

IN THE COMMON PLEAS COURT

STARK COUNTY, OHIO

- - -

SANDRA J. SHONK, et al.,)

Plaintiffs,)

vs.)

No. 2003CV000056

DOCTORS HOSPITAL OF STARK)
COUNTY, et al.,)

Defendants.)

- - -

Deposition of DANIEL J. CAIN, D.O., a Defendant
herein, called by the Plaintiffs for cross-examination,
pursuant to the Rules of Civil Procedure, taken before me,
the undersigned, Stephanie R. Dean, a Stenographic
Reporter and Notary Public in and for the State of Ohio,
at the offices of Daniel J. Cain, D.O., 123 Third Street,
S.E., Massillon, Ohio, on Monday, the 15th day of
September, 2003, at 11:10 o'clock, a.m.

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1 APPEARANCES:

2 On behalf of the Plaintiffs:

3 Thomas J. Henretta, Attorney at Law,
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7 (330) 434-4100

8 On behalf of the Defendant, Dr. Cain:

9 Weston Hurd;

10 By: Pamela E. Loesel, Attorney at Law,
11 2500 Terminal Tower,
12 50 Public Square,
13 Cleveland, Ohio 44113-2241.

14 (216) 687-3225

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16 (Plaintiffs' Exhibits 1 through 11
17 were marked for identification.)

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DANIEL J. CAIN, D.O.

of lawful age, a Defendant herein, having been first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION

By Mr. Henretta:

Q You are Dr. Daniel J. Cain?

A Correct.

Q We met at the Courthouse one day and then again today, and I will introduce myself. For the record, I'm Tom Henretta and I represent the Plaintiff, Sandra and Todd Shonk in this matter that they filed in the Stark County Court of Common Pleas. I'm going to ask you a number of questions today. If you do not understand a question or want me to repeat it, please don't hesitate to do so and I'll be happy to repeat the question.

A Okay.

Q If you do answer the question, I'm going to rely upon the fact that you did understand it, fair enough?

A Okay.

Q And your answers are audible and I appreciate that. In common conversation, we nod our heads one way or the other and we usually know what that means, but

1 for this purpose today we need to give audible
2 answers.

3 Fair enough?

4 A Yes.

5 Q Have you given deposition testimony before in any
6 proceeding?

7 A Yes.

8 Q Can you tell me a little bit about that, the number
9 of times and under what circumstances?

10 MS. LOESEL: I'll raise an objection, but
11 go ahead.

12 A I gave a deposition once in another case.

13 By Mr. Henretta:

14 Q When you say "another case," what type of case?

15 MS. LOESEL: I'm going to have a
16 continuing line of objections to the questions
17 with regards to any case the Doctor has been
18 involved in, but go ahead and answer those and
19 my objections will continue.

20 A I had a case of baby that had difficulty after a
21 ruptured uterus in a VBAC case.

22 By Mr. Henretta:

23 Q In what kind of case?

24 A Vaginal birth after cesarean.

25 Q When you say "another case," you mean somebody

1 brought an action against you for professional
2 negligence?

3 A Yes.

4 Q Was that in Stark County?

5 A No.

6 Q Where was that?

7 A Guernsey County.

8 Q And when was that?

9 A I'd have to say 1999 or 2000.

10 Q Did the case go to trial?

11 A No.

12 Q Was it settled?

13 A No.

14 Q What happened with the case?

15 A I was dismissed.

16 Q Were there a number of Defendants in the action,
17 like a hospital and you and somebody else if you
18 recall?

19 A The hospital was also named, yes.

20 Q And the hospital, did that case go forward against
21 the hospital?

22 A Not to my knowledge.

23 Q So you don't know what the disposition of the case
24 was?

25 A No.

1 Q Do you remember the Plaintiff's name?

2 A Yes.

3 Q Can you tell me that?

4 A Maybe I don't. I would have it written down
5 someplace though. I'm sorry. I'll have to think
6 about that.

7 Q So it was 1999 and an action was brought against you
8 in Guernsey County Court of Common Pleas, right?

9 A Uh-huh.

10 Q And that was the only one -- is that the only
11 professional negligence case that's ever been
12 brought against you or have there been others? And
13 I know your Lawyer has objected to these questions.

14 A There have been others.

15 Q Do you know how many?

16 A Yes. This is I believe the third case.

17 Q And what time frame, Dr. Cain?

18 A I started practice in 1995.

19 Q Wait I minute, that was the first case brought
20 against you?

21 A No, that's when I started practice.

22 Q So tell me when those cases were filed against you,
23 what years?

24 A Again, I'd have to -- I don't recall exactly. It
25 was -- it may have been '97 and '99 were the other

1 two. I'm just not sure exactly.

2 Q Is the case that brings us here today the fourth
3 case?

4 A Only if you count the dismissal that you had
5 earlier.

6 Q So the dismissal is one, two others, and then this
7 one?

8 A Correct.

9 Q What were the issues or the allegations of
10 wrongdoing in the other two cases?

11 MS. LOESEL: Continuing objection.

12 A Can you rephrase that question?

13 By Mr. Henretta:

14 Q Okay. Let's go with the very first time you were
15 sued for professional negligence.

16 Was that the case you talked about earlier
17 that was dismissed?

18 A No, that was the second one.

19 Q What was the first case all about?

20 A Preterm delivery.

21 Q And what did they say you did wrong in that case?

22 A That would be hard to say because my partner was
23 handling the case.

24 Q And you didn't give any testimony in that case?

25 A No.

1 Q And what happened with that case?

2 A It also was dismissed.

3 Q And was the entire case dismissed or just the matter
4 against you?

5 A The entire case.

6 Q That was No. 2. Now how about the third case?

7 A That was the first one, and the second one was the
8 injured baby after a ruptured uterus in a vaginal
9 birth after cesarean.

10 Q That's the one you talked about earlier that you had
11 been dismissed out?

12 A Correct.

13 Q How about the third one?

14 A That would be your case, I believe.

15 Q I thought there were four.

16 A No, that would be your first filing.

17 Q Let's go back again.

18 MS. LOESEL: I think the problem is you've
19 filed and then dismissed and refiled, so he's
20 looking at this as the fourth case because
21 it's been dismissed and refiled.

22 By Mr. Henretta:

23 Q Three women brought actions against you since you've
24 been practicing medicine?

25 A Correct.

1 Q You've been named as an Expert Witness in this case
2 by your Attorney along with other Expert Witnesses,
3 so are you aware that you've been named as an Expert
4 Witness?

5 A Yes.

6 Q So I need to focus on your qualifications to render
7 Expert opinions so we need to go down that road a
8 little bit, okay.

9 Can you tell me if you have testified as an
10 Expert Witness in any other professional negligence
11 case?

12 A No.

13 Q Have you ever been named as an Expert Witness in any
14 other professional negligence case?

15 A That actually went to trial, no.

16 Q No, my question is have you ever been named as an
17 Expert Witness?

18 A I am not aware -- I do not know whether I was named
19 in the other case.

20 Q No Lawyer has contacted you and said, "Dr. Cain,
21 would you like to serve as an Expert Witness in this
22 particular case"?

23 A No.

24 Q So you haven't done that.

25 And your testimony as far as giving deposition

1 testimony is limited to the one case you talked
2 about earlier that was dismissed.

3 A That's correct.

4 Q And I take it then you've not testified live in
5 Court on the witness stand in a professional
6 negligence case?

7 A That's correct.

8 Q Have you been a party to any other legal action
9 other than a -- you know what I mean by a party,
10 either a Plaintiff or a Defendant?

11 A No.

12 Q And other legal proceeding, that is to say you
13 haven't sued anybody, and other than what we talked
14 about nobody has sued you?

15 MS. LOESEL: Objection. I guess I'm going
16 to raise an objection.

17 A I want to -- I have another case where --

18 MS. LOESEL: Pending?

19 A -- I'm the Plaintiff and it's pending.

20 By Mr. Henretta:

21 Q That's why I asked you about that.

22 So you have sued somebody?

23 A I have a case pending right now.

24 Q You have sued somebody, right, because you're the
25 Plaintiff?

1 A Right.

2 Q What's that case all about?

3 MS. LOESEL: Objection.

4 Go ahead.

5 THE WITNESS: I answer these questions?

6 By Mr. Henretta:

7 Q I need to know. Whether it's going to come in
8 admissibility in trial is another story. I just
9 need to discover it now.

