If what I'm telling you is wrong and he does not have a permanent wrist drop, every question I've asked you relative to this will be moot, so it won't mean anything. But assume for purposes of today that he continues to have permanent wrist drop.
It's your belief that that was caused as a result of bruising to the radial nerve during the venipuncture?
A. That possibly could have been due to bruising of the nerve at the time of the venipuncture, yes.
Q. And --
A. That injury, injury, quotations, to the radial nerve could possibly have been --

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occurred in a bruised fashion to the nerve at the time of the venipuncture.
Q. Understanding that's true, is there anything else that you can think of as we sit here today?
A. No. I've answered that same question four times now.
Q. Yes, you have.
A. And I have answered four times no.
Q. Thank you.
A. All right.
Q. It sounds to me from what you said earlier that it's your understanding that venipunctures are performed with larger gauge needles rather than smaller gauge needles; is that correct?
A. Yes, because I've had venipuncture, and I'm sure -- have you had blood drawn? But you wouldn't know. Yes, the gauge of the needle is usually large, fairly large.
Q. And in a patient like Mr. Hatfield, it would be normal phlebotomy to come up and draw his blood with an 18- or 16-gauge needle; is that correct?
MR. RICHARDS: Objection.

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A. Let's just cut to the chase on this.
MS. DISILVIO: Objection. If you know.
A. All I can say is this: I do not know exactly what needle Parma Hospital uses for their routine phlebotomy. I am sure that they probably have a routine needle that they use, and I think the easiest way to find that out is to ask them what they do.
Q. Which I shall, sir.
A. The person who drew the blood, just ask them, what needle did you use.
Q. I intend to do that.
A. I think that would be good. That would be a good thing.
Q. I'm asking you based on your documentation, which is what I'm talking to you about today. This is my one opportunity to get your understanding what you mean by words like "aberrant" and "16-gauge" because I don't want to assume I know anything. That's why I'm sitting here today. And Mr. Richards is going to make the phlebotomy people available to me. It's not a problem.
A. Okay.

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Q. Is there a principle in phlebotomy as a vascular surgeon that you're aware of that in elderly patients, patients in dialysis, in coagulable states, heparinized, et cetera, that it's prudent to use the smallest caliber needle possible to do blood draws?
MR. RICHARDS: Objection.
A. No. I don't know of any principle -- to cut to the chase again, when you draw blood, what's very important is to draw what we call a clean specimen, okay, so it's not traumatized by the actual draw. The smaller the gauge needle you do use, the greater the chance you can traumatize the elements within the blood. So you have to balance the two.
Q. So to use a --
A. To make a long story short, what policy Parma uses to draw blood from their laboratory, I have no idea.
Q. If they used a 16-gauge needle to draw from Mr. Hatfield, knowing his vasculature the way you do, that would have been prudent phlebotomy?
MR. RICHARDS: Objection.
MS. DISILVIO: Objection. If you

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know.
A. Yes. I'll answer that question, I think absolutely it would be prudent phlebotomy if it's right in the vein.
Q. So the size needle was not an issue, just where the needle ended up, for you?
A. Well, yeah. I mean, let's cut to the chase again. I don't think we would be here today if the needle was put directly in a superficial vein. We wouldn't be here, would we?
Q. I don't know.
A. How many bloods are drawn in the hospital every day?
Q. You're asking me a hypothetical I couldn't answer.
A. A lot. A lot. We wouldn't be here today.
Q. You may not be able to answer this. When this phlebotomist is sticking Mr. Hatfield, and this is going through the vein and this incorrect way of drawing the blood was being drawn --
MR. RICHARDS: Objection.
Q. -- whatever words you want to use,

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just whatever that is, would that phlebotomist have seen something when she pulled the needle in, out, around?
A. She's not a doctor. I don't know if she -- I don't know.
Q. Would she have seen bright red blood in her tube as opposed to --
A. My guess? My guess? Yes.
Q. What do you base that on?
A. Size of the hematoma.
Q. So you're saying that, had you been at the bedside while she was doing that, just doing your routine rounds, in all likelihood, when she pulled back that needle, she would have had bright red blood in her tube as opposed to dark red blood?
A. It's not as simple as that.
Q. Okay.
A. It would be impractical to think that the lab person would know in -- probably impractical to think that they would know what they did.
Q. My question is, though, would you see bright red blood or venous blood in that tube based on what you observed when you were in

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there?
A. My guess is you would see bright red, but you can see bright red from a vein puncture or persons on oxygen, some other issues. I don't think you could use it one way or the other.
Q. Based on what you think happened injury-wise, when the phlebotomist finally did obtain the specimen, in all likelihood, what she had was arterial blood as opposed to venous blood; is that correct?
A. I don't know. I can't make that assumption because I didn't see the blood come out of it.
Q. Based on this injury, if you can say, would a hematoma have formed immediately?
A. No. They never do. I mean, it always takes time.
Q. About how much time?
A. Can't tell.
Q. So it's possible that the phlebotomist went in, traumatized the nerve, lacerated the basilic vein and the brachial artery?
A. No. Branch. Brachial branch. The

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main brachial was okay.
Q. And collected her goods and had not a clue that she had done this? She would have seen nothing that would have alerted her?
MS. DISILVIO: Objection. If you know.
MR. RICHARDS: Objection.
A. I don't know. It's possible either way. It's possible that right away she might have seen some swelling start to develop, and it's possible that right away it could have been normal and two minutes after she walked out of the room it started to swell up. So it could be either way.
Q. Is there one more likely than the other --
A. No.
Q. -- based on the injury that you saw?
A. No. Because I can't tell.
Q. What about on the 7th when you saw this hematoma, could you base anything on that?
A. No. No. I mean, I can't tell at that point now what -- the most likely thing in my mind -- at that point now. Remember, this is before I even explored the arm, that I thought

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the puncture just went into the artery and then came back out and it oozed. More often than not, they usually just stop.

