IN THE COMMON PLEAS COURT

STARK COUNTY, OHIO

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SANDRA J. SHONK, et al., Plaintiffs,	)	
vs.	)	No. 2003CV00056
DOCTORS HOSPITAL OF STARK COUNTY, et al., Defendants.	)	

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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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APPEARANCES:

On behalf of the Plaintiffs:

Thomas J. Henretta, Attorney at Law,
401 Quaker Square,
120 E. Mill Street,
Akron, Ohio 44308.

(330) 434-4100

On behalf of the Defendant, Dr. Cain:

Weston Hurd;

By: Pamela E. Loesel, Attorney at Law,
2500 Terminal Tower,
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(Plaintiffs' Exhibits 1 through 11 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

for this purpose today we need to give audible answers.

Fair enough?

A Yes.

Q Have you given deposition testimony before in any proceeding?

A Yes.

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

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

A I gave a deposition once in another case.

By Mr. Henretta:

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

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

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

By Mr. Henretta:

Q In what kind of case?

A Vaginal birth after cesarean.

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

brought an action against you for professional negligence?

A Yes.

Q Was that in Stark County?

A No.

Q Where was that?

A Guernsey County.

Q And when was that?

A I'd have to say 1999 or 2000.

Q Did the case go to trial?

A No.

Q Was it settled?

A No.

Q What happened with the case?

A I was dismissed.

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

A The hospital was also named, yes.

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

A Not to my knowledge.

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

A No.

Q Do you remember the Plaintiff's name?
A Yes.
Q Can you tell me that?
A Maybe I don't. I would have it written down someplace though. I'm sorry. I'll have to think about that.
Q So it was 1999 and an action was brought against you in Guernsey County Court of Common Pleas, right?
A Uh-huh.
Q And that was the only one -- is that the only professional negligence case that's ever been brought against you or have there been others? And I know your Lawyer has objected to these questions.
A There have been others.
Q Do you know how many?
A Yes. This is I believe the third case.
Q And what time frame, Dr. Cain?
A I started practice in 1995.
Q Wait I minute, that was the first case brought against you?
A No, that's when I started practice.
Q So tell me when those cases were filed against you, what years?
A Again, I'd have to -- I don't recall exactly. It was -- it may have been '97 and '99 were the other

two. I'm just not sure exactly.

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

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

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

A Correct.

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

MS. LOESEL: Continuing objection.

A Can you rephrase that question?

By Mr. Henretta:

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

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

A No, that was the second one.

Q What was the first case all about?

A Preterm delivery.

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

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

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

A No.

Q And what happened with that case?
A It also was dismissed.
Q And was the entire case dismissed or just the matter against you?
A The entire case.
Q That was No. 2. Now how about the third case?
A That was the first one, and the second one was the injured baby after a ruptured uterus in a vaginal birth after cesarean.
Q That's the one you talked about earlier that you had been dismissed out?
A Correct.
Q How about the third one?
A That would be your case, I believe.
Q I thought there were four.
A No, that would be your first filing.
Q Let's go back again.

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

By Mr. Henretta:
Q Three women brought actions against you since you've been practicing medicine?
A Correct.

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

A Yes.

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

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

A No.

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

A That actually went to trial, no.

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

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

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

A No.

Q So you haven't done that.

And your testimony as far as giving deposition

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

A That's correct.

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

A That's correct.

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

A No.

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

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

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

MS. LOESEL: Pending?

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

By Mr. Henretta:

Q That's why I asked you about that.

So you have sued somebody?

A I have a case pending right now.

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

A Right.
Q What's that case all about?
MS. LOESEL: Objection.
Go ahead.
THE WITNESS: I answer these questions?
By Mr. Henretta:
Q I need to know. Whether it's going to come in admissibility in trial is another story. I just need to discover it now.
A I had a billing service working for me that did less than an adequate job.
Q That's pending right now in the Stark County Court of Common Pleas or Canton Muni Court?
A I don't know that. That's what my Attorneys do.
Q They're supposed to know that.
Then what opinions are you going to offer in this case as an Expert Witness?
A Regarding what?
Q Well, I mean, you're going to give professional opinions in this case that's brought against you.
MS. LOESEL: And you're asking about the standard of care and the proximate cause.
By Mr. Henretta:
Q Whatever. What opinions are you going to give in this case; do you know?

