Certified Copy

IN THE COURT OF COMMON PLEAS
STARK COUNTY, OHIO

SANDRA J. SHONK, ET AL.,	)	
Plaintiffs,	)	
vs.	)	Case No. 2001 CV 01895
DOCTORS HOSPITAL OF STARK COUNTY, ET AL.,	)	
Defendants.	)	

DEPOSITION OF

MARC COOPERMAN, M.D.

Taken at the offices of
Marc Cooperman, M.D.
250 Deer Creek
Powell, Ohio 43065

on October 2, 2003, at 10:31 a.m.

Reported by: Sara S. Fuller, RPR/CRR

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APPEARANCES:

J. Thomas Henretta
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on behalf of the Plaintiffs

VIA TELEPHONE:

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on behalf of the Defendant,
Daniel J. Cain, D.O.

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that the deposition of MARC COOPERMAN, M.D., the Witness herein, called by the Defendant under the applicable Rules of Civil Procedure, may be taken at this time by the notary pursuant to agreement of counsel; that said deposition may be reduced to writing in stenotypy by the notary, whose notes thereafter may be transcribed out of the presence of the witness; and that the proof of the official character and qualification of the notary is waived.

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MARC COOPERMAN, M.D.

being first duly sworn, as hereinafter certified, deposes and says as follows:

EXAMINATION

BY MR. LOESEL:

Q As I already mentioned, my name is Pam Loesel and I represent Dr. Cain in this case, Dr. Cooperman.

Can you state your full name for the record.

A Marc Cooperman.

Q And have you ever had your deposition taken before, Dr. Cooperman?

A Yes.

Q Okay. Just to go through some of the formalities, I do ask that you please answer all of my questions verbally, and try to stay away from saying uh-huh or hmm-hmm, or nodding your head. Of course, I can't see a nod of the head on this end.

Also, I do ask that if a question is unclear, please let me know that and I will either rephrase the question or have the court reporter repeat it, whatever is

necessary. Is that fair?

A Yes.

Q Okay. And finally, if, for some reason, you get beeped and need to answer a call or have to take a break, let me know, okay?

A That's fine. Thank you.

Q Okay. Thank you.

Dr. Cooperman, I received a curriculum vitae from Mr. Henretta's office, and it appears that you had sent this curriculum vitae to them in January of 2003. I know you cannot see a copy of what I have here. There are approximately eight pages to this curriculum vitae.

Have you updated your CV since January of 2003?

A Yes, I did it just relatively recently.

Q Okay. And do you have a copy of your current CV there with you today?

A I can certainly make one.

Q Okay. I would ask that you do so, and then I would like the court reporter to

mark that as defendant's first exhibit, okay?

A Yes. And the changes are relatively small. There are no additional publications.

Q Okay. Can you tell me to the best of your recollection what those changes would be?

A An addition would be that I'm now a surgical consultant for the Veterans Administration Hospital clinic in Columbus.

Q Okay. Anything else?

A You'd have to tell me what hospital privileges you have on yours.

Q Okay. The hospital privileges that this CV indicates are Ohio State University Medical Center East Campus, which is active.

A Yes.

Q Okay. Mount Carmel, it looks like East Hospital, active.

A That's changed to courtesy.

Q Okay. And Mount Carmel Medical Center is courtesy?

A Yes.

Q And Riverside Methodist Hospital, honorary.

A Yes.

Q Okay. And are there any additional?

A The Veterans Administration would be active.

Q Okay. Nothing else beyond that?

A No.

Q Okay. Can you briefly give me a little bit of information regarding your educational background.

A Yes. I did my undergraduate at Yale University and got a bachelor's degree in 1969. I then went to medical school at Stanford and received my MD in 1973. I then did the first two years of my general surgery residency at the University of Chicago, and then completed it at Ohio State in 1977.

Q Why did you change schools?

A Residencies?

Q Yes.

A They had a pyramid after the end of two years where they cut from 12 people to

four, and I wasn't offered a spot there as one of the four.

Q Okay. So then you went on to OSU and completed your residency there?

A Yes.

Q Okay. And your current practice is located where?

A It's at 1492 East Broad Street, Columbus, Ohio. And it's Suite 1403.

Q And what does your current practice consist of?

A Well, it consists of a variety of things. One of the things that I should tell you is that until March of 2001, I had a very busy, active general surgery practice, doing between 500 and a thousand cases a year. In March of 2001, I had a heart attack and was out completely until August of 2001. I then started going back and seeing patients in the office, follow-up patients, doing some pre and postoperative care and consultations, but I did not go back to do -- to doing major surgery. And I have not gone back to doing that.

Q You have not to this date?

A That's correct. The only procedures that I am currently doing are relatively minor procedures in the office. And at the VA, we're doing -- in the operating room, we're doing minor procedures, things that can be done under local anesthesia. But I have no plans, and my cardiologist says that there's no way that I'm going to be going back to doing major abdominal surgery.

Q Now, when you say that you're currently doing minor procedures under local anesthesia, what type of minor procedures are you referring to?

A They would be things like -- like pomas, cysts, biopsies, skin tumors.

Q And at the time that you were performing surgery, I guess, up until March of 2001, what types of surgeries were you generally performing at that time?

A Well, I did the whole variety of general surgical procedures. I probably did a hundred laparoscopic cholecystectomies a year. I did hernia repairs. I did colon

resections. I did pancreatic resections. I did a lot of very complicated surgery, because I had been on the surgical faculty at Ohio State until 1985. And that was a major tertiary referral center, so I had a lot of complicated patients that were sent in. And when I went into private practice, a lot of the referring doctors from smaller towns surrounding Columbus continued to send those types of cases that they didn't want to do at the local hospitals.

