IN THE COURT OF COMMON PLEAS

OF CUYAHOGA COUNTY, OHIO

Doc 108

FRANCES SMITH, etc.,

Plaintiff,

vs. Case No.

ST. LUKES HOSPITAL, et al., 100877

Defendants.

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Deposition of ROBERT D. CENDO, a witness herein, called by the Plaintiff for examination under the statute, taken before me, Tia G. Moseley, a Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel, at St. Luke's Hospital, 11311 Shaker Boulevard, Cleveland, Ohio, on Tuesday, March 10, 1987, at 3:30 o'clock p.m.

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APPEARANCES:

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MR. KAMPINSKI: Swear in the witness, please.

ROBERT DAMEAN CENDO, of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF ROBERT DAMEAN CENDO

BY-MR. KAMPINSKI:

Q. Would you state your full name, please.

A. Robert Damean Cendo.

Q. Where do you live, Mr. Cendo?

A. At 12900 Lake Avenue, PH 30.

Q. PH 30?

A. Penthouse 30, Lakewood, Ohio, 44107.

Q. Where are you employed, sir?

A. St. Luke's Hospital.

Q. And in what position?

A. I'm a resident in orthopedics.

Q. How old are you?

A. 32.

Q. I'm going to ask you a number of questions. If you don't understand any of them please tell me and I'll be happy to rephrase them. When you respond, please speak out

verbally.

A. I understand.

Q. Run me through your educational background, sir, please, if you would.

A. I was actually born in Ljbljuana, it's a city on the border of Austria and Yugoslavia, and went to first grade there.

I then arrived the United States in 1962, went to two years of the St. Vitus and continued my education through various public schools around the city as we moved.

Q. In Cleveland?

A. Well, Cleveland and Parma and then Strongsville, as we moved economically to the suburbs, sort of my schools changed, and then I enrolled in Lake Ridge Academy, where I graduated in 1972, it's a high school out in North Ridgeville.

Q. What did you do after that?

A. I went to Case-Western Reserve where I received a B.S. Degree in chemistry.

Q. When?

A. Actually, in 1975 is when I finished. I went for three years. I then went down to University of Autonomous in Guadalajara.

Q. Mexico?
A. Mexico, correct, and I went there for about three years.
Q. When did you go?
A. It would have been in 1976.
Q. Until when?
A. Until 1979.
Q. Did you apply to any American medical schools?
A. No, I only went to three years in college.
Q. Did you get a degree?
A. I did. I was missing eight hours and I received them through advanced placement in Spanish which I learned in Mexico in 1982.
Q. Let's go slow. You went to Case-Western Reserve from what years, 1972 to 1975?
A. To 1975, correct.
Q. And you left there before you graduated?
A. Technically, yes.
Q. Right?
A. Yes.
Q. You needed eight credits?
A. Eight credits.
Q. You didn't get those until 1982?
A. I didn't apply for them until 1982. The

credits were actually received in 1976 through a six-month intensive Spanish course which I took in Mexico.

Q. What kind of course was that?

A. Spanish.

Q. Oh, it was a language course?

A. Right, right.

Q. Those are the eight credits you needed was the Language?

A. Correct, and I came back and actually took a test and sat down with a Spanish teacher for a half an hour and we spoke in Spanish and he said, I'll give you eight hours.

Q. And when was that, 1982?

A. That was in 1982 actually, yes.

Q. What Spanish teacher was that?

A. I don't know, somebody at the Spanish department at Case.

Q. So you got a diploma then in 1982?

A. In 1982. However, they backdated it to 1976 and I'm considered to be a graduate of 1976. It's a little complicated because --

Q. We'll take all the time we need to understand it. That's all right.

A. Okay, and then I transferred from

Guadalajara to the Medical College of Ohio.
Q. Just hold on for a second because I want to know how it is that you got into the University of Autonomous without a graduate degree.
A. There is no undergraduate degree required in Mexico and the United States of America. You simply are required to take a core curriculum of two years of biology, one year of chemistry, one year of math, one year of physics and six months of English. That qualifies you for admission to an American medical school.
Q. But you didn't go to an American medical school.
A. I did. Let me finish the story. I then transferred from Guadalajara to the Medical College of Ohio in 1980.
Q. Wait. To which college? I'm sorry, sir.
A. Medical College of Ohio, Toledo.
Q. Why did you transfer?
A. Well, you know, when I went to Mexico, I thought it would be a little exciting to go to a different country and leave Cleveland, I had been here in high school and college and

decided that perhaps my training would be better served by an American medical school.