10 A I had a billing service working for me that did less
11 than an adequate job.

12 Q That's pending right now in the Stark County Court
13 of Common Pleas or Canton Muni Court?

14 A I don't know that. That's what my Attorneys do.

15 Q They're supposed to know that.

16 Then what opinions are you going to offer in
17 this case as an Expert Witness?

18 A Regarding what?

19 Q Well, I mean, you're going to give professional
20 opinions in this case that's brought against you.

21 MS. LOESEL: And you're asking about the
22 standard of care and the proximate cause.

23 By Mr. Henretta:

24 Q Whatever. What opinions are you going to give in
25 this case; do you know?

1 MS. LOESEL: As to whether or not he met
2 the standard of care?

3 MR. HENRETTA: That's one of them. I just
4 want to know does he know what opinions he's
5 going to give?

6 THE WITNESS: My opinion is that this is a
7 known complication of the procedure, and that
8 it was discussed with the patient and was
9 appropriately handled.

10 By Mr. Henretta:

11 Q When you say this procedure, you mean the
12 laparoscopic procedure?

13 A Correct.

14 Q Now what about your -- we'll go in much greater
15 detail, I just wanted a general idea of what your
16 testimony is going to be.

17 You just moved to this address here at
18 123 Southeast Third?

19 A Right.

20 Q And where was your previous address?

21 A For my private practice?

22 Q Yes.

23 A Because this was not -- it didn't have anything to
24 do with my private practice. My private practice
25 was at 2920 Market Avenue, North.

- 1 Q How long were you there?
- 2 A Three years and a couple months.
- 3 Q And before that, where did you practice?
- 4 A In Cambridge, Ohio.
- 5 Q Down in Guernsey County?
- 6 A Right.
- 7 Q How long were you in Cambridge?
- 8 A Approximately five years.
- 9 Q Now does that take us to -- back to the very
10 beginning of your career?
- 11 A Correct.
- 12 Q Is that from the date you received your degree or
13 after you completed?
- 14 A I completed residency.
- 15 Q Now how do you hold yourself out to the public in
16 the professional capacity today, as an OB-GYN or
17 family doctor?
- 18 A No, I'm an Obstetrician-Gynecologist.
- 19 Q Your Attorneys have provided me with a Curriculum
20 Vitae and I've marked that as Plaintiffs' Exhibit 1
21 and I'll hand that to you now and ask you if you can
22 look at that and tell me whether or not that is your
23 CV.
- 24 A Yes.
- 25 Q Is that current?

1 A No.

2 Q In what respect is it not current?

3 A I have since this time taken a position with the
4 Mercy Medical Center Ambulatory Care. I work at the
5 clinic at Mercy Medical Center and I moved my
6 office. Otherwise -- and there would be some --
7 I've gone to a couple CME courses since then.

8 Q CME?

9 A Continuing medical education.

10 Q Do you know which particular CME courses?

11 A Right. If you look at it, I always go to AAO
12 convocation and AACOG convention.

13 Q What are those?

14 A AAO is American Academy of Osteopathy, and they have
15 two annual events, I go to the convocation, which is
16 one of their annual CME courses. And then the
17 American College of Osteopathic Obstetricians and
18 Gynecologists, they also have two annual events and
19 I go to the annual convention.

20 Q You're Board certified in obstetrics and gynecology?

21 A Yes.

22 Q Who certified you?

23 A The American Osteopathic Board of Obstetric
24 Gynecology.

25 Q When did you receive that certification?

1 A May 5 of 2001.

2 Q Was there a test involved in obtaining that
3 certification?

4 A Yes.

5 Q How many times did you take the test?

6 A Just once.

7 Q So you passed it up on the first taking?

8 A Yes.

9 Q I take it then that you had not applied before that
10 date for the certification?

11 A That's correct.

12 Q What all was involved in the certification process?

13 A There's a written examination, an oral examination,
14 and review of records or cases.

15 Q Tell me about your hospital privileges today.

16 A I am on active staff at Mercy Medical Center and
17 Massillon Community Hospital and on courtesy staff
18 at Doctors Hospital.

19 Q What does that mean, courtesy staff?

20 A It's a -- that means I don't have to do emergency
21 room call.

22 Q You don't have to? So it's a benefit?

23 A Right.

24 Q Here's Plaintiffs' Exhibit 11. This looks like a
25 letter you sent to -- well, you tell me what that

1 is.

2 A That's a letter I sent out to patients. I was --
3 the Ambulatory Care Center at Doctors Hospital
4 decided they were going to -- when contract came up
5 for renewal, with very little notice they decided to
6 give the contract to Atrium, and that's another
7 large OB-GYN group in this area, and so I felt that
8 I needed to inform my patients of the fact that I
9 was no longer providing care at that clinic, but I
10 would be willing to continue their care at my
11 private office in Canton, and that was for
12 continuity of care purposes.

13 Q The privileges that you have at Doctors Hospital,
14 how do they differ today from what they were before?

15 A I was on active staff previously, and then once I
16 was no longer working at the clinic I went down to
17 courtesy staff and concentrated mostly on Mercy
18 Medical Center and Massillon.

19 Q Thank you. These are going to stay with the Court
20 Reporter. I just want to keep track of my own
21 Exhibits.

22 Had you ever lost hospital privileges other
23 than what you've talked about here in that letter of
24 5-31-02?

25 MS. LOESEL: Objection. He didn't say

1 lost.

2 A I never lost.

3 By Mr. Henretta:

4 Q I understand. Other than the circumstances that
5 surrounded this termination of privileges such as
6 they were at that hospital, have you ever had
7 hospital privileges suspended?

8 A Including those, I have never lost hospital
9 privileges.

10 Q Including those.

11 You've never been suspended from a hospital?

12 A I've never been suspended or limited.

13 Q That's the focus of my question. Thank you.

14 Where did you -- you went to which school to
15 get your degree?

16 A Ohio University, College of Osteopathic Medicine.

17 Q And you graduated in what year?

18 A '91.

19 Q Then you had a period of internship or not?

20 A Yes.

21 Q Where was that and how long was that?

22 A Grandview Hospital in Dayton, Ohio for one year.

23 Q Then you had a period of residency?

24 A Doctor's Hospital in Massillon.

25 Q For how long?

1 A Three years.

2 Q Does that take us to 1995 roughly?

3 A Yes.

4 Q And then the first thing you do in 1995 is what in
5 terms of active practice of medicine?

6 A I was employed by -- I went down to Cambridge and
7 was actually employed by Superior Med, Inc. It's a
8 corporation associated with the hospital down there,
9 Southeastern Ohio Regional Medical Center.

10 Q Has your license been ever been suspended?

11 A No.

12 MS. LOESEL: Objection.

13 By Mr. Henretta:

14 Q Have you ever been disciplined by any medical or
15 osteopathic board?

16 MS. LOESEL: Objection.

17 A No.

18 By Mr. Henretta:

19 Q How many laparoscopic procedures have you performed
20 since you've been in practice?

21 A I don't know an exact number.

22 Q Do you know how many -- I mean of all kinds. Let's
23 talk about in general. Laparoscopic procedures are
24 in a number of varieties I understand.

25 A Right.

1 Q Why don't we focus on the types of laparoscopic
2 procedures you have performed since you've been
3 licensed to practice.

4 MS. LOESEL: You're asking him for the
5 different types he has performed?

6 MR. HENRETTA: That he has performed.

7 By Mr. Henretta:

8 Q Why don't we talk about principally the type of
9 laparoscopic procedures you have performed.

10 A I would start with diagnostic laparoscopy, and then
11 it runs a gamut of laparoscopic pelvic surgery, from
12 removal of tubes, ovaries, ectopic pregnancies,
13 uteruses, of course tubal ligations.

14 Q Sure.

15 A There's a variety.

16 Q I guess it stands to reason that you've done more of
17 a diagnostic nature than surgical nature because --

18 A I have a tendency to -- most of my diagnostics end
19 up with operative.

20 Q Do they? Because one doesn't necessarily have to
21 follow the other. I mean, one could I suppose --

22 A That's correct.

23 Q Diagnostic could go in and look around and say I
24 don't need to perform any surgery.

25 A Right.

1 Q That's why I thought there would be more of those.

2 You said tubal -- how many tubal ligation?

3 Why don't we focus on that?

4 A Again, it's hard for me to say exactly. I don't
5 have a log of exact numbers, but I would say I
6 probably do a few a month.

7 Q That's fair. I was going to ask you to get into the
8 week or month and if you have some sense of how many
9 you do a month or some period of time.