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

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

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

By Mr. Henretta:

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

A Correct.

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

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

A Right.

Q And where was your previous address?

A For my private practice?

Q Yes.

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

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

A No.
Q In what respect is it not current?
A I have since this time taken a position with the Mercy Medical Center Ambulatory Care. I work at the clinic at Mercy Medical Center and I moved my office. Otherwise -- and there would be some -- I've gone to a couple CME courses since then.
Q CME?
A Continuing medical education.
Q Do you know which particular CME courses?
A Right. If you look at it, I always go to AAO convocation and AACOG convention.
Q What are those?
A AAO is American Academy of Osteopathy, and they have two annual events, I go to the convocation, which is one of their annual CME courses. And then the American College of Osteopathic Obstetricians and Gynecologists, they also have two annual events and I go to the annual convention.
Q You're Board certified in obstetrics and gynecology?
A Yes.
Q Who certified you?
A The American Osteopathic Board of Obstetric Gynecology.
Q When did you receive that certification?

A May 5 of 2001.
Q Was there a test involved in obtaining that certification?
A Yes.
Q How many times did you take the test?
A Just once.
Q So you passed it up on the first taking?
A Yes.
Q I take it then that you had not applied before that date for the certification?
A That's correct.
Q What all was involved in the certification process?
A There's a written examination, an oral examination, and review of records or cases.
Q Tell me about your hospital privileges today.
A I am on active staff at Mercy Medical Center and Massillon Community Hospital and on courtesy staff at Doctors Hospital.
Q What does that mean, courtesy staff?
A It's a -- that means I don't have to do emergency room call.
Q You don't have to? So it's a benefit?
A Right.
Q Here's Plaintiffs' Exhibit 11. This looks like a letter you sent to -- well, you tell me what that

is.

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

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

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

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

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

MS. LOESEL: Objection. He didn't say

lost.

A I never lost.

By Mr. Henretta:

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

A Including those, I have never lost hospital privileges.

Q Including those.

You've never been suspended from a hospital?

A I've never been suspended or limited.

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

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

A Ohio University, College of Osteopathic Medicine.

Q And you graduated in what year?

A '91.

Q Then you had a period of internship or not?

A Yes.

Q Where was that and how long was that?

A Grandview Hospital in Dayton, Ohio for one year.

Q Then you had a period of residency?

A Doctor's Hospital in Massillon.

Q For how long?

A Three years.
Q Does that take us to 1995 roughly?
A Yes.
Q And then the first thing you do in 1995 is what in terms of active practice of medicine?
A I was employed by -- I went down to Cambridge and was actually employed by Superior Med, Inc. It's a corporation associated with the hospital down there, Southeastern Ohio Regional Medical Center.
Q Has your license been ever been suspended?
A No.

MS. LOESEL: Objection.

By Mr. Henretta:
Q Have you ever been disciplined by any medical or osteopathic board?

MS. LOESEL: Objection.

A No.
By Mr. Henretta:
Q How many laparoscopic procedures have you performed since you've been in practice?
A I don't know an exact number.
Q Do you know how many -- I mean of all kinds. Let's talk about in general. Laparoscopic procedures are in a number of varieties I understand.
A Right.

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

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

MR. HENRETTA: That he has performed.

By Mr. Henretta:

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

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

Q Sure.

A There's a variety.

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

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

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

A That's correct.

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

A Right.

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

You said tubal -- how many tubal ligation? Why don't we focus on that?

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

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

Twenty a year or twenty-some a year?

A Or more.

Q Possibly 30, 35, something like that?

A (Witness nodding.)

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

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

A No.

Q How did that happen in her case?

A That I'm not sure of.

Q It's not supposed to happen?

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

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

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

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

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

Q What do you mean half and half?

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

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

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

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

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

A No.

Q Or how about during the residency like a course?

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

Q Are you familiar with gasless laparoscopies?

A Yes.

Q What are those all about?