Q. Why, weren't you receiving good training?

MR. ZELLERS: Objection.

A. I was. In fact, I did same externships here at St. Luke's.

Q. Did some what?

A. Externship is when a medical student goes to a hospital and spends a couple months as a medical student.

Q. When did you do that?

A. When did I do that?

Q. Yes.

A. Oh, gosh, 1977, 1978, in those years.

Q. Like summer?

A. Oh, no no, no, this was during the school year.

Q. How long would these externships take?

A. Anywhere between three and six months. I don't want to bore you with all the details.

Q. Oh, no, you're not boring me.

A. The fact was that I wanted to get clinical training in an American medical school so Medical College of Ohio was a three year program, so I went into there.

I passed the national boards, did well enough to transfer my college credits and my AMCAT scores were good enough and they took me in in 1980 to their second year, which would be today's fourth year medical school, third year, which meant I spent two years of pure clinical training as a Medical College of Ohio student, no difference.

Q. Is that an osteopathic college?

A. Oh, no, Medical College of Ohio in Toledo.

If

MR. KALUR: Off the record.

(Discussion had off the record.)

A. It's a fairly large medical school, established in 1964.

Q. So you went through two years there, right?

A. Two out of three, two years, The basic science part I had done, I had passed the boards and that was not required.

Q. So you were there until when, 1982?

A. 1982, correct.

Q. Then what did you do?

A. I'm sorry?

Q. Then what did you do?

A. I came here as a resident in orthopedics.

Q. Did you have to fill out an application?
A. Of course.
Q. And did you tell them everything you're telling me on that application?
A. Of course.
Q. And you were approved for residency here beginning when?
A. 1982.
Q. When in 1982?
A. It would be July 1st, 1982.
Q. When is it that you decided that you wanted to go into orthopedics?
A. I can't really give you a specific date. I believe when I did a one-week externship here in the late 70's I enjoyed it and I decided to go into that.
Q. Did you do anything at the Medical College of Ohio of Toledo that led you to a specialty in orthopedics?
A. I had made my decision before then.
Q. So you came here as an orthopedic resident; is that correct?
A. Correct. My mother was a pediatric resident here many years ago, I actually lived across the street when I was very young.

Q. I see. So your mother is a pediatrician?
A. Yes.
Q. How about your father?
A. My father is a metallurgist, engineer, but he's retired many years.
Q. You're still doing your residency now?
A. Fifth year.
Q. Do you have a job lined up for when you finish this particular year?
A. I have a fellowship lined up, yes.
Q. Where?
A. Grand Rapids with Dr. Alfred Swanson, starting in January of 1988.
Q. In 1984, you were a second year resident; is that correct?
A. That would have been correct. It depends which month.
Q. November.
A. Third year resident.
Q. When does it switch?
A. July 1st.
Q. As a third year resident --
A. I'm sorry, it would be second year, it would be a second year resident, 1984, but I would be, it's a little complicated, I would be

a second year orthopedic resident but I would be a postgraduate three year resident, first year is spent in general surgery as required by the American Board of Orthopedics.

Q. So how were you a third year resident? I mean you came here in 1982, July of 1982.

A. July of 1982 to June of 1983.

Q. You did general surgery residency?

A. You're correct.

Q. First year orthopedic?

A. First year orthopedic, yes, second year post medical school, correct.

Q. And what do you do as a first year orthopedic resident? I mean is that the bottom of the totem pole so you do everything that everybody else wants you to do?

A. Not really. The program is set up where you have two chief residents and the other residents are basically on par with each other to a degree.