So I did a fair amount of major pancreatic surgery, inflammatory bowel disease, that type of thing. I did not do vascular surgery since 1978. I did it for one year after I finished my training, but I didn't do vascular surgery, and I did not do thoracic surgery.

Q At this time, you said that you have a position as a surgical consultant for VA Hospital. What percentage of your time do you currently spend at the VA Hospital?

A Well, of my professional time?

Q Yes.

A I don't know. It's hard -- it's really hard to give you a number, because I spend anywhere from four to eight hours a week there, and I spend four hours a week seeing follow-up patients in my office. And then I do disability evaluations for State Teachers Retirement and School Employees Retirement and the Public Employee Retirement System.

Q And how much time do you spend a week doing that?

A Gosh. That's probably -- it's variable, anywhere from three to 10 hours.

Q That's per week?

A Yes.

Q Okay.

A And then I also do some outside peer review for a group called Quality Management Consultants, which is a division of a law firm in Columbus called Bricker & Eckler. And what they'll do is if a hospital has a peer review problem that they can't handle internally, they'll ask for consultants from the outside to look at the cases or look at

their systems. And I do some of that. And that can take anywhere from zero to 30 hours a week, just depending upon what the project is. So it's really hard for you to -- for me to give you straight percentages.

Q Now, this outside peer review work that you do, is that primarily reviewing medical records in cases that have been filed?

A No, not cases that have been filed. These are cases that are -- it has nothing to do with medical malpractice. These are cases that have fallen out in a hospital's internal peer review process, patient -- for example, they may have patients that have had to go back to the operating room, or patients that are readmitted within 30 days. And if they have a pattern, or even if they have one case that they're extremely concerned about, and the hospital is small enough that the medical staff can't do its own internal peer review objectively, then they'll get outside people to give them an opinion.

But it can also be things like, for example, there was a hospital in Ohio where a general surgeon made the allegation that the operating room was unsafe. And so the head nurse from an operating room and I spent a couple of days reviewing their procedures. We spent a day on site observing the function of the operating room, and then we spent time after that doing a report and meeting with administration about ways that the operating room could be improved.

Q How many of those cases do you tend to do each month?

A What, for the Quality Management group?

Q Yes.

A It's extremely variable. I would say on an average, it would be two or three cases a month, because what will happen is I won't have any for a month or two, and then I'll be sent a batch of 10 cases from one hospital, for example. So to try to average it out, I would say it would be a couple --

two to three a month.

Q And is this primarily hospitals that you're dealing with, then?

A Yes. My report goes to the medical executive committee of the hospital.

Q And is it always in Ohio, or is it in other locations?

A The majority of it has been in Ohio, but there have been -- there has been one hospital in Pennsylvania that I did it for, and there is a hospital in Idaho.

Q And you said you also did some disability evaluations. What would that consist of?

A That consists of reviewing a teacher's medical records, seeing the patient in the office and doing a history and physical examination, and then preparing a written report.

Q And is this to recommend retirement, or disability, or what specifically would the -- would this examination be for?

A It would be for disability, as to whether the teacher or the school employee

was able to continue to perform the job that they were in and the duration that that disability is -- would be likely to last.

Q Now, you also said that you did follow-up with patients. What type of patients would you be seeing in follow-up?

A Well, from my 25 years of my busy practice, there are a lot of women with breast cancer that I followed for recurrence, patients who I've done colon resections on, stomach resections. And these people all would come back at varying intervals to be seen. And there are also a large number of women with fibrocystic breast disease that will come in and have me do their annual examination.

Q If any of those individuals were to -- were requiring at this point in time any additional surgical interventions, is it your practice at this point in time, then, to refer them out to somebody else?

A Yes, it would be.

Q Do you have any kind of administrative responsibilities with the VA

Hospital?

A No.

Q And have you admitted any patients to the VA Hospital within, say, the past year?

A Well, the VA Hospital does -- at this point, does not have inpatient beds. It's strictly an outpatient facility.

Q Okay. So when you say you have privileges there, what would those privileges be for?

A They would be to see patients and perform procedures on them there.

Q On an outpatient basis?

A Yes.

Q And I assume that the privileges that you have at Ohio State University Medical Center, when you say active privileges, those are admitting privileges.

A Yes.

Q Have you admitted any patients to OSU Medical Center in the past year?

A Yes.

Q Okay. And what would those patients

have been admitted for?

A The most recent, which is probably about six months ago, was referred in with a gastric outlet problem. And I did the initial evaluation and management of the patient, and it turned out that he needed surgery. And my former partner did that.

Q Now, you mentioned that you are in a private practice. Do you have partners associated with you in that practice?

A Not currently. When I had my heart attack, I was in a partnership with one other general surgeon. And we had a relationship where we took all of the income and put it in a pot and split it equally. When I stopped doing major procedures, there was no way that we could have an equitable relationship that way, so we dissolved the partnership. And then I had -- and I just had an office-sharing relationship with him, where I paid part of the rent and paid the secretary, but we didn't -- no longer had a partnership.

Q Okay. What was the name of the

physician who was your partner?

A Dr. John Schwarzell.

Q How do you spell his last name?

A S-c-h-w-a-r-z-e-l-l.

Q And what was the name of your corporation that you had established as partners?

A It was Surgical Associates of Columbus.

Q Does that corporation exist any longer?

A Yes. He's -- well, it's not a corporation, it's a partnership. And he still has it.

Q But you're no longer a partner in Surgical Associates of Columbus; is that correct?

A That's correct.

Q And at this point in time, I assume, then, that you're independent and not associated with any kind of partnership.

A That's correct.

Q Are you board certified?

A Yes.