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

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

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

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

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

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

A You mean in the gasless laparoscopy?
Q When you say gasless --
A Again, I'm not familiar with it. I've never been trained to do that. All I know is just looking at journals and stuff.
Q So then I take it from that response that you did not consider that gasless procedure as an option for Sandra?
A No. I'm not trained to do that.
Q Would you consider yourself an Expert in performing laparoscopic procedures for tubal ligations?
A Yes.
Q I've read a lot of articles on this procedure, but I'm a layperson when it comes to this, so I want you to tell me, if I were a new medical student and I decided at age 58 I'm going to change my career and go to medical school and be a doc and I wanted to learn about these procedures, what would you tell me? How are they done? What would you tell me about the laparoscopic procedure? Sort of guide me through one.
A That's a pretty broad question.
Q I know. Of course it is. But I'm asking you how are they done? What would you do?

MS. LOESEL: Are you asking about a

gasless procedure?

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

By Mr. Henretta:

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

What are you going to do?

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

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

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

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

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

By Mr. Henretta:

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

A What did I say to this patient?

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

MS. LOESEL: You're asking his routine?

By Mr. Henretta:

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

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

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

Is that the form?

A That's correct.

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

A No.

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

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

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

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

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

Q Did you do that in this case?

A She needed an annual exam and that was performed.

Q By you or by somebody else?

A By me.

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

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

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

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

same discussion, I can do that.

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

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

Q I suppose you would.

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

A Describing a tubal ligation to a --

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

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

By Mr. Henretta:

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

to know because I want to learn.

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

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

By Mr. Henretta:

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

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

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

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

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

By Mr. Henretta:

Q Tell me how you do one.

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

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

What's the next thing you do?

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

By Mr. Henretta:

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

A Yes.

Q What's the next thing you do?

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

Q Which consent form?

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

Q Or they don't pay?

A Or they don't pay.

Q Okay.

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

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

Q So you give her the options?

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

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

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

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

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

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

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

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

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

Does that sound about right?

A No, 6-26.

Q 7-20-2000 is the date you signed it?
A No, that's date of surgery. This is following surgery.
Q Okay.
A This is filled out.
Q So this was given 6-26-2000.

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

A Yes.
Q Then surgical -- the date is I guess then 7-24-2000.
A That's on the second consent form.
Q Is that the day of the surgery?
A No.
Q The consent form then is signed -- this particular one was signed how many days in advance of the surgery?
A Four days.
Q So now after the Government form is discussed and explained to the patient, what's the next thing?
A Then she's brought back for a second visit and that's where we do -- we discuss the hospital's consent form, and I do it the same way, I go paragraph by paragraph explaining what it means.
Q And then this one, Plaintiffs' Exhibit 5, which I

think mirrors what you have in front of you there --
A Correct.
Q -- that is the consent form that the hospital uses?
A Correct.
Q Then you wrote in -- I take it you wrote in, I don't know whose handwriting that is.
A That's my handwriting.
Q How much time can you recall that you spent with the patient in going over this particular consent for operation/procedure?
A I would have to say it takes at least 20 minutes.
Q Is that done by you or somebody in your office?
A That's done by me.
Q And the patient only or is there somebody else in the room?
A Typically the patient and anybody she has with her.
Q Spouse, parent?
A Yes.
Q Was she alone at the time; do you know?
A It was my recollection that the husband was there for this discussion, but that's not reflected in the medical records.
Q What is meant by the term "failure rate equals 1 in 200 procedures"?
A Out of 200 women that gets their tubes tied, one of

them is going to get pregnant anyway.

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

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

Were those structures damaged in Sandra's laparoscopic procedure?

A Yes, the bowel and surrounding structures were damaged.

Q What is meant by the surrounding structures?

A In her case it was large blood vessels.

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

A That there are -- yes.

Q Did you tell her that?

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

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

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

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

Q Did you tell Sandra -- I don't see it on here. Did you tell her that -- did you give her an option of a laparotomy?
A We didn't discuss laparotomy.
Q I take it most women who elect -- and this is an elective procedure; isn't it?
A That's correct.
Q Who elect this procedure elect the laparoscopic procedure for the simple reason, I would guess, that there is less visible scarring from the procedure if all things being equal, right?
A Correct.
Q If it's the same as the two arthroscopic procedures I've had on my medial meniscal, there are three holes, right, generally three?

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

A Four.
By Mr. Henretta:
Q But they're small holes?
A On a knee surgery? I don't do knee surgery.
Q On the stomach.
A For a laparoscopy there's only one hole.
Q One site and that's for the Veress needle which also insufflates, I understand, puts carbon dioxide in

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

A Through the same incision.