10 Twenty a year or twenty-some a year?

11 A Or more.

12 Q Possibly 30, 35, something like that?

13 A (Witness nodding.)

14 Q Of course what happened to Sandra Shonk was rather
15 tragic.

16 Had that type of incident where you had some
17 major vessel damage, had that occurred before in any
18 of those tubal ligations?

19 A No.

20 Q How did that happen in her case?

21 A That I'm not sure of.

22 Q It's not supposed to happen?

23 A No, but it can happen. It's not the first time that
24 it's ever happened. It's the first time it's ever
25 happened to me.

1 Q Your training for laparoscopy, can you tell us or
2 tell me how you were so trained, where, when, and
3 that sort of thing?

4 A It was part of the residency training, so internship
5 and residency, you're kind of brought along first
6 year just holding the camera and holding
7 instruments, and as the years progress then you
8 become more active in what you're doing. I've also
9 taken CME courses that involve laparoscopic trainers
10 and animal models and such.

11 Q In that residency training, how many years, weeks,
12 months or so forth are devoted to laparoscopic
13 procedures, if you can?

14 A I would say -- I believe the time is about half and
15 a half devoted where you're on the obstetrics
16 service or on the gynecology service.

17 Q What do you mean half and half?

18 A Half of the time frame. Half of the four years
19 would be, so six months out of each year you would
20 be on the obstetrical service and six months on the
21 gynecological.

22 Q And of that, how much would be devoted to
23 laparoscopic procedures or laparotomies?

24 A That's really hard to say. We did surgeries when
25 surgeries were needed. We had probably two to three

1 days a week where we would be in the operating room
2 for the majority of the time.

3 Q Was there a specific course in laparoscopic surgery
4 or procedures while you were in medical school?

5 A No.

6 Q Or how about during the residency like a course?

7 A No. We had -- I wouldn't say there's a specific
8 course. Like I said, we had pelvic trainers where
9 you get to handle the instruments in a little box.

10 Q Are you familiar with gasless laparoscopies?

11 A Yes.

12 Q What are those all about?

13 A I'm barely familiar with them. They use some kind
14 of instrument to tent the abdominal wall instead of
15 filling up with gas.

16 Q What does that mean, "tent the abdominal wall"?

17 A To lift the abdominal wall. We use gas to lift the
18 abdominal wall. There's an instrument you can put
19 in that lifts it.

20 Q You do it with the Veress needle and insufflate the
21 cavity?

22 A That's the way it was done, correct.

23 Q And the tent up procedure, how is that done, just by
24 palpation or is there an actual device or instrument
25 used for that?

1 A You mean in the gasless laparoscopy?

2 Q When you say gasless --

3 A Again, I'm not familiar with it. I've never been
4 trained to do that. All I know is just looking at
5 journals and stuff.

6 Q So then I take it from that response that you did
7 not consider that gasless procedure as an option for
8 Sandra?

9 A No. I'm not trained to do that.

10 Q Would you consider yourself an Expert in performing
11 laparoscopic procedures for tubal ligations?

12 A Yes.

13 Q I've read a lot of articles on this procedure, but
14 I'm a layperson when it comes to this, so I want you
15 to tell me, if I were a new medical student and I
16 decided at age 58 I'm going to change my career and
17 go to medical school and be a doc and I wanted to
18 learn about these procedures, what would you tell
19 me? How are they done? What would you tell me
20 about the laparoscopic procedure? Sort of guide me
21 through one.

22 A That's a pretty broad question.

23 Q I know. Of course it is. But I'm asking you how
24 are they done? What would you do?

25 MS. LOESEL: Are you asking about a

1 gasless procedure?

2 MR. HENRETTA: No, the one that he did. A
3 normal laparoscopic.

4 By Mr. Henretta:

5 Q If you're going to use a Veress needle to
6 insufflate, the patient comes to you and says, "I
7 would like to have a tubal ligation."

8 What are you going to do?

9 MS. LOESEL: Tom, before we get started,
10 let me ask a question for clarification
11 because are you asking him how he would
12 proceed from the time she walked in the door
13 and the first office appointment with consent
14 forms and everything and then appointments all
15 the way?

16 MR. HENRETTA: Everything, all the way
17 through it.

18 MS. LOESEL: You would like it specific to
19 this type and this type of patient in a clinic
20 setting.

21 MR. HENRETTA: In a clinic setting, this
22 type of patient, her size, her age, her
23 wishes, your concerns.

24 THE WITNESS: That sounds like a very
25 different question from the one you asked.

1 By Mr. Henretta:

2 Q That's where I'm going. I want you to tell me --

3 A What did I say to this patient?

4 Q Not what you told her, we're going to get into that.

5 MS. LOESEL: You're asking his routine?

6 By Mr. Henretta:

7 Q Your routine. We're not going to talk about Sandra
8 for a while. I want to know about your routine.

9 A Typically, this was a Medicaid patient, so there is
10 a form that needs to be filled out for the Ohio
11 Department of Human Services, it's a 30-day consent
12 form. So the first visit --

13 Q I'm going to show you No. 6.

14 Is that the form?

15 A That's correct.

16 Q Plaintiffs' Exhibit 6. Do you need to look at that?
17 I don't. You identified it.

18 A No.

19 Q Now why is that -- that's a separate consent form
20 from the one that you used; is it not?

21 A No, that is the consent form I use for Medicaid
22 patients because the Ohio Department of Human
23 Services requires that to be signed before the tubal
24 is done.

25 Q So is that the first thing you do, or do you

1 interview the patient to find out what she wants, or
2 do --

3 A It depends on what -- every patient is different.
4 And if we're not talking about this patient, then it
5 depends on what the patient is coming in for. If
6 the patient is coming in specifically for a tubal
7 ligation, to request a tubal ligation, we find out
8 if she's up to date on her annual exams. If she's
9 up to date on her annual exams, then we want some
10 kind of copy of those records to verify a medical
11 condition.

12 Q Did you do that in this case?

13 A She needed an annual exam and that was performed.

14 Q By you or by somebody else?

15 A By me.

16 Q What was the result of that annual exam? Any
17 abnormalities?

18 A No. I believe everything was normal. And so then
19 we would talk about the tubal ligation and consent
20 form.

21 Q What do you mean talk about tubal ligation? What
22 will you talk about?

23 A I basically used the consent form as a guideline to
24 lead the discussion, and I can give you -- I do it
25 the same each time. If you want me to give you the

1 same discussion, I can do that.

2 Q I just want to know because I'm that new medical
3 student, and I want to learn, Doctor.

4 A I would say something entirely different to a
5 medical student than I would to a patient.

6 Q I suppose you would.

7 Tell me, what would you say to a medical
8 student? You're teaching now.

9 A Describing a tubal ligation to a --

10 Q And what are your concerns and what do you tell the
11 patient?

12 MS. LOESEL: You're still focussing on the
13 consent issue?

14 By Mr. Henretta:

15 Q I'm focusing on the entire thing when she walks in.
16 What are you going to tell me if I wanted to do one
17 of those? What are you going to tell me to look
18 for? What are you going to tell me to tell the
19 patient? How are you going to tell me to conduct
20 the interview? What are you going to tell me about
21 the patient's anatomy? I want to know. I want to
22 know what your concerns are because I don't think
23 it's as simple as somebody says, "Hey, I want a
24 tubal," you say, "Okay, let's go." I think you
25 would inquire a little better and that's what I want

1 to know because I want to learn.

2 THE WITNESS: Do you want to explain to
3 me what you want me to do here?

4 MS. LOESEL: If you have difficulty with
5 what --

6 By Mr. Henretta:

7 Q You have to ask me if you don't understand that
8 question.

9 You teach, I've read somewhere in your CV
10 where you teach, so teach me. Tell me how you do
11 it.

12 A I'm just a little bit confused by what you want. I
13 mean, I can't fit four years of medical education
14 into this morning's discussion.

15 Q Let's try. Let's try to do the best you can. With
16 your training you can do a lot better than I can.

17 MS. LOESEL: I'm going to object to try to
18 fit all that into one --

19 By Mr. Henretta:

20 Q Tell me how you do one.

21 Do you examine the patient? Let me get real
22 basic. Maybe I can ask the questions. If you can't
23 tell me how this procedure is done with all your
24 years, I suspect you can, so why don't you tell me?
25 Well, the first thing I do is you told me I wanted

1 to know if she's on Medicaid so I show her the
2 Medicaid form and get her to sign it.

3 What's the next thing you do?

4 MS. LOESEL: I object. I think he said he
5 examined the patient first.

6 By Mr. Henretta:

7 Q Okay, you examine the patient, you find out whether
8 or not she has -- did she have an annual? You found
9 out she didn't so you conducted an annual.