Just think of this. We draw blood gases every day. Every day in the hospital, we take needles and put them in arteries every day. When I do x-rays of the artery circulation, every day, I put a big needle in the artery.

Q. So in Mr. Hatfield's case --

A. That's in an artery, though.

Q. Is this because of the two lacerations that he had the large hematoma?

A. Oh, no question. Because, remember, if we put this into a superficial vein, we don't have this issue. Even if we put it into an artery and we knew it and we put compression on it above, right off the bat, like we do when we do an arteriogram, we don't have these kind of issues develop. Sometimes you do; about one in a hundred arteriograms.

Q. So it's because the artery and the vein were allowed to leak the fluid into the arm that caused the hematoma; is that correct?

A. No. Artery and vein weren't allowed to do anything. I mean, that's what occurred.

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Q. That's what occurred.

A. Nobody allowed it. Nobody allowed this. Nobody wanted this, you know.

Q. But that's what caused the hematoma --

A. Yes.

Q. -- was the leaking from, and you don't know whether it was the vein or artery?

A. No. I know it was both.

Q. It was both?

A. Because, remember, there was a laceration in the vein, and there was a laceration in the branch of the brachial artery.

Q. Now, we talked about whether or not she would see anything in the tube. Would she have felt anything that would have alerted her that she was going through vessels?

A. No. I don't think a lay person would know.

Q. Should a phlebotomist be trained to know what they're feeling when they're puncturing?

MR. RICHARDS: Objection.

A. I don't know their training routine. You know, I do think that they would be taught

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to stay superficial, yes. But I don't know.

Q. And we can assume from this injury that it was not superficial?

A. Oh, absolutely not. This was not superficial.

Q. So you would expect phlebotomists to stay superficial; is that correct?

MR. RICHARDS: Objection.

A. Correct.

Q. Can you give us a depth, when you say not superficial, or is it hard to say? I mean, he was a very skinny man. Are we talking like an inch, half-inch below where they should have been superficially, or was it just right behind the vein?

A. I can't give you that kind of dimension. Again, I'll show you the arm. If you go in the arm (indicating) and -- let me see -- you see that vein right there?

Q. Yes.

A. That's superficial.

Q. Okay.

A. If you go -- if you stay right underneath here, I would say about that depth (indicating), you're superficial. If you go

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into that depth (indicating), now you're deeper.

Q. Would you say that if a phlebotomist goes to that depth, that that's a violation of prudent phlebotomy?

MR. RICHARDS: Objection.

A. I don't know what the phlebotomy policy is, but it's not good policy to be deep.

Q. Do you have any phlebotomists working here for you?

A. No. We don't draw blood here.

Q. But if a phlebotomist -- I'll ask the phlebotomist. That sounds good.

A. Good.

Q. The word "compartment" comes up a lot with this kind of injury, and it looks to me like you said, and here again it may be a syntactical error or I may be reading it incorrectly, that you said that the compartment was affected.

MS. DISILVIO: Which note are we reading from?

MS. TRESL: Hold on. I'll get it for you.

Q. First of all, what I want to ask you before I do that, am I using the correct term;

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is that what we're referring to as the compartment when we're talking about where the hematoma was?
A. Yes. In a forearm situation like this, the actual compartments of note are actually what we call superficial compartments. Deep compartment would be down deep near the bone, per se, when we do the venipuncture thing. In this area of the forearm, this area is superficial, considered superficial anatomically.
Q. When you're discussing compartment in your notes, and we'll get to that in a minute, and maybe you need to refer to it to answer this question, but you're referring to the superficial compartment, not the deep compartment; is that correct?
A. Correct.
Q. Now we're going to spend a lot of time on the progress notes and the orders, so if you want to go to that, I would be grateful, and I will ask you specifically when you took over the care of Mr. Hatfield. If you need to leave or counsel needs to leave at 7:00, let me know.
MS. DISILVIO: Did you say at 7:00?

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A. We're going to spend five hours?
Q. We're going to go through the questions until we get to the end. I'm just saying if you need a break.
A. Where are we going now? Let's try to speed this up a little bit.
Q. Progress notes.
MS. DISILVIO: I don't have to leave. Dan, do you have to leave?
MR. RICHARDS: I have to leave at about 6:15.
Q. If you need a break or need to stop, just let me know.
A. Need a break? I'm trying to go the other way.
Q. Great. It looks to me like the first time that Dr. Chang notes this injury is in his note on the 6th. It would be sometime before 10:55 he orders ice for Mr. Hatfield's injury. What's the purpose of putting ice on this hematoma?
A. I don't know. It's good primary care to -- when you have oozing from anywhere in the body, ice is a reasonable thing. He's trying to use ice to decrease swelling.

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Q. Have you ever noticed in an injury like this where ice has decreased swelling?
A. Oh, absolutely.
Q. Can you point me to any literature that supports that?
A. No. Twenty-five years of experience. That's what I point to.
Q. You were consulted, it appears from the orders, prior to 10:55 a.m. on August 6; is that correct?
A. Where is that now?
Q. He wrote his consult on August 6 prior to 10:55 a.m.; is that correct? I think you need the orders.
MS. DISILVIO: Are you asking about the orders or the consult?
MS. TRESL: I'm asking if he agrees that the request for his consult was August 6, 2002 prior to 10:55, and I am trying to point him to where in the records I found it. And I believe that was at --
A. Oh, yeah. Here we go. It says Dr. Bertin on consult.
Q. Can we agree that that was on August 6th?

