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1 IN THE COURT OF COMMON PLEAS
2 OF CUYAHOGA COUNTY, OHIO
3 -----
4 JESSE HATFIELD, et al.
5 Plaintiffs,
6 vs. Case No. 502766
7 PARMA COMMUNITY GENERAL
8 HOSPITAL, et al.,
9 Defendants.
10 -----
11 DEPOSITION OF VINCENT J. BERTIN, M.D.
12 Wednesday, December 17, 2003
13 -----
14 Deposition of VINCENT J. BERTIN,
15 M.D., a Defendant herein, called by the
16 Plaintiffs for examination under the statute,
17 taken before me, Karen M. Patterson, a
18 Registered Merit Reporter and Notary Public in
19 and for the State of Ohio, pursuant to notice of
20 counsel, at the offices of Vincent J. Bertin,
21 M.D., 18660 Bagley Road, Building II, Suite 201,
22 Cleveland, Ohio, on the day and date set forth
23 above, at 2:20 o'clock p.m.
24 -----
25

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1 APPEARANCES:
2 On behalf of the Plaintiffs:
3 Becker & Mishkind Co., L.P.A., by
4 JACQUELINE TRESL, ESQ.
5 660 Skylight Office Tower
6 1660 West Second Street
7 Cleveland, Ohio 44113
8 (216) 241-2600
9 On behalf of the Defendant Parma Community
10 General Hospital:
11 Weston, Hurd, Fallon, Paisley &
12 Howley, by
13 DANIEL A. RICHARDS, ESQ.
14 2500 Terminal Tower
15 50 Public Square
16 Cleveland, Ohio 44113
17 (216) 687-3321
18 On behalf of the Defendant Vincent J.
19 Bertin, M.D.:
20 Reminger & Reminger Co., L.P.A., by
21 MARILENA DISILVIO, ESQ.
22 1400 Midland Building
23 101 West Prospect Avenue
24 Cleveland, Ohio 44115
25 (216) 687-1311

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1 VINCENT J. BERTIN, M.D., of lawful age,
2 called for examination, as provided by the Ohio
3 Rules of Civil Procedure, being by me first duly
4 sworn, as hereinafter certified, deposed and
5 said as follows:
6 EXAMINATION OF VINCENT J. BERTIN, M.D.
7 BY MS TRESL:
8 Q. Dr. Bertin, we met earlier; Jackie
9 Tresl, attorney for Mr. and Mrs. Hatfield. Have
10 you ever had your deposition taken before, sir?
11 A. Yes.
12 Q. Can you tell me in how many
13 instances?
14 A. No.
15 Q. Have you had your deposition taken
16 more than twice?
17 A. Yes.
18 Q. Have you had your deposition taken
19 in medical malpractice cases?
20 A. Yes.
21 Q. Have you been named as a defendant
22 in those medical malpractice cases?
23 A. Yes.
24 MS. DISILVIO: Objection. And,
25 Jackie, just so I don't keep interrupting you,

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1 may I have a continuing objection to any
2 questioning regarding prior medical malpractice
3 lawsuits?
4 MS. TRESL: Not a problem.
5 Q. Have you been named as a defendant
6 in a medical malpractice case more than five
7 times?
8 A. Yes.
9 Q. And you don't want to share with me
10 any of the names of the parties involved in any
11 of those cases; is that correct?
12 A. Yes.
13 Q. Were you found liable in any of the
14 cases in which you were a defendant?
15 MS. DISILVIO: Objection to being
16 found liable. If you know what that means,
17 doctor, you may answer.
18 A. I don't know what liable means in a
19 case like that.
20 Q. Were you found to be negligent in
21 the suit in which you were brought as a
22 defendant?
23 MS. DISILVIO: Let me interrupt for
24 a minute. By that, do you mean has there ever
25 been a jury verdict rendered against him?

<p style="text-align: right;">Page 5</p> <p>1 MS. TRESL: Or a settlement or in 2 any way has anyone said as a defendant you 3 violated the standard of care, that you were 4 negligent in your care. 5 MS. DISILVIO: Objection. He's not 6 going to answer that. Settlements do not imply 7 liability by any stretch of the imagination. 8 Oftentimes settlements are entered into as a 9 business decision. 10 So, to the extent that that question 11 asks for information which is deemed 12 confidential in terms of settlement agreements, 13 I'll object. If you want to know if a jury has 14 ever returned a verdict against him, you can 15 certainly ask him that question. 16 Q. Has a jury ever returned a verdict 17 against you, Dr. Bertin? 18 A. No. 19 Q. When was the last time you were 20 named as a defendant, what year? 21 A. Other than this case? 22 Q. Correct. 23 A. 2002. 24 Q. Prior to that? 25 A. 1999.</p>	<p style="text-align: right;">Page 7</p> <p>1 Q. Since you've had your deposition 2 taken many times, I will just short and sweet 3 set out the guidelines. If I ask you questions 4 you don't understand, please tell me that you 5 don't understand it. 6 A. Okay. 7 Q. If you answer my question, I will 8 assume you understand it, okay? That's a yes? 9 A. Yes. 10 Q. I need you to answer yes or no 11 rather than nod or shake your head so that Karen 12 can put it down on the record. 13 A. Yes. 14 Q. I ask that you let me finish my 15 question before you answer, and I will give you 16 the same courtesy, to let you finish your answer 17 before I ask my next question. Okay? 18 A. Yes. 19 Q. For the record, can you tell us your 20 name and address, please. 21 A. A. Vincent Bertin, 18660 Bagley 22 Medical Arts II, Number 201, Middleburg Heights, 23 Ohio. 24 Q. You are a vascular surgeon; is that 25 correct?</p>
<p style="text-align: right;">Page 6</p> <p>1 Q. Prior to that? 2 A. I don't recall. 3 Q. Have you ever served as an expert in 4 any lawsuits where you were asked to give an 5 opinion on the standard of care? 6 A. Not at trial, but I have reviewed 7 cases, yes. 8 Q. About how many cases have you 9 reviewed? 10 A. Probably seven or eight. 11 Q. Plaintiff and defendant, or patient? 12 A. Both sides. 13 Q. More one than the other? 14 A. More defendant. 15 Q. And were any of the cases that you 16 served as an expert on related at all to the 17 facts surrounding Mr. Hatfield? 18 A. No. 19 Q. So you've never testified relative 20 to compartment syndrome? 21 A. No. 22 Q. Have you ever testified relative to 23 an injury caused by trauma, let's say 24 venipuncture? 25 A. No.</p>	<p style="text-align: right;">Page 8</p> <p>1 A. Correct. 2 Q. Are you board certified? 3 A. Yes. 4 Q. Since when did you get your board 5 certification? 6 A. Board certified in general surgery 7 in 1987 and vascular surgery in 1990. 8 Q. Then it looks like you were 9 recertified both in '95 and '97; is that 10 correct? 11 A. Recertified a little later than 12 that, '98 or '99. 13 Q. In vascular surgery? 14 A. In both. 15 Q. I notice here that 1995 through 1997 16 you were chief of vascular surgery, and it looks 17 like now you are staff surgeon and director of 18 vascular laboratory. Can you tell me the 19 different duties and responsibilities relative 20 to that sort of difference in title? 21 A. Yes. Basically, I've been chief of 22 surgery at Southwest -- I don't know if it's 23 even on that CV -- I've been chief of surgery at 24 Southwest Hospital for three or four years. 25 I've been chief of vascular surgery at Southwest</p>

<p>Page 9</p> <p>1 Hospital and Parma Hospital probably about -- 2 between three and four years at each 3 institution. 4 What it is, basically, is a 5 political position. You get elected by your 6 department peers, and when you no longer want to 7 do that position, then you don't try to be 8 elected again. 9 Q. In '97, you didn't want to be the 10 chief of vascular surgery at Parma Community any 11 longer; is that correct? 12 A. Correct. 13 Q. You are currently staff surgeon at 14 Southwest General; yes? 15 A. Yes. 16 Q. And staff surgeon, director of 17 vascular laboratory at Parma Community; yes? 18 A. Correct. 19 Q. Are you still staff surgeon at 20 Deaconess? I'm going to guess the answer is no. 21 A. Fortunately. 22 Q. Because Deaconess is no longer 23 there. You were until last month? 24 A. I was until the final death nell, 25 yes.</p>	<p>Page 10</p> <p>1 Q. Anywhere else that's not reflected 2 on here? 3 A. No. 4 Q. This is current, as far as you can 5 tell? 6 A. That's correct. 7 MS. DISILVIO: With the exception of 8 the title that he gave as it relates to chief of 9 surgery at Southwest, which I think Dr. Bertin 10 said was not on that CV. 11 MS. TRESL: Correct. 12 Q. So because you're a staff surgeon 13 and a vascular surgeon then, do you do both 14 general surgery and vascular surgery? 15 A. No. My practice is totally confined 16 to vascular surgery. 17 Q. Tell me a little bit about your 18 practice, what kind of patients you see. 19 A. A whole realm of peripheral vascular 20 patients. 21 Q. You go in to do emergency 22 procedures? 23 A. Yes. 24 Q. When? 25 A. When necessary.</p>	<p>Page 11</p> <p>1 Q. Do you do a lot of vascular studies, 2 or do you send someone to a vascular lab for 3 that, or is that all incorporated together? 4 A. Well, vascular labs are set up in -- 5 some are in the hospital, some are in your 6 office. I have capability to do it in both 7 places. 8 Q. How commonly do you perform 9 fasciotomies? Is that a common procedure or 10 uncommon procedure in your day-to-day practice? 11 A. Relatively uncommon. 12 Q. And why is that, sir? 13 A. It's mainly because I don't have a 14 lot of trauma patients in my -- I'm not at a 15 trauma center, per se. You see the fasciotomy 16 type procedures more in trauma centers, let's 17 put it that way. 18 Q. How many, let's say, forearm 19 fasciotomies have you performed, say, in the 20 last two years? 21 A. Superficial? 22 MS. DISILVIO: If you know. 23 A. Superficial forearm fasciotomy. 24 Q. I think you did both superficial and 25 deep in this case. So why don't we say you can</p>	<p>Page 12</p> <p>1 do one or the other or both, however you would 2 like to break it down. 3 A. I might have to look back and see, 4 but probably two or three. 5 Q. In the last two or three years? 6 A. Probably. 7 Q. It does not look like you do any 8 active teaching right now. 9 A. Correct. 10 Q. Do you do any in-servicing of 11 residents or interns in your daily practice when 12 you're making rounds at the hospital? 13 A. No. I don't practice at a teaching 14 hospital. 15 Q. Nobody sends students over if it's 16 not a teaching hospital then? 17 A. Pretty much, no. 18 Q. Are you part of a practice group? 19 A. I'm a solo practitioner. 20 Q. What's the name of the corporation? 21 A. Southwest Vascular, Inc. 22 Q. You are the statutory agent of that? 23 A. Correct. 24 Q. How long has Southwest Vascular, 25 Inc. been incorporated?</p>
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1 A. Since, I believe, 1989.
2 Q. If you want to take a vacation, do
3 you have someone that you call to step into your
4 shoes?
5 A. Correct, yes. We have coverage
6 arrangements.
7 Q. With other vascular surgeons?
8 A. Correct.
9 Q. Other sole practitioners?
10 A. Right.
11 Q. For today's deposition, what did you
12 review?
13 A. Basically the medical record, my
14 office notes.
15 Q. Your office notes. Do I have a copy
16 of your office notes? I don't believe I do. Do
17 I have a copy of your office notes?
18 MS. DISILVIO: I think you should.
19 I think I sent them.
20 MS. TRESL: May I see what they look
21 like and then I will know whether I have them or
22 not.
23 MS. DISILVIO: You can take the
24 binder. That's my binder.
25 Q. It will be so much quicker if he

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

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

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1 A. No.
2 Q. Were you aware that two of the
3 nurses in this case were deposed last week?
4 MS. DISILVIO: Objection to any
5 question that might ask about any discussions he
6 has had with me. If you know anything about
7 depositions, doctor, from any other source than
8 me, you can let Ms. Tresi know.
9 A. No.
10 Q. Neither of the nurses told you that
11 their deposition was going to be taken?
12 A. No.
13 Q. Have you spoken to either of the
14 nurses that I spoke to last week since their
15 deposition?
16 A. No.
17 Q. Do you know the names of the nurses
18 that were involved in Mr. Hatfield's care during
19 that period of time between August 6th and
20 August 8th?
21 A. No.
22 Q. Do you have an independent memory of
23 Mr. Hatfield relative to his stay in Parma in
24 August of 2002?
25 A. I took care of Mr. Hatfield for 13