Q. Regardless of what year they are in?

A. If it comes to scheduling for types of surgeries to assist in, your year would count, but as far as taking call, that's not changed.

Q. What does taking call involve?

A. It involves handling any acute problems that develop on the floor and covering emergencies in the emergency room.

Q. And you can do that as a first year resident?

A. Certainly. I received one year of general surgery training, which was basically a well-rounded training on medical and surgical management of patients.

MR. ZELLERS: He would have been in his third year in November of 1984.

MR. KAMPINSKI: July of 1982 to July of 1983 and July of 1983 to July of 1984.

A. So I was right.

Q. So third year post medical and second year orthopedic?

A. Right.

Q. Who were the two chief residents in 1984?

A. It would have been, at that time, the chief resident would have been Michael Morrison. The other fifth year resident would have been Michael Gill.

Q. How about Miller?

A. Miller is in my year.

Q. How about Peters?
A. Peters is a general surgery resident and he notated through the orthopedic program for a period of I believe two months.
Q. When you say on call, that's what, midnight shift when nobody else was around or any time?
A. From 8:00 o'clock in the morning until 8:00 o'clock the next day.
Q. Is a certain resident scheduled to be on call during specific shifts? Is that how it works?
A. It's a 24 hour shift, a certain resident covers a 24 hour shift.
Q. So when we see your name on November 16th for the on-call note, that reflects that you would have been there the entire day?
A. From that morning until the next morning.
Q. So that at 9:30 p.m., you would have been in the middle of your shift?
A. Yes.
Q. Would you have worked that day?
A. Yes.
Q. Were you the only orthopedic resident on call? I mean would there only be one on call

per night?
A. Only one in the house. There is always a second resident on call from either the call room or from home.
Q. Is the reason that you weren't called the evening of November 17th is you'd been working all day and you were sleeping at night?
MR. ZELLERS: Objection, if you know.
A. Why I wasn't called on the 17th?
Q. Yes.
A. There would be no reason for me to be called.
Q. Have you looked at the nurses notes?
A. I read through the nurses notes.
Q. Did you see that there was a note, a couple notes reflecting that Mr. Smith's left leg was internally rotated, did you read those notes, sir? I'm just asking if you read them.
A. Yes.
Q. Did you read the notes on the 17th, the day of the 17th?
MR. ZELLERS: The nursing notes.
A. Yes, I read all the notes.

Q. Should you have been called, sir, in your opinion?

MR. ZELLERS: Objection. At what time?

MR. KAMPINSKI: Midnight.

MR. ZELLERS: Do you want to read the note?

A. I'm not sure how I can answer that.

Q. Well, try.

A. Okay.

MR. ZELLERS: If you can.

A. Sure. If the nurse was concerned that there was a dislocation, then the procedure would be to call me.

Q. There was a dislocation, wasn't there, sir?

MR. ZELLERS: Objection.

A. There is nothing to indicate there was a dislocation.

Q. Well, they operated on the man the next day, didn't they?

A. There was no dislocation confirmed until the next morning when the X-ray was obtained.

Q. Well, it was confirmed then, but do you see anything that took place between the notes

of November 17th starting at 12:00 p.m. until the time it was confirmed the next morning?

A. Would you rephrase that? I'm not sure what you mean.

Q. Do you see anything that would have caused the dislocation between the midnight entry and the time when they in fact confirmed that the leg was dislocated?

MR. ZELLERS: Objection.

A. Nothing to cause dislocation, no.

Q. Sure, and there are notes in there indicating that the leg was internally rotated, are there not?

A. There are notes indicating the patient kept his leg in some internal rotation, correct.

Q. I don't see where it says the patient kept his leg in internal rotation. Can you point that out?

A. The notes state that patient was advised not to keep his leg in internal rotation.

Q. No, no, no, the note of the 17th starting at 12:00 o'clock, Dr. Cendo.

A. You said several notes and there are several.

Q. Let's start with the 17th starting at

midnight. That's the night you were duty, right?