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A. Correct.
Q. Can we agree that was prior to 10:55 a.m.?
A. Correct.
Q. Can we agree that the first time you saw Mr. Hatfield on consult was the following morning?
A. Correct. Because usually consults, by tradition, what we do is, if we get a consult, we usually -- it usually means within 24 hours. So we usually try to see it within 24 hours.
Q. Do you have any independent memory, other than what's in the record, about being called about the CAT scan that was done on August 6th?
A. I don't have any independent recollection.
Q. Do you, based on your records, have it documented that you were made aware of the CAT scan that was done on August 6th?
A. Do I have it documented?
Q. Can you see documented that you were made aware of the CAT scan on August 6th?
MS. DISILVIO: Is there a particular

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note you would like to reference him to in order to save time?
Q. Sure. The nurse's notes on the 6th, and I will even give you the nurse's note if you would like.
A. Oh, this is 4:00 o'clock at night. 4:00 o'clock that day, aware of CT scan right arm. That's what the nurse's notes say.
Q. You have no reason to dispute that you were notified about the results of the CAT scan? If the nurses document that, even though you have no independent recollection of it, you have no reason to doubt that that's correct, is my question.
A. Yes. I mean, I don't recall specifically being called about the CAT scan, per se, but this is -- I mean, it's reasonable to assume that, if they called me, that -- I don't know. I don't recall specifically. I mean, remembering 18 months later if I was called about the CAT scan, I don't recall that.
Q. You have no reason, as you sit here today, to believe that that may be some sort of charting error? If they said that they called you, then in all probability they did; is that

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correct? Like we talked about this syntax error, you know.
A. I don't know. I mean, I don't know. I just can't recall. I can't say one way or the other, to be perfectly honest. I normally don't order CAT scans for this kind of problem because they're not that helpful.
Q. Why aren't CAT scans helpful for this kind of problem?
A. Because it doesn't help us in deciding on the management of the patient to get a CAT scan. We already know we have some swelling in the arm. We're hoping that by elevation and rest and compression that it goes down. The CAT scan doesn't help us one way or the other decide, okay, now we have to go to surgery or, okay, no, now we can wait. It doesn't help us.
Q. So the size of the hematoma --
A. So I would not have ordered a CAT scan.
Q. I didn't ask if you ordered it. I asked if you were made aware of the results. You didn't order it, I don't believe.
Does the size of the hematoma as

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seen on CAT scan affect the management at all?
A. No.
Q. There's no hematoma that's clinically significant size-wise in imaging that makes you decide medical management versus surgical management?
A. Correct.
MS. DISILVIO: You mean radiologically significant versus clinical?
MS. TRESL: I'm talking about CAT scan.
A. The CAT scan, per se, doesn't dictate whether or not I would do surgery.
Q. The size of the hematoma by CAT scan --
A. That's why I wouldn't order a CAT scan.
Q. The size of the hematoma was two by five by eight centimeters. Is that of any clinical significance size-wise?
A. I told you, I don't use a CAT scan for size, dimension, in this type of circumstance, period. I just don't use them.
Q. Can you tell me approximately for a two by five by eight centimeter hematoma, how

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big that would be?
A. Well, look at it this way: 2.5 centimeters, one inch. So two centimeters would be about one inch, okay, one inch, and five centimeters would be about a little over two -- what -- a little over two inches. So one inch, two inch.
Q. By eight centimeters?
A. So in this area here --
Q. Yes.
A. Eight is probably length. That doesn't mean anything, because look at how long your arm is.
Q. Give me something --
A. So eight centimeters is about two-and-a-half inches. Five centimeters is -- what would it be? 2.5 is an inch, so figure --
Q. Can you give me something I can visualize is about that size? Is it bigger than a quarter?
A. I would say about the size of a --
Q. Size of a dollar bill?
A. Not that -- a dollar bill won't help you.
Q. Knowing that that's flat.

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A. Which size are we talking about?
Q. Two-by-five-by-eight.
A. I would say about the size of a cue ball.
Q. That would be round?
A. That would be hard. This is more diffuse.
Q. I'm sort of thinking like the size of a bar of soap.
A. Okay.
Q. I sort of measured it out.
A. Probably not as big as a bar of soap. Maybe a small bar. Maybe one of those hotel bars, two of those. Two of those hotel bars.
Q. Having a hematoma that size in the superficial compartment is not an area -- tell me when that size hematoma, understanding that size isn't the important factor, when is that of clinical significance? What do you see or observe that makes that of clinical significance?
A. Rapid expansion.
Q. Okay.
A. Okay. If the patient has developed

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what we call a pulsatile aspect to it so it's kind of like -- we call it a pulsatile hematoma, that would be significant. Rapid expansion and pulsatile. Those would be the two.
Q. What about an increase in pain over the area?
A. That's subjective because everybody is different.
Q. What about induration?
A. Induration, that can help a little bit in just determining the severity, per se. But it's just one component, just one component.
Q. What about redness?
A. That doesn't help, because older people in particular, the skin can stretch out and it gets white and sometimes it will look kind of red, sometimes it will look purple. Have you ever seen an old person get a bruise? You know how the blood disects out over the whole arm for just one tiny little bruise? So it's hard to predict.
Q. An increase in pain from one day to the next is subjective and it doesn't have a great deal of clinical significance as you're putting together your differential on this

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hematoma?
A. I'm not putting together any differential on the hematoma. He had the hematoma. I know that. There's no differential.
Q. Differential for medical versus surgical management.
A. The basic thing is, if it's not pulsatile and not expanding, we try to go with conservative management. Conservative management meaning elevation, rest, ice application.
Q. How do you know if the hematoma is causing compression such that it's affecting the underlying structures, specifically the nerves? How do you know that -- what factors do you use to determine if there's, say, microcellular ischemia going on?
A. It's a function of the hand neurologically.
Q. And is there documentation in your record that you determined the functionality of his hand?
A. Yes. When I say in my consult -- when I said here the two issues that could

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arise -- I mean not there. Where is it? For the present time, we're going -- let's go to my consult note. Are we on the same page?
Q. Yes. We surely are.
A. At the present time I cannot palpate a definite two-way aneurysm. That's what we're talking about, the pulsatile situation. The right arm hematoma was not in an expanding mode.
So the basic treatment at that point is the elevation and the serial evaluation, as I said. The main issues here are compartment syndrome, which is certainly not present, by the way. It's not present. Compartment syndrome is certainly not present at this time. And the reason we make that determination is by the sensory exam, motor exam, the nerves, and the pulse exam. And by saying no compartment syndrome, all those examinations were normal.
Q. Even though it does say that it certainly is present at this time?
A. No. That is a typo. It is certainly not present. Compartment syndrome is certainly not present at this time. That's why I said that, has satisfactory distal flow, and the neurologic impairment -- there was no major

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neurologic impairment. That's why I said sensation is normal distally. If there was a compartment syndrome, the usual first manifestation would be by the -- possibly the first manifestation could be by neurologic impairment.