<p style="text-align: right;">Page 17</p> <p>1 years. Is the question you were asking --</p> <p>2 Q. If I ask you specifically about what</p> <p>3 happened when he was there in August of 2002, do</p> <p>4 you remember, independent from what you wrote,</p> <p>5 what happened in your care of him? Or</p> <p>6 everything that you're telling me, will you be</p> <p>7 relying on your records for?</p> <p>8 A. Basically, I would be relying on the</p> <p>9 records.</p> <p>10 Q. It looks to me that you began caring</p> <p>11 for Mr. Hatfield in 1991, just from glancing at</p> <p>12 that.</p> <p>13 A. Correct.</p> <p>14 Q. Can you just tell me briefly how you</p> <p>15 happened to become his doctor in 1991?</p> <p>16 A. Did you take that section in --</p> <p>17 Q. I thought they would have given it</p> <p>18 back to you.</p> <p>19 A. Here we go. He was referred to me</p> <p>20 initially February 5th, 1991. At that time, he</p> <p>21 had significant arterial occlusive disease of</p> <p>22 the lower extremity. What that basically means</p> <p>23 is blocked circulation in the pelvis and lower</p> <p>24 legs.</p> <p>25 Q. And the abbreviation of IPVSC would</p>	<p style="text-align: right;">Page 19</p> <p>1 endarterectomy on him in 1997. And I also was</p> <p>2 the surgeon who performed his vascular access</p> <p>3 procedures on his left arm.</p> <p>4 Q. On May 29 of 2002 when you say</p> <p>5 that -- I'm assuming that's the fistula -- the</p> <p>6 shunt is ready for puncture, that means that the</p> <p>7 fistula is being ready to be used for dialysis;</p> <p>8 is that correct?</p> <p>9 A. Correct.</p> <p>10 Q. At the time Mr. Hatfield was</p> <p>11 hospitalized in August, was that fistula</p> <p>12 accessible to -- well, let me ask you this way.</p> <p>13 Who is that A-V fistula opening accessible to in</p> <p>14 terms of when he's in the hospital? Is it only</p> <p>15 for dialysis, or is it for other things?</p> <p>16 A. The fistula, per se, is only for</p> <p>17 dialysis unless there were a dire emergency</p> <p>18 situation where access was required.</p> <p>19 Q. Is fistula the correct word or is</p> <p>20 shunt more appropriate?</p> <p>21 A. They mean three different things.</p> <p>22 Q. I want to be sure we're talking</p> <p>23 about the same thing. It's the thing under the</p> <p>24 arm where the needle for dialysis goes. What</p> <p>25 would be the best word to use here?</p>
<p style="text-align: right;">Page 18</p> <p>1 stand for?</p> <p>2 A. Inpatient vascular surgery consult.</p> <p>3 Q. And PCH?</p> <p>4 A. Parma Community Hospital.</p> <p>5 Q. The last time that you saw Mr.</p> <p>6 Hatfield was when? Do you know that date?</p> <p>7 A. I believe it was around January or</p> <p>8 February of 2003, I believe. No. Actually,</p> <p>9 probably it was October 25th, 2002 because he</p> <p>10 cancelled the appointment in January of 2003.</p> <p>11 Q. Have you contacted him or his family</p> <p>12 in any way to reschedule, or do you know if he's</p> <p>13 gotten another vascular surgeon?</p> <p>14 A. There was a request from another</p> <p>15 vascular surgeon across the street here, Dr.</p> <p>16 Rogers, for his records, so I assume that they</p> <p>17 obtained the services of another vascular</p> <p>18 surgeon.</p> <p>19 Q. In just briefly glancing through the</p> <p>20 records, it looked to me primarily what you were</p> <p>21 seeing Mr. Hatfield for were lower extremity</p> <p>22 issues.</p> <p>23 A. No. He also had carotid disease.</p> <p>24 If I recall, I did a carotid surgery on him at</p> <p>25 some point. I think I did a right carotid</p>	<p style="text-align: right;">Page 20</p> <p>1 A. In his case, graft would be the</p> <p>2 best. It's a forearm graft.</p> <p>3 Q. That forearm graft, in his case,</p> <p>4 while they're doing dialysis, can they also be</p> <p>5 doing transfusions through it? Could they also</p> <p>6 be doing blood draws through it?</p> <p>7 A. No. Those are reserved for dialysis</p> <p>8 purposes only unless there is an extremist case</p> <p>9 where access was required. If he had a cardiac</p> <p>10 arrest and we needed fast access, then you can</p> <p>11 probably use the access. Otherwise, no. It's</p> <p>12 used strictly for dialysis purposes.</p> <p>13 Q. At the time he was in in August,</p> <p>14 that's what they were using in terms of the</p> <p>15 hemodialysis records?</p> <p>16 A. Correct.</p> <p>17 Q. It looks to me there were no</p> <p>18 problems with the fistula. The sort of weeping</p> <p>19 and seeping associated with it kind of</p> <p>20 simultaneously in August, is that normal?</p> <p>21 A. That can happen after any dialysis</p> <p>22 session, yes.</p> <p>23 Q. Explain to me briefly why that is.</p> <p>24 A. Because you're taking a needle and</p> <p>25 sticking a needle into a tube, and that tube</p>

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

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

13 A. Almost always.

14 Q. Sometimes pressure is needed, or not
15 generally?

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

19 Q. I see.

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

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

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1 heparinized?

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

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

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

9 Q. Okay.

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

13 Q. Subcutaneously also?

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

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

20 A. Please do.

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

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

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

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

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

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

17 MS. DISILVIO: What are you
18 referring to?

19 A. To the operative note.

20 Q. Correct.

21 A. I got that.

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

25 A. Okay. Status post, aberrant needle

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

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

8 (Record read.)

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

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

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

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

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

<p style="text-align: right;">Page 25</p> <p>1 there may be some significance to that. Perhaps 2 there wasn't when you wrote it, which is why I'm 3 asking you about it. I'm not fixating on it. 4 It looks to me you're looking at a needle 5 puncture and describing it as an aberrant needle 6 puncture. I don't know what that means, if that 7 meant that it was raggedy, if the skin was 8 hanging, if it was crooked. It looks like it 9 describes the puncture. 10 A. No. Aberrant, the term that I used 11 here, had nothing to do with any of those you 12 just mentioned. 13 Q. So what you meant by it was that 14 what you saw when you came in to consult was 15 that there was more blood there than you would 16 have expected? 17 A. From a vein puncture, yes. 18 Q. From a vein puncture. Do you draw 19 any conclusion from that when you see that? 20 MS. DISILVIO: From the blood or 21 from his use of the terminology? 22 MS. TRESL: From what he meant when 23 he described what he saw as aberrant. 24 A. My conclusion from that is that the 25 artery probably was entered by the needle. That</p>	<p style="text-align: right;">Page 27</p> <p>1 Q. But no one said -- and I don't want 2 to put words -- 3 A. I don't know one hundred percent 4 whether there was an IV attempt placement there 5 or whether it was a blood draw, to be perfectly 6 honest. I don't know one hundred percent. I 7 was not there when that person performed the 8 act. 9 Q. I understand. But this note, this 10 patient is a 78-year-old white male, status post 11 aberrant needle puncture to the right 12 antecubital fossa by the laboratory, that looks 13 fairly definitive. What I'm trying to determine 14 is if someone told you that or said, Dr. Bertin, 15 we have this patient with a large arm, can you 16 look at it; and you looked at it and put two and 17 two together, if you remember. 18 A. I don't remember. 19 Q. So this may be your observation, but 20 not based on facts that you were told? 21 A. I don't understand the whole line of 22 questioning. I just don't. 23 Q. Well, with all due respect, sir -- 24 A. I don't know how to answer it. 25 Q. -- you don't have to understand the</p>
<p style="text-align: right;">Page 26</p> <p>1 was my conclusion at that point. 2 Q. Could you sort of flesh out that 3 idea a little bit more for me. 4 A. No. 5 Q. Was it speculation, or is it more 6 likely than not that was what you thought it was 7 the result of when you saw it? I mean, could it 8 have also been lymph fluid, could it have been 9 someone injected normal saline in there 10 inadvertently? This is what I'm after. 11 MR. RICHARDS: Objection. 12 A. No. The patient had a blood draw. 13 Nobody was putting an IV in. Blood draw, excess 14 bleeding in that position could be arterial 15 stick. 16 Q. What led you to the conclusion that 17 it was connected to a blood draw as opposed to 18 someone doing something else, starting an IV or 19 attempting to start an IV? 20 A. I thought that was common. I mean, 21 I didn't see the person do it. But from my 22 review of the situation, there was no other 23 reason for me to think that there was a -- it 24 would be an unusual place to put an IV, let's 25 put it that way.</p>	<p style="text-align: right;">Page 28</p> <p>1 line of questioning. 2 A. I can't answer something if I don't 3 understand what the question is. 4 MS. DISILVIO: Why don't we take 5 this opportunity to take a break. Jackie, you 6 can review the records. 7 (Recess had.) 8 (Record read.) 9 Q. In the same vein of questioning, if 10 I can draw your attention to the consultation 11 report that you dictated on 8-7 at 8:55. 12 A. Let me find that. Got it. 13 Q. First of all, before we discuss 14 that, the operative note that we read before, 15 what was the date on that, sir? 16 A. 8-8. 17 Q. And the date on this consultation 18 report is? 19 A. 8-7. 20 Q. And if you could read for me the 21 first line of the third paragraph there. 22 A. The right arm problem developed 23 after venipuncture was performed by apparently a 24 medical laboratory at Parma Community Hospital. 25 Q. If you could finish it, please.</p>

<p style="text-align: right;">Page 29</p> <p>1 A. Where inadvertently the brachial 2 artery most likely was stuck with a 16-gauge 3 needle, and this resulted in extravasation of 4 hematoma involving the right antecubital area 5 extending into the right biceps and also into 6 the right forearm. 7 Q. This was written 24 hours before you 8 took Mr. Hatfield to the operating room. First, 9 let me ask you, on what did you base your 10 observation or your knowledge that this was a 11 16-gauge needle? 12 MS. DISILVIO: Objection. If you 13 remember. 14 A. I have no knowledge because I never 15 saw the actual performance of the -- 16 Q. So you just -- 17 A. I don't know if it's a 16-gauge 18 needle or not. My only reason I would have 19 thought -- 20 MS. DISILVIO: Don't guess. 21 A. I really can't guess. 22 MS. DISILVIO: Nobody wants you to 23 guess. 24 A. I can't guess with any degree of 25 accuracy, I suppose.</p>	<p style="text-align: right;">Page 31</p> <p>1 Q. Dr. Bertin, you put here that this 2 brachial artery was most likely stuck with a 3 16-gauge needle. 4 A. Yes. 5 Q. You have no memory whatsoever how 6 you determined, of all the gauge needles in the 7 whole world that he could have been stuck with, 8 you determined that most likely it was a 9 16-gauge needle? 10 MS. DISILVIO: Objection. If you 11 remember. 12 A. The only way I could have thought, 13 okay -- I just can't remember for sure why I put 14 16-gauge needle. But if you go to the blood lab 15 and you get -- if the tech comes around to the 16 floor and they're drawing blood in the patients 17 and they put the blood into the bottle, the 18 usual gauge needle that they use is either 18 or 19 16, and that's what I've been familiar with. 20 When I've had blood drawn myself, someone comes 21 around for -- you know, if you go to a lab and 22 have blood drawn, check your cholesterol or 23 whatever, that's usually what it is, a 16- or 24 18-gauge needle. That's why that came up. I 25 personally did not see a 16-gauge needle go into</p>
<p style="text-align: right;">Page 30</p> <p>1 Q. So when you write something in the 2 medical record and you document that as being 3 what you're seeing and what you're acting on, do 4 you generally document things which you don't 5 know? 6 MS. DISILVIO: Wait a minute. 7 Objection. I think what he told you is he 8 doesn't remember how he got that information for 9 that note and doesn't know today what size gauge 10 was being used. I don't think that's the same 11 question as to what he knew or what he wrote at 12 the time of the events. 13 MS. TRESL: Just say you object, 14 okay. 15 MS. DISILVIO: Let's not 16 mischaracterize his testimony, and I will say I 17 object. I'm going to protect the record in the 18 appropriate manner for my client, and I will 19 object when all I need to do is object. When I 20 need to clarify the testimony, I'm going to 21 clarify it. 22 MS. TRESL: Are you done? 23 MS. DISILVIO: Am I done? 24 MS. TRESL: Yes. 25 MS. DISILVIO: I certainly am.</p>	<p style="text-align: right;">Page 32</p> <p>1 Mr. Hatfield's arm. 2 Q. But as you sit here now telling me 3 it could have been an 18-gauge just as easily, 4 that's your understanding of the size that they 5 use to draw blood at Parma Community; is that 6 correct? 7 A. I don't know what they use on the 8 floor, per se. All I know is from times that 9 I've seen them, when I make rounds early in the 10 morning and I see them draw blood, the 11 appearance of that needle appears to be that 12 size. 13 Q. This statement in your consultation 14 report that, was likely stuck with a 16-gauge 15 needle, is based on when you make rounds in the 16 hospitals in the mornings and you observe the 17 lab, going from room-to-room, the size needle 18 that they generally use? 19 MS. DISILVIO: Objection. I think 20 he told you in this case he doesn't recall what 21 the information was that he used to arrive at 22 this conclusion, and he is giving you the 23 best -- 24 MS. TRESL: Marilena -- 25 MS. DISILVIO: I'm going to have her</p>