A. Correct.

Q. And it says at the 12:00 o'clock entry, the very last part of that entry, left leg rotated internally?

A. Correct.

Q. It doesn't anything about the patient keeping his leg rotated internally, does it?

A. No.

Q. And then the 6:00 a.m. entry, left leg remains internally rotated, right?

A. Correct.

Q. Now, is there anything from midnight, I'll ask the question again, of November 17th until the time that it was diagnosed that you can see that would have caused the dislocation?

A. No.

Q. So would it be fair to assume that looking at these records, and obviously you didn't examine it then, but that the dislocation existed at midnight of the 17th?

MR. ZELLERS: Objection.

A. No, not at all.

Q. When did it occur?

MR. ZELLERS: Objection.

A. That's something that I really can't answer. I was not there.

Q. Looking at these notes, in terms of probabilities, when would you say it occurred? We know it occurred.

MR. ZELLERS: If you can answer.

Q. Right?

A. I can't answer. It's a hypothetical question for me to give you an answer of when it occurred. I'm not sure anybody could know,

Q. But you do see the notes though that say patient, left leg rotated internally?

A. I see that, correct.

Q. That doesn't mean that it was dislocated, to you?

A. It does not mean dislocation.

Q. The next entry the following morning, the 8:00 a.m. entry by Nurse Kennedy, what does that reflect to you in terms of a dislocation, anything?

A. At the bottom of the page here?

Q. Well, it starts there, yes, and it goes to the next page. Why don't you read it so we

know what we're talking about.
A. Starting at the beginning?
Q. Yes, sure.
A, Awake and alert, slightly diaphoretic, 02 maintained at: four liters, something per, no nasal cannula, IV patent, left forearm site good, refusing per pump, left leg in five pounds Buck's traction and internally rotated, unable *to* reposition to proper alignment.
Q. Does that indicate anything to you with respect ***to*** a dislocation, sir?
A. It may make you suspicious that there are problems in the hip. It does not confirm anything.
Q. Well, you would need an X-ray to confirm it, wouldn't you?
A. Correct.
Q. But this is the same entry, except with the attempt to reposition it, that we see in the early morning of the 17th, is it not, that is the internal rotation of the left leg?
A. But it states unable to reposition, not attempt. There is nothing written before about attempt.
Q. When you see a left leg internally rotated,

is that what you're supposed to do, to try to reposition it to determine if there is a problem?

A. If you feel that there is some problem with the leg, yes.

Q. So that would then tip you off, if you couldn't reposition it, to call a doctor, is that what you're saying?

A. It would make you suspicious, correct,

Q. And apparently the nurse on duty the night before made no such attempt to reposition it, correct?

MR. ZELLERS: Objection.

A. Not that I can read from her notes,

Q. You were called at some point at 9:30 p.m. on the 16th; is that right, doctor?

A. Yes.

Q. Why were you called?

A. Patient had some emesis of coffee ground material.

Q. Emesis means what, doctor, vomited?

A. Vomited.

Q. Did you read the entire note and record regarding Mr. Smith when you went to see him or did you just go examine him? What did you do

when you got there if you remember?
A. I don't remember. I can tell you what I've always done when I've been on call, but I can't give you specifics.
Q. Go ahead.
A. The nurse would call, I would speak to her, look at the chart to get an idea of what the patient had done, what his general conditions were, what the physicians notes were and what the lab values are.
Q. When you say the lab values, what lab values would you check?
A. Depending on the problem, for suspected bleeding in the upper intestinal tract, I would look for the hemoglobin.
Q. How was the hemoglobin?
MR. ZELLERS: As of when?
MR. KAMPINSKI: As of 9:30 when he went to see him.
A. I believe it was 11.4.
Q. How would it have been before that?
A. Before when? On his admission?
Q. Sure.
A. It was in the 15 range, I believe.
Q. So it decreased from 15 to, what did you