Q In what areas?
A In general surgery.
Q And have you renewed that certification recently?
A I've been recertified twice. The most recent would be on the CV. It was sometime in the 1990s.
Q I think -- according to the CV, it says 1996. Does that sound correct?
A Yes.
Q Okay. And how often do you have to be recertified?
A Every 10 years.
Q At this point in time, 10 years out from '96, are you planning on being recertified?
A Yes.
Q And what do you have to do to be recertified?
A You have to take a written examination.
Q And are there any practice hour requirements for recertification?
A I don't know the answer to that. I

guess I'm going to find out.

Q You also had a list of publications in your curriculum vitae. And I believe you testified that there were no additional publications since January of 2003; is that correct?

A Yes.

Q Okay. And I assume you do not have a copy of your CV in front of you, correct?

A That's correct.

Q Okay. And I know this is probably difficult to do, but out of your memory right now, are there any publications that you have done in the past that would be relative to the issues in this particular case?

A No.

Q And I believe that you said you also had some academic appointments; is that correct?

A Yes.

Q Are those still current?

A Yes.

Q And where are they?

A Well, I'm the clinical assistant professor at Ohio State in surgery, and I'm also on the teaching faculty at Mount Carmel.

Q Okay. What responsibilities do you have with the clinical assistant professor of surgery at OSU?

A Well, now they're relatively minimal. If I would admit a patient, the surgical residents would see the patient with me, and there would be some bedside teaching involved. What I'm anticipating, and what I've discussed with the chairman of the department at Ohio State, is that as the volume of outpatient surgery increases at the VA, that we may be able to rotate surgical residents over there to do some of that surgery under my supervision, but that hasn't happened yet.

Q Okay. And what about the teaching faculty at Mount Carmel?

A That's the -- that would be the same. Again, admitting patients, I would work with the residents taking care of the

patient, but I've also -- they have me participating in their mock board exams, where -- to prepare the residents to take their oral boards, they have groups of two doctors ask the types of questions that they'll experience on their boards, and then evaluate them afterwards.

Q How often do you do that?

A That's a once-a-year thing.

Q Okay. How often have you served as an expert in reviewing medical malpractice cases?

A I look at probably 15 cases a year. I used to probably look at 30, but it's decreased to the point I think it's about 15 in a given year.

Q Until what point in time did it start decreasing?

A After my heart attack.

Q And out of those cases, how many of those cases have been reviewed for a plaintiff?

A It's about half and half.

Q How many times have you testified at

trial?

A Not very often. Some years none. I would think maybe the most would be three or four that would have happened in a year.

Q And how many years have you been working as an expert in medical malpractice cases?

A I think the first time I was asked to review a case was in the early 1980s, when I was on the faculty at Ohio State.

Q And at what point in time were you up to reviewing approximately 30 cases a year?

A For the several years prior to my heart attack.

Q Would you say throughout the 1990s, you would have been reviewing cases at approximately -- at a rate of approximately 30 per year?

A No, but I would say for the last half of the 1990s probably at that rate.

Q And at the early part of the 1990s, what number of cases would you be averaging per year?

A I don't know, maybe 15 or 20.
Q Hello?
A Hello.
Q Did you hear my question?
A Yes. I said maybe 15 or 20.
Q Okay. I didn't hear your answer. Thank you.
A I'm sorry.
Q And how many times have you had to issue a report for the cases that you've reviewed?
A Relatively infrequently.
Q Approximately how many times have you been deposed in those cases that you've reviewed?
A I would say it has varied between two and 10 times a year. It's extremely variable.
Q Have you published in any journals for expert service?
A No.
Q Have you published anywhere for expert service?
A No. I've never advertised, and I've

never been a member of any expert referral service.

Q How is it that you've been acquired so many cases per year?

A Well, I think initially it was based on the subject matters of my publications. And after that, it was simply word of mouth. I mean, I've had -- given a deposition, and then been contacted six months later by the opposing counsel and asked if I would review a case for him.

Q Have you worked for any other Cleveland or Akron area attorneys?

A Yes. I've worked for the Reminger & Reminger firm up in Cleveland. I've done a couple of cases for them.

Q Okay. For any plaintiff's counsel up in the Cleveland or Akron area?

A I have a long time ago. There was an attorney, and I don't remember his name, from Cleveland who sent me a case, but I don't remember the case and I don't remember his name. It's been over five years ago.

Q Okay. Have you ever done any work

for Mr. Henretta prior to this?

A I honestly don't know. I was trying -- I was thinking about that yesterday, and I honestly don't know the answer to that. If I -- if I have, it -- maybe it's been one other case, but it certainly would not have been more than that.

Q Doctor, have you ever been named as a defendant in a medical negligence, medical malpractice case?

A Yes.

Q How many times?

A I think seven.

Q And of those seven cases, how many of them went to trial?

A Two.

Q And was that in Franklin County?

A Yes.

Q And what was the outcome of those two cases?

A They were both unanimous defense verdicts.

Q And of the two cases that went to

trial, what were the issues in those two cases?

A One case was a patient who presented with a very atypical presentation of appendicitis. He had right upper quadrant pain, and we thought he actually had gallbladder disease. And he was admitted to the hospital, and it took us two or three days to figure out that he needed to be operated on. And he had a ruptured appendix. In fact, it had probably ruptured while he was in the hospital. And he did fine after the surgery, with the exception of a superficial wound infection. And the allegation was that he should have been diagnosed earlier.

Q And what was the defense of that case?

A The defense of the case was that it was a very unusual presentation appendicitis, and one shouldn't have been expected to make the diagnosis based on the way he presented.

Q And the second case, what were

issues in that?

A The second case involved a patient who had been a patient of Dr. John Minton, who is a surgical oncologist in Columbus at Ohio State. And Dr. Minton was killed in an automobile accident, and his widow asked me to take over his practice. And we did do that, and we inherited about 5,000 files. And in there, there was a patient that Dr. Minton had operated on a couple of months before he died, and had biopsied duodenal tumor, which had come back malignant. And Dr. Minton had been aware of that, and for some reason, had never called the patient or brought him back for a definitive operation.