8 (Pages 29 to 32)

<p style="text-align: right;">Page 33</p> <p>1 read back the answer because I'm not going to 2 have you misconstrue this gentleman's testimony. 3 Could you please read back the answer to the 4 question which began with the answer "I don't 5 recall." 6 (Record read.) 7 Q. The question is: At the time that 8 you wrote that this was likely stuck by a 9 16-gauge needle, it's your understanding from 10 making rounds in the hospital that Parma 11 Community generally draws blood, or 12 phlebotomists generally draw blood, using 16- or 13 18-gauge needles? 14 MR. RICHARDS: Objection. 15 MS. DISILVIO: You may answer. 16 A. To my knowledge, when blood is drawn 17 from a routine venipuncture on the floor, that 18 the needle used is 16- or 18-gauge. I'm not 19 sure why the number 16 is actually there, to be 20 perfectly honest. Whether I said 16, whether I 21 dictated 18, I don't know. 22 Q. If I told you that the 23 phlebotomists -- and just assume that what I'm 24 telling you is correct -- do not use 16-gauge 25 needles ever to draw blood, would that change</p>	<p style="text-align: right;">Page 35</p> <p>1 specifically, but I believe there are notes in 2 the chart that said it was from the laboratory. 3 Q. Can you point me to those notes? 4 A. No. I mean, I don't know where. I 5 would have to -- at some point during that -- 6 when I came to see him, during the consultation, 7 the laboratory drawing the blood was what I 8 assumed had occurred. 9 Q. The answer to my question was that 10 you had seen somewhere in the record where it 11 was referred to, and I would like to take the 12 time, if I could ask you, to please find that. 13 MS. DISILVIO: Let's go off the 14 record. 15 A. I don't know if I saw it in the 16 record or if it was hearsay from the nursing 17 staff on the floor. I don't know. It really 18 didn't -- at that point, it was -- it didn't 19 matter, from my standpoint. 20 Q. Rather than having Karen read the 21 record again -- 22 MS. DISILVIO: Is what you're asking 23 is for us to take a moment, take a break, and 24 for Dr. Bertin to go through the chart and find 25 reference to the blood draw?</p>
<p style="text-align: right;">Page 34</p> <p>1 your understanding of the 16-gauge needle that 2 likely caused this? 3 MS. DISILVIO: Objection to the 4 hypothetical. 5 A. No. The whole point is, whether it 6 was a 16, 18, 20, it really doesn't matter. The 7 whole point is that the artery was entered with 8 the puncture. I can't tell by looking at the 9 skin, if that's your question, I can't tell by 10 looking at the skin if it was a 16-gauge, 11 18-gauge or 20. Nobody can. All I can say is 12 the artery was punctured. 13 Q. So why put 16-gauge needle into your 14 consultation report? 15 A. I don't know. I don't know. 16 Q. Am I correct in saying that the 7th 17 is the first day that you saw Mr. Hatfield? 18 A. Correct. 19 Q. At the time that you observed this 20 hematoma, did you inquire into, if you remember, 21 how the injury occurred? 22 A. Inquired to whom? 23 Q. Nursing, Dr. Chang, nursing 24 supervisor, phlebotomy department. 25 A. I don't recall talking to anybody</p>	<p style="text-align: right;">Page 36</p> <p>1 MS. TRESL: Well, I believe, in 2 answer to my question of how he came to that 3 determination, I believe he said, and we can 4 have Karen read it, that he believed he saw 5 somewhere a reference in the chart that it was 6 caused from a blood stick, which was partially 7 what helped him to formulate his opinion. 8 Then I believe you said you aren't 9 sure now whether you read it or it was something 10 that you had heard on the floor. 11 MS. DISILVIO: Karen, why don't we 12 go back and let's read the record. 13 (Record read.) 14 MS. DISILVIO: The answer, Jackie, 15 so it's clear, is I believe it's from the 16 record. He did not say it was from the record. 17 If you would like us at this juncture -- 18 MS. TRESL: I would. 19 MS. DISILVIO: Then what I ask is 20 that we take a break and have Dr. Bertin go 21 through the chart. 22 MS. TRESL: That's fine with me. 23 (Discussion off the record.) 24 Q. When we left, Dr. Bertin, you were 25 going to find for us in the medical record where</p>

<p style="text-align: right;">Page 37</p> <p>1 the reference to the lab stick is.</p> <p>2 A. Well, the only thing we find in the</p> <p>3 record is the report on the nursing note that</p> <p>4 said that the patient had bloody drainage, right</p> <p>5 antecubital fossa area. And that's where we</p> <p>6 have that.</p> <p>7 Q. This would be what time?</p> <p>8 A. This was at 6:00 in the morning,</p> <p>9 5:20.</p> <p>10 Q. 5:20.</p> <p>11 A. That's when the nursing note is</p> <p>12 placed in the chart.</p> <p>13 Q. So based on that reference, that's</p> <p>14 where you drew the conclusion that this was as a</p> <p>15 result of lab work that was drawn?</p> <p>16 A. No. That's where it's placed in the</p> <p>17 chart. My conclusion came from being in</p> <p>18 practice 25 years, knowing that in this</p> <p>19 particular area, a patient who is a renal</p> <p>20 failure patient, that this most likely</p> <p>21 represented an area of a blood draw. I mean, I</p> <p>22 don't know any other way I can say that. This</p> <p>23 area represented, most likely, a blood draw.</p> <p>24 Q. Right. But the reference is not</p> <p>25 just to an area of a blood draw; it's also</p>	<p style="text-align: right;">Page 39</p> <p>1 observation.</p> <p>2 A. No. Based on the note and</p> <p>3 observation, no.</p> <p>4 Q. So it would look, from your</p> <p>5 consultation report, that it was from your</p> <p>6 observation at the bedside before you took Mr.</p> <p>7 Hatfield into surgery, it looked to you that it</p> <p>8 was a single puncture; is that correct?</p> <p>9 A. Correct.</p> <p>10 Q. And then once you went into --</p> <p>11 A. No. Let me put it this way. I</p> <p>12 would assume it's a single puncture, because</p> <p>13 when you go to draw blood, you go in once, draw</p> <p>14 the blood, come back out.</p> <p>15 Q. And in your operative note, you say</p> <p>16 aberrant needle punctures.</p> <p>17 A. Correct.</p> <p>18 Q. So tell me what changed from your</p> <p>19 consult note to your OR note that caused you to</p> <p>20 pluralize that.</p> <p>21 A. Well, give me one second to review</p> <p>22 the operative note.</p> <p>23 At the time of the surgery, I found</p> <p>24 the laceration of a branch of the brachial</p> <p>25 artery; I found a hematoma in the brachialis</p>
<p style="text-align: right;">Page 38</p> <p>1 reference to aberrancy and also reference to the</p> <p>2 size of the needle. So we're talking about the</p> <p>3 totality of the note, not just the fact that you</p> <p>4 observed this in the antecubital.</p> <p>5 MS. DISILVIO: Is there a question?</p> <p>6 MS. TRESL: No. I'm clarifying</p> <p>7 because he was attempting to clarify for me.</p> <p>8 MS. DISILVIO: No. He was answering</p> <p>9 the question.</p> <p>10 Q. Do you know, based on your</p> <p>11 observations with the antecubital and needle</p> <p>12 stick, was there an incident report filed, if</p> <p>13 you know?</p> <p>14 MR. RICHARDS: Objection.</p> <p>15 A. No. I do not know.</p> <p>16 Q. As you sit here today, you have no</p> <p>17 recollection of doing any independent</p> <p>18 investigation about that stick; is that correct?</p> <p>19 A. Correct.</p> <p>20 Q. Could you tell, from your</p> <p>21 observation then or your note now, if the area</p> <p>22 was stuck more than one time?</p> <p>23 MS. DISILVIO: Based on his note and</p> <p>24 observation or also his surgery?</p> <p>25 MS. TRESL: His note and his</p>	<p style="text-align: right;">Page 40</p> <p>1 muscle area; I also found a laceration of the</p> <p>2 basilic vein.</p> <p>3 The laceration of the basilic vein</p> <p>4 was at an area different from the laceration of</p> <p>5 the brachial artery. So for a needle to</p> <p>6 possibly hit -- it's conceivable one needle</p> <p>7 stick could have done all of the three things</p> <p>8 there, but it's probably not likely. My feeling</p> <p>9 is that there was probably -- you know, if</p> <p>10 you're going to draw blood, you jab. If you</p> <p>11 miss, you jab again. That was my observation</p> <p>12 from being there at surgery at the time that</p> <p>13 that's what went on.</p> <p>14 Q. The second area where you thought</p> <p>15 may have been a second stick, is it possible,</p> <p>16 and I know you said it's possible, would that</p> <p>17 area theoretically, depending on anatomy, have</p> <p>18 been behind the area of the stick, or is it over</p> <p>19 to the side that it would almost have to be a</p> <p>20 second needle?</p> <p>21 MR. RICHARDS: Objection.</p> <p>22 Q. Could you just draw me a little</p> <p>23 diagram?</p> <p>24 A. Let's just cut to the chase here.</p> <p>25 Look at this here. See this, this is the</p>

<p>Page 41</p> <p>1 basilic vein (indicating). This is where you 2 would normally do a venipuncture. 3 Q. Okay. 4 A. If you put a needle through this, 5 you go right to here (indicating). Let me find 6 it for you. Right there. If you go through 7 that, next thing you'll hit, brachial artery, it 8 will be right here, okay. You can feel it with 9 your finger, but that's where it is. So if the 10 needle is going in like that, it can go right 11 in, hit the artery. Normally it goes right into 12 the vein. If it goes deeper, it's the artery. 13 I mean, I don't know what else to tell you. 14 That's exactly the spot. This is where the 15 hematoma was, right here. 16 Q. But based on that, it looks to me 17 like one single needle easily could have gone 18 through both. 19 A. Possibly. It's possible. It's 20 possible. One needle could have done, if you 21 take it and you went like this (indicating) and 22 you went -- well, the areas of the injury were 23 separated about this far (indicating). It's 24 possible if you came in at a particular angle 25 that you could have done that with one stick,</p>	<p>Page 43</p> <p>1 we're talking about two venipunctures at least, 2 and it looks like one is earlier than the 3 second. 4 A. No. No. That's not what that 5 meant. That's not what that meant by this. 6 Q. In this case, what do you mean by -- 7 A. There was a branch vessel in the 8 brachial artery lacerated -- but that's why I'm 9 there. I'm doing the surgery because there's a 10 hematoma here. Do you understand? I think 11 they're getting caught up on a word there that 12 doesn't mean a lot. 13 Q. So "previous" means you were in 14 there because of the previous venipuncture that 15 brought you to where you're at right now and 16 not, rather, that there was a venipuncture 17 before the -- 18 A. No. I am there. There has been a 19 laceration of the branch of the brachial artery, 20 and I am there because there was a venipuncture 21 that -- 22 Q. Done previously -- 23 A. Yes. 24 Q. -- that caused this? 25 A. Yes, done previously, exactly.</p>
<p>Page 42</p> <p>1 but not likely. I still say there was more than 2 one jab. 3 Q. By your operative note towards the 4 bottom, there was a branch vessel that had been 5 lacerated by a previous venipuncture and the 6 basilic vein has been lacerated. What does that 7 mean, previous venipuncture? 8 A. Remember, when we're dictating 9 operative notes, it's not like this -- it's like 10 perfect -- you get some corrections and things 11 like that. The transcriptionist may put a word 12 in different than what you said. Sometimes you 13 may say something different than what you really 14 meant. There can be -- how should I say it -- 15 syntax errors, if you will. 16 Q. So the word "previous" is a syntax 17 error? 18 A. Yeah. "Previous" just means by a 19 venipuncture. Again, my assumption through this 20 whole thing, okay, is that this represented to 21 me a venipuncture that was done. I have no 22 other reason to think, from putting together my 23 25 years in practice and the type of situation 24 like this, that this was a venipuncture. 25 Q. But the operative note looks like</p>	<p>Page 44</p> <p>1 MR. RICHARDS: Objection. 2 Q. Since we're on the operative report, 3 describe to me, when you went in there, what you 4 saw apart from just having me read the words. 5 A. This was 18 months ago. 6 Q. I understand. 7 A. Have you ever done any surgery? 8 Q. Never. What is meant by deep 9 hematoma? Then I'll ask you my questions in 10 here. What does that mean, deep? 11 A. Let me go back to this again. Is it 12 okay? 13 Q. Yes. Although a picture would be 14 great. 15 A. I don't have one of the upper 16 extremity, though. 17 Q. You can draw it. 18 A. I can't draw that great. But, 19 again, this is a good example. Here is the area 20 of concern. Hematoma means there is like a 21 swelling right in this area like this 22 (indicating). What was the other question? 23 Q. Deep. 24 A. Deep means -- remember, when I 25 opened up this arm, because he had a hematoma</p>