say, 11.4?
A. He had had major surgery between that time.
Q. What kind of blood loss did he have during surgery, did you look at that?
A. Actually, I don't know the numbers. I believe 200 rings a bell.
Q. 200 cc's?
MR. ZELLERS: If you know.
A. I can't be positive.
Q. Well, take a look.
A. Okay, as stated by Dr. Gill in his note, estimated blood loss was approximately 200 cc's.
Q. Which operation, second one?
A. No, I saw him after the first operation.
Q. So 200 cc's, would that account for a blood loss of or the hemoglobin decrease from 15 to 11.4?
MR. ZELLERS: If you know.
A. 200 cc's is the blood that was lost to the floor.
Q. Yes.
A. Blood lost from the patient's intravenous blood volume would be much more.
Q. Where would you lose the blood?

A. You could easily lose two units in a thigh.

Q. How about internally, could that account for a decrease in the hemoglobin?

A. It can, yes.

Q. An intestinal bleed?

A. Certainly.

Q. Did you check it out?

A. Did I check out if he had an intestinal bleed?

Q. Yes, did you?

A. He had a Guaiac positive emesis.

Q. Which tells you what?

A. Indicates very strongly that there is some blood in the stomach.

Q. What did you do for it?

A. I treated him with a medicine meant to lower the acidity in the stomach.

Q. How is that going to assist: the bleed, sir?

A. I suspect that he had gastritis, an inflammation of the stomach.

Q. How about an ulcer, did you suspect that, a bleeding ulcer?

A. It's possible. However, this medicine

would also stabilize the bleeding ulcer.

Q. So did you order any tests to be done to determine where the bleed was from?

A. He was getting a hemoglobin the next morning, which would be my test of interest. The diagnosis of what his upper GI bleeding was would be done by his internist.

Q. Who was his internist?

A. Dr., I believe it was, Jackson.

Q. Wasn't he an orthopedic patient?

A. He was at that time under the orthopedic care. However, orthopedists do not investigate GI bleeds.

Q. They don't?

A. No.

Q. What do they do, get consults?

A. Yes, and he had already had a consult.

Q. He did, for a GI bleed?

A. For medical problems, of which GI bleed is included.

Q. How about do orthopedists deal with cardiac problems if a patient has cardiac problems or do they get a consult with that?

A. The orthopedist as primary physician, the responsibility to the patient is to get

whatever help is needed to resolve any problems the patient may have.

Q. Including cardiac problems?

A. Any problem.

Q. Was a cardiac consult called in, to your knowledge, on Mr. Smith?

A. An internist is qualified to handle cardiac problems.

Q. Is it your testimony then that you didn't do anything other than -- what medication did you prescribe, sir?

A. Tagamet and Maalox.

Q. -- other than prescribe Tagamet and Maalox, is that what I understand you to say?

MR. ZELLERS: Objection.

A. My focus at that time was to stabilize the patient's problem, not to investigate his problem. I have not, at that time or since then, investigated GI bleed nor would I.

Q. Did you check other lab values?

A. I went through his seven and noticed that he had a decreasing BUN, which could also account for the lowering of the hemoglobin, dilution.

Q. Did you ask about the CPK enzymes?

A. The patient had some type of stomach problem, no complaints of chest pain or gastritis.
Q. Was he diaphoretic?
A. When I saw him, he was not. He actually felt better after the emesis.
Q. But it was reported to you that he was, right?
A. There was some notes previously that he had had some episodes of that, apparently from previous medical problems that he might have had.
Q. So what you're saying is you didn't look at all the lab valves, only those that concerned you with respect to the complaints of stomach pain and the vomiting?
A. I looked at all the values relative to the patient's problem at the time.
Q. Well, were his CPK enzymes relevant to his problems at the time?
A. No.
Q. So you didn't look at them?
A. I may have looked at them but they wouldn't have meant anything to me.
Q. Why is that?