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

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

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

A "I permit Dr. Cain" --

Q "To perform" --

A "If any unexpected condition occurs."

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

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

A No, I don't know how she could think that.
Q That's what she thought because that's what she said you told her.

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

MS. LOESEL: Objection.

A Is she wrong when she said what?
By Mr. Henretta:
Q I was only told that I had a risk of infection because of the opening and air would go in and I could have an infection and that's all the doctor I said I was going to have. He never told me I was going to have a big scar running from my sternum down to my pubic bone. That's what she told me.

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

MS. LOESEL: Objection.

By Mr. Henretta:
Q I don't think you did.

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

Q You did not tell her that?

MS. LOESEL: Objection.

A No.

By Mr. Henretta:

Q Fair enough, Doctor.

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

Q I heard you say that and I appreciate that.

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

MS. LOESEL: The surgery for the 28th?

By Mr. Henretta:

Q Yes.

A I couldn't tell you for sure.

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

Did she come in Doctors Hospital?

A Yes.

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

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

laparoscopic procedure on July 28, 2000?

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

(Discussion had off record.)

(Question read by Reporter.)

By Mr. Henretta:

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

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

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

A Then we position her on the table.

Q How do you position her?

A It's called low dorsal lithotomy position.

Q Is that supine?

A In stirrups.

Q On her back and her feet are in stirrups?

A Correct.

(Discussion had off record.)

By Mr. Henretta:

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

MS. LOESEL: If you need your notes.

By Mr. Henretta:

Q Feel free. Absolutely.
A If you want me to read through, it's going to take a lot longer. Usually there's a Nurse Anesthetist and an Anesthesiologist, a scrub nurse, a circulator, and in this case there was a general surgery resident with me.
Q Now then what is the first thing you do to begin this procedure?
A After the patient is positioned, I go in and scrub in, and then the first thing I'll do is drain the bladder with a straight catheter, put the speculum in the vagina so I can find the cervix, and then I put a tenaculum on the cervix to allow for manipulation during the procedure.
Q What's that device called?
A A tenaculum.
Q Prior to this, had you already selected the instruments of surgery for this procedure?
A Yes. They're standard instruments.
Q Veress needle, trocar and a scope, I guess.
A Correct.
Q Are some of those elective? By that I mean, is it necessary in all cases to use a Veress needle?
A I know of some surgeons that do trocar insertion without a Veress, at least that's the case.

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

A Without insufflation.

Q Without insufflation.

Why do they do that; do you know?

Those who choose, why is it?

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

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

A If what is done?

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

MS. LOESEL: If you know.

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

By Mr. Henretta:

Q Just a few minutes?

A Uh-huh.

Q So you elected because that's how you were trained primarily you elected to use the Veress needle -- does that pump in the C02?

A Yes.

Q And then the opening is made.

How large is the opening from the Veress

needle?

A The Veress needle is probably only about two millimeters.

Q Pretty small.

A Uh-huh.

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

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

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

A Right.

Q And how big of an incision is that?

A Typically a centimeter to centimeter and a half.

Q This all starts around the belly button?

A Correct.

Q Do you have a choice of size of trocar?

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

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

Does that make any difference?

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

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

Plaintiffs' Exhibit 7. Is that a typical

looking Veress needle?

A Yeah, that looks like a reusable Veress needle.

Q And is that the kind you used?

A No.

Q What kind of a Veress needle did you use?

A Disposable.

Q That's Plaintiffs' Exhibit 7.

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

A That, again, is a reusable trocar.

Q And you used a disposable trocar?

A Correct.

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

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

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

You used a disposable?

A Correct.

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

A Yeah, the reusable have been around much longer.

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

MS. LOESEL: If you know.

By Mr. Henretta:

Q If you don't know --

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

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

A Yes.

Q Within seconds or a minute or so?

A Yes.

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

A Uh-huh.

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

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

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

A Correct.

(Discussion had off record.)

By Mr. Henretta:

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

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

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

A It's right almost inside the belly button.

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

A Correct.

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

A Pretty much.

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

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

Q Would it be about a 45 degree angle?

A Generally.

Q Tell me about that.

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

Q The hollow area being in this vicinity?

A Over the top of this sacral promontory.