<p style="text-align: right;">Page 45</p> <p>1 here, I make what we call a lazy S incision. 2 The reason I do the lazy S is because it heals 3 better. If you make one vertical incision here, 4 it doesn't heal as great. The lazy S heals 5 because there's a flexibility here. I go like 6 that, make a lazy S. When I open this up here, 7 you could imagine, there's nerve, artery, vein, 8 and there's muscle here. He had a fair blood 9 collection back here in the muscle down deep to 10 here. Here is your biceps tendon here. Right 11 down here he had blood collection and then he 12 had superficial blood collection all right in 13 this area. 14 Q. You describe the nerve and the 15 muscle as viable. 16 A. That means the color. The color, 17 appearance of the nerve and the muscle itself is 18 what you would expect normally. See, nerves 19 have kind of a very whitish-yellow tinge to it, 20 and that's the way this nerve looked. 21 The muscle is a -- a viable muscle 22 has a pink appearance, okay. This particular 23 muscle was still pink and, obviously, viable. 24 Muscle that dies has a black appearance, like 25 gangrene. That's a good way to look at it.</p>	<p style="text-align: right;">Page 47</p> <p>1 particular case would the wrist drop have 2 resulted from needle trauma? 3 A. It's hard to tell. 4 MR. RICHARDS: Same objection. 5 Continuing objection to this line. 6 A. If it bruises the nerve at all, that 7 could be probably the most likely, I would 8 think, a bruising of the nerve. 9 Q. Would you see bruising of the nerve 10 when you were in there? 11 A. You can't tell. This is going out 12 at a microscopic type level. 13 Q. So a viable nerve then wouldn't 14 speak to whether or not it was a bruised nerve? 15 A. Correct. 16 Q. And compression trauma, describe how 17 that would have occurred. 18 A. Compression trauma is not likely 19 because, in this particular area, the most 20 significant compression would be on the median 21 nerve more than the radial nerve, which would be 22 the problem with a wrist drop. So I think I'll 23 scratch that compression phenomenon. 24 Q. So, in your opinion, the most likely 25 cause of this was trauma from the venipuncture?</p>
<p style="text-align: right;">Page 46</p> <p>1 When it's black, or brownish -- that would be 2 probably even a better description, brownish -- 3 then that's a bad muscle. He had no evidence of 4 that. 5 Q. So your use of the word "viable" 6 then does not mean functionality as much as it 7 means color and appearance? 8 A. Right. 9 Q. What can you assume when you see 10 viable muscle and nerve tissue when you're in 11 there? 12 A. That it hasn't died. 13 Q. Do you have any opinion as to how 14 this wrist drop was caused? 15 MR. RICHARDS: Objection. 16 A. No. I mean, there's a couple ways 17 it could happen. But do I know exactly in his 18 particular instance why he has that? No. 19 Q. Tell me the couple of ways it could 20 have happened. 21 MR. RICHARDS: Same objection. 22 A. Could be needle trauma, could be 23 some compression trauma. Those would be 24 probably the two. 25 Q. If it was needle trauma, how in this</p>	<p style="text-align: right;">Page 48</p> <p>1 MR. RICHARDS: Objection. 2 A. My guess is, because the nerve was 3 not lacerated -- 4 Q. Right. 5 A. -- my guess is bruising of the 6 nerve. It makes the most sense. I don't think 7 anybody knows for sure. Maybe God knows. 8 Q. If the nerve was bruised, how was it 9 bruised if it wasn't lacerated? 10 A. You have a piece of spaghetti coming 11 along like this (indicating). If you go down 12 and you bang the piece of spaghetti but don't 13 cut it, there could be some trauma to the 14 spaghetti, but it's still intact. Does that 15 make sense to you? 16 Q. And that trauma would be enough to 17 cause permanent wrist drop? 18 A. It's hard to tell what goes on at a 19 microscopic level within a nerve. 20 Q. More likely than not, that would be 21 enough to cause permanent wrist drop? 22 MR. RICHARDS: Objection. 23 A. I can't say that. I would say it's 24 possible. 25 Q. You've enumerated that that's the</p>

<p>Page 49</p> <p>1 only thing that's possible when you stand back 2 and look at this case. 3 MR. RICHARDS: Objection. 4 Q. Because we've scratched compression 5 trauma. Is there any other theory other than 6 the nerve was bruised as the puncture was made? 7 A. That would be my -- that would be my 8 theory. Maybe a nerve specialist might have a 9 different theory. Maybe a neurosurgeon may have 10 a different theory. I don't know. 11 Q. Have you ever had a case where a 12 nerve was bruised and resulted in permanent 13 disability like this? 14 A. Have I particularly had a case or do 15 I know of a case? 16 Q. Particularly where you've worked, 17 surgically intervened in a case. 18 A. In this area of the body? 19 Q. Any area of the body. 20 A. Where penetrating things can cause a 21 nerve problem? Sure. 22 Q. Give me an example. 23 A. Sure. Aortic balloon pump. You put 24 those in through the femoral artery. Sometimes 25 there will be oozing. Sometimes from the trauma</p>	<p>Page 51</p> <p>1 when nerves have been injured, a lot of times 2 most neurosurgeons even would wait two to three 3 years before they decide whether you have 4 permanent versus nonpermanent nerve injury. 5 Q. Can you -- 6 A. So my guess is, to answer that 7 question, probably at least three, four years. 8 Q. Can you point me to any literature 9 that you rely on that a nerve being bruised like 10 that can result in permanent disability? 11 A. No. 12 Q. This is based on your practice and 13 what you've seen -- 14 A. Yes. 15 Q. -- as a vascular surgeon? 16 A. Correct. 17 Q. So, more likely than not, not to 18 beat this dead horse, the cause of Mr. 19 Hatfield's permanent wrist drop, assuming that 20 he continues to have permanent wrist drop, is 21 that the venipuncture traumatized and bruised 22 his radial nerve; is that correct? 23 MR. RICHARDS: Objection. 24 MS. DISILVIO: Objection. 25 Q. The radial nerve is what we're</p>
<p>Page 50</p> <p>1 of the balloon pump going in right adjacent to 2 the nerve, you get bruised up. When we do 3 carotid surgery, if there's a nerve -- a good 4 example is the nerve that comes right underneath 5 the chin. If we just stretch it a little bit, 6 just stretch it, it will be bruised up. And 7 patients get a little droop in the face which 8 usually resolves itself in about six to eight 9 weeks. Sometimes, sometimes, depending on the 10 severity of the bruising of the nerve, it can 11 last longer. 12 Q. Is this the first instance that you 13 know of where the bruising caused permanent 14 disability? 15 MR. RICHARDS: Objection. 16 A. I don't know in this instance if the 17 bruising caused permanent disability. 18 Q. Take my word that he continues to 19 have permanent wrist drop. Assume for this 20 deposition that he does have permanent wrist 21 drop. Have you ever seen a scenario where a 22 bruised nerve, as it heals, and I think you said 23 six to eight weeks, where the injury was 24 permanent, resulting in permanent disability? 25 A. Well, in fact, in my experience,</p>	<p>Page 52</p> <p>1 talking about; correct? 2 A. For wrist drop. 3 Q. Yes. 4 A. It would be radial nerve, correct. 5 Q. That's the most likely cause of his 6 permanent wrist drop? 7 A. I think it's a possible cause. 8 Q. I believe I asked you if there was 9 any other causes, and I believe you said no. 10 MR. RICHARDS: Objection. 11 MS. DISILVIO: And he also deferred 12 to a neurosurgeon and/or a neurologist. So with 13 that in mind, you may answer. 14 A. Yes. I mean, I would be -- that's 15 the answer. 16 Q. So that's it, when you look at this 17 injury, you would say in your practice that it 18 was the result of trauma to the radial nerve 19 caused by the venipuncture? 20 A. No. I think this patient had trauma 21 to the radial nerve. Whether it was caused by 22 the venipuncture, per se, it's a possibility. 23 Q. What else could have caused it? 24 MS. DISILVIO: Objection. If you 25 know.</p>

<p style="text-align: right;">Page 53</p> <p>1 MR. RICHARDS: Same objection. 2 A. That would definitely be it. 3 Q. That's what I thought you were 4 saying. So, as we're sitting here today, more 5 likely than not, as a vascular surgeon who 6 practices, you would say that Mr. Hatfield's 7 permanent wrist drop was as a result of -- 8 A. I question Mr. Hatfield's permanent 9 wrist drop because I do not know that Mr. 10 Hatfield has a permanent wrist drop. 11 Q. If what I'm telling you is wrong and 12 he does not have a permanent wrist drop, every 13 question I've asked you relative to this will be 14 moot, so it won't mean anything. But assume for 15 purposes of today that he continues to have 16 permanent wrist drop. 17 It's your belief that that was 18 caused as a result of bruising to the radial 19 nerve during the venipuncture? 20 A. That possibly could have been due to 21 bruising of the nerve at the time of the 22 venipuncture, yes. 23 Q. And -- 24 A. That injury, injury, quotations, to 25 the radial nerve could possibly have been --</p>	<p style="text-align: right;">Page 55</p> <p>1 A. Let's just cut to the chase on this. 2 MS. DISILVIO: Objection. If you 3 know. 4 A. All I can say is this: I do not 5 know exactly what needle Parma Hospital uses for 6 their routine phlebotomy. I am sure that they 7 probably have a routine needle that they use, 8 and I think the easiest way to find that out is 9 to ask them what they do. 10 Q. Which I shall, sir. 11 A. The person who drew the blood, just 12 ask them, what needle did you use. 13 Q. I intend to do that. 14 A. I think that would be good. That 15 would be a good thing. 16 Q. I'm asking you based on your 17 documentation, which is what I'm talking to you 18 about today. This is my one opportunity to get 19 your understanding what you mean by words like 20 "aberrant" and "16-gauge" because I don't want 21 to assume I know anything. That's why I'm 22 sitting here today. And Mr. Richards is going 23 to make the phlebotomy people available to me. 24 It's not a problem. 25 A. Okay.</p>
<p style="text-align: right;">Page 54</p> <p>1 occurred in a bruised fashion to the nerve at 2 the time of the venipuncture. 3 Q. Understanding that's true, is there 4 anything else that you can think of as we sit 5 here today? 6 A. No. I've answered that same 7 question four times now. 8 Q. Yes, you have. 9 A. And I have answered four times no. 10 Q. Thank you. 11 A. All right. 12 Q. It sounds to me from what you said 13 earlier that it's your understanding that 14 venipunctures are performed with larger gauge 15 needles rather than smaller gauge needles; is 16 that correct? 17 A. Yes, because I've had venipuncture, 18 and I'm sure -- have you had blood drawn? But 19 you wouldn't know. Yes, the gauge of the needle 20 is usually large, fairly large. 21 Q. And in a patient like Mr. Hatfield, 22 it would be normal phlebotomy to come up and 23 draw his blood with an 18- or 16-gauge needle; 24 is that correct? 25 MR. RICHARDS: Objection.</p>	<p style="text-align: right;">Page 56</p> <p>1 Q. Is there a principle in phlebotomy 2 as a vascular surgeon that you're aware of that 3 in elderly patients, patients in dialysis, in 4 coagulable states, heparinized, et cetera, that 5 it's prudent to use the smallest caliber needle 6 possible to do blood draws? 7 MR. RICHARDS: Objection. 8 A. No. I don't know of any principle 9 -- to cut to the chase again, when you draw 10 blood, what's very important is to draw what we 11 call a clean specimen, okay, so it's not 12 traumatized by the actual draw. The smaller the 13 gauge needle you do use, the greater the chance 14 you can traumatize the elements within the 15 blood. So you have to balance the two. 16 Q. So to use a -- 17 A. To make a long story short, what 18 policy Parma uses to draw blood from their 19 laboratory, I have no idea. 20 Q. If they used a 16-gauge needle to 21 draw from Mr. Hatfield, knowing his vasculature 22 the way you do, that would have been prudent 23 phlebotomy? 24 MR. RICHARDS: Objection. 25 MS. DISILVIO: Objection. If you</p>

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

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1 just whatever that is, would that phlebotomist
2 have seen something when she pulled the needle
3 in, out, around?
4 A. She's not a doctor. I don't know if
5 she -- I don't know.
6 Q. Would she have seen bright red blood
7 in her tube as opposed to --
8 A. My guess? My guess? Yes.
9 Q. What do you base that on?
10 A. Size of the hematoma.
11 Q. So you're saying that, had you been
12 at the bedside while she was doing that, just
13 doing your routine rounds, in all likelihood,
14 when she pulled back that needle, she would have
15 had bright red blood in her tube as opposed to
16 dark red blood?
17 A. It's not as simple as that.
18 Q. Okay.
19 A. It would be impractical to think
20 that the lab person would know in -- probably
21 impractical to think that they would know what
22 they did.
23 Q. My question is, though, would you
24 see bright red blood or venous blood in that
25 tube based on what you observed when you were in