Well, that patient presented to our group about a year later with metastatic disease, and when we operated on him, he was unresectable. And the allegation in that case is that we should have gone through every one of those 5,000 files and identified that patient and called him.

Q And you said you got a defense

verdict on that case also?

A Yes.

Q And your defense of the case was?

A The defense of the case was that it would have been impossible to have gone through all of those records in a timely fashion, and that every patient of Dr. Minton's had been sent a letter, asking that patient to contact us, and this particular patient hadn't until he got sick a year later.

Q You said you also were named in approximately five other cases; is that correct?

A Yes. I was dismissed from all of them.

Q Okay. So none of those cases were settled?

A I've never paid a penny.

Q And of those cases that you were dismissed from, do you recall if any of those cases had anything to do with laparoscopic procedures?

A One case had to do with a

thoracoscopy that was performed by an expartner. And I was the first assistant on the case.

Q And what were the allegations in that case?

A Well, the patient had a tumor, which turned out to be benign, in his lung. And Dr. Slanger took that out and got into bleeding and ended up having to do a pneumonectomy on the patient to stop the hemorrhage. And I was simply there in the operating room holding the camera. So I don't know what the allegations were against me, but, you know, I was dismissed from that relatively early in the case.

Q Did you ever hear about the outcome of the case?

A Dr. Slanger settled it.

Q Okay. And none of the other cases had anything to do with laparoscopic procedures, then?

A No. There's one case that's still pending, actually, which is -- started out as a laparoscopic case. It was a lady that

needed a Nissen fundoplication, and Dr. Slanger attempted to do it laparoscopically and was unable to and converted it to an open and did the procedure. And, again, I was the first assistant on the case. It was done over 10 years ago, and apparently she recently noticed some problem with her incision. I fully expect to be dismissed from that, as well.

Q Okay. But that one is currently pending?

A Yes.

Q And that's in Franklin County?

A Yes.

Q What do you currently charge for deposition?

A I charge $500 an hour with a $1,500 minimum.

Q And what are your fees for reviewing records and producing a written report?

A I charge $250 an hour.

Q And what is your charge for trial?

A $3,500, plus expenses.

Q And have you been asked to testify at the trial of this matter?

A I had assumed that I would be, and I plan to.

Q Okay. That was my next question. You anticipated it.

THE WITNESS: Can we take a two-minute break?

MR. LOESEL: Absolutely. Go ahead.

(Break taken.)

BY MR. LOESEL:

Q Dr. Cooperman, how were you first contacted for this case?

A I don't remember. I would assume it would have been by telephone and asked if I would be willing to review the case. And then I would have received a letter along with the medical records.

Q Okay. Do you have any correspondence or letter from -- letters from plaintiffs' counsel in a file with you?

A I do.

Q Hello?

A Yes.

Q Yes, you do?
A Yes.
Q Okay. Can you tell me how many letters you have there first.
A Just one.
Q Was that one?
A Yes.
Q Okay. And essentially, what is the content of that letter? Is it just an "enclosed is" type of letter, or is there a description of facts in the case, or what?
A It's very brief. I'll just read it to you.
Q Okay.
A "Dr. Cooperman, at your earliest convenience, please advise whether or not you can render an opinion regarding the enclosed materials, client information packet on Sandee Shonk and complaint. Thanks for your attention to this matter."
Q And what is the date of that letter?
A December 7th, 2001.
Q And what materials did you receive at that time to review?

A I received a copy of the complaint, and I received the medical records of her three hospitalizations.

Q Okay. And can you give me the admission date for each of those hospitalizations, please.

A July 28th, 2000.

Q Okay.

A Then there was an emergency room visit at Mercy Medical Center on September 24th, 2000. And then there's medical records from Doctors Hospital of Stark County from September 29th, 2000. There's an emergency room visit at Doctors Hospital on October 1st, 2000, and then there was another surgical record from Doctors Hospital from March 19th, 2001.

Q Anything else?

A There's medical records of Dr. Conklin of Perry Hill Surgeons. Then there were some medical records from Mercy Medical Center from 1995.

Q And are those emergency room visits or admissions?

A I honestly don't remember.
Q Do you have them there with you right now?
A I do. I think it had to do with a delivery.
Q Okay. And were there any other records?
A No.
Q Okay.
A At a subsequent time, I also received two depositions.
Q And those depositions are of whom?
A One was of Ms. Shonk, and the other was Dr. Cain.
Q And do you recall how long ago you received those depositions?
A Mrs. Shonk was quite some time ago. Dr. Cain's was only in the past couple of days.
Q And at the time that you produced your first report, which I believe is dated January 5th of 2002, had you looked at any of the deposition testimony?
A I don't remember.

Q You can't recall?

A No. If I had, it would only have been Ms. Shonk's.

Q It appears that -- I think Mrs. Shonk's deposition was taken on February 22nd of 2002. Given that, is it likely that you had not reviewed her deposition at the time you produced your first report in January of 2002?

A I think it's extremely likely.

Q Okay. So you would have received that after you authored your report, correct?

A Yes.

Q Okay. And I guess I'll ask this, too: Had you received all of the records that you just indicated to me, the medical records, prior to authoring the January of 2002 report?

A Yes.

Q Okay. Have you reviewed any other materials that have been provided to you by Mr. Henretta in preparation for your deposition today?

A Yes.
Q And what would that be?
A At some point, I was sent a copy of Dr. Shalowitz's report.
Q And this would be an expert report from Dr. Shalowitz?
A Yes.
Q Okay.
A And then --
Q Anything else?
A Yes. This morning, Mr. Henretta showed me your expert's report.
Q And which expert reports would those be?
A From a Dr. Grischkan.
Q Any other reports?
A That's all that I've seen.
Q Okay. Has any of the new material that you've received since you authored your January 5th, 2002 report changed any of the opinions in that report?
A No.
Q Now, you also authored another report on September 12th, 2003, correct?