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

A The most serious complication that could occur, death.

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

A It's hard to quantify.

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

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

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

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

MS. LOESEL: An independent recollection?

MR. HENRETTA: Yes.

MS. LOESEL: Over and above his notes?

By Mr. Henretta:

Q You can look at the notes.

Do you remember the surgery?

A Yes.

Q Do you remember inserting the trocar?
A Yes.
Q Tell me what you remember next after you inserted the trocar.
A Describe it just like I described to you. I inserted the trocar and felt that it had hit something solid, and so when I removed the obturator --
Q What is obturator?
A The obturator is the sharp point on that trocar. It goes down the middle.
Q That? (Indicating)
A Yeah.
Q The pointy end?
A Right. And then the obturator will come out and leave the trocar, the sheath that you operate --
Q Where is the sheath, up at this end?
A On this diagram, I would guess it comes apart somewhere up in here, and there's the part with the blade on it that comes through the tube, and when you take that out, you leave just the tube --
Q Leave the tube so you can go through otherwise the body will close up?
A Correct.
Q What is your next recollection after the insertion

of the trocar?

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

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

A That there had been damage to a vessel.

Q At that point did you know which vessel?

A No.

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

MS. LOESEL: Objection.

By Mr. Henretta:

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

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

Q It had to go through the other side.

A Correct.

Q Which would be posterior?

A That depends on what you mean by posterior.

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

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

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

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

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

A (Witness complies with request.)

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

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

Q When you say up above --

A These are kidneys.

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

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

Q Can we go with --

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

A Yes.
Q Can you tell me what this represents to you in a very crude fashion? I take it these are kidneys over here.
A This should be the aorta, this would be the vena cava, and this would be your -- the injury was right in this area here. (Indicating)
Q Right here?
A Uh-huh.
Q How far I guess -- what's the length of that trocar? I mean, how does this happen? How did it happen in this case; do you know?
A No.
Q We do know that it must have happened upon insertion of the trocar?
A Yes.
Q And you're telling me that's a recognized risk to go right through the abdominal -- into the peritoneal cavity and out to the other side, that is a recognized risk of this procedure?
A Correct.
Q Can you tell me about the pressure that's used to insert the trocar? Can you quantify that at all?
A Not really.
Q Or the force?

A The force that I used to insert trocar?

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

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

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

Q And how do we avoid problems with blind insertions?

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

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

A No.

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

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

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

Q It was 12 millimeters in diameters?

A No, it comes to a point.

Q At it's widest it was 12 millimeters?

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

diameter of the trocar is. Right, makes sense.

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

MS. LOESEL: Objection.

A No, I don't.

By Mr. Henretta:

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

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

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

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

Q What happened?

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

By Mr. Henretta:

Q How do you account for this?

A I don't know.

Q Now this is Exhibit 2.

Is this your report of operation, Dr. Cain?

A Yes.
Q And it's a two-page report?
A Correct.
Q And it says "Postoperative Diagnosis is iliac vascular injury and small bowel injury."
What does that mean?
A There was an injury to the iliac vessel and there was an injury to the small bowel.
Q Then at what point did you make another cut into the patient?
A As soon as I saw nothing but blood through the camera, I took the trocar out and made the incision.
Q And how long or deep -- long, I guess, would be the incision, vertical -- was it a vertical incision?
A Yes. I made the incision from the umbilicus to the pubis.
Q What is that, about three, four inches?
A On her, yeah, it would be four or five inches probably.
Q Then what did you do after you made that incision? Was that the beginning of the laparotomy?
A Yes. Then we got into the pelvis and found the site of bleeding and put pressure on it until Dr. Conklin could arrive.
Q How did you exert pressure? Tell me what you did.

A Got wet lap tapes, and with a hand in there pushed as well as I could to stop the bleeding.
Q Who repaired the right iliac artery and vein?
A Dr. Conklin.
Q How did you get Dr. Conklin to the surgery?
A All I did was say, "Get Dr. Conklin in here quick" and they did the rest.
Q Did you assist?
A Yes.
Q What is a salpingectomy?
A That is tubal ligation.
Q Was that completed?
A Yes.
Q Did you do it or did Dr. Conklin do that?
A I did that.
Q That's after -- was that after she was entirely opened up?
A Yes.
Q Did Dr. Conklin open her up from her sternum down to the umbilicus?
A He enlarged the incision, yes.
Q Did she have any complications after the tubal or vascular injuries, anything that would keep her in the hospital a little longer?
A The whole case is about the vascular injury. I'm

not sure what your question is.