A. The person had no chest pain. He was being followed by a medical doctor.
Q. How did you know he was being followed by a medical doctor on November 16th at 9:30 p.m.?
A. Because the first thing I would do for a medical problem is to either see if a medical doctor is following him or to obtain a medical doctor's consult.
Q. My question is how did you know there was a medical doctor following him, Dr. Cendo?
A. He had a consult in the chart,
Q. Where was that?
A. Usually it's kept in the front of the chart and it clears the patient for surgery. He was cleared for his first surgery by Dr. Jackson on a consult which is written in the chart.
Q. So did you call then for Dr. Jackson to come in and look at him?
A. I believe I informed Dr. Jackson.
Q. When was that?
A. That would have been that evening.
Q. Is there anything in the chart that reflects that you did that?
A. No.

Q. How is it that you say that you did?
A. Any medical problem, I call the medical doctor.
Q. So it's your testimony that you called Dr. Jackson?
A. I believe so, at least informed Dr. Smith of this, of the situation.
Q. And that's not in the chart either?
A. Correct, because I wrote the note and then made the calls.
Q. Well, wouldn't you write who you called in the note?
A. Not until I got my page through and received a callback.
Q. And then you came back and you wrote it then?
A. No, I did not write it. I wrote the note first and then made the call.
Q. Aren't you supposed to go back and indicate that you did call a consult?
A. You're not supposed to, no.
Q. You're not?
A. No.
Q. Read your note for me if you would.
A. Certainly, page number 119, the date in

the note is 11-16, on the same line if says on-call note in capital letters, the time below the date is written as 9:30 p.m., note begins with patient had coffee ground emesis, positive Guaiac tonight, also complains of some abdominal distress, unable to void, no other complaints, there is a line and then patient may have gastritis or stress ulcer (stablize intubation) plan, Tagamet IVPO, Maalox PV, Foley catheter, and my signature.

Q. How long would you say that you saw Mr. Smith?

A. For what period of time?

Q. Yes, how long were you up there?

A. I can't recall, however long it took to assess the problem.

Q. And you didn't go back to see him later that night?

A. I routinely make rounds around 11:30 or 12:00 o'clock when I'm on call and talk to the nurses to see if there are any problems.

Q. Did you or didn't you see him that night, sir?

A. I can't recall.

Q. There are no other notes in the chart,

are there?
A. The patient apparently stabilized his gastritis and there would be --
Q. Stabilized, that's a word I've heard before today. What does that mean?
A. Stopped vomiting.
Q. Since he was an orthopedic patient and you would be the person on call, would you have been the one that should have been called if there was a problem, an orthopedic problem?
A. I would have been called first if there was any problem unless the patient had an arrest, in which case a code would be called and any nearby physician would respond.
Q. Did you have anything else to do with Mr. Smith during his hospitalization at St. Luke's?
A. Not that I can recall.
Q. Have you gone through the chart?
A. I've gone through the chart and I've seen no other evidence of it.
Q. Did you discuss Mr. Smith's situation with anybody after his death?
A. I was not aware that he died.
Q. Until when?
A. About a month ago.

Q. Was it typical during your residency, which you're still involved in, to assist surgeons, orthopedic surgeons in various types of surgery?
A. Yes.
Q. And these are staff physicians, I take it?
A. Correct.
Q. And you're supposed to receive training from them?
A. Correct.
Q. Would they rely on you in 1984 to obtain consent forms, signed consent forms?
MR. ZELLERS: Objection.
A. Yes, we obtain a consent form for a total hip. I'm not sure what we rely on.
Q. Would they have the residents do that, I mean go and explain the risks and procedures to the patient?
A. Oh, no, no.
Q. They just have you actually physically get the signature?
A. Physically get the signature, yes,
MR. ZELLERS: Just for clarification, is that what you mean when you say we? You said we yet a consent form.

THE WITNESS: The residents.
MR. ZELLERS: Yes.
THE WITNESS: A simple signature. The attending physician explains the procedure to the patient.
Q. So yours is just a ministerial function to get the signature, not to explain the risks?
A. Yes.
Q. Would the orthopedic surgeon rely on the residents in 1984 to check on past lab values of a patient and apprise him of those values?
MR. ZELLERS: Objection.
A. The attending physician has the responsibility of making sure that the patient is ready for surgery. His consult to a medical person would be the person that he would rely on. Certainly we have input into a situation but they make the decisions.
Q. What kind of input?
A. Well, if I see a value that I think is questionable or I have some question, I --
Q. Tell them?
A. -- I will ask him, yes.
Q. How about checking on the pre anesthesia note, would you do that or was that something

that residents did in 1984?