10 A Yes.

11 Q What's the next thing you do?

12 A We did a full physical examination, and then we
13 discussed the case, and, again, I mentioned I used
14 the consent form as a guide to discuss it.

15 Q Which consent form?

16 A The first one that we do is the Ohio Department of
17 Human Services consent form because that one has to
18 be signed 30 days prior to the procedure.

19 Q Or they don't pay?

20 A Or they don't pay.

21 Q Okay.

22 A And so I -- and especially with younger women, I
23 discuss the fact -- I say it exactly like this, "The
24 Ohio Department of Human Resources requires that you
25 sign this form 30 days prior to the procedure," and

1 I think what they want you to see is this paragraph
2 right here that's in all capital letters and
3 bold-faced typed that says it's permanent and not
4 reversible. You're never going to have children
5 after you have this procedure. And then I'll start
6 up at the top. This first paragraph says that
7 you're making this decision of your own free will,
8 there's nobody forcing you to have your tubes tied,
9 it doesn't have anything to do with your benefits
10 from programs receiving Federal funds. The second
11 paragraph says this is permanent and not reversible.
12 You're never going to have any more children.
13 There's a lot of temporary methods of birth control
14 available, there's the birth control pill, there's a
15 shot that you get once every three months, there's
16 an IUD that lasts for five years and an IUD that
17 lasts for ten years, there's condoms, there's
18 cervical caps, there's diaphragms.

19 Q So you give her the options?

20 A There's a lot of different methods of birth control.
21 They all have one thing in common, if you change
22 your mind, all you do is stop using them and you can
23 have a baby. This one is different. We're going to
24 be doing a tubal ligation. I'll make a little
25 incision in the belly button, go in and put bands

1 around each side of the tube. There's possible
2 complications with any kind of surgery. The most
3 common complications are bleeding or infection.

4 Q Is that from this form or are we going to go your
5 own form?

6 A The discomforts, risks and benefits questions have
7 been answered to my satisfaction.

8 Q Now, I guess what I want to ask you is you have
9 discussed the consent form that the Ohio Department
10 of Human Services provides, and included in that are
11 your -- you are telling the patient of all the risks
12 with this procedure.

13 A We discuss them briefly with this and then again
14 with the second one.

15 Q Do you go outside this document when you're
16 discussing this document or do you pretty much stay
17 with the language that the Government has provided?

18 A I just demonstrated to you how I proceed with the
19 conversation so I obviously don't read it verbatim.
20 I follow paragraph by paragraph and explain to them
21 what each paragraph means.

22 Q This one is dated July 28, 2000, Plaintiffs'
23 Exhibit 6.

24 Does that sound about right?

25 A No, 6-26.

1 Q 7-20-2000 is the date you signed it?

2 A No, that's date of surgery. This is following
3 surgery.

4 Q Okay.

5 A This is filled out.

6 Q So this was given 6-26-2000.

7 Is that the date she came to visit you asking
8 for the -- had the appointment to talk about the
9 tubal?

10 A Yes.

11 Q Then surgical -- the date is I guess then 7-24-2000.

12 A That's on the second consent form.

13 Q Is that the day of the surgery?

14 A No.

15 Q The consent form then is signed -- this particular
16 one was signed how many days in advance of the
17 surgery?

18 A Four days.

19 Q So now after the Government form is discussed and
20 explained to the patient, what's the next thing?

21 A Then she's brought back for a second visit and
22 that's where we do -- we discuss the hospital's
23 consent form, and I do it the same way, I go
24 paragraph by paragraph explaining what it means.

25 Q And then this one, Plaintiffs' Exhibit 5, which I

1 think mirrors what you have in front of you there --

2 A Correct.

3 Q -- that is the consent form that the hospital uses?

4 A Correct.

5 Q Then you wrote in -- I take it you wrote in, I don't
6 know whose handwriting that is.

7 A That's my handwriting.

8 Q How much time can you recall that you spent with the
9 patient in going over this particular consent for
10 operation/procedure?

11 A I would have to say it takes at least 20 minutes.

12 Q Is that done by you or somebody in your office?

13 A That's done by me.

14 Q And the patient only or is there somebody else in
15 the room?

16 A Typically the patient and anybody she has with her.

17 Q Spouse, parent?

18 A Yes.

19 Q Was she alone at the time; do you know?

20 A It was my recollection that the husband was there
21 for this discussion, but that's not reflected in the
22 medical records.

23 Q What is meant by the term "failure rate equals 1 in
24 200 procedures"?

25 A Out of 200 women that gets their tubes tied, one of

1 them is going to get pregnant anyway.

2 Q And then the next paragraph there's a discussion
3 about the risk of complications or side effects.

4 Now, you then wrote in some other language it
5 looks like in parenthesis, damage to uterus, tubes,
6 ovaries and surrounding structures, UG bowel,
7 bladder, ureters.

8 Were those structures damaged in Sandra's
9 laparoscopic procedure?

10 A Yes, the bowel and surrounding structures were
11 damaged.

12 Q What is meant by the surrounding structures?

13 A In her case it was large blood vessels.

14 Q I mean, is that what you were referring to here in
15 this?

16 A That there are -- yes.

17 Q Did you tell her that?

18 A I'd say the most common complications with any
19 surgery are bleeding and infection.

20 Q And I think there's no question she heard that
21 infection.

22 Did you tell her that there was a risk that
23 she could have major vessel damage from your
24 procedure?

25 A In specifically those words, I don't believe so.

1 Q Did you tell Sandra -- I don't see it on here. Did
2 you tell her that -- did you give her an option of a
3 laparotomy?

4 A We didn't discuss laparotomy.

5 Q I take it most women who elect -- and this is an
6 elective procedure; isn't it?

7 A That's correct.

8 Q Who elect this procedure elect the laparoscopic
9 procedure for the simple reason, I would guess, that
10 there is less visible scarring from the procedure if
11 all things being equal, right?

12 A Correct.

13 Q If it's the same as the two arthroscopic procedures
14 I've had on my medial meniscal, there are three
15 holes, right, generally three?

16 MS. LOESEL: I don't know if he does those
17 surgeries.

18 A Four.

19 By Mr. Henretta:

20 Q But they're small holes?

21 A On a knee surgery? I don't do knee surgery.

22 Q On the stomach.

23 A For a laparoscopy there's only one hole.

24 Q One site and that's for the Veress needle which also
25 insufflates, I understand, puts carbon dioxide in

1 the cavity to kind of open it up, and then the
2 trocar is placed in the same site?

3 A Through the same incision.

4 Q Did you tell Sandra that if there is major organ
5 vessel damage, then more than likely we are going to
6 open you up and you're going to end up with one long
7 scar as opposed to one little hole? Did you tell
8 her that in the consent?

9 A Yeah. Down here it says if any additional or
10 different procedure is required for -- if we run
11 into an unexpected condition, then a different
12 procedure may be required and we'll do whatever it
13 takes.

14 Q Now where is that? Tell me where that is in the
15 consent form.

16 A "I permit Dr. Cain" --

17 Q "To perform" --

18 A "If any unexpected condition occurs."

19 Q Up here in the handwritten portion you were good
20 enough to include some problems to uterus, tubes,
21 ovaries, surrounding structures, bowel, bladder and
22 ureters. She, I will tell you, took that to mean
23 risk of infection only.

24 Did you know that when you were talking to
25 her, that that's what she thought?

1 A No, I don't know how she could think that.

2 Q That's what she thought because that's what she said
3 you told her.

4 Is she wrong when she said that, in your
5 opinion?

6 MS. LOESEL: Objection.

7 A Is she wrong when she said what?

8 By Mr. Henretta:

9 Q I was only told that I had a risk of infection
10 because of the opening and air would go in and I
11 could have an infection and that's all the doctor I
12 said I was going to have. He never told me I was
13 going to have a big scar running from my sternum
14 down to my pubic bone. That's what she told me.

15 What I'm asking you, down here, when you go
16 below, why don't you go a little further and
17 explain, by the way, other procedures could mean
18 major vessel damage resulting in a laparotomy, which
19 means we're going to open you up, and not just that
20 little two or three inch opening, we're going to
21 open you from the chest all the way down? Did you
22 tell her that?