Q Fair enough.

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

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

Q Did you have an option of the amount of C02 gas to insufflate with?

A Yes.

Q Tell me about why you chose 4.5 liters.

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

Q This says laps were used to tamponade the major vessels.

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

A Yes.

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

A Yes.

Q You signed off on that as well?

A No.

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

A Copy.
Q But you said you assisted in this.
A Yes.
Q What's meant by the term exposure -- withdraw.
What's meant by the term "hypotensive"?
A Drop in blood pressure.
Q Can you talk about the blood loss? Do you know anything about how much blood she lost?
A It was estimated to three to four liters of blood.
Q Is that significant?
A Absolutely.
Q She was then in the process of being volume resuscitated.
What does that mean, putting more blood in?
A Correct. She was given packed cells, there was cell saver recycling the blood that we could collect from the cavity, and fluids.
Q What's meant by the term "retroperitoneal hematoma"?
A That would be a collection of blood behind the peritoneum.
Q In this case it says "There was already blood and a significant retroperitoneal hematoma around the iliac bifurcation."
Where is that?
A That would be that other pictures that --

Q Where is the iliac bifurcation?
A This is the iliac bifurcation. (Indicating)
Q I see. I'll put yellow on that.
How do we determine the distance from the point of insertion on Sandra to the right iliac artery? How far -- I don't know in terms of distance and how do you -- how can you tell me that? Was it five inches, six inches?
MS. LOESEL: Objection. If you can tell.
A Yeah, it would be hard to say.
By Mr. Henretta:
Q Why?
A It would vary with the insufflation of the abdomen as well, so --
Q Explain that. What do you mean it would vary with that?
A With the insufflation of the abdomen, the anterior abdominal wall is brought away from the posterior, spine and so that distance would increase.
Q But as far as you know, there was sufficient insufflation?
A Yes.
Q And you base that on the fact that you put in 4 something -- 4.2 liters?
A I believe it said 4.5 liters.

Q And how did you know that was a sufficient insufflator?
A Again, there's a pressure gauge on the insufflation machine.
Q Indicating that there's enough of a vacuum inside?
A Enough pressure, and you can also percuss the abdomen to know the sound that the -- the sound of the liver dulls and you don't have -- you can listen to organs just under the surface if the gas has sufficiently lifted the abdominal wall.
Q Here is Exhibit 4, Discharge Summary by Dr. Conklin. I believe you've signed off on it as the attending or assisting.
A Yes.
Q And I just wanted to talk a little bit about the final discharge diagnoses. I think we already know what elective sterilization means because we talked about it. No. 2 it says, "Accidental injury to the right iliac artery and a portion of the right iliac vein, small bowel injury."

Is that three injuries or two? What is that?

A It was all one injury, it's just three --
Q Three different areas?
A Three different structures.
Q Who dictated this summary?

A That was Dr. Conklin, I believe.
Q Did you help in the preparation of it or simply sign off or do you recall?
A They asked me to sign it off for some reason. I'm not sure why.
Q What is meant by "acute intraoperative hemorrhage"?
A She bled during the surgery.
Q I guess 4 means she lost blood?
A And it was measurable.
Q "5, Postop respiratory failure."
What happened there?
A That, I'm not sure about. That is probably the only diagnosis I would question. She was left on the ventilator after surgery prophylactic.
Q "Hypovolemic shock," what's that mean?
A That would be low volume drop in blood pressure is probably what they're indicating.
Q No. 7 discharge diagnosis, coagulopathy, significant to blood loss.
What's that mean?
A Coagulopathy is a disorder in blood clotting and I believe they were looking for DIC, disseminated intervascular coagulation, but I don't believe they found it, so I'm not exactly sure about that diagnosis either. She was given blood products to

prevent that.

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

A Uh-huh.

MS. LOESEL: You have to say yes.

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

By Mr. Henretta:

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

Hypokalemia, what's that mean?

A That's low potassium.

Q Where did that come from, loss of blood?

A It's probably related.

Q And vasovagal syncope?