A Yes.

Q How did that come about?

A Mr. Henretta contacted me and asked me about the issue of informed consent and whether I felt that her consent had been appropriate and adequate. And I felt that it hadn't, and he asked me to supplement my initial report with a brief second report.

Q And at that time, did you have the deposition of Ms. Shonk to review?

A Yes.

Q And at that time, did you have the expert report from either Dr. Shalowitz or Dr. Grischkan to review?

A Well, I didn't have Dr. Grischkan's, but I did have Dr. Shalowitz.

Q And at that time, had you had Dr. Cain's deposition to review?

A No.

Q Since you've received some additional information from the time that you authored the September 12th, 2003 report, has that other information changed your opinion in that report in any way?

A No.

Q Have you done any kind of literature search or literature review in preparation for either writing your report, for reviewing this case, or for your deposition today?

A No.

Q Have you done any kind of literature review in any way related to this case?

A No, I have not.

Q Dr. Cooperman, did you take any notes as you reviewed records and prepared for this case?

A The only notes that I have is on the content page for the client information packet. From the original reports that were sent to me, I made just some chronologic notes.

Q Is that on one page?

A Yes.

Q Do you have a way to make a copy of that one page and have the court reporter then mark that as my next exhibit?

A Sure, I'd be happy to.

Q Okay. We can do that after the deposition is over to save time, if you'd like --

A Okay.

Q -- okay?

How many notes are on that page, Dr. Cooperman? Is it quite extensive?

A No, they're very brief. None of them are interpretive. They're all just really chronology of what happened.

Q Okay. Is it something that would take quite a while for you to just read to me quickly, or not?

A I don't think it would take very long.

Q Okay. If you could, I'd like you to at least kind of read through what you have written there.

A 7-28, tubal by Dr. Cain. Veress needle. 1 trocar. Bright bleeding. Blood pressure dropped to 60. Injuries to right iliac artery. Branch of iliac vein. And through-and-through ileal injury. Dr. Conklin did repair. No postop

complications.

Then in reference to the ER visit of September 24th, my note says abdominal pain. White count equals 13,000. CAT scan showed abdominal wall thickening and thickened omentum. Patient discharged.

Then under medical records from 9-29, 2000, my note says I&D. Abdominal wall abscess. 2 centimeter cavity. 5 to 10 cc's pus. General anesthesia. Cultures showed staph.

Then from emergency room records from 10-1, just says wound packing change, parenthesis weekend.

Then next under radiology reports from 3-15, CAT scan of abdomen and pelvis. Small amount pelvic fluid. Small bilateral ovarian cysts.

Next, surgery reports from 3-19, draining sinus abdominal wall just below umbilicus, dash, suture removed.

And those are all of my notes.

Q Okay. Thank you.

I had a little difficulty hearing.

Did you say at the last note on 7-28, no postop complications?

A Yes.

Q Okay. And you have no other notes, then, other than the ones you just read to me, Dr. Cooperman?

A That's correct.

Q Okay. Did you have any draft reports that you put together from either the January 5th or the September 12th report?

A No, I didn't do a draft.

Q So you didn't do any kind of preliminary report for Mr. Henretta to review?

A That's correct.

Q Who typed up your report?

A I did.

Q Okay. And you haven't issued any additional reports other than the January 5th, 2002, and the September 12th, 2003 reports?

A That's correct.

Q Okay. And have you consulted with

any other physicians or other experts with regards to the issues in this case?

A I did briefly discuss the case with Dr. Schwarzell.

Q Okay. And what was that discussion?

A I just asked -- I asked him about the vascular injury and whether he felt that it could occur, you know, within the standard of care. And he agreed with me that it didn't. It was a very brief discussion.

Q Okay. Anybody else?

A No.

Q What did you do to prepare for your deposition today?

A I read through the records again, and I reread the highlighted portions of the depositions, and I reread my reports.

Q When you said you read highlighted portions of the deposition, are those portions that you highlighted or someone highlighted for you?

A That I highlighted, just to make it easier for me to prepare for something like

this.

Q And what parts of Ms. Shonk's deposition were of interest to you?

A Well, I'd have to go through the whole deposition with you. Do you want to do that?

Q I guess if you can tell me, in general, what aspects you were looking for as you reviewed her case, that would be sufficient -- her deposition. I'm sorry.

A Well, I have some of the discussion -- or the questions to her regarding consent for the procedure and what she thought could be the complications. I've highlighted some of the things that she said were the damages that she suffered.

I was just trying to highlight things that I thought were substantive versus those that were not.

Q Okay. Did you look at similar types of things when you reviewed Dr. Cain's deposition?

A Yes. I mean, for example, I didn't highlight anything about prior malpractice

history or his education, because I didn't think that I would want to go back and reread that again.

Q Okay. Is there any additional information, Dr. Cooperman, that you feel would -- you would like or that you feel would be helpful for you in this case?

A No.

Q And are any of the opinions that you've expressed in the two reports that you've authored based on any kind of assumptions?

MR. HENRETTA: Objection.

Go ahead.

A No. Well, the opinion that I expressed in the letter about the informed consent was really based on the consent form, substantially. So I -- I didn't make any assumptions regarding that.

Q Okay.

A And I guess I really don't understand your question regarding the other.

Q Well, you know what an assumption

is, correct --

A Yes.

Q -- versus an actual piece of information or a fact that you would find in a medical record, correct?

A Yes.