23 MS. LOESEL: Objection.

24 By Mr. Henretta:

25 Q I don't think you did.

1 A No, it would be impossible to cover every possible
2 complication.

3 Q You did not tell her that?

4 MS. LOESEL: Objection.

5 A No.

6 By Mr. Henretta:

7 Q Fair enough, Doctor.

8 A But I also did not tell her that only infection
9 could damage the uterus, tubes and ovaries.

10 Q I heard you say that and I appreciate that.

11 So after I guess it's the 24th, after the
12 consent form, is surgery then scheduled, Doctor, or
13 had it already been scheduled?

14 MS. LOESEL: The surgery for the 28th?

15 By Mr. Henretta:

16 Q Yes.

17 A I couldn't tell you for sure.

18 Q All we know is she came in on the 28th.

19 Did she come in Doctors Hospital?

20 A Yes.

21 Q Now, tell me again what the -- we'll now switch to
22 the actual procedure itself and tell me how to do it
23 and tell me what you did is fair enough.

24 What did you do for Sandra Shonk when she
25 arrived at Doctors Hospital for the scheduled

1 laparoscopic procedure on July 28, 2000?

2 A I see her briefly just before surgery, just before
3 she's put to sleep and talked to her briefly, ask
4 her if she has any questions, and then anesthesia
5 puts her to sleep.

6 (Discussion had off record.)

7 (Question read by Reporter.)

8 By Mr. Henretta:

9 Q What sort of -- general, I imagine -- any particular
10 anesthesia that's used?

11 A That would be the Anesthesiologist. It's general
12 anesthesia.

13 Q Then what do you do? Now she's asleep.

14 A Then we position her on the table.

15 Q How do you position her?

16 A It's called low dorsal lithotomy position.

17 Q Is that supine?

18 A In stirrups.

19 Q On her back and her feet are in stirrups?

20 A Correct.

21 (Discussion had off record.)

22 By Mr. Henretta:

23 Q Who was in the operating room with you, Doctor?

24 MS. LOESEL: If you need your notes.

25 By Mr. Henretta:

1 Q Feel free. Absolutely.

2 A If you want me to read through, it's going to take a
3 lot longer. Usually there's a Nurse Anesthetist and
4 an Anesthesiologist, a scrub nurse, a circulator,
5 and in this case there was a general surgery
6 resident with me.

7 Q Now then what is the first thing you do to begin
8 this procedure?

9 A After the patient is positioned, I go in and scrub
10 in, and then the first thing I'll do is drain the
11 bladder with a straight catheter, put the speculum
12 in the vagina so I can find the cervix, and then I
13 put a tenaculum on the cervix to allow for
14 manipulation during the procedure.

15 Q What's that device called?

16 A A tenaculum.

17 Q Prior to this, had you already selected the
18 instruments of surgery for this procedure?

19 A Yes. They're standard instruments.

20 Q Veress needle, trocar and a scope, I guess.

21 A Correct.

22 Q Are some of those elective? By that I mean, is it
23 necessary in all cases to use a Veress needle?

24 A I know of some surgeons that do trocar insertion
25 without a Veress, at least that's the case.

1 Q In other words, just use -- go in with the trocar
2 without --

3 A Without insufflation.

4 Q Without insufflation.

5 Why do they do that; do you know?

6 Those who choose, why is it?

7 A That's probably because that's the way they were
8 trained.

9 Q Is the procedure shortened in terms of time if that
10 is done or not?

11 A If what is done?

12 Q If the Veress needle as an insufflation device is
13 not used.

14 MS. LOESEL: If you know.

15 A I suppose that would shorten the time by a couple
16 minutes.

17 By Mr. Henretta:

18 Q Just a few minutes?

19 A Uh-huh.

20 Q So you elected because that's how you were trained
21 primarily you elected to use the Veress needle --
22 does that pump in the CO2?

23 A Yes.

24 Q And then the opening is made.

25 How large is the opening from the Veress

1 needle?

2 A The Veress needle is probably only about two
3 millimeters.

4 Q Pretty small.

5 A Uh-huh.

6 Q How is the trocar -- you use a 12 millimeter trocar?

7 A It's got a point on it with a blade.

8 Q First, though, did you make an incision near the
9 umbilicus with a scalpel?

10 A Right.

11 Q And how big of an incision is that?

12 A Typically a centimeter to centimeter and a half.

13 Q This all starts around the belly button?

14 A Correct.

15 Q Do you have a choice of size of trocar?

16 A To a certain degree, but the operative scope needs a
17 12 millimeter trocar to go through, so that choice
18 is limited by the procedure you're choosing to do.

19 Q What, if anything, does the anatomy of the patient
20 have to do with this? She's not an obese woman.

21 Does that make any difference?

22 A No, not in any way, shape or form.

23 Q I want to show you -- I don't know if they're crude
24 or not. Let's just look at a couple pictures here.

25 Plaintiffs' Exhibit 7. Is that a typical

1 looking Veress needle?

2 A Yeah, that looks like a reusable Veress needle.

3 Q And is that the kind you used?

4 A No.

5 Q What kind of a Veress needle did you use?

6 A Disposable.

7 Q That's Plaintiffs' Exhibit 7.

8 How about Plaintiffs' Exhibit 8, does that
9 look like what the trocar looks like?

10 A That, again, is a reusable trocar.

11 Q And you used a disposable trocar?

12 A Correct.

13 Q One is more expensive than the other, I would
14 imagine?

15 A I'm sure this one is more expensive but you reuse it
16 many times.

17 Q So maybe it's a cost savings in the long run.

18 You used a disposable?

19 A Correct.

20 Q Are those newer or have they -- newer on the market
21 than --

22 A Yeah, the reusable have been around much longer.

23 Q What is the cannula on here? As I keep reading it
24 looking trying to figure out what is cannula, is
25 that a cover or a shield or something?

1 MS. LOESEL: If you know.

2 By Mr. Henretta:

3 Q If you don't know --

4 A I would have to assume they mean cannula, channel
5 for the device to go through.

6 Q Before we get to the actual procedure that you
7 performed, when the trocar is inserted -- first of
8 all, is that done immediately after the opening --
9 after the insufflation occurs?

10 A Yes.

11 Q Within seconds or a minute or so?

12 A Yes.

13 Q As long as it takes to get the right instrument?

14 A Uh-huh.

15 Q How about the length of the trocar, are they
16 standard lengths?

17 A Yes, pretty much. There might be a long trocar
18 available, but it wouldn't have been necessary in
19 this case.

20 Q Again, I suppose a longer trocar might be necessary
21 in a very obese person?

22 A Correct.

23 (Discussion had off record.)

24 By Mr. Henretta:

25 Q Where on the anatomy of -- I think you've already

1 testified. Here's Plaintiffs' Exhibit 9, a very
2 crude anatomical black and white drawing.

3 Can you show me on there where the incision is
4 made for the Veress needle or with the Veress
5 needle?

6 A It's right almost inside the belly button.

7 Q And then do you -- now she is on her back with legs
8 in stirrups?

9 A Correct.

10 Q So that presumably I guess the spine is flat on the
11 table or not?

12 A Pretty much.

13 Q At what angle is first the Veress needle inserted?
14 If this were I guess a flat surface, how would you
15 insert that, at a particular angle or straight?

16 A You can actually feel the sacral promontory where
17 this sticks up, and the angle, that varies, and the
18 trocar would be into the hollow area.

19 Q Would it be about a 45 degree angle?

20 A Generally.

21 Q Tell me about that.

22 A Again, you can feel the sacral promontory and aim
23 for the hollow area.

24 Q The hollow area being in this vicinity?

25 A Over the top of this sacral promontory.

1 Q What's the, in your opinion, most serious
2 complication from the procedure that you were about
3 to perform or did perform or started to perform on
4 Sandra? What's the most serious complication?

5 A The most serious complication that could occur,
6 death.

7 Q Other than death. I was going to say that.

8 A It's hard to quantify.

9 Q Well, penetrating injuries, I suppose, but I mean
10 which vessels?

11 A I suppose the one that would bleed the fastest would
12 be the aorta.

13 Q And then how do -- was her injury -- tell me if you
14 recall or can you read from the op notes on -- let's
15 go a little more.