So, to make a long story short, my note says the main issues here are compartment syndrome. It says "certainly is present," but there's a typo there. It should be "certainly is not present." I think if you follow the train of thought through the whole paragraph there, it would be clear to you that "not present" should be in there, not "present."

Q. When you're concerned about compartment syndrome but you're trying to do conservative management, is there a technique that you can use to determine if the compartment pressures are rising?

A. No. There's no accurate technique. In the lower extremities in particular and major trauma, sometimes we'll use a technique where we'll measure comparment pressures, but in the superficial compartment in the forearm, in a case like this where you have a hematoma

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develop, we normally wouldn't use it. We don't.

Q. Is that in your practice or in vascular surgery pretty much in the community, if you know?

A. Yes. I mean, I would assume that it's pretty much in the community. I would assume that.

Q. Would it have been possible for you to have measured pressures in that area, in this superficial --

A. No, not really. There's no way to determine the accuracy of it. So to do something that -- it doesn't help you, a positive or a negative. No, I wouldn't do it, to make a long story short.

Q. The nurses document that he had less pain if he kept his arm still on the 6th and the 7th. Can you explain that to me, why that would be, if you can?

A. Did you ever twist your ankle?

Q. Yes.

A. If you keep it still, does it feel better?

Q. Yes. That's the significance of that?

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A. Correct.

Q. On August 7th, you saw Mr. Hatfield twice; in the morning, and then I think at 1337, something like that.

A. Right.

Q. And you may not have any recollection of this, you may have to refer to your notes, but you said that when you saw him at 1:30, that he was showing some improvement.

A. Yes. I think at that point that the arm swelling that he had was actually going down. I don't know where it is in the notes. I actually thought the elevation was starting to get a little better, which would have been good because then we could avoid doing any surgery.

So we're on the 8-7 note. That's at 1:30 in the afternoon, and I thought at that point that he was actually improving a little.

Q. Based just on looking at his arm --

A. I think at that juncture, too -- I don't recall this particular -- I think I talked with Dr. Chang about this, too. So we thought we were making some progress here with the elevation and the ice application.

Q. Did it concern you then in the

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evening when the nurses noted that his pain was up to a nine and he had to go from Darvocet to Vicodin? Was that significant clinically?

A. No. Like I said, pain is a subjective thing. When you change a nursing shift, now you got two subjective things that come into it. So, to be perfectly honest, no, that wasn't a major deal breaker, so to speak. It wasn't a major issue.

Q. Did it shift your --

A. Usually my -- I don't recall that phone conversation, but usually what I would do in that situation is probably make sure that they're elevating it higher and -- like I don't recall for sure, but I think we were on pillows at first, and then I had them put it up on an IV pole, which is actually better elevation, because the higher the better.

Q. The fact that the pain went from four to nine and required Vicodin versus Darvocet, in your mind, could be explained by the fact that the shift changed and the pain is subjective?

A. Yes. The difference between Darvocet and Vicodin is not huge.

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Q. The difference between a pain level of four and nine?
A. Yes. I mean, it's very subjective. That's a very subjective measurement.
Q. On, I believe the 7th, you and Dr. Chang consulted and agreed on local treatments and antibiotics. I believe that that was the note.
A. No. I never -- he wrote antibiotics. I don't remember discussing antibiotics. He was comfortable with, and I would assume even I was comfortable with, the conservative management, which was the elevation and the rest.
Q. There is a note in here, hematoma versus cellulitis. Was there any question in your mind that this was a cellulitis?
A. No.
Q. So you always thought it was a hematoma?
A. This was a hematoma.
Q. The antibiotics were not something you disagreed with, but you didn't think that they were going to help the hematoma?
A. I didn't order it.

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Q. Correct, but you didn't say --
A. That's the answer.
Q. It looks as if in the consult note that it wasn't until he had difficulty with dorsiflexion of his wrist that you decided to evacuate the hematoma.
A. No.
Q. We can find that in the records. No?
A. No. What made me do this was two things.
Q. Yes.
A. When I went in on 8-8, he started to have -- and he was pretty clear about this, he felt decreased sensation right here (indicating). And he also, when I had him just try to go like that, he said he couldn't do it as well as before, okay. It's what we call apposition test.
So at that point, my feeling was that I'm concerned that he could have had median nerve involvement. So in that finding, plus the fact that he was going to be undergoing -- remember, he was in chronic renal failure. So if they had to put him on dialysis again, he

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would get heparin. So with that combination, with this hematoma, that's what made the decision for surgery.
Q. That's interesting, because you parsed out for us earlier median versus radial. Radial is wrist drop. Assuming he has wrist drop, that's only radial involvement; is that correct, or it's mostly radial involvement?
MR. RICHARDS: Objection.
MS. DISILVIO: Objection.
A. Wrist drop is radial, correct.
Q. And the median, you're saying you're seeing some median nerve involvement?
A. Clinically. Clinically.
Q. If the median nerve had been traumatized or harmed, let's say, from the hematoma, what would you have seen afterwards? You would not have seen wrist drop; is that correct?
A. Right. If the median nerve were, say, compressed, or something on that order, if the median nerve -- yes, that affects a different area of the hand. It affects the ability of the hand to oppose the thumb and forefinger and that type of thing.