Q Okay. And I guess my question, again, is when you authored -- I mean, you already said there were no assumptions in your 2003 report. When you offered your January 5th, 2002 report, at that time, were there any assumptions that you had to make in order to come to your opinion?

A No.

Q No?

A No, it was all based on the medical record.

Q Doctor, what is a laparoscopic procedure?

A Well, a laparoscopic procedure is a procedure that is done through small incisions using a fiberoptic camera and ports through which instruments can be used within the abdominal cavity rather than a

laparotomy, where a large incision is made.

Q And as a surgeon, what types of tools or devices do you use for a laparoscopic procedure?

A Well, there's a whole huge spectrum depending upon what you're doing. I mean, there's staplers and graspers, and there are dissectors. But, I mean, you use -- and there are various different ways of insufflating the abdomen and different types of trocars. So I don't know how to answer your question.

Q Okay. That's fair.

Traditionally, what techniques do you use or have you used in the past with a laparoscopic procedure to insufflate the abdomen?

A The two techniques that I've used have been the Veress needle, which I've used in patients who have not had previous abdominal surgery.

Q And why is that?

A Why do I use it just in that group of patients?

Q Yes.

A Because in patients who have had prior abdominal surgery, there's an increased likelihood that they can have adhesions with bowel stuck to the abdominal wall, and you could cause an injury inserting the needle.

Q And when you say "insufflate," what do you mean?

A Insufflate means to deliver the carbon dioxide into the peritoneal cavity.

Q And what is the purpose of insufflating the abdomen?

A It's to create a safe work space by elevating the abdominal wall up away from the abdominal viscera.

Q And how do you gauge or know when sufficient CO_2 has been insufflated into the abdomen?

A In two ways. One, you can perfuse a good pneumoperitoneum and feel the tension on the abdominal wall. And also, by the pressure measurement after the CO_2 is put in, that it should be about 15 millimeters

of mercury. But I didn't finish one of my other answers.

Q Right. I know. You said you used the Veress needle, and you also had a second means of insufflating the abdomen; is that correct?

A Yes, that's correct.

Q And what is your second way?

A The second is the open technique, using a Hasson, H-a-s-s-o-n, catheter.

Q And can you spell the name of the catheter for me?

A H-a-s-s-o-n.

Q And how is that performed?

A You make a small incision, either above or below the umbilicus and carry it down through the subcutaneous tissue and the facia, and open the peritoneum so that you can -- you're actually looking into the peritoneal cavity. And you insert the port under direct vision, and then you suture the tissue around the port so that you have an adequate seal so that you don't lose gas.

Q What percentage of your laparoscopic

procedures have you used the Veress needle versus the Hasson catheter?

A Probably 50/50.

Q And why would you choose one over the other?

A Well, as I said earlier, I would try the -- I would try the Veress needle in patients who had not had prior abdominal surgery, and I would use the Hasson catheter either if -- either if I was unsuccessful in getting good placement of the Veress needle, or in patients who had had prior surgery.

Q Now, in this particular case, Dr. Cain used a Veress needle, correct?

A Yes.

Q Are you critical of him at all in his use of a Veress needle in this case?

A No.

Q Okay. And are you critical at all with regards to how he used the Veress needle in this case?

A Yes.

Q So you have no criticism surrounding the Veress needle procedure?

A No. I think that a lot of surgeons are getting away from using the Veress needle and going for the Hasson because it's a safer technique. But use of the Veress needle is certainly well in the standard of care.

Q Okay. Doctor, you're a general surgeon; is that correct?

A Yes.

Q And you are not an ob/gyn?

A That's correct.

Q And have you ever done any tubal ligations?

A Yes.

Q You have?

How long ago?

A Gosh, I don't know. 15 years ago maybe. I've done two or three of them in my entire career. They were all done open as part of other procedures, where the woman had requested that it be done but was primarily being operated on for another reason.

Q You've never done a laparoscopic

tubal ligation?

A That's correct.

Q Have you ever had to convert any of your laparoscopic procedures to an open laparotomy?

A Of course.

Q Under what circumstances?

A Well, a variety of circumstances. Patient -- the leading one is that the anatomy isn't clear through the laparoscope, either due to acute inflammation or adhesions from prior surgery.

Q How many times have you, in your career, had to convert a laparoscopic procedure to a laparotomy?

A I would say between 5 and 10 percent of the time. Probably closer to the 5 percent.

Q And have you had to convert the procedure -- well, strike that. I'm going to go back a little bit.

What kind of complications are there with a laparoscopic procedure?

A Well, I mean, that's sort of

encyclopedic. There can be infection, there can be bleeding, there can be damage to structures within the abdominal cavity. There can be cardio or ventilatory problems based on the CO_2. I mean, there are a lot of complications that can be associated with laparoscopy.

Q And the ones that you've named are, in general, the ones you're -- that are known and in literature?

A Yes.

Q And when you say "damage to structures in the abdominal cavity," what exactly -- what structures are you referring to?

A Well, it depends where you're operating. I mean, you can end up with injury to the intestine. There's certainly bile duct injuries that are reported during laparoscopic cholecystectomy. You can have vascular injuries, bleeding that can be impossible to control laparoscopically.

Q So all of that would be included in what you mean by "structures in the

abdominal cavity"?

A Yes.

Q It would be including vessels, then?

A Yes. Now, I'm not saying that these complications should occur, but I'm saying that they're certainly reported as occurring.

Q And, Doctor, would you agree that just because a complication does occur, that it doesn't necessarily have to be negligence or malpractice?

A Yes.

MR. HENRETTA: Object -- let me get the objection in.

Go ahead.

A Yes, I agree with that as a general statement.

Q Okay. Now, you said that you've had to convert 5 to 10 percent of your laparoscopic procedures to an open laparotomy, correct?

A Yes.

Q Have you ever had to convert any of your procedures because of a complication?