16 Do you recall having inserted the trocar in
17 Sandra's case? Do you have a recollection of that
18 insertion?

19 MS. LOESEL: An independent recollection?

20 MR. HENRETTA: Yes.

21 MS. LOESEL: Over and above his notes?

22 By Mr. Henretta:

23 Q You can look at the notes.

24 Do you remember the surgery?

25 A Yes.

- 1 Q Do you remember inserting the trocar?
- 2 A Yes.
- 3 Q Tell me what you remember next after you inserted
- 4 the trocar.
- 5 A Describe it just like I described to you. I
- 6 inserted the trocar and felt that it had hit
- 7 something solid, and so when I removed the
- 8 obturator --
- 9 Q What is obturator?
- 10 A The obturator is the sharp point on that trocar. It
- 11 goes down the middle.
- 12 Q That? (Indicating)
- 13 A Yeah.
- 14 Q The pointy end?
- 15 A Right. And then the obturator will come out and
- 16 leave the trocar, the sheath that you operate --
- 17 Q Where is the sheath, up at this end?
- 18 A On this diagram, I would guess it comes apart
- 19 somewhere up in here, and there's the part with the
- 20 blade on it that comes through the tube, and when
- 21 you take that out, you leave just the tube --
- 22 Q Leave the tube so you can go through otherwise the
- 23 body will close up?
- 24 A Correct.
- 25 Q What is your next recollection after the insertion

1 of the trocar?

2 A When the obturator came out, there was blood in the
3 trocar. I put the camera in to see if I could see
4 to what extent she was bleeding and all I saw was
5 blood so we opened her up.

6 Q So what was your conclusion when you saw that blood?

7 A That there had been damage to a vessel.

8 Q At that point did you know which vessel?

9 A No.

10 Q Now is it true that in this case the trocar went
11 into the peritoneal cavity and through the other
12 side of the peritoneal cavity?

13 MS. LOESEL: Objection.

14 By Mr. Henretta:

15 Q How does it damage the iliac artery if it doesn't go
16 through the other side of that cavity? This is a
17 sac, we're talking about a membrane, a peritoneal
18 lining.

19 A Yeah. There's a lining that goes all the way
20 around. Yes, it would have gone through.

21 Q It had to go through the other side.

22 A Correct.

23 Q Which would be posterior?

24 A That depends on what you mean by posterior.

25 Q If this is anterior and you're inserting in a

1 downward fashion and it goes into the cavity, it
2 must come out the other side to hit the vessels that
3 are damaged.

4 A You're pointing to your back and posterior
5 peritoneum is more anterior than posterior if you're
6 looking at your whole body.

7 Q Okay. Let's see if we can get a drawing here
8 because it will help me with the anatomy. I had
9 another one here that might make sense to me. It's
10 on the back of No. 9.

11 Can you use this yellow just to help me and
12 outline the peritoneal cavity, if this is what it
13 is?

14 A (Witness complies with request.)

15 Q Are you able to show with this red pen the insertion
16 point for the Veress needle?

17 A No, because I think you're up above the umbilicus.

18 Q When you say up above --

19 A These are kidneys.

20 Q Are the vessels that are -- where are the vessels
21 that were damaged in this case?

22 A Again, you're in the wrong area of the body.

23 Q Can we go with --

24 Here's No. 10. Would that drawing at all
25 help?

1 A Yes.

2 Q Can you tell me what this represents to you in a
3 very crude fashion? I take it these are kidneys
4 over here.

5 A This should be the aorta, this would be the vena
6 cava, and this would be your -- the injury was right
7 in this area here. (Indicating)

8 Q Right here?

9 A Uh-huh.

10 Q How far I guess -- what's the length of that trocar?
11 I mean, how does this happen? How did it happen in
12 this case; do you know?

13 A No.

14 Q We do know that it must have happened upon insertion
15 of the trocar?

16 A Yes.

17 Q And you're telling me that's a recognized risk to go
18 right through the abdominal -- into the peritoneal
19 cavity and out to the other side, that is a
20 recognized risk of this procedure?

21 A Correct.

22 Q Can you tell me about the pressure that's used to
23 insert the trocar? Can you quantify that at all?

24 A Not really.

25 Q Or the force?

1 A The force that I used to insert trocar?

2 It's a moderate force. I don't know how to
3 quantify that. That's why the skin incision is
4 made, to allow for less force to be used.

5 Q What is meant by the term in your mind "blind
6 insertion"?

7 A That means that you cannot see where that trocar is
8 going.

9 Q And how do we avoid problems with blind insertions?

10 A Again, as I described, feeling for the sacral
11 promontory, inflating the abdomen prior to
12 insertion.

13 Q And you don't believe that you used too much force
14 in this?

15 A No.

16 Q Is it fair to say that if you had a smaller trocar,
17 I guess end or -- let's go back to the term here.

18 What's that distal end, what's it called, the
19 end of this trocar, that little point?

20 A I would call -- on disposable, it's like an actual
21 blade.

22 Q It was 12 millimeters in diameters?

23 A No, it comes to a point.

24 Q At it's widest it was 12 millimeters?

25 A I presume. It should be very close to what the

1 diameter of the trocar is. Right, makes sense.

2 Q Do you believe if you had a smaller diameter trocar
3 that less force is required to insert it in the area
4 where the Veress needle was?

5 MS. LOESEL: Objection.

6 A No, I don't.

7 By Mr. Henretta:

8 Q If the area was smaller, you wouldn't have to use as
9 much force?

10 A In my personal opinion, it doesn't make that much
11 difference because I use smaller trocars for
12 different procedures.

13 Q You have really no explanation on how you hit a
14 right iliac artery with that trocar and caused that
15 sort of vessel damage?

16 A It would be only speculation on my part because I
17 did everything exactly as I always do.

18 Q What happened?

19 MS. LOESEL: Objection. He's not going to
20 speculate if he doesn't know.

21 By Mr. Henretta:

22 Q How do you account for this?

23 A I don't know.

24 Q Now this is Exhibit 2.

25 Is this your report of operation, Dr. Cain?

1 A Yes.

2 Q And it's a two-page report?

3 A Correct.

4 Q And it says "Postoperative Diagnosis is iliac
5 vascular injury and small bowel injury."

6 What does that mean?

7 A There was an injury to the iliac vessel and there
8 was an injury to the small bowel.

9 Q Then at what point did you make another cut into the
10 patient?

11 A As soon as I saw nothing but blood through the
12 camera, I took the trocar out and made the incision.

13 Q And how long or deep -- long, I guess, would be the
14 incision, vertical -- was it a vertical incision?

15 A Yes. I made the incision from the umbilicus to the
16 pubis.

17 Q What is that, about three, four inches?

18 A On her, yeah, it would be four or five inches
19 probably.

20 Q Then what did you do after you made that incision?
21 Was that the beginning of the laparotomy?

22 A Yes. Then we got into the pelvis and found the site
23 of bleeding and put pressure on it until Dr. Conklin
24 could arrive.

25 Q How did you exert pressure? Tell me what you did.

- 1 A Got wet lap tapes, and with a hand in there pushed
2 as well as I could to stop the bleeding.
- 3 Q Who repaired the right iliac artery and vein?
- 4 A Dr. Conklin.
- 5 Q How did you get Dr. Conklin to the surgery?
- 6 A All I did was say, "Get Dr. Conklin in here quick"
7 and they did the rest.
- 8 Q Did you assist?
- 9 A Yes.
- 10 Q What is a salpingectomy?
- 11 A That is tubal ligation.
- 12 Q Was that completed?
- 13 A Yes.
- 14 Q Did you do it or did Dr. Conklin do that?
- 15 A I did that.
- 16 Q That's after -- was that after she was entirely
17 opened up?
- 18 A Yes.
- 19 Q Did Dr. Conklin open her up from her sternum down to
20 the umbilicus?
- 21 A He enlarged the incision, yes.
- 22 Q Did she have any complications after the tubal or
23 vascular injuries, anything that would keep her in
24 the hospital a little longer?
- 25 A The whole case is about the vascular injury. I'm

1 not sure what your question is.

2 Q Fair enough.

3 Did you follow up with her after the tubal
4 ligation was completed?

5 A I saw her in the hospital. She did not keep her
6 follow-up appointment in the clinic.

7 Q Did you have an option of the amount of CO2 gas to
8 insufflate with?

9 A Yes.

10 Q Tell me about why you chose 4.5 liters.

11 A I used an amount sufficient to distend the abdomen
12 to approximately 12 to 15 millimeters of mercury on
13 the dial. We have a gauge that measures the
14 abdominal pressure.