MR. ZELLERS: Objection.

A. You have to explain to me pre anesthesia note, I'm not sure what you mean.

Q. Sure.

MR. ZELLERS: I think it's 152.

MR. KAMPINSKI: That's where I'm at.

Q. Would the residents in 1984 make it a habit of checking the pre anesthetic evaluation sheet?

MR. ZELLERS: Objection.

A. No, this sheet is in the possession of the anesthesiologist.

Q. If a resident did look at that, the purpose would be what, to insure the accuracy of the things contained on the sheet?

MR. ZELLERS: Objection.

A. I don't know.

Q. Did you ever work with Dr. Stephens or Dr. Smith?

A. Yes.

Q. You still do, I take it?

A. Yes.

Q. Do you ever do surgeries with them observing?
A. I assist them in surgery.
Q. That wasn't my question.
A. That's a broad question, have they observed me doing surgery?
Q. That's right.
A. Have they watched me doing a case with another attending?
Q. No, no, with them being the attending.
MR. ZELLERS: Objection.
Q. You understand my question?
A. I'm there as an assistant.
Q. Have you ever done a surgery where they've just watched?
MR. ZELLERS: On a private patient?
MR. KAMPINSKI: On any patient.
A. They're always there directing me. On a private patient, it's their patient.
Q. So?
A. Well, they are there, they are in their scrubs.
Q. I didn't ask you if they were there. I

asked who did the operation, you or them.

MR. ZELLERS: Just in general in any case?

MR. KAMPINSKI: That's right.

Q. Have you ever done it with them just watching and not doing anything other than directing and observing?

MR. ZELLERS: Objection.

A. In a private patient?

Q. Either private patient or a staff patient.

A. I've done surgery on their direction, right. I'm not sure what you mean by just watching. It sounds so casual. They are there directing whatever I'm doing.

Q. And I take it this would be true of other residents as well, that's part of your training, to get involved in actual surgeries?

MR. ZELLERS: Objection.

A. Of all residency programs, yes.

Q. You weren't involved in either of the surgeries on Mr. Smith, were you?

A. No.

Q. Who makes a decision as to where a patient goes from surgery, whether he goes to the recovery room or ICU, to your knowledge, is

that the attending, the anesthesiologist, both?
A. It's always been both, but I believe the anesthesiologist is in control in the operating room and in the recovery room of the patient, he has the final word there.
Q. That's how you've been trained, that your patient --
A, That's my impression. I've never really had a conflict. We work in cooperation. If one of the physicians feels that the patient needs something, then there is really not much disagreement usually.
Q. Did you have to take a test in Ohio for Licensure as far as practicing medicine?
A. Sure.
Q. When did you take it?
A. I took the national board exam, parts one two and three.
Q. So you're not board certified?
MR. ZELLERS: Objection.
A. Of course.
Q. When were you board certified?
MR. ZELLERS: I think you're --
THE WITNESS: Does he mean

orthopedics?

MR. ZELLERS: You explain to him what you mean by being board certified.

A. I passed parts one, two, and three of the American boards which makes me certified to practice medicine by the national boards. I received a license in the State of Ohio, permanent license in the State of Ohio in 1983, I believe in August, after the required one year of residency that the State of Ohio requires.

Q. Was it necessary for you to get your undergraduate degree before getting your medical degree?

A. No.

Q. After a procedure such as a hip replacement, what's the purpose of Buck's traction?

A. It helps to take some of the spasm out of the leg, it makes the patient more comfortable, it also helps to insure that the legs are in a position of abduction, which means spread apart.