A There was one case that I converted because I saw bile leakage, and I wanted to make certain that I didn't have a major ductile injury.

Q And what did you find?

A I found that there was a small injury to the right hepatic duct, which I fixed with one suture.

Q And how did that injury to the duct occur?

A The gallbladder was stuck to it, and I think it was a cautery injury, taking the gallbladder out.

Q Now, you didn't mention cautery injuries as one of the complications. Is that also a complication?

A Well, I mean, you can injure things with the cautery or you can injure it with a sharp instrument. I wasn't trying to break them down.

Q Okay. And in a laparoscopic procedure, I've read that this is a blind procedure; is that correct?

A Well, the insertion of the Veress

needle and the insertion of the first trocar are essentially a blind procedures.

Q And when we say a "blind procedure," what does that mean?

A It means you can't see where the tip of that instrument is going.

Q Now, when you converted your one hepatic duct laparoscopy that we just talked about to an open, at that time, did your patient end up filing a suit against you for malpractice?

A No.

Q Doctor?

A I said no.

Q Okay. I'm sorry.

What type of trocar do you use in your laparoscopic procedures?

A Disposable trocar from U.S. Surgical.

Q Does that trocar have a shield on it?

A Yes.

Q What is the purpose of the shield?

A To protect the underlying structures

so that the blade snaps back into the device as soon as it enters the abdominal cavity.

Q And that's supposed to protect the underlying structures from any kind of injury?

A Yes.

Q Have you ever heard of the disposable trocars with the shields failing?

A Not personally, but I imagine it could happen.

Q And if the shield were to fail, it could potentially cause an injury?

A Potentially.

Q I didn't hear you, Doctor.

A I said yes, potentially.

Q Okay.

A But, again, even if the shield failed, unless you inserted the trocar with excessive force, you really shouldn't injure another structure.

Q I -- you cut out on me, so I didn't hear your complete answer. Can you repeat that for me one more time, please?

A I said even if the shield failed,

unless you inserted it with excessive force, you really shouldn't hit underlying structures.

Q And when you say "excessive force," what do you mean?

A Well, inserting it harder and deeper into the abdominal cavity than you should.

Q And how do you measure excessive force?

A I guess it's just something you learn by doing a lot of them. And you simply want to insert the trocar until you're in the peritoneal cavity. Once you're in, then you want to take your trocar out and advance the sheath without it.

Q How do you know you're in the peritoneal cavity?

A You can feel it pop in, and you can tell -- there's a little lever on the side that vents the trocar, and if you open that and air escapes, you know that you're in.

Q Is that then kept open as you insert the trocar?

A No, you close it.

Q Okay. So at what point in time do you know when to open the vent?

A As soon as you feel that you're in.

Q So as a rule, there's a different feeling in the trocar itself once the trocar is in?

A Yes, you can feel it pop through the abdominal wall.

Q Okay. Now, when you say a measurement of force, I believe you said you can tell because you've done a lot of them. Is that based on each individual physician's own experience?

A No. I mean, I think that, you know, you apply a general steady force to it, sufficient to go through the, you know, abdominal cavity. I can't give you a measurement of the number of joules of injury or something to tell you what that force is or pounds per square inch.

Q So it is on an individual basis, then?

A Yes.

Q And how many procedures do you -- if

you can say -- do you feel a physician -- a surgeon needs to perform, laparoscopic procedures, to have a feel for the amount of force?

A Most hospitals require a surgeon to do five cases being proctored by another surgeon before he's given privileges. So I guess that would be the prevailing number of cases that is felt necessary, you know, to be certain someone has adequate skills. I mean, there's no question there's a learning curve in doing laparoscopic procedures, and that the incidence of complications has been reported to be higher, you know, in the first 10 or 20 than it is later on in a surgeon's practice.

Q And when we talk about complications, when, during a laparoscopic procedure, a complication such as an injury to a vessel or a bowel occurs, does that become an emergency?

A Yes.

Q And why is that?

A Well, certainly if you've got an

injury to a major vessel, you have to control the bleeding to prevent the patient from exsanguinating. If you have an injury to the intestine, it's not such an immediate life-threatening emergency, but, again, you have to recognize it and repair it to prevent infectious complications occurring as a result.

Q And the way to do that is to convert to an open procedure?

A Generally, that's what's required. I mean, you can have bleeding, for example, from the cystic artery, taking out the gallbladder, that you can control laparoscopically by placing a clip on it. And I'm sure that there's some advanced laparoscopic surgeons who could have a bowel injury and who could suture that injury laparoscopically. I think the overwhelming majority of surgeons and gynecologists, however, would convert to an open procedure to repair it.

Q Now, in this particular case, Dr. Cain did convert to an open procedure,

correct?

A Yes.

Q And are you critical of him for converting to an open procedure at the time that he did?

A Absolutely not. It was essential that he do it, and he recognized the complication promptly and dealt with it appropriately.

Q And this was, at that point in time, a life-threatening situation, potentially?

A There's no question that it was. The patient became hypotensive, with her blood pressure dropping to 60.

THE WITNESS: I need another quick break.

MR. LOESEL: Okay. Go ahead, Doctor.

(Break taken.)

BY MR. LOESEL:

Q Doctor, what's hypertrophy?

A Hypertrophy just means an enlargement, such as hypertrophy of a muscle after exercise, the muscle gets larger.

Q How is hypertrophy related to an incision?

A It's not, as far as I know.

Q Okay. So you've never heard of that?

A I've never heard that term applied.

Q Okay.

A I mean, you can have a hypertrophic scar.

Q And what is a hypertrophic scar?

A Well, it's like a keloid. It's a scar that's larger and thicker than normal.

Q What causes that?

A It's caused really by the individual's way of healing. For example, it's very common in blacks to have hypertrophic scars.