15 Q This says ligs were used to tamponade the major
16 vessels.

17 Is that what you're talking about earlier
18 about holding it down?

19 A Yes.

20 Q Here's Plaintiffs' Exhibit 3. This appears to be
21 Dr. Conklin's op report.

22 A Yes.

23 Q You signed off on that as well?

24 A No.

25 Q You did not. I thought I saw your name somewhere.

1 A Copy.

2 Q But you said you assisted in this.

3 A Yes.

4 Q What's meant by the term exposure -- withdraw.

5 What's meant by the term "hypotensive"?

6 A Drop in blood pressure.

7 Q Can you talk about the blood loss? Do you know
8 anything about how much blood she lost?

9 A It was estimated to three to four liters of blood.

10 Q Is that significant?

11 A Absolutely.

12 Q She was then in the process of being volume
13 resuscitated.

14 What does that mean, putting more blood in?

15 A Correct. She was given packed cells, there was cell
16 saver recycling the blood that we could collect from
17 the cavity, and fluids.

18 Q What's meant by the term "retroperitoneal hematoma"?

19 A That would be a collection of blood behind the
20 peritoneum.

21 Q In this case it says "There was already blood and a
22 significant retroperitoneal hematoma around the
23 iliac bifurcation."

24 Where is that?

25 A That would be that other pictures that --

1 Q Where is the iliac bifurcation?

2 A This is the iliac bifurcation. (Indicating)

3 Q I see. I'll put yellow on that.

4 How do we determine the distance from the
5 point of insertion on Sandra to the right iliac
6 artery? How far -- I don't know in terms of
7 distance and how do you -- how can you tell me that?
8 Was it five inches, six inches?

9 MS. LOESEL: Objection. If you can tell.

10 A Yeah, it would be hard to say.

11 By Mr. Henretta:

12 Q Why?

13 A It would vary with the insufflation of the abdomen
14 as well, so --

15 Q Explain that. What do you mean it would vary with
16 that?

17 A With the insufflation of the abdomen, the anterior
18 abdominal wall is brought away from the posterior,
19 spine and so that distance would increase.

20 Q But as far as you know, there was sufficient
21 insufflation?

22 A Yes.

23 Q And you base that on the fact that you put in 4
24 something -- 4.2 liters?

25 A I believe it said 4.5 liters.

1 Q And how did you know that was a sufficient
2 insufflator?

3 A Again, there's a pressure gauge on the insufflation
4 machine.

5 Q Indicating that there's enough of a vacuum inside?

6 A Enough pressure, and you can also percuss the
7 abdomen to know the sound that the -- the sound of
8 the liver dulls and you don't have -- you can listen
9 to organs just under the surface if the gas has
10 sufficiently lifted the abdominal wall.

11 Q Here is Exhibit 4, Discharge Summary by Dr. Conklin.
12 I believe you've signed off on it as the attending
13 or assisting.

14 A Yes.

15 Q And I just wanted to talk a little bit about the
16 final discharge diagnoses. I think we already know
17 what elective sterilization means because we talked
18 about it. No. 2 it says, "Accidental injury to the
19 right iliac artery and a portion of the right iliac
20 vein, small bowel injury."

21 Is that three injuries or two? What is that?

22 A It was all one injury, it's just three --

23 Q Three different areas?

24 A Three different structures.

25 Q Who dictated this summary?

1 A That was Dr. Conklin, I believe.

2 Q Did you help in the preparation of it or simply sign
3 off or do you recall?

4 A They asked me to sign it off for some reason. I'm
5 not sure why.

6 Q What is meant by "acute intraoperative hemorrhage"?

7 A She bled during the surgery.

8 Q I guess 4 means she lost blood?

9 A And it was measurable.

10 Q "5, Postop respiratory failure."

11 What happened there?

12 A That, I'm not sure about. That is probably the only
13 diagnosis I would question. She was left on the
14 ventilator after surgery prophylactic.

15 Q "Hypovolemic shock," what's that mean?

16 A That would be low volume drop in blood pressure is
17 probably what they're indicating.

18 Q No. 7 discharge diagnosis, coagulopathy, significant
19 to blood loss.

20 What's that mean?

21 A Coagulopathy is a disorder in blood clotting and I
22 believe they were looking for DIC, disseminated
23 intervascular coagulation, but I don't believe they
24 found it, so I'm not exactly sure about that
25 diagnosis either. She was given blood products to

1 prevent that.

2 Q And then the check sterilization I guess means that
3 the tubal was completed?

4 A Uh-huh.

5 MS. LOESEL: You have to say yes.

6 A I saw it was there twice and I'm not exactly sure
7 why.

8 By Mr. Henretta:

9 Q Yes, there it is, No. 1 and No. 8.

10 Hypokalemia, what's that mean?

11 A That's low potassium.

12 Q Where did that come from, loss of blood?

13 A It's probably related.

14 Q And vasovagal syncope?

15 A Syncope.

16 Q Syncope postoperatively, what's that?

17 A Apparently she passed out or they said she passed
18 out, but she passed out in bed. I don't know how --
19 maybe they attributed that to just vasovagal
20 response.

21 Q You haven't seen the scar on this patient, have you?

22 A No.

23 Q Have you done other laparoscopic procedures besides
24 tubal ligations?

25 A Yes.

1 Q What others have you done?

2 A Again, oophorectomy, salpingectomies, removal of
3 ovaries, removal of tubes, removal of ectopic
4 pregnancies, aspiration of cysts, laparoscopies,
5 vaginal hysterectomies, and given time I could
6 probably come up with a couple more.

7 Q How do those procedures differ from the tubal in
8 terms of where you start?

9 A They all start the same.

10 Q At the umbilicus?

11 A Well, actually preparing the uterus for
12 manipulation.

13 Q Do you enter in the same place?

14 A Yes.

15 Q And basically the same instruments?

16 A Yes. Most of those would require additional sites
17 of entry.

18 Q Different sites of entry?

19 A Additional.

20 Q In other words, instead of just the one hole, there
21 may be a couple, three?

22 A (Witness nodding.)

23 Q Is it essentially the same, you've got a Veress
24 needle which serves as an insufflation device, the
25 trocar provides an opening, and then a scope can be

1 inserted to look around and see what we need to do,
2 and then presumably something else to do whatever it
3 is we need to do?

4 Fair enough?

5 A Yes.

6 Q Is there anything unique about a tubal ligation in
7 terms of it being the goal of a laparoscopic
8 procedure? I mean, what's different about a tubal
9 other than its ultimate goal is to sterilize?

10 A I'm not sure I understand your question.

11 Q I don't know how I can phrase it.

12 In all of these laparoscopic procedures,
13 laparoscopy is laparoscopy, and it uses those basic
14 instruments that we talked about. Once we're
15 inside, once you're inside, you may do a different
16 procedure, but you get in the same way.

17 A Right.

18 Q And you prepare the patient the same way in terms of
19 insufflation?

20 A Right.

21 Q Artfully I can't go beyond that.

22 (Plaintiffs' Exhibits 12 and 13
23 were marked for identification.)

24 By Mr. Henretta:

25 Q Here's 12. There's a drawing at the top, a very,

1 very crude drawing. It looks as though there's a
2 needle being inserted into some part of the anatomy.

3 Is that the way one usually does it, by
4 pulling the skin up and then inserting it?

5 A Yes.

6 Q Did you do that in this case?

7 A Yes.

8 Q Why is that done that way?

9 A To make room between the umbilicus and the bowel, to
10 give you space to insert the Veress without hitting
11 any organs.

12 Q Here is 13 and if we believe what it says below, it
13 says insertion of the primary trocar and cannula.

14 Is that generally the mechanical way that
15 particular procedure is done?

16 A Yes.

17 Q Is that how you did it?

18 A Yes.

19 Q Are you right-handed or left-handed?

20 A Right.

21 Q Where do you stand in relation to the patient?

22 A On the patient's left side.

23 Q That's what you did in this case?

24 A Yes.

25 Q How about training in laparotomy, been so trained as

1 trained in laparoscopic procedures?

2 A Yes. Again, it's part of the residency program.

3 Q How many laparotomies have you done?

4 A I actually do fewer of those than I do
5 laparoscopies.

6 Q I suppose there are certain considerations on the
7 patient. If the patient has been surgically invaded
8 a number of times, you might consider a laparotomy
9 as opposed to a laparoscopic procedure or no?

10 A Depending.

11 Q Why would you choose one over the other? Why would
12 you choose laparotomy over laparoscopic for a tubal?

13 A For a tubal?

14 Q For a tubal.

15 A That might be one reason to do that. Again, I don't
16 typically -- I've done very few laparotomies for
17 tubal ligation.

18 Q Not too popular.

19 Is that because of the --

20 A Scarring.

21 Q Do you remember a phone conversation or with Sandy
22 discussing any of the consent items or
23 complications?

24 A No.

25 Q Do you remember discussing risk of damage to an

1 organ through air hitting it with a bacteria as she
2 would put it?