Q. How long is Buck's traction left on a patient following surgery?

A. Typically 24 to 48 hours, but again it's

under the discretion of the attending surgeon.
Q. Can it cause problems if it's left on too long?
A. I have not seen any,
Q. How long was it left on Mr. Smith?
MR. ZELLERS: If you know,
A. I don't know.
Q. Why don't you take a look,
A, This would be the 17th and the surgery was --
Q. It was on when you saw him, right?
A. Yes, yes. I believe three days.
Q. Until he went into surgery again on the 17th?
A. The 14th through the 17th, correct.
Q. Do you know why it was on on the 17th?
A. As I said, it helps the patient with muscle spasms, makes them more comfortable and helps secure the leg in the spread-out position
Q. Would it have any effect on a leg that was rotated internally?
MR. ZELLERS: Objection.
A. I don't think so.
Q. Is methyl methacrylate -- is that it?
A. Yes, methyl methacrylate.

Q. -- still used?
A. Certainly it is.
Q. To your knowledge, does it have any problems associated with heart attacks, MI's?
MR. ZELLERS: Objection.
A. There is some studies in literature suggesting that in the first several hours there may be some difficulties.
Q. Do you know what those difficulties are?
A. Not specifically. They are still controversial, nothing has been defined.
Q. Well, I mean are you taught here in the course of your residency to be aware of the potential of those problems when that substance is used in a hip replacement?
A. The anesthesiologist is aware of it.
Q. Well, how about the orthopedic surgeon, I mean don't you have any relationship with respect to your patient or responsibility to insuring that he doesn't encounter problems, sir?
MR. ZELLERS: Objection.
A. I've not seen a problem in my training.
Q. Did Mr. Smith receive methyl methacrylate?
A. Yes.

Q. He wasn't supposed to though, was he?

MR. ZELLERS: Objection.

MR. GROEDEL: Objection.

A. I have no idea.

Q. And do you know if he had any prior cardiac problems before he was admitted for this surgery?

MR. ZELLERS: If you know.

A. I don't know.

Q. Would that be something that would be taken into account before using that substance --

MR. ZELLERS: Objection.

Q. -- Dr. Cendo?

MR. ZELLERS: I object. If you have an opinion, you can give it.

A. I honestly have no, have not ever seen a problem with that.

Q. So if somebody has hypertension, you just go ahead and use the substance anyhow, right, regardless of the potential effects it can have on his heart, is that your testimony, Dr. Cendo?

MR. ZELLERS: Objection. You're asking him a hypothetical question. He had no contact with this patient. He doesn't

know this patient's background.

MR. KAMPINSKI: Have I asked him about Mr. Smith?

MR. ZELLERS: No, but you're asking him a very general hypothetical question.

MR. KAMPINSKI: Let him answer. He testified that he is very adept at handling acute problems and, you know, I get the feeling from Dr. Cendo that he's certainly aware of problems that patients can have and I'm asking him about a potential problem.

A. Methyl methacrylate is being used for about 25 years and there has really been no studies in the literature showing that it's had any problems.

Q. You just told me that there have been studies.

A. There were studies in dogs suggesting that the first couple hours after surgery there might be some problems but again, they were controversial.

Q. So you don't worry about it?

MR. ZELLERS: Objection.

A. That's all the studies that I know of. That's nothing that's really been translated

into human studies.

Q. How about studies reflecting the incidence of death following myocardial infarction followed by a second surgery, how about any of those studies, are you aware of them?

MR. ZELLER: That you're aware of as an orthopedic resident.

A. No.

Q. You're not aware of any of those?

A. No.

MR. KAMPINSKI: That's all I have.

MR. GROEDEL: I have no questions.

MR. ALBERT: No questions.

MR. KAMPINSKI: You have a right to read your testimony. You have a right to waive your signature. Your attorney can advise you.

MR. ZELLER: I advise you not to waive your signature.

CERTIFICATE

The State of Ohio,)

SS:

County of Cuyahoga.)

I, Tia G. Moseley, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, ROBERT DAMEAN CENDO, 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 above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

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 for 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 Cleveland, Ohio, on this 24th day of March, 1986.

Tia G. Moseley, Notary Public
within and for the State of Ohio

My commission expires March 14, 1991.