Q So it has nothing to do with the way the incision is made?

A Well, it can. I mean, I think if you have a wound infection and an incision that's allowed to heal by secondary intention, you're much more likely to have a widened, thicker scar than one that is

closed primarily.

Q Okay. I'm going to go on to your first report from January 5th of 2002.

A Okay.

Q And you have in the first paragraph, I think, kind of a summary of the background of the case; is that correct?

A Yes.

Q Okay. And those are the facts that you pulled out of the records, correct?

A Yes.

Q Okay. And then at the second paragraph, I believe, you then have stated some of your opinions; is that correct?

A Yes.

Q Okay. And the first opinion that you have is that Dr. Cain fell below the standard of care in the technical performance of Mrs. Shonk's laparoscopy, correct?

A Yes.

Q What do you mean by "technical performance"?

A That the insertion of the trocar was

done improperly, resulting in the injury to the artery, the vein, and the small intestine.

Q And how was the insertion done improperly?

A It had to have been inserted with excessive force and deeper than it should have been to injure those structures, and, in fact, also rather than going in straight, was placed in at an angle, off to the right.

Q Now, you said, first off, that there was excessive force, correct?

A Well, it just has to be. I mean, in order -- this is one of those injuries that simply shouldn't occur if the trocar is inserted properly, in the absence of abnormal anatomy, and there's no evidence. And, in fact, Dr. Cain in his deposition said that there were no anatomic abnormalities.

Q Did you find that there were any anatomic abnormalities in your review of the records?

A No.

Q Was Ms. Shonk a candidate for a laparoscopic procedure --

A Yes.

Q -- in your review of the records?

A Yes. There was no contraindication to or attempting to perform this laparoscopically.

Q How did you determine, then, that excessive force was used in the insertion of the trocar?

A Because there has to be in order for it to get to the point where it did. If you have an adequate pneumoperitoneum, and Dr. Cain described that the pressure was 12 to 15 millimeters of mercury, and that he had put in 4-1/2 liters of CO_2, that should have produced an adequate pneumoperitoneum. So in order for this injury to occur, you simply have to put this thing in excessively hard to traverse the entire pneumoperitoneum visceral structures and skewer the iliac artery.

Q So is it your testimony, then, that excessive force was used strictly based on

the injury occurring?

A Yes, that's basically it. What I'm basically saying is that this type of injury does not occur absent improper insertion of the trocar.

Q Now, you also said something about the wrong angle; is that correct?

A Yes. According to the vascular surgeon, Dr. Conklin, this injury occurred in the distal one-third of the iliac vessel, which places it well off the midline. So this trocar was put in at an angle.

Q How is the trocar to be inserted?

A Well, I don't think that there's any set guideline as to what angle it should be applied at. Some people say that you put them in at a 45-degree angle. Other surgeons put them in directly, essentially at a 90-degree angle. But you do put them in to the midline rather than putting them in at an angle, and you do put them in simply to get into the peritoneal cavity.

In order for this injury to occur, this patient -- this trocar would have had

to have been inserted at least 8 or 10 inches -- 6 to 8 inches, anyway, beyond where it should have been.

Q Why is that?

A Well, this was not a skinny girl. She weighed 160 or 170 pounds, as I recall from the record. And you have the pneumoperitoneum, which would have elevated the abdominal wall several inches farther. And the abdominal cavity, from one side to the other, probably measures 10 to 12 inches from front to back. And the arteries run in the retroperitoneum.

So he went completely through the abdominal wall, through the entire peritoneal cavity, and then into the retroperitoneum in order to cause this injury. And that's just a trocar that's been inserted too far.

Q Do you know what kind of trocar Dr. Cain used?

A No, I don't.

Q You didn't see that in his deposition testimony?

A Well, I may have, but I don't recall.

Q What standard size trocar should be used in a laparoscopy?

A Well, he used -- that was a 12-millimeter trocar, which is appropriate for the camera. There's nothing wrong with the size of the trocar.

Q Okay. And there's nothing wrong with using a disposable trocar?

A No, absolutely not.

Q Are you critical of anything else with regard to Dr. Cain's performance of the surgery?

A No.

Q You have no other opinion, then, with regard to the surgery itself?

A That's correct.

Q Now, you also went ahead and authored a second report on September 12th of 2003, correct?

A That's correct.

Q And one of the questions I have is: Did you have an opportunity to review the

consent form that Ms. Shonk signed?

A Yes.

Q Okay. Are you familiar with either of those forms in your personal practice?

A Give me a minute to find them.

Q Okay.

(Pause in proceedings.)

A Yes, I've got these forms.

Q Okay. And there are two different ones, correct?

A Yes.

Q Okay. Have you seen either of those forms in your practice at all?

A Well, not identical to this, but, you know, basic operative consent form that's similar to these.

Q Okay. And given the fact that you're not an ob/gyn and you don't perform tubal ligations, the one consent to sterilization form, which is a form from the Ohio Department of Human Services, that would not be a form that you traditionally would use in your old practice, correct?

A No. That's correct.

Q Okay.

A I think on the cases where I did tubals, I did have to obtain a separate consent form for that to be done, but it wasn't a Ohio State form like this.

Q Okay. And what was the purpose of that separate consent form?

A It was, again, that the patient understood what the purpose of the procedure was and that it was going to be permanent sterilization. And I think that on the cases that I did, there's a 30-day waiting period as part of the hospital policy on that.

Q So you're familiar with that type of wasting period?

A Yes. I think whenever you're going to do something with those kinds of consequences that's elective, it's reasonable to have the patient have some time.

Q Okay. And you have no criticisms of the use of that particular consent form or the consent for operation procedure form,

correct?

A That's correct.

Q Okay. And based on the fact that Ms. Shonk has signed both forms, that -- you have -- I mean, you're not