3 A By phone or in person?

4 Q Yes. Do you remember that?

5 A No. That would be like an old wives' tale.

6 Q You mean air -- bacteria carried through air through
7 that small opening is going to cause damage?

8 A The old wives' tale is if you let air into the
9 abdomen, the cancer is going to spread. It might
10 have been some extension of that.

11 Q Is it fair to say that Dr. Conklin saved Sandra's
12 life?

13 A Yes, we did.

14 Q You did?

15 MS. LOESEL: He said "we."

16 By Mr. Henretta:

17 Q Well, without Dr. Conklin, I don't know -- what
18 would you have done without a vascular surgeon? You
19 were going to do this yourself?

20 A No, we needed a vascular surgeon, but he needed the
21 patient to be alive when he got there.

22 Q So you kept her alive.

23 How did you keep her alive?

24 A By tamponading the blood vessels.

25 Q So you don't believe that you deviated from the

1 standard of care in this case?

2 A No.

3 Q How did you help her? Tell us how you helped
4 Sandra.

5 A By recognizing the problem immediately and taking
6 the appropriate action.

7 Q And you can't tell us what caused that problem, can
8 you?

9 A No, I can't.

10 Q Is it safe to say that the problem occurred upon
11 insertion of the trocar?

12 A I believe so, yes.

13 Q And tell me every fact or circumstance that supports
14 your view that the insertion of a 12 millimeter
15 trocar that you used in this case met the standard
16 of care.

17 A I followed every procedure that I would normally
18 follow from insufflation of the -- from insertion of
19 the Veress needle to verification of its placement,
20 and insufflation of the abdomen to appropriate
21 pressure and holding the trocar in a way that should
22 prevent insertion too far, and I did everything
23 exactly the way I've always done it.

24 Q So it's just one of those things that just happened?

25 MS. LOESEL: Objection.

1 A I can't explain it.

2 By Mr. Henretta:

3 Q How do you account for it?

4 A I can't explain it.

5 Q This was a major vessel damage.

6 A Correct.

7 Q Could it have been the incorrect angle of insertion
8 of the trocar that could have caused this?

9 MS. LOESEL: Objection. I think he said
10 he can't explain it.

11 By Mr. Henretta:

12 Q I'm asking if that could cause it.

13 A Could that cause it?

14 Q Yes.

15 A Yeah, that could cause it.

16 Q Likewise, could excessive pressure or force in the
17 insertion of the trocar caused damage to these
18 structures that we're talking about, the right iliac
19 vein, the small intestine?

20 A You're asking as a general question?

21 Q Yes, can that happen from excessive force or
22 pressure from the insertion of the trocar?

23 A It could.

24 Q Do you know what the statistical incidence of damage
25 to those structures in a laparoscopic procedure for

1 a tubal ligation are? I mean, how often, in your
2 opinion, does damage to all three of these
3 structures occur?

4 A No, I do not.

5 Q Do you have that data?

6 A No.

7 Q What else could you do other than a blind insertion?
8 How else would you do one of these without that?

9 A You can cut down and place it under direct
10 observation. There are trocars that are made that
11 supposedly you could put the camera in and see where
12 you're going. There are -- I suppose that those
13 would be the two options.

14 Q Do you know what an Open Hassen procedure is?

15 A Yes.

16 Q What is that?

17 A That's where you would open up -- make the incision
18 and insert it under direct visualization.

19 Q And why did you not elect that procedure in this
20 case?

21 A Because I did all my cases with a Veress needle and
22 trocar.

23 Q Were you ever trained or schooled or taught in any
24 way about the Open Hassen procedure?

25 A We may have done it a couple times during my

1 residency.

2 Q Why don't you do it? Does it cost more or
3 something?

4 A I don't believe there's a difference in cost unless
5 you're talking about operating room time.

6 Q Does the Medicare consideration have anything to do
7 with the options available to you?

8 MS. LOESEL: Medicare or Medicaid?

9 By Mr. Henretta:

10 Q Medicaid, I'm sorry.

11 A I didn't understand the question.

12 Q Well, I mean, if a patient is on Medicaid, does that
13 make a difference to you in terms of the selection
14 of surgical procedure?

15 A No.

16 Q But you've never utilized the Open Hassen procedure?

17 A Yes, I have.

18 Q You have.

19 And why didn't you do it here? If I asked you
20 that, I'm sorry.

21 A Again, I did 99 percent of my cases with --

22 Q I understand that, but why didn't you use it here?
23 Just because of -- anything, any reason?

24 A There was no prior history of surgeries, no reason
25 to suspect that there would be problems with the

1 trocar insertion.

2 Q Would you think this is a fair statement, that a
3 major factor in the high rate of injury is the
4 establishment of a pneumoperitoneum?

5 What does that mean?

6 A That's insufflation of the abdomen.

7 Q "A major factor in the high rate of injury is the
8 insufflation and insertion of trocars at the
9 beginning of a procedure, particularly when it is a
10 blind insertion."

11 Would you agree with that statement, that
12 that's a major factor in the rate of injury?

13 MS. LOESEL: Objection.

14 By Mr. Henretta:

15 Q Or not?

16 A I would suspect that trocar insertion is one of the
17 areas where there is damage. It doesn't matter
18 whether it's Open Hassen or a sharp trocar or
19 reusable or disposable. That is probably one of the
20 most likely places to have injury.

21 Q What did you do to, you know, conceptualize, if you
22 will, the spatial distance, relationships between
23 the organs, instruments and the tissue plains of
24 this patient? Did you do anything like that?

25 A Again, there's a -- of course, the examination

1 before the procedure, and then once the patient is
2 under anesthesia, it's fairly easy to palpate the
3 sacral promontory so you know where the rim of the
4 pelvis is.

5 Q Does that translate into that you thought there was
6 enough room in there to get the trocar in without
7 hitting any major organs?

8 A Yes.

9 Q What are the contraindications for this procedure,
10 Doctor, on her?

11 A Contraindications on her?

12 Q Were there any?

13 MS. LOESEL: For a tubal?

14 A I don't believe so.

15 By Mr. Henretta:

16 Q What are they in general?

17 A If you had known bowel adhesions, prior umbilical
18 hernia, something like that where you could suspect
19 there would be scars or scar tissue or adhesions
20 right under the belly button. Other than that, it's
21 hard to imagine contraindications.

22 (Discussion had off record.)

23 By Mr. Henretta:

24 Q As far as Sandra's -- I don't know if I use the term
25 gross anatomy -- were there any abnormalities with

1 Sandra that you were able to observe in terms of her
2 anatomy, her history?

3 A No.

4 Q Anything to suggest that her organs are in a
5 different place than somebody else's organs?

6 A No.

7 MR. HENRETTA: Thank you, Doctor. I
8 appreciate your time.

9 MS. LOESEL: Thank you.

10 - - -

11 (Deposition concluded at 12:55 o'clock, p.m.)

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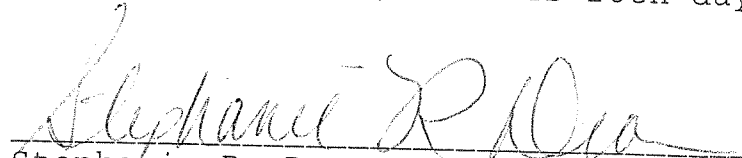
1 CERTIFICATE
2 STATE OF OHIO,)) SS:
3 SUMMIT COUNTY.)

4 I, Stephanie R. Dean, a Notary Public within and for
5 the State of Ohio, duly commissioned and qualified, do
6 hereby certify that the within named Witness, DANIEL J.
7 CAIN, D.O., was by me first duly sworn to testify the
8 truth, the whole truth and nothing but the truth in the
9 cause aforesaid; that the testimony then given by the
10 Witness was by me reduced to Stenotypy in the presence of
11 the Witness; afterwards transcribed by computer-aided
12 transcription, and that the foregoing is a true and
13 correct transcription of the testimony so given by the
14 Witness as aforesaid.

15 I do further certify that this deposition was taken
16 at the time and place in the foregoing caption specified,
17 and was completed without adjournment.

18 I do further certify that I am not a relative,
19 Counsel or Attorney of either party, or otherwise
20 interested in the event of this action.

21 IN WITNESS WHEREOF, I have hereunto set my hand and
22 affixed my seal of office at Akron, Ohio, on this 26th day
23 of September, 2003.

24 
Stephanie R. Dean, Notary Public
25 in and for the State of Ohio.

My commission expires August 30, 2005.

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LAWYER'S NOTES

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