A Syncope.

Q Syncope postoperatively, what's that?

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

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

A No.

Q Have you done other laparoscopic procedures besides tubal ligations?

A Yes.

Q What others have you done?
A Again, oophorectomy, salpingectomies, removal of ovaries, removal of tubes, removal of ectopic pregnancies, aspiration of cysts, laparoscopies, vaginal hysterectomies, and given time I could probably come up with a couple more.
Q How do those procedures differ from the tubal in terms of where you start?
A They all start the same.
Q At the umbilicus?
A Well, actually preparing the uterus for manipulation.
Q Do you enter in the same place?
A Yes.
Q And basically the same instruments?
A Yes. Most of those would require additional sites of entry.
Q Different sites of entry?
A Additional.
Q In other words, instead of just the one hole, there may be a couple, three?
A (Witness nodding.)
Q Is it essentially the same, you've got a Veress needle which serves as an insufflation device, the trocar provides an opening, and then a scope can be

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

Fair enough?

A Yes.

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

A I'm not sure I understand your question.

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

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

A Right.

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

A Right.

Q Artfully I can't go beyond that.

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

By Mr. Henretta:

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

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

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

A Yes.

Q Did you do that in this case?

A Yes.

Q Why is that done that way?

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

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

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

A Yes.

Q Is that how you did it?

A Yes.

Q Are you right-handed or left-handed?

A Right.

Q Where do you stand in relation to the patient?

A On the patient's left side.

Q That's what you did in this case?

A Yes.

Q How about training in laparotomy, been so trained as

trained in laparoscopic procedures?

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

Q How many laparotomies have you done?

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

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

A Depending.

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

A For a tubal?

Q For a tubal.

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

Q Not too popular.

Is that because of the --

A Scarring.

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

A No.

Q Do you remember discussing risk of damage to an

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

A By phone or in person?

Q Yes. Do you remember that?

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

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

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

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

A Yes, we did.

Q You did?

MS. LOESEL: He said "we."

By Mr. Henretta:

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

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

Q So you kept her alive.

How did you keep her alive?

A By tamponading the blood vessels.

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

standard of care in this case?

A No.

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

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

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

A No, I can't.

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

A I believe so, yes.

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

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

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

MS. LOESEL: Objection.

A I can't explain it.
By Mr. Henretta:
Q How do you account for it?
A I can't explain it.
Q This was a major vessel damage.
A Correct.
Q Could it have been the incorrect angle of insertion of the trocar that could have caused this?
MS. LOESEL: Objection. I think he said he can't explain it.
By Mr. Henretta:
Q I'm asking if that could cause it.
A Could that cause it?
Q Yes.
A Yeah, that could cause it.
Q Likewise, could excessive pressure or force in the insertion of the trocar caused damage to these structures that we're talking about, the right iliac vein, the small intestine?
A You're asking as a general question?
Q Yes, can that happen from excessive force or pressure from the insertion of the trocar?
A It could.
Q Do you know what the statistical incidence of damage to those structures in a laparoscopic procedure for

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

A No, I do not.

Q Do you have that data?

A No.

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

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

Q Do you know what an Open Hassen procedure is?

A Yes.

Q What is that?

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

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

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

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

A We may have done it a couple times during my

residency.

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

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

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

MS. LOESEL: Medicare or Medicaid?

By Mr. Henretta:

Q Medicaid, I'm sorry.

A I didn't understand the question.

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

A No.

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

A Yes, I have.

Q You have.

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

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

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

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

trocar insertion.

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

What does that mean?

A That's insufflation of the abdomen.

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

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

MS. LOESEL: Objection.

By Mr. Henretta:

Q Or not?

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

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

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

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

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

A Yes.

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

A Contraindications on her?

Q Were there any?

MS. LOESEL: For a tubal?

A I don't believe so.

By Mr. Henretta:

Q What are they in general?

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

(Discussion had off record.)

By Mr. Henretta:

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

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

A No.

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

A No.

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

MS. LOESEL: Thank you.

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

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C E R T I F I C A T E

STATE OF OHIO,)
)SS:
SUMMIT COUNTY.)

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

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

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

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

Stephanie R. Dean, Notary Public
in and for the State of Ohio.
My commission expires August 30, 2005.

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LAWYER'S NOTES

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