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Q. Just by virtue of the injury he ended up with, we can rule out the fact that the median nerve had been compressed, assuming that he has permanent wrist drop; is that correct?
A. No. No. We can assume this, absolutely. The median nerve is normal in this patient. That's what we can assume. So there was really -- whatever sensory feelings he was having were resolved when the hematoma was removed in the median nerve area.
Q. This brings me back to when we were discussing the anatomy in the antecubital. Was it the radial nerve that was traumatized when the stick went in?
MR. RICHARDS: Objection.
A. I don't know that for sure. All I'm saying is that that's a possibility.
Q. The radial nerve was close enough in that little area where it could have been traumatized?
A. The radial nerve is in a different area. Median nerve is right here, next to the artery.
Q. Okay.
A. Radial nerve is back over here

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(indicating).
Q. But if he has permanent wrist drop, can we say then it's a radial nerve injury?
A. That's what a wrist drop implies, yes.
Q. How would we get the radial nerve injury from an aberrant needle puncture or from this needle puncture?
MR. RICHARDS: Objection.
Q. Just talking anatomically. Would that have been a third injury? How did the wrist drop occur then?
MR. RICHARDS: Objection.
A. Wrist drop implies radial nerve injury.
Q. Got you.
A. How the radial nerve injury occurred, I can't tell you, but I can say that it's possible there could have been bruising of the radial nerve at the time of the venipuncture, yes.
Q. That was my question, because you said it was a little farther over, but it's possible.
A. Yes.

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Q. Excuse me if you've explained it to me, but I'm just trying to understand brachial, median, artery, vein, okay. Just by what you're saying, median and wrist drop are not synonymous?
A. No. They have nothing to do --
Q. It's simple to you, but to me that's --
MS. DISILVIO: Let's not underestimate here. You're a nurse; you know exactly what's going on.
MS. TRESL: I truly did not know it precluded it being wrist drop. No.
A. You thought wrist drop was median nerve?
Q. I didn't know that it was only radial nerve. I didn't know it was only radial nerve.
On August 7th, 1:30 p.m., you wrote continued expected management. That may not be the correct word. Can you read that for me?
A. Expected just means conservative management.
Q. That would be ice and elevation?
A. Yes.

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Q. Have you ever had a hematoma of this size in a forearm --
A. Resolve?
Q. Yes.
A. Oh, yeah.
Q. What did you do for that?
A. Absolutely. Just elevate, and over time it just kind of dissects out and resolves.
Q. Have you ever had one where you had to take them to surgery?
A. Mr. Hatfield.
Q. Other than.
A. Yes. I've had other hematomas. I've had -- you know, we do a lot of hematoma repairs after cardiac caths, you know, when the artery leaks. I've taken some of those to surgery, sure. Probably do that about four or five times a year.
Q. When you pulled this hematoma out, it's interesting that --
A. You don't really pull it out.
Q. That was my question. It comes out all -- it's not encapsulated?
A. You scoop it.
Q. You scoop it.

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A. It's like Jello. Best way to look at it.
Q. Pathology said there were five to six milliliters of blood, so that isn't the whole clot. Some of it must have spilled out?
A. You can't put any credence on any of the pathology measurements of blood or anything like that. So don't waste the time.
Q. So it's not something that you would even consider measuring the compartments in his antecubital area for compartment syndrome; it's totally based on the -- is that finger extension? Is that what that's called?
A. It's based on overall clinical exam, mainly.
Q. Did anyone examine him in the evening on the 7th to see if he could still do what you had just done by touching your fingers together?
A. Oh, I don't know.
Q. When you left at 1:30 on August 7th, he was able to do that?
A. Yes. But like I'm telling you, the important issue here is, when I came in on the 8th, he has some sensation diminution in the

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hand, and he was going to require dialysis session. Those two were the reasons that changed the management from conservative elevation and observation to evacuation.

Q. And had he just been facing hemodialysis but not the change in this, you would not have taken him to surgery?

A. That would have been tough. I probably would have seen him early in the morning that day, and if he wasn't going on dialysis and going to get a heparin dose and things like that, if that wasn't looming there as part of the problem, I might have waited a few more hours yet because this could have resolved, but probably not. Most likely -- but the dialysis thing is in combination. It's not like everything is separate. It's all in combination. The combination of clinical factors are what leads to the surgery.

Q. And the hematoma really had nothing to do then with the permanent wrist drop; is that correct?

MR. RICHARDS: Objection.

A. I would -- no. I think the presence of the hematoma, per se, probably had nothing to

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do with it. In fact, to be perfectly honest, if the hematoma was the major problem, as far as any nerve issues go, the median nerve would have been more of an issue. And we have, you know, he didn't have any median nerve dysfunction.

MS. TRESL: Let me defer to Mr. Richards for a little bit, see if he has any questions. Let me look through my notes, and I will come back.

MR. RICHARDS: Just a few questions, doctor.

EXAMINATION OF VINCENT J. BERTIN, M.D.

BY MR. RICHARDS:

Q. Doctor, you were asked a lot of questions about the gauge of the needle. Let me make sure I understand what I think you were trying to say, which is that you didn't mean to indicate anything significant by use of the word 16-gauge. You were, instead, just throwing out the type of gauge needle that you think may be used by the phlebotomy department.

A. Correct.

Q. Is that fair?

A. Correct.

Q. As far as you know, you're not

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really certain what type gauge needles they use over at Parma Hospital in the phlebotomy department, the exact gauge?