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

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

<p>Page 61</p> <p>1 the puncture just went into the artery and then 2 came back out and it oozed. More often than 3 not, they usually just stop. 4 Just think of this. We draw blood 5 gases every day. Every day in the hospital, we 6 take needles and put them in arteries every day. 7 When I do x-rays of the artery circulation, 8 every day, I put a big needle in the artery. 9 Q. So in Mr. Hatfield's case -- 10 A. That's in an artery, though. 11 Q. Is this because of the two 12 lacerations that he had the large hematoma? 13 A. Oh, no question. Because, remember, 14 if we put this into a superficial vein, we don't 15 have this issue. Even if we put it into an 16 artery and we knew it and we put compression on 17 it above, right off the bat, like we do when we 18 do an arteriogram, we don't have these kind of 19 issues develop. Sometimes you do; about one in 20 a hundred arteriograms. 21 Q. So it's because the artery and the 22 vein were allowed to leak the fluid into the arm 23 that caused the hematoma; is that correct? 24 A. No. Artery and vein weren't allowed 25 to do anything. I mean, that's what occurred.</p> <p>Page 62</p> <p>1 Q. That's what occurred. 2 A. Nobody allowed it. Nobody allowed 3 this. Nobody wanted this, you know. 4 Q. But that's what caused the 5 hematoma -- 6 A. Yes. 7 Q. -- was the leaking from, and you 8 don't know whether it was the vein or artery? 9 A. No. I know it was both. 10 Q. It was both? 11 A. Because, remember, there was a 12 laceration in the vein, and there was a 13 laceration in the branch of the brachial artery. 14 Q. Now, we talked about whether or not 15 she would see anything in the tube. Would she 16 have felt anything that would have alerted her 17 that she was going through vessels? 18 A. No. I don't think a lay person 19 would know. 20 Q. Should a phlebotomist be trained to 21 know what they're feeling when they're 22 puncturing? 23 MR. RICHARDS: Objection. 24 A. I don't know their training routine. 25 You know, I do think that they would be taught</p>	<p>Page 63</p> <p>1 to stay superficial, yes. But I don't know. 2 Q. And we can assume from this injury 3 that it was not superficial? 4 A. Oh, absolutely not. This was not 5 superficial. 6 Q. So you would expect phlebotomists to 7 stay superficial; is that correct? 8 MR. RICHARDS: Objection. 9 A. Correct. 10 Q. Can you give us a depth, when you 11 say not superficial, or is it hard to say? I 12 mean, he was a very skinny man. Are we talking 13 like an inch, half-inch below where they should 14 have been superficially, or was it just right 15 behind the vein? 16 A. I can't give you that kind of 17 dimension. Again, I'll show you the arm. If 18 you go in the arm (indicating) and -- let me 19 see -- you see that vein right there? 20 Q. Yes. 21 A. That's superficial. 22 Q. Okay. 23 A. If you go -- if you stay right 24 underneath here, I would say about that depth 25 (indicating), you're superficial. If you go</p> <p>Page 64</p> <p>1 into that depth (indicating), now you're deeper. 2 Q. Would you say that if a phlebotomist 3 goes to that depth, that that's a violation of 4 prudent phlebotomy? 5 MR. RICHARDS: Objection. 6 A. I don't know what the phlebotomy 7 policy is, but it's not good policy to be deep. 8 Q. Do you have any phlebotomists 9 working here for you? 10 A. No. We don't draw blood here. 11 Q. But if a phlebotomist -- I'll ask 12 the phlebotomist. That sounds good. 13 A. Good. 14 Q. The word "compartment" comes up a 15 lot with this kind of injury, and it looks to me 16 like you said, and here again it may be a 17 syntactical error or I may be reading it 18 incorrectly, that you said that the compartment 19 was affected. 20 MS. DISILVIO: Which note are we 21 reading from? 22 MS. TRESL: Hold on. I'll get it 23 for you. 24 Q. First of all, what I want to ask you 25 before I do that, am I using the correct term;</p>
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<p style="text-align: right;">Page 65</p> <p>1 is that what we're referring to as the 2 compartment when we're talking about where the 3 hematoma was? 4 A. Yes. In a forearm situation like 5 this, the actual compartments of note are 6 actually what we call superficial compartments. 7 Deep compartment would be down deep near the 8 bone, per se, when we do the venipuncture thing. 9 In this area of the forearm, this area is 10 superficial, considered superficial 11 anatomically. 12 Q. When you're discussing compartment 13 in your notes, and we'll get to that in a 14 minute, and maybe you need to refer to it to 15 answer this question, but you're referring to 16 the superficial compartment, not the deep 17 compartment; is that correct? 18 A. Correct. 19 Q. Now we're going to spend a lot of 20 time on the progress notes and the orders, so if 21 you want to go to that, I would be grateful, and 22 I will ask you specifically when you took over 23 the care of Mr. Hatfield. If you need to leave 24 or counsel needs to leave at 7:00, let me know. 25 MS. DISILVIO: Did you say at 7:00?</p>	<p style="text-align: right;">Page 67</p> <p>1 Q. Have you ever noticed in an injury 2 like this where ice has decreased swelling? 3 A. Oh, absolutely. 4 Q. Can you point me to any literature 5 that supports that? 6 A. No. Twenty-five years of 7 experience. That's what I point to. 8 Q. You were consulted, it appears from 9 the orders, prior to 10:55 a.m. on August 6; is 10 that correct? 11 A. Where is that now? 12 Q. He wrote his consult on August 6 13 prior to 10:55 a.m.; is that correct? I think 14 you need the orders. 15 MS. DISILVIO: Are you asking about 16 the orders or the consult? 17 MS. TRESL: I'm asking if he agrees 18 that the request for his consult was August 6, 19 2002 prior to 10:55, and I am trying to point 20 him to where in the records I found it. And I 21 believe that was at -- 22 A. Oh, yeah. Here we go. It says Dr. 23 Bertin on consult. 24 Q. Can we agree that that was on August 25 6th?</p>
<p style="text-align: right;">Page 66</p> <p>1 A. We're going to spend five hours? 2 Q. We're going to go through the 3 questions until we get to the end. I'm just 4 saying if you need a break. 5 A. Where are we going now? Let's try 6 to speed this up a little bit. 7 Q. Progress notes. 8 MS. DISILVIO: I don't have to 9 leave. Dan, do you have to leave? 10 MR. RICHARDS: I have to leave at 11 about 6:15. 12 Q. If you need a break or need to stop, 13 just let me know. 14 A. Need a break? I'm trying to go the 15 other way. 16 Q. Great. It looks to me like the 17 first time that Dr. Chang notes this injury is 18 in his note on the 6th. It would be sometime 19 before 10:55 he orders ice for Mr. Hatfield's 20 injury. What's the purpose of putting ice on 21 this hematoma? 22 A. I don't know. It's good primary 23 care to -- when you have oozing from anywhere in 24 the body, ice is a reasonable thing. He's 25 trying to use ice to decrease swelling.</p>	<p style="text-align: right;">Page 68</p> <p>1 A. Correct. 2 Q. Can we agree that was prior to 10:55 3 a.m.? 4 A. Correct. 5 Q. Can we agree that the first time you 6 saw Mr. Hatfield on consult was the following 7 morning? 8 A. Correct. Because usually consults, 9 by tradition, what we do is, if we get a 10 consult, we usually -- it usually means within 11 24 hours. So we usually try to see it within 24 12 hours. 13 Q. Do you have any independent memory, 14 other than what's in the record, about being 15 called about the CAT scan that was done on 16 August 6th? 17 A. I don't have any independent 18 recollection. 19 Q. Do you, based on your records, have 20 it documented that you were made aware of the 21 CAT scan that was done on August 6th? 22 A. Do I have it documented? 23 Q. Can you see documented that you were 24 made aware of the CAT scan on August 6th? 25 MS. DISILVIO: Is there a particular</p>

<p style="text-align: right;">Page 69</p> <p>1 note you would like to reference him to in order 2 to save time? 3 Q. Sure. The nurse's notes on the 6th, 4 and I will even give you the nurse's note if you 5 would like. 6 A. Oh, this is 4:00 o'clock at night. 7 4:00 o'clock that day, aware of CT scan right 8 arm. That's what the nurse's notes say. 9 Q. You have no reason to dispute that 10 you were notified about the results of the CAT 11 scan? If the nurses document that, even though 12 you have no independent recollection of it, you 13 have no reason to doubt that that's correct, is 14 my question. 15 A. Yes. I mean, I don't recall 16 specifically being called about the CAT scan, 17 per se, but this is -- I mean, it's reasonable 18 to assume that, if they called me, that -- I 19 don't know. I don't recall specifically. I 20 mean, remembering 18 months later if I was 21 called about the CAT scan, I don't recall that. 22 Q. You have no reason, as you sit here 23 today, to believe that that may be some sort of 24 charting error? If they said that they called 25 you, then in all probability they did; is that</p>	<p style="text-align: right;">Page 71</p> <p>1 seen on CAT scan affect the management at all? 2 A. No. 3 Q. There's no hematoma that's 4 clinically significant size-wise in imaging that 5 makes you decide medical management versus 6 surgical management? 7 A. Correct. 8 MS. DISILVIO: You mean 9 radiologically significant versus clinical? 10 MS. TRESL: I'm talking about CAT 11 scan. 12 A. The CAT scan, per se, doesn't 13 dictate whether or not I would do surgery. 14 Q. The size of the hematoma by CAT 15 scan -- 16 A. That's why I wouldn't order a CAT 17 scan. 18 Q. The size of the hematoma was two by 19 five by eight centimeters. Is that of any 20 clinical significance size-wise? 21 A. I told you, I don't use a CAT scan 22 for size, dimension, in this type of 23 circumstance, period. I just don't use them. 24 Q. Can you tell me approximately for a 25 two by five by eight centimeter hematoma, how</p>
<p style="text-align: right;">Page 70</p> <p>1 correct? Like we talked about this syntax 2 error, you know. 3 A. I don't know. I mean, I don't know. 4 I just can't recall. I can't say one way or the 5 other, to be perfectly honest. I normally don't 6 order CAT scans for this kind of problem because 7 they're not that helpful. 8 Q. Why aren't CAT scans helpful for 9 this kind of problem? 10 A. Because it doesn't help us in 11 deciding on the management of the patient to get 12 a CAT scan. We already know we have some 13 swelling in the arm. We're hoping that by 14 elevation and rest and compression that it goes 15 down. The CAT scan doesn't help us one way or 16 the other decide, okay, now we have to go to 17 surgery or, okay, no, now we can wait. It 18 doesn't help us. 19 Q. So the size of the hematoma -- 20 A. So I would not have ordered a CAT 21 scan. 22 Q. I didn't ask if you ordered it. I 23 asked if you were made aware of the results. 24 You didn't order it, I don't believe. 25 Does the size of the hematoma as</p>	<p style="text-align: right;">Page 72</p> <p>1 big that would be? 2 A. Well, look at it this way: 2.5 3 centimeters, one inch. So two centimeters would 4 be about one inch, okay, one inch, and five 5 centimeters would be about a little over two -- 6 what -- a little over two inches. So one inch, 7 two inch. 8 Q. By eight centimeters? 9 A. So in this area here -- 10 Q. Yes. 11 A. Eight is probably length. That 12 doesn't mean anything, because look at how long 13 your arm is. 14 Q. Give me something -- 15 A. So eight centimeters is about 16 two-and-a-half inches. Five centimeters is -- 17 what would it be? 2.5 is an inch, so figure -- 18 Q. Can you give me something I can 19 visualize is about that size? Is it bigger than 20 a quarter? 21 A. I would say about the size of a -- 22 Q. Size of a dollar bill? 23 A. Not that -- a dollar bill won't help 24 you. 25 Q. Knowing that that's flat.</p>

<p style="text-align: right;">Page 73</p> <p>1 A. Which size are we talking about?</p> <p>2 Q. Two-by-five-by-eight.</p> <p>3 A. I would say about the size of a cue</p> <p>4 ball.</p> <p>5 Q. That would be round?</p> <p>6 A. That would be hard. This is more</p> <p>7 diffuse.</p> <p>8 Q. I'm sort of thinking like the size</p> <p>9 of a bar of soap.</p> <p>10 A. Okay.</p> <p>11 Q. I sort of measured it out.</p> <p>12 A. Probably not as big as a bar of</p> <p>13 soap. Maybe a small bar. Maybe one of those</p> <p>14 hotel bars, two of those. Two of those hotel</p> <p>15 bars.</p> <p>16 Q. Having a hematoma that size in the</p> <p>17 superficial compartment is not an area -- tell</p> <p>18 me when that size hematoma, understanding that</p> <p>19 size isn't the important factor, when is that of</p> <p>20 clinical significance? What do you see or</p> <p>21 observe that makes that of clinical</p> <p>22 significance?</p> <p>23 A. Rapid expansion.</p> <p>24 Q. Okay.</p> <p>25 A. Okay. If the patient has developed</p>	<p style="text-align: right;">Page 75</p> <p>1 hematoma?</p> <p>2 A. I'm not putting together any</p> <p>3 differential on the hematoma. He had the</p> <p>4 hematoma. I know that. There's no</p> <p>5 differential.</p> <p>6 Q. Differential for medical versus</p> <p>7 surgical management.</p> <p>8 A. The basic thing is, if it's not</p> <p>9 pulsatile and not expanding, we try to go with</p> <p>10 conservative management. Conservative</p> <p>11 management meaning elevation, rest, ice</p> <p>12 application.</p> <p>13 Q. How do you know if the hematoma is</p> <p>14 causing compression such that it's affecting the</p> <p>15 underlying structures, specifically the nerves?</p> <p>16 How do you know that -- what factors do you use</p> <p>17 to determine if there's, say, microcellular</p> <p>18 ischemia going on?</p> <p>19 A. It's a function of the hand</p> <p>20 neurologically.</p> <p>21 Q. And is there documentation in your</p> <p>22 record that you determined the functionality of</p> <p>23 his hand?</p> <p>24 A. Yes. When I say in my consult --</p> <p>25 when I said here the two issues that could</p>
<p style="text-align: right;">Page 74</p> <p>1 what we call a pulsatile aspect to it so it's</p> <p>2 kind of like -- we call it a pulsatile hematoma,</p> <p>3 that would be significant. Rapid expansion and</p> <p>4 pulsatile. Those would be the two.</p> <p>5 Q. What about an increase in pain over</p> <p>6 the area?</p> <p>7 A. That's subjective because everybody</p> <p>8 is different.</p> <p>9 Q. What about induration?</p> <p>10 A. Induration, that can help a little</p> <p>11 bit in just determining the severity, per se.</p> <p>12 But it's just one component, just one component.</p> <p>13 Q. What about redness?</p> <p>14 A. That doesn't help, because older</p> <p>15 people in particular, the skin can stretch out</p> <p>16 and it gets white and sometimes it will look</p> <p>17 kind of red, sometimes it will look purple.</p> <p>18 Have you ever seen an old person get a bruise?</p> <p>19 You know how the blood dissects out over the</p> <p>20 whole arm for just one tiny little bruise? So</p> <p>21 it's hard to predict.</p> <p>22 Q. An increase in pain from one day to</p> <p>23 the next is subjective and it doesn't have a</p> <p>24 great deal of clinical significance as you're</p> <p>25 putting together your differential on this</p>	<p style="text-align: right;">Page 76</p> <p>1 arise -- I mean not there. Where is it? For</p> <p>2 the present time, we're going -- let's go to my</p> <p>3 consult note. Are we on the same page?</p> <p>4 Q. Yes. We surely are.</p> <p>5 A. At the present time I cannot palpate</p> <p>6 a definite two-way aneurysm. That's what we're</p> <p>7 talking about, the pulsatile situation. The</p> <p>8 right arm hematoma was not in an expanding mode.</p> <p>9 So the basic treatment at that point</p> <p>10 is the elevation and the serial evaluation, as I</p> <p>11 said. The main issues here are compartment</p> <p>12 syndrome, which is certainly not present, by the</p> <p>13 way. It's not present. Compartment syndrome is</p> <p>14 certainly not present at this time. And the</p> <p>15 reason we make that determination is by the</p> <p>16 sensory exam, motor exam, the nerves, and the</p> <p>17 pulse exam. And by saying no compartment</p> <p>18 syndrome, all those examinations were normal.</p> <p>19 Q. Even though it does say that it</p> <p>20 certainly is present at this time?</p> <p>21 A. No. That is a typo. It is</p> <p>22 certainly not present. Compartment syndrome is</p> <p>23 certainly not present at this time. That's why</p> <p>24 I said that, has satisfactory distal flow, and</p> <p>25 the neurologic impairment -- there was no major</p>

<p style="text-align: right;">Page 77</p> <p>1 neurologic impairment. That's why I said 2 sensation is normal distally. If there was a 3 compartment syndrome, the usual first 4 manifestation would be by the -- possibly the 5 first manifestation could be by neurologic 6 impairment. 7 So, to make a long story short, my 8 note says the main issues here are compartment 9 syndrome. It says "certainly is present," but 10 there's a typo there. It should be "certainly 11 is not present." I think if you follow the 12 train of thought through the whole paragraph 13 there, it would be clear to you that "not 14 present" should be in there, not "present." 15 Q. When you're concerned about 16 compartment syndrome but you're trying to do 17 conservative management, is there a technique 18 that you can use to determine if the compartment 19 pressures are rising? 20 A. No. There's no accurate technique. 21 In the lower extremities in particular and major 22 trauma, sometimes we'll use a technique where 23 we'll measure compartment pressures, but in the 24 superficial compartment in the forearm, in a 25 case like this where you have a hematoma</p>	<p style="text-align: right;">Page 79</p> <p>1 A. Correct. 2 Q. On August 7th, you saw Mr. Hatfield 3 twice; in the morning, and then I think at 1337, 4 something like that. 5 A. Right. 6 Q. And you may not have any 7 recollection of this, you may have to refer to 8 your notes, but you said that when you saw him 9 at 1:30, that he was showing some improvement. 10 A. Yes. I think at that point that the 11 arm swelling that he had was actually going 12 down. I don't know where it is in the notes. I 13 actually thought the elevation was starting to 14 get a little better, which would have been good 15 because then we could avoid doing any surgery. 16 So we're on the 8-7 note. That's at 17 1:30 in the afternoon, and I thought at that 18 point that he was actually improving a little. 19 Q. Based just on looking at his arm -- 20 A. I think at that juncture, too -- I 21 don't recall this particular -- I think I talked 22 with Dr. Chang about this, too. So we thought 23 we were making some progress here with the 24 elevation and the ice application. 25 Q. Did it concern you then in the</p>
<p style="text-align: right;">Page 78</p> <p>1 develop, we normally wouldn't use it. We don't. 2 Q. Is that in your practice or in 3 vascular surgery pretty much in the community, 4 if you know? 5 A. Yes. I mean, I would assume that 6 it's pretty much in the community. I would 7 assume that. 8 Q. Would it have been possible for you 9 to have measured pressures in that area, in this 10 superficial -- 11 A. No, not really. There's no way to 12 determine the accuracy of it. So to do 13 something that -- it doesn't help you, a 14 positive or a negative. No, I wouldn't do it, 15 to make a long story short. 16 Q. The nurses document that he had less 17 pain if he kept his arm still on the 6th and the 18 7th. Can you explain that to me, why that would 19 be, if you can? 20 A. Did you ever twist your ankle? 21 Q. Yes. 22 A. If you keep it still, does it feel 23 better? 24 Q. Yes. That's the significance of 25 that?</p>	<p style="text-align: right;">Page 80</p> <p>1 evening when the nurses noted that his pain was 2 up to a nine and he had to go from Darvocet to 3 Vicodin? Was that significant clinically? 4 A. No. Like I said, pain is a 5 subjective thing. When you change a nursing 6 shift, now you got two subjective things that 7 come into it. So, to be perfectly honest, no, 8 that wasn't a major deal breaker, so to speak. 9 It wasn't a major issue. 10 Q. Did it shift your -- 11 A. Usually my -- I don't recall that 12 phone conversation, but usually what I would do 13 in that situation is probably make sure that 14 they're elevating it higher and -- like I don't 15 recall for sure, but I think we were on pillows 16 at first, and then I had them put it up on an IV 17 pole, which is actually better elevation, 18 because the higher the better. 19 Q. The fact that the pain went from 20 four to nine and required Vicodin versus 21 Darvocet, in your mind, could be explained by 22 the fact that the shift changed and the pain is 23 subjective? 24 A. Yes. The difference between 25 Darvocet and Vicodin is not huge.</p>

<p style="text-align: right;">Page 81</p> <p>1 Q. The difference between a pain level 2 of four and nine? 3 A. Yes. I mean, it's very subjective. 4 That's a very subjective measurement. 5 Q. On, I believe the 7th, you and Dr. 6 Chang consulted and agreed on local treatments 7 and antibiotics. I believe that that was the 8 note. 9 A. No. I never -- he wrote 10 antibiotics. I don't remember discussing 11 antibiotics. He was comfortable with, and I 12 would assume even I was comfortable with, the 13 conservative management, which was the elevation 14 and the rest. 15 Q. There is a note in here, hematoma 16 versus cellulitis. Was there any question in 17 your mind that this was a cellulitis? 18 A. No. 19 Q. So you always thought it was a 20 hematoma? 21 A. This was a hematoma. 22 Q. The antibiotics were not something 23 you disagreed with, but you didn't think that 24 they were going to help the hematoma? 25 A. I didn't order it.</p>	<p style="text-align: right;">Page 82</p> <p>1 Q. Correct, but you didn't say -- 2 A. That's the answer. 3 Q. It looks as if in the consult note 4 that it wasn't until he had difficulty with 5 dorsiflexion of his wrist that you decided to 6 evacuate the hematoma. 7 A. No. 8 Q. We can find that in the records. 9 No? 10 A. No. What made me do this was two 11 things. 12 Q. Yes. 13 A. When I went in on 8-8, he started to 14 have -- and he was pretty clear about this, he 15 felt decreased sensation right here 16 (indicating). And he also, when I had him just 17 try to go like that, he said he couldn't do it 18 as well as before, okay. It's what we call 19 apposition test. 20 So at that point, my feeling was 21 that I'm concerned that he could have had median 22 nerve involvement. So in that finding, plus the 23 fact that he was going to be undergoing -- 24 remember, he was in chronic renal failure. So 25 if they had to put him on dialysis again, he</p>	<p style="text-align: right;">Page 83</p> <p>1 would get heparin. So with that combination, 2 with this hematoma, that's what made the 3 decision for surgery. 4 Q. That's interesting, because you 5 parsed out for us earlier median versus radial. 6 Radial is wrist drop. Assuming he has wrist 7 drop, that's only radial involvement; is that 8 correct, or it's mostly radial involvement? 9 MR. RICHARDS: Objection. 10 MS. DISILVIO: Objection. 11 A. Wrist drop is radial, correct. 12 Q. And the median, you're saying you're 13 seeing some median nerve involvement? 14 A. Clinically. Clinically. 15 Q. If the median nerve had been 16 traumatized or harmed, let's say, from the 17 hematoma, what would you have seen afterwards? 18 You would not have seen wrist drop; is that 19 correct? 20 A. Right. If the median nerve were, 21 say, compressed, or something on that order, if 22 the median nerve -- yes, that affects a 23 different area of the hand. It affects the 24 ability of the hand to oppose the thumb and 25 forefinger and that type of thing.</p>	<p style="text-align: right;">Page 84</p> <p>1 Q. Just by virtue of the injury he 2 ended up with, we can rule out the fact that the 3 median nerve had been compressed, assuming that 4 he has permanent wrist drop; is that correct? 5 A. No. No. We can assume this, 6 absolutely. The median nerve is normal in this 7 patient. That's what we can assume. So there 8 was really -- whatever sensory feelings he was 9 having were resolved when the hematoma was 10 removed in the median nerve area. 11 Q. This brings me back to when we were 12 discussing the anatomy in the antecubital. Was 13 it the radial nerve that was traumatized when 14 the stick went in? 15 MR. RICHARDS: Objection. 16 A. I don't know that for sure. All I'm 17 saying is that that's a possibility. 18 Q. The radial nerve was close enough in 19 that little area where it could have been 20 traumatized? 21 A. The radial nerve is in a different 22 area. Median nerve is right here, next to the 23 artery. 24 Q. Okay. 25 A. Radial nerve is back over here</p>
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1 (indicating).
2 Q. But if he has permanent wrist drop,
3 can we say then it's a radial nerve injury?
4 A. That's what a wrist drop implies,
5 yes.
6 Q. How would we get the radial nerve
7 injury from an aberrant needle puncture or from
8 this needle puncture?
9 MR. RICHARDS: Objection.
10 Q. Just talking anatomically. Would
11 that have been a third injury? How did the
12 wrist drop occur then?
13 MR. RICHARDS: Objection.
14 A. Wrist drop implies radial nerve
15 injury.
16 Q. Got you.
17 A. How the radial nerve injury
18 occurred, I can't tell you, but I can say that
19 it's possible there could have been bruising of
20 the radial nerve at the time of the
21 venipuncture, yes.
22 Q. That was my question, because you
23 said it was a little farther over, but it's
24 possible.
25 A. Yes.