A. No. Actually, as of like today or as of a year ago or two years ago, no. No. I don't know the exact gauge, no.

Q. You don't mean to indicate anything significant in regards to 16 versus 18 or 21 or 24 even; you were just trying to indicate that you thought that there was a venipuncture from a needle similar to the type used by the phlebotomy department?

A. I mean, I don't -- the 16-gauge portion, I don't even -- I don't know what significance to make of that. I mean, to get to this answer, why don't we just ask the lab what needle they used.

Q. Let me ask you this. I don't want to belabor points. I just want to make sure that what you were saying and my understanding are the same thing.

The other thing it sounded like you said is, all your testimony here today on the fact that this was -- the hematoma resulted from a venipuncture is based upon assumptions, quite

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possibly reasonable assumptions, but not actually witnessing the puncture, first of all?

A. Right.

Q. Not witnessing -- or not having a discussion with somebody, or at least not recalling a discussion that you had with anybody saying this is from a venipuncture?

MS. DISILVIO: Not recalling or not having? That's two questions.

Q. Let me break it down. You don't have any specific recollection of talking to anyone who told you, Dr. Bertin, this is from a venipuncture?

A. No. I did not have any recollection of that.

Q. And you said repeated times today, you didn't see the venipuncture, you weren't there?

A. Correct.

Q. So what you're saying is, based upon your observation, this is what you're assuming caused this situation?

A. Yes. To be perfectly honest, I don't understand why this is a big issue. We know the lab went in there and they drew some

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blood.
Q. I understand, and I agree. I just want to make sure we're clear. You're saying it's based on what you saw and what you heard, but I think what I understand you're saying is it's not necessarily even anything you heard. You're just basing it on an assumption. You walk in, you see what you see, and you made an assumption. It may be a reasonable assumption, but it was just an assumption. Is that fair?
MS. DISILVIO: Objection.
A. Yes. I guess from a legal standpoint, whatever you want to call it, it's probably an assumption.
Q. What I'm saying is, you don't remember any of --
A. If I didn't eyewitness it, it's an assumption.
Q. And you didn't hear it either?
MS. DISILVIO: Objection. I think he said he doesn't recall.
A. Right. I don't recall. I just don't recall.
Q. That's all. That's what I'm saying. You indicated that when you first

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saw the hematoma and you first started indicating how you wanted the hematoma treated, you wanted to do it in a conservative manner; right?
A. Conservative means we're trying to avoid an operation.
Q. Right.
A. In an elderly multi-organ failure type of patient.
Q. So elevation.
A. Yes.
Q. Elevation and ice packs?
A. It has to be strict elevation, too. I think that's why we changed it from a couple pillows to higher than this so we could get even maximum elevation.
Q. Gradually up on to the IV pole?
A. Exactly.
Q. And ice packs?
A. Yes, exactly.
Q. That was done, as far as the records indicate; isn't that fair?
A. Yes.
Q. You don't have any criticism of the nursing care in regards to that?

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A. No. I think the nursing care was fine.
Q. Can I ask you that in regards to all the nursing care; do you feel that all the nursing care was fine in regards to the treatment of this patient?
A. Yes. I have no issue with that.
Q. Is it fair to say, and this is my understanding, but let me know if this is a fair comment, that an accepted risk of venipuncture -- or I'm sorry -- an accepted risk of drawing blood in this area is that you may hit an artery on occasion?
A. I would say it's a possible risk you can hit an artery during a venipuncture. It doesn't -- let's face it, it doesn't happen often.
Q. But it happens?
A. It can happen. It can happen.
Q. And it can happen without anybody doing anything wrong?
A. You can walk out and get hit by a car. It can happen.
Q. But what I'm saying is, it can happen without somebody doing something wrong,

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without somebody deviating from a standard?
A. I don't know what the standard is. You know, that's the -- I don't know.
Q. As far as the bruising you described of a radial nerve, or trauma to a radial nerve, if a radial nerve receives the kind of trauma that you're describing, would you expect an immediate onset of symptoms stemming from that?
A. No. The problem with the nerve thing is you just can't tell sometimes. Sometimes you can have a nerve injury with a delayed manifestation clinically. Sometimes it can be immediate. Usually, if you have a total laceration of the nerve or, I mean, sometimes, even then, if you had a partial laceration of a nerve, for example, or a brusing of the nerve, the manifestation could come on delayed, it could come on immediately. It's hard to tell. There's no way to predict that. Ask the neurosurgeon. He'll tell you.
Q. That's a good point. You're not a neurosurgeon; right?
A. That's correct.
Q. You noted in your operative note that there is no compression on the median nerve

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itself directly from the hematoma. Is that a fair statement of your operative note?
A. No. I mean, I don't know if I -- oh, no actual compression on the median nerve itself directly from the hematoma, right.
Q. The significance of that is, I think you were saying, that would lead to your conclusion that there was no median nerve injury?
A. It just meant that the sensation and the motor dysfunction that I saw in the hand -- I mean, you couldn't tell from -- again, you have to remember this, that nerve could have been bruised somewhat and then it -- if you think of it microscopically in the nerve, you get some diminution in nerve impulses, it gives you a little decreased sensation, and all of the sudden, when you evacuate this, even without severe compression, it suddenly gets better.
Q. There's no indication of any compression on the radial nerve either in your note, is there?
A. No. Most of the hematoma was pretty far away from the radial nerve region, so I don't think that was too much of an issue.

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Q. If you had seen compression on the radial nerve, is that something you would normally note?
A. I mean, I couldn't tell that one way or another.
Q. How quickly would you expect the onset of a hematoma after a blood draw where you stick an artery?
A. It's hard to predict that. Hard to predict because sometimes it could bleed a fair amount and stop; bleed some more, stop; bleed some more, stop. Sometimes it will just expand out and just never stop.
Q. Is it the kind of thing that you might expect to see normally, though, within a few hours?
A. Like I said, you can't tell. Everybody is different.
Q. Could it be a matter of over a day?
MS. DISILVIO: Objection. Asked and answered. You can answer again.
A. I mean, it's just -- it's very --
Q. I just want to know.
A. No. There's no -- how should I say it -- there's no absolute formula.

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Q. But you said it could stop and start and stop and start up again?
A. Oh, sure.
Q. Do you have any criticisms of Parma Hospital employees in this case?
MS. DISILVIO: Other than what he said about phlebotomy?
Q. I don't know if that was a criticism. He said he thinks it may have been from the stick.
A. I just don't think you should hit an artery with a needle stick. It shouldn't be deep; it should be superficial. I don't know any other way to say that.
Q. But as far as that, though, I think you already testified you're not sure as to what the standards and practices are as to how deep a phlebotomist can go; right?
A. Yes. I don't know what their protocol is, but I do know that, you know, you're not supposed to hit an artery.
Q. Well, nobody wants to hit an artery.
A. Well, unless you need to hit it. I hit arteries every day.
Q. Well, that's another thing. You've

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also indicated that you sometimes intend to hit an artery; right?
A. Absolutely.
Q. There's nothing in and of itself problematic about hitting an artery?
A. Oh, yes, there is.
Q. There's situations in which you intend to go into an artery?
A. Yes. Remember, when we're doing a test on an artery or drawing something from an artery, then we'll do extra measures to stop the artery. I mean, I put catheters in arteries every day almost as big as the pen tip or as big as this portion here, but we stop that.
Q. With compression?
A. Yes, whatever.
Q. In your note where you indicated there was a brachial vessel lacerated by a previous venipuncture in your operative note, there was some discussion over what you meant by previous.
A. Yes. I know. Again, it's a word situation.
Q. Could that just have meant prior to your operation?

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A. Yes. It just meant -- whatever issue went on here to make this hematoma here is what that means.
Q. There was no active bleeding at the time of the exploration?
A. No. In fact, all bleeding had stopped, which oftentimes it does.
Q. What's the significance of that?
A. It just means that, you know, possibly if we -- in a case where, say, he wasn't going to get further heparin and go on dialysis, or something like that, we probably could have waited this out.
Q. In the normal course of things, the swelling could have gone down just with additional elevation?
A. Yes, exactly. It's possible. If you can avoid an operation, you try to avoid it.
MR. RICHARDS: I don't have anything else.
MS. DISILVIO: I have some questions.
EXAMINATION OF VINCENT J. BERTIN, M.D.
BY MS. DISILVIO:
Q. Dr. Bertin, you have been asked

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several questions about the size gauge of the needle. Is the size gauge of the needle at all pertinent to your evaluation of this patient from a vascular surgery perspective?
A. No.
Q. When we talk about mechanism of injury in this case, is the size of the needle hub of any significance?
A. Not in the end result, no.
Q. Would you tell us, please, based upon your observation, what you believe the injury was and how you believe the mechanism of injury occurred.
MR. RICHARDS: Objection.
A. Well, the injury is well described in my operative note. Branch of radial artery lacerated, branch of the vein -- I mean, a deep vein, lacerated.
Q. When we heard so much about hitting the artery, when you talk about the branch of the vein that was lacerated and the branch of the artery that was lacerated, is that separate from hitting the artery?
A. Like I say, the main artery, if you look at my operative note, the main artery was

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not entered. Remember the brachial artery is -- let me draw this. The brachial artery is like this, and then you have various branches that go, you know, they go off like that (indicating).
Now, if we put a hole in here in a main artery, I would have probably been doing Mr. Hatfield that night, okay. If there was a hole in this main artery, then we get what we call that big pulsatile hematoma and all the big problems. But in this case, remember, there's a vein that comes adjacent to the artery, there's another vein that comes adjacent to the artery here, but these are deep veins. If you look at my arm, this is a superficial vein. This is the kind of vein you hit when you draw blood. This artery is not that much deeper.
So to hit a branch here, this particular branch, it was one of these median branches like this. I mean, you have to come in, come right next to the artery, hit the vein, because there was a laceration of the vein here, and then go through the artery like that. So the only way the needle could have come in is like this.

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MS. TRESL: Can you put on there where the radial nerve and median nerve is.
THE WITNESS: Median nerve would be over in this region. Radial nerve is a distance away from there. In terms of the arm anatomy itself, probably about down here. That's a pretty good distance. It's conceivable, it's possible.
MS. TRESL: Can you write that that's median and that's radial. It will make it easier, so when we're reading the transcript we'll know what you're saying.
THE WITNESS: Okay. Median.
MS. TRESL: And then the branches and everything that you did.
THE WITNESS: Nerve, and brachial branch.
MS. TRESL: That's of the vein; yes?
THE WITNESS: It's brachial branches, arterial branch.
MS. TRESL: Okay.
THE WITNESS: And the laceration of the vein area was right, you know, adjacent to the artery here, so that would be right about there. Remember, in a human body, you got the

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artery, two veins, pretty much everywhere you go.
BY MS. DISILVIO:
Q. You asked several questions about assumptions. Dr. Bertin, I take it that when you see a patient, whether or not you recall what you heard 18 months ago, it's your custom and practice to talk to the nursing staff?
A. Yes. I mean, if my general custom is -- I mean, I deal with nursing staff every day in every department.
Q. Certainly when you come in to see a patient, you talk to the nurse about patient status, how they're doing while you're there?
A. My guess is, this whole venipuncture issue, I'm sure I was told by the nurses that it was a venipuncture at some point. I'm sure of it. It just doesn't make any sense that I wouldn't be.
Q. You spoke with Dr. Chang about this case?
A. Yes. We talked about this.
Q. You actually came up with a plan for expected management?
A. Exactly. Everybody seemed to be

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comfortable with that.
Q. Certainly you talked about what it was you were managing in terms of the injury with Dr. Chang, albeit you don't remember the particulars of the conversation?
A. Yes.
Q. Certainly you talked about what you were doing and why you were doing it?
A. Correct.
Q. It's not as though you made up, or practice according to assumptions; you practice based on what you hear, what you know, your clinical information, your discussions with nurses and your discussion with physicians; true?
A. Yes. The other issue is, in a case like this, too, is serial evaluation.
Q. All right.
A. You follow a problem over time.
Q. What time are morning labs typically drawn? Somewhere between 5:00 and 6:00 in the morning?
A. Yes. I would assume that. I see them in the elevators so, yes, I would say between 5:00 and 7:00 for sure.

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Q. And certainly the note you pointed out to Ms. Tresl indicated the onset of injury or pain or edema to the antecubital fossa is about 5:28 in the morning on August 6th; right, the note that you showed her --
A. Yes.
Q. -- based on her request?
A. Yes.
Q. All right. Are you licensed to practice medicine?
A. Yes.
Q. Do you spend greater than 50 percent of your professional time in the active clinical practice of medicine?
A. Yes.
MS. DISILVIO: I don't have anymore questions.
MS. TRESL: A couple things and we'll be done.
FURTHER EXAMINATION OF VINCENT J. BERTIN, M.D.
BY MS. TRESL:
Q. Is it possible hypothetically that, even though you did not see any compression on the median nerve, that there could have been ischemia that you would not have been able to

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visualize?
A. No. I mean, it's not likely. It's possible, not likely. Very unlikely. In fact, it would be very unlikely.
Q. Why would it be very unlikely?
A. Because there wasn't -- you know, there wasn't any other evidence of, like we were talking about before, muscle problem, any other soft tissue, fat necrosis, none of that type of situation. So you don't have enough pressure to be causing those issues.
Q. If further down the road, just hypothetically tested, he had proof that he did have some median nerve damage, is it possible that it could have been caused from the compression of the hematoma if we look backwards to that?
A. No. I mean, Mr. Hatfield has numerous reasons to have -- he has renal failure, all sorts of other issues that could give him peripheral neuropathies.
Q. Which would be the same as median nerve?
A. Median nerve, it could be radial nerve neuropathies. I mean, this gentleman has

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a lot of issues.
Q. Back to the lab. Very briefly we'll revisit and we will be done.
Although Mr. Richards asked you if artery puncture is a risk, it is my understanding that in order to have punctured the artery or that vein, that the puncture was more than superficial; correct?
MR. RICHARDS: Objection.
A. Yes. I mean, it would have to be. Yes, it would have to be.
Q. And reasonable and prudent phlebotomy is not deep; it's superficial; correct?
MR. RICHARDS: Objection.
A. I'm not sure what they're -- normally when you're doing venipuncture phlebotomy, you don't hit an artery.
Q. In discussing the picture and the areas of injury, is it more likely than not that it's one needle that got stuck and just wiggled all around looking for the vein, or is it more likely that it was boom, boom, boom, three needles, four needles? Can you say, based on what you saw when you got in there?

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A. I can't tell with certainty when I got in there. I think the -- I couldn't tell. I mean, really, it doesn't matter too much when you think about it because if you go in just once through the skin and jab around versus -- I mean, how would you know that? You wouldn't know. The only person that would know that is the person who did it.
Q. I guess based on visualizing, just more likely than not kind of where they hit it --
A. Like anything else, just think of this, if you're a phlebotomist, once you get through the skin, that's the most painful part to the patient. So if you redirect, that would be probably as likely as anything, I would think.
Q. Would you say that it seems intuitive that a 16-gauge or an 18-gauge being wiggled around in there, assuming that was how this was injured, would be more traumatic than a 20- or a 22-gauge?
A. A bigger needle would be more traumatic, yes. But, again, I have no knowledge of what gauge needle, to be perfectly honest.

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Q. I understand. If we determine the gauge of the needle, the bigger the needle, the more trauma if it's being wiggled?
A. Correct.
Q. Finally, anything that you remember that we, the three of us, have not thought to ask you?
A. How could we possibly have missed anything?
Q. Anything you remember, though, about those three days maybe that we've not brought up that --
A. Like I say, I just think that, you know, in a patient with as many medical problems as this guy, Mr. Hatfield has -- remember, I took care of this guy for 13 years. When I got sued, to be perfectly honest, that really set me back a little bit.
You know, we're trying to avoid a surgery, trying to get him through the medical, you know, the problem here without having to lay open his arm, but it wasn't meant to be.
MS. TRESL: I'm done. Thank you, doctor.
MS. DISILVIO: I have a couple more.

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FURTHER EXAMINATION OF VINCENT J. BERTIN, M.D.
BY MS. DISILVIO:
Q. Doctor, you're not a neurosurgeon; correct?
A. Correct.
Q. You're not a neurologist; correct?
A. Correct.
Q. And as it relates to issues on causation, obviously, you would defer to those specialties to talk about nerve injuries and the cause therefore?
A. Correct.
MS. DISILVIO: Thanks.
- - - - -
(Thereupon, PLAINTIFFS' Deposition Exhibit 1 was marked for purposes of identification.)
- - - - -
(Deposition concluded at 5:00 o'clock p.m.)
(Signature not waived.)

AFFIDAVIT

I have read the foregoing transcript from page 1 through 112 and note the following corrections:

PAGE LINE REQUESTED CHANGE

_____
VINCENT J. BERTIN, M.D.

Subscribed and sworn to before me this _____ day of _____, 2003.

_____
Notary Public

My commission expires _____.

CERTIFICATE

State of Ohio,)
) SS:
County of Cuyahoga.)

I, Karen M. Patterson, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named VINCENT J. BERTIN, M.D. was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action. I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 30th day of December 2003.

Karen M. Patterson

Karen M. Patterson, Notary Public
Within and for the State of Ohio

My commission expires October 7, 2004.

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EXHIBITS