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

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1 Q. Have you ever had a hematoma of this
2 size in a forearm --
3 A. Resolve?
4 Q. Yes.
5 A. Oh, yeah.
6 Q. What did you do for that?
7 A. Absolutely. Just elevate, and over
8 time it just kind of dissects out and resolves.
9 Q. Have you ever had one where you had
10 to take them to surgery?
11 A. Mr. Hatfield.
12 Q. Other than.
13 A. Yes. I've had other hematomas.
14 I've had -- you know, we do a lot of hematoma
15 repairs after cardiac cath, you know, when the
16 artery leaks. I've taken some of those to
17 surgery, sure. Probably do that about four or
18 five times a year.
19 Q. When you pulled this hematoma out,
20 it's interesting that --
21 A. You don't really pull it out.
22 Q. That was my question. It comes out
23 all -- it's not encapsulated?
24 A. You scoop it.
25 Q. You scoop it.

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1 A. It's like Jello. Best way to look
2 at it.
3 Q. Pathology said there were five to
4 six milliliters of blood, so that isn't the
5 whole clot. Some of it must have spilled out?
6 A. You can't put any credence on any of
7 the pathology measurements of blood or anything
8 like that. So don't waste the time.
9 Q. So it's not something that you would
10 even consider measuring the compartments in his
11 antecubital area for compartment syndrome; it's
12 totally based on the -- is that finger
13 extension? Is that what that's called?
14 A. It's based on overall clinical exam,
15 mainly.
16 Q. Did anyone examine him in the
17 evening on the 7th to see if he could still do
18 what you had just done by touching your fingers
19 together?
20 A. Oh, I don't know.
21 Q. When you left at 1:30 on August 7th,
22 he was able to do that?
23 A. Yes. But like I'm telling you, the
24 important issue here is, when I came in on the
25 8th, he has some sensation diminution in the

<p>Page 89</p> <p>1 hand, and he was going to require dialysis 2 session. Those two were the reasons that 3 changed the management from conservative 4 elevation and observation to evacuation. 5 Q. And had he just been facing 6 hemodialysis but not the change in this, you 7 would not have taken him to surgery? 8 A. That would have been tough. I 9 probably would have seen him early in the 10 morning that day, and if he wasn't going on 11 dialysis and going to get a heparin dose and 12 things like that, if that wasn't looming there 13 as part of the problem, I might have waited a 14 few more hours yet because this could have 15 resolved, but probably not. Most likely -- but 16 the dialysis thing is in combination. It's not 17 like everything is separate. It's all in 18 combination. The combination of clinical 19 factors are what leads to the surgery. 20 Q. And the hematoma really had nothing 21 to do then with the permanent wrist drop; is 22 that correct? 23 MR. RICHARDS: Objection. 24 A. I would -- no. I think the presence 25 of the hematoma, per se, probably had nothing to</p>	<p>Page 90</p> <p>1 do with it. In fact, to be perfectly honest, if 2 the hematoma was the major problem, as far as 3 any nerve issues go, the median nerve would have 4 been more of an issue. And we have, you know, 5 he didn't have any median nerve dysfunction. 6 MS. TRESL: Let me defer to Mr. 7 Richards for a little bit, see if he has any 8 questions. Let me look through my notes, and I 9 will come back. 10 MR. RICHARDS: Just a few questions, 11 doctor. 12 EXAMINATION OF VINCENT J. BERTIN, M.D. 13 BY MR. RICHARDS: 14 Q. Doctor, you were asked a lot of 15 questions about the gauge of the needle. Let me 16 make sure I understand what I think you were 17 trying to say, which is that you didn't mean to 18 indicate anything significant by use of the word 19 16-gauge. You were, instead, just throwing out 20 the type of gauge needle that you think may be 21 used by the phlebotomy department. 22 A. Correct. 23 Q. Is that fair? 24 A. Correct. 25 Q. As far as you know, you're not</p>	<p>Page 91</p> <p>1 really certain what type gauge needles they use 2 over at Parma Hospital in the phlebotomy 3 department, the exact gauge? 4 A. No. Actually, as of like today or 5 as of a year ago or two years ago, no. No. I 6 don't know the exact gauge, no. 7 Q. You don't mean to indicate anything 8 significant in regards to 16 versus 18 or 21 or 9 24 even; you were just trying to indicate that 10 you thought that there was a venipuncture from a 11 needle similar to the type used by the 12 phlebotomy department? 13 A. I mean, I don't -- the 16-gauge 14 portion, I don't even -- I don't know what 15 significance to make of that. I mean, to get to 16 this answer, why don't we just ask the lab what 17 needle they used. 18 Q. Let me ask you this. I don't want 19 to belabor points. I just want to make sure 20 that what you were saying and my understanding 21 are the same thing. 22 The other thing it sounded like you 23 said is, all your testimony here today on the 24 fact that this was -- the hematoma resulted from 25 a venipuncture is based upon assumptions, quite</p>	<p>Page 92</p> <p>1 possibly reasonable assumptions, but not 2 actually witnessing the puncture, first of all? 3 A. Right. 4 Q. Not witnessing -- or not having a 5 discussion with somebody, or at least not 6 recalling a discussion that you had with anybody 7 saying this is from a venipuncture? 8 MS. DISILVIO: Not recalling or not 9 having? That's two questions. 10 Q. Let me break it down. You don't 11 have any specific recollection of talking to 12 anyone who told you, Dr. Bertin, this is from a 13 venipuncture? 14 A. No. I did not have any recollection 15 of that. 16 Q. And you said repeated times today, 17 you didn't see the venipuncture, you weren't 18 there? 19 A. Correct. 20 Q. So what you're saying is, based upon 21 your observation, this is what you're assuming 22 caused this situation? 23 A. Yes. To be perfectly honest, I 24 don't understand why this is a big issue. We 25 know the lab went in there and they drew some</p>
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<p style="text-align: right;">Page 93</p> <p>1 blood.</p> <p>2 Q. I understand, and I agree. I just</p> <p>3 want to make sure we're clear. You're saying</p> <p>4 it's based on what you saw and what you heard,</p> <p>5 but I think what I understand you're saying is</p> <p>6 it's not necessarily even anything you heard.</p> <p>7 You're just basing it on an assumption. You</p> <p>8 walk in, you see what you see, and you made an</p> <p>9 assumption. It may be a reasonable assumption,</p> <p>10 but it was just an assumption. Is that fair?</p> <p>11 MS. DISILVIO: Objection.</p> <p>12 A. Yes. I guess from a legal</p> <p>13 standpoint, whatever you want to call it, it's</p> <p>14 probably an assumption.</p> <p>15 Q. What I'm saying is, you don't</p> <p>16 remember any of --</p> <p>17 A. If I didn't eyewitness it, it's an</p> <p>18 assumption.</p> <p>19 Q. And you didn't hear it either?</p> <p>20 MS. DISILVIO: Objection. I think</p> <p>21 he said he doesn't recall.</p> <p>22 A. Right. I don't recall. I just</p> <p>23 don't recall.</p> <p>24 Q. That's all. That's what I'm saying.</p> <p>25 You indicated that when you first</p>	<p style="text-align: right;">Page 95</p> <p>1 A. No. I think the nursing care was</p> <p>2 fine.</p> <p>3 Q. Can I ask you that in regards to all</p> <p>4 the nursing care; do you feel that all the</p> <p>5 nursing care was fine in regards to the</p> <p>6 treatment of this patient?</p> <p>7 A. Yes. I have no issue with that.</p> <p>8 Q. Is it fair to say, and this is my</p> <p>9 understanding, but let me know if this is a fair</p> <p>10 comment, that an accepted risk of</p> <p>11 venipuncture -- or I'm sorry -- an accepted risk</p> <p>12 of drawing blood in this area is that you may</p> <p>13 hit an artery on occasion?</p> <p>14 A. I would say it's a possible risk you</p> <p>15 can hit an artery during a venipuncture. It</p> <p>16 doesn't -- let's face it, it doesn't happen</p> <p>17 often.</p> <p>18 Q. But it happens?</p> <p>19 A. It can happen. It can happen.</p> <p>20 Q. And it can happen without anybody</p> <p>21 doing anything wrong?</p> <p>22 A. You can walk out and get hit by a</p> <p>23 car. It can happen.</p> <p>24 Q. But what I'm saying is, it can</p> <p>25 happen without somebody doing something wrong,</p>
<p style="text-align: right;">Page 94</p> <p>1 saw the hematoma and you first started</p> <p>2 indicating how you wanted the hematoma treated,</p> <p>3 you wanted to do it in a conservative manner;</p> <p>4 right?</p> <p>5 A. Conservative means we're trying to</p> <p>6 avoid an operation.</p> <p>7 Q. Right.</p> <p>8 A. In an elderly multi-organ failure</p> <p>9 type of patient.</p> <p>10 Q. So elevation.</p> <p>11 A. Yes.</p> <p>12 Q. Elevation and ice packs?</p> <p>13 A. It has to be strict elevation, too.</p> <p>14 I think that's why we changed it from a couple</p> <p>15 pillows to higher than this so we could get even</p> <p>16 maximum elevation.</p> <p>17 Q. Gradually up on to the IV pole?</p> <p>18 A. Exactly.</p> <p>19 Q. And ice packs?</p> <p>20 A. Yes, exactly.</p> <p>21 Q. That was done, as far as the records</p> <p>22 indicate; isn't that fair?</p> <p>23 A. Yes.</p> <p>24 Q. You don't have any criticism of the</p> <p>25 nursing care in regards to that?</p>	<p style="text-align: right;">Page 96</p> <p>1 without somebody deviating from a standard?</p> <p>2 A. I don't know what the standard is.</p> <p>3 You know, that's the -- I don't know.</p> <p>4 Q. As far as the bruising you described</p> <p>5 of a radial nerve, or trauma to a radial nerve,</p> <p>6 if a radial nerve receives the kind of trauma</p> <p>7 that you're describing, would you expect an</p> <p>8 immediate onset of symptoms stemming from that?</p> <p>9 A. No. The problem with the nerve</p> <p>10 thing is you just can't tell sometimes.</p> <p>11 Sometimes you can have a nerve injury with a</p> <p>12 delayed manifestation clinically. Sometimes it</p> <p>13 can be immediate. Usually, if you have a total</p> <p>14 laceration of the nerve or, I mean, sometimes,</p> <p>15 even then, if you had a partial laceration of a</p> <p>16 nerve, for example, or a bruising of the nerve,</p> <p>17 the manifestation could come on delayed, it</p> <p>18 could come on immediately. It's hard to tell.</p> <p>19 There's no way to predict that. Ask the</p> <p>20 neurosurgeon. He'll tell you.</p> <p>21 Q. That's a good point. You're not a</p> <p>22 neurosurgeon; right?</p> <p>23 A. That's correct.</p> <p>24 Q. You noted in your operative note</p> <p>25 that there is no compression on the median nerve</p>

<p style="text-align: right;">Page 97</p> <p>1 itself directly from the hematoma. Is that a 2 fair statement of your operative note? 3 A. No. I mean, I don't know if I -- 4 oh, no actual compression on the median nerve 5 itself directly from the hematoma, right. 6 Q. The significance of that is, I think 7 you were saying, that would lead to your 8 conclusion that there was no median nerve 9 injury? 10 A. It just meant that the sensation and 11 the motor dysfunction that I saw in the hand -- 12 I mean, you couldn't tell from -- again, you 13 have to remember this, that nerve could have 14 been bruised somewhat and then it -- if you 15 think of it microscopically in the nerve, you 16 get some diminution in nerve impulses, it gives 17 you a little decreased sensation, and all of the 18 sudden, when you evacuate this, even without 19 severe compression, it suddenly gets better. 20 Q. There's no indication of any 21 compression on the radial nerve either in your 22 note, is there? 23 A. No. Most of the hematoma was pretty 24 far away from the radial nerve region, so I 25 don't think that was too much of an issue.</p>	<p style="text-align: right;">Page 99</p> <p>1 Q. But you said it could stop and start 2 and stop and start up again? 3 A. Oh, sure. 4 Q. Do you have any criticisms of Parma 5 Hospital employees in this case? 6 MS. DISILVIO: Other than what he 7 said about phlebotomy? 8 Q. I don't know if that was a 9 criticism. He said he thinks it may have been 10 from the stick. 11 A. I just don't think you should hit an 12 artery with a needle stick. It shouldn't be 13 deep; it should be superficial. I don't know 14 any other way to say that. 15 Q. But as far as that, though, I think 16 you already testified you're not sure as to what 17 the standards and practices are as to how deep a 18 phlebotomist can go; right? 19 A. Yes. I don't know what their 20 protocol is, but I do know that, you know, 21 you're not supposed to hit an artery. 22 Q. Well, nobody wants to hit an artery. 23 A. Well, unless you need to hit it. I 24 hit arteries every day. 25 Q. Well, that's another thing. You've</p>
<p style="text-align: right;">Page 98</p> <p>1 Q. If you had seen compression on the 2 radial nerve, is that something you would 3 normally note? 4 A. I mean, I couldn't tell that one way 5 or another. 6 Q. How quickly would you expect the 7 onset of a hematoma after a blood draw where you 8 stick an artery? 9 A. It's hard to predict that. Hard to 10 predict because sometimes it could bleed a fair 11 amount and stop; bleed some more, stop; bleed 12 some more, stop. Sometimes it will just expand 13 out and just never stop. 14 Q. Is it the kind of thing that you 15 might expect to see normally, though, within a 16 few hours? 17 A. Like I said, you can't tell. 18 Everybody is different. 19 Q. Could it be a matter of over a day? 20 MS. DISILVIO: Objection. Asked and 21 answered. You can answer again. 22 A. I mean, it's just -- it's very -- 23 Q. I just want to know. 24 A. No. There's no -- how should I 25 say it -- there's no absolute formula.</p>	<p style="text-align: right;">Page 100</p> <p>1 also indicated that you sometimes intend to hit 2 an artery; right? 3 A. Absolutely. 4 Q. There's nothing in and of itself 5 problematic about hitting an artery? 6 A. Oh, yes, there is. 7 Q. There's situations in which you 8 intend to go into an artery? 9 A. Yes. Remember, when we're doing a 10 test on an artery or drawing something from an 11 artery, then we'll do extra measures to stop the 12 artery. I mean, I put catheters in arteries 13 every day almost as big as the pen tip or as big 14 as this portion here, but we stop that. 15 Q. With compression? 16 A. Yes, whatever. 17 Q. In your note where you indicated 18 there was a brachial vessel lacerated by a 19 previous venipuncture in your operative note, 20 there was some discussion over what you meant by 21 previous. 22 A. Yes. I know. Again, it's a word 23 situation. 24 Q. Could that just have meant prior to 25 your operation?</p>

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

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1 several questions about the size gauge of the
2 needle. Is the size gauge of the needle at all
3 pertinent to your evaluation of this patient
4 from a vascular surgery perspective?
5 A. No.
6 Q. When we talk about mechanism of
7 injury in this case, is the size of the needle
8 hub of any significance?
9 A. Not in the end result, no.
10 Q. Would you tell us, please, based
11 upon your observation, what you believe the
12 injury was and how you believe the mechanism of
13 injury occurred.
14 MR. RICHARDS: Objection.
15 A. Well, the injury is well described
16 in my operative note. Branch of radial artery
17 lacerated, branch of the vein -- I mean, a deep
18 vein, lacerated.
19 Q. When we heard so much about hitting
20 the artery, when you talk about the branch of
21 the vein that was lacerated and the branch of
22 the artery that was lacerated, is that separate
23 from hitting the artery?
24 A. Like I say, the main artery, if you
25 look at my operative note, the main artery was

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

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1 MS. TRESL: Can you put on there
2 where the radial nerve and median nerve is.
3 THE WITNESS: Median nerve would be
4 over in this region. Radial nerve is a distance
5 away from there. In terms of the arm anatomy
6 itself, probably about down here. That's a
7 pretty good distance. It's conceivable, it's
8 possible.
9 MS. TRESL: Can you write that
10 that's median and that's radial. It will make
11 it easier, so when we're reading the transcript
12 we'll know what you're saying.
13 THE WITNESS: Okay. Median.
14 MS. TRESL: And then the branches
15 and everything that you did.
16 THE WITNESS: Nerve, and brachial
17 branch.
18 MS. TRESL: That's of the vein; yes?
19 THE WITNESS: It's brachial
20 branches, arterial branch.
21 MS. TRESL: Okay.
22 THE WITNESS: And the laceration of
23 the vein area was right, you know, adjacent to
24 the artery here, so that would be right about
25 there. Remember, in a human body, you got the

<p style="text-align: right;">Page 105</p> <p>1 artery, two veins, pretty much everywhere you 2 go. 3 BY MS. DISILVIO: 4 Q. You asked several questions about 5 assumptions. Dr. Bertin, I take it that when 6 you see a patient, whether or not you recall 7 what you heard 18 months ago, it's your custom 8 and practice to talk to the nursing staff? 9 A. Yes. I mean, if my general custom 10 is -- I mean, I deal with nursing staff every 11 day in every department. 12 Q. Certainly when you come in to see a 13 patient, you talk to the nurse about patient 14 status, how they're doing while you're there? 15 A. My guess is, this whole venipuncture 16 issue, I'm sure I was told by the nurses that it 17 was a venipuncture at some point. I'm sure of 18 it. It just doesn't make any sense that I 19 wouldn't be. 20 Q. You spoke with Dr. Chang about this 21 case? 22 A. Yes. We talked about this. 23 Q. You actually came up with a plan for 24 expected management? 25 A. Exactly. Everybody seemed to be</p>	<p style="text-align: right;">Page 107</p> <p>1 Q. And certainly the note you pointed 2 out to Ms. Tresl indicated the onset of injury 3 or pain or edema to the antecubital fossa is 4 about 5:28 in the morning on August 6th; right, 5 the note that you showed her -- 6 A. Yes. 7 Q. -- based on her request? 8 A. Yes. 9 Q. All right. Are you licensed to 10 practice medicine? 11 A. Yes. 12 Q. Do you spend greater than 50 percent 13 of your professional time in the active clinical 14 practice of medicine? 15 A. Yes. 16 MS. DISILVIO: I don't have anymore 17 questions. 18 MS. TRESL: A couple things and 19 we'll be done. 20 FURTHER EXAMINATION OF VINCENT J. BERTIN, M.D. 21 BY MS. TRESL: 22 Q. Is it possible hypothetically that, 23 even though you did not see any compression on 24 the median nerve, that there could have been 25 ischemia that you would not have been able to</p>
<p style="text-align: right;">Page 106</p> <p>1 comfortable with that. 2 Q. Certainly you talked about what it 3 was you were managing in terms of the injury 4 with Dr. Chang, albeit you don't remember the 5 particulars of the conversation? 6 A. Yes. 7 Q. Certainly you talked about what you 8 were doing and why you were doing it? 9 A. Correct. 10 Q. It's not as though you made up, or 11 practice according to assumptions; you practice 12 based on what you hear, what you know, your 13 clinical information, your discussions with 14 nurses and your discussion with physicians; 15 true? 16 A. Yes. The other issue is, in a case 17 like this, too, is serial evaluation. 18 Q. All right. 19 A. You follow a problem over time. 20 Q. What time are morning labs typically 21 drawn? Somewhere between 5:00 and 6:00 in the 22 morning? 23 A. Yes. I would assume that. I see 24 them in the elevators so, yes, I would say 25 between 5:00 and 7:00 for sure.</p>	<p style="text-align: right;">Page 108</p> <p>1 visualize? 2 A. No. I mean, it's not likely. It's 3 possible, not likely. Very unlikely. In fact, 4 it would be very unlikely. 5 Q. Why would it be very unlikely? 6 A. Because there wasn't -- you know, 7 there wasn't any other evidence of, like we were 8 talking about before, muscle problem, any other 9 soft tissue, fat necrosis, none of that type of 10 situation. So you don't have enough pressure to 11 be causing those issues. 12 Q. If further down the road, just 13 hypothetically tested, he had proof that he did 14 have some median nerve damage, is it possible 15 that it could have been caused from the 16 compression of the hematoma if we look backwards 17 to that? 18 A. No. I mean, Mr. Hatfield has 19 numerous reasons to have -- he has renal 20 failure, all sorts of other issues that could 21 give him peripheral neuropathies. 22 Q. Which would be the same as median 23 nerve? 24 A. Median nerve, it could be radial 25 nerve neuropathies. I mean, this gentleman has</p>

<p style="text-align: right;">Page 109</p> <p>1 a lot of issues.</p> <p>2 Q. Back to the lab. Very briefly we'll</p> <p>3 revisit and we will be done.</p> <p>4 Although Mr. Richards asked you if</p> <p>5 artery puncture is a risk, it is my</p> <p>6 understanding that in order to have punctured</p> <p>7 the artery or that vein, that the puncture was</p> <p>8 more than superficial; correct?</p> <p>9 MR. RICHARDS: Objection.</p> <p>10 A. Yes. I mean, it would have to be.</p> <p>11 Yes, it would have to be.</p> <p>12 Q. And reasonable and prudent</p> <p>13 phlebotomy is not deep; it's superficial;</p> <p>14 correct?</p> <p>15 MR. RICHARDS: Objection.</p> <p>16 A. I'm not sure what they're --</p> <p>17 normally when you're doing venipuncture</p> <p>18 phlebotomy, you don't hit an artery.</p> <p>19 Q. In discussing the picture and the</p> <p>20 areas of injury, is it more likely than not that</p> <p>21 it's one needle that got stuck and just wiggled</p> <p>22 all around looking for the vein, or is it more</p> <p>23 likely that it was boom, boom, boom, three</p> <p>24 needles, four needles? Can you say, based on</p> <p>25 what you saw when you got in there?</p>	<p style="text-align: right;">Page 111</p> <p>1 Q. I understand. If we determine the</p> <p>2 gauge of the needle, the bigger the needle, the</p> <p>3 more trauma if it's being wiggled?</p> <p>4 A. Correct.</p> <p>5 Q. Finally, anything that you remember</p> <p>6 that we, the three of us, have not thought to</p> <p>7 ask you?</p> <p>8 A. How could we possibly have missed</p> <p>9 anything?</p> <p>10 Q. Anything you remember, though, about</p> <p>11 those three days maybe that we've not brought up</p> <p>12 that --</p> <p>13 A. Like I say, I just think that, you</p> <p>14 know, in a patient with as many medical problems</p> <p>15 as this guy, Mr. Hatfield has -- remember, I</p> <p>16 took care of this guy for 13 years. When I got</p> <p>17 sued, to be perfectly honest, that really set me</p> <p>18 back a little bit.</p> <p>19 You know, we're trying to avoid a</p> <p>20 surgery, trying to get him through the medical,</p> <p>21 you know, the problem here without having to lay</p> <p>22 open his arm, but it wasn't meant to be.</p> <p>23 MS. TRESL: I'm done. Thank you,</p> <p>24 doctor.</p> <p>25 MS. DISILVIO: I have a couple more.</p>
<p style="text-align: right;">Page 110</p> <p>1 A. I can't tell with certainty when I</p> <p>2 got in there. I think the -- I couldn't tell.</p> <p>3 I mean, really, it doesn't matter too much when</p> <p>4 you think about it because if you go in just</p> <p>5 once through the skin and jab around versus -- I</p> <p>6 mean, how would you know that? You wouldn't</p> <p>7 know. The only person that would know that is</p> <p>8 the person who did it.</p> <p>9 Q. I guess based on visualizing, just</p> <p>10 more likely than not kind of where they hit</p> <p>11 it --</p> <p>12 A. Like anything else, just think of</p> <p>13 this, if you're a phlebotomist, once you get</p> <p>14 through the skin, that's the most painful part</p> <p>15 to the patient. So if you redirect, that would</p> <p>16 be probably as likely as anything, I would</p> <p>17 think.</p> <p>18 Q. Would you say that it seems</p> <p>19 intuitive that a 16-gauge or an 18-gauge being</p> <p>20 wiggled around in there, assuming that was how</p> <p>21 this was injured, would be more traumatic than a</p> <p>22 20- or a 22-gauge?</p> <p>23 A. A bigger needle would be more</p> <p>24 traumatic, yes. But, again, I have no knowledge</p> <p>25 of what gauge needle, to be perfectly honest.</p>	<p style="text-align: right;">Page 112</p> <p>1 FURTHER EXAMINATION OF VINCENT J. BERTIN, M.D.</p> <p>2 BY MS. DISILVIO:</p> <p>3 Q. Doctor, you're not a neurosurgeon;</p> <p>4 correct?</p> <p>5 A. Correct.</p> <p>6 Q. You're not a neurologist; correct?</p> <p>7 A. Correct.</p> <p>8 Q. And as it relates to issues on</p> <p>9 causation, obviously, you would defer to those</p> <p>10 specialties to talk about nerve injuries and the</p> <p>11 cause therefore?</p> <p>12 A. Correct.</p> <p>13 MS. DISILVIO: Thanks.</p> <p>14 -----</p> <p>15 (Thereupon, PLAINTIFFS' Deposition</p> <p>16 Exhibit 1 was marked for purposes</p> <p>17 of identification.)</p> <p>18 -----</p> <p>19 (Deposition concluded at 5:00 o'clock p.m.)</p> <p>20 (Signature not waived.)</p> <p>21 -----</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>

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E X H I B I T S

PLAINTIFFS' Deposition
Exhibit 1 was marked 112

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

Notary Public

My commission expires _____

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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, Notary Public
Within and for the State of Ohio

My commission expires October 7, 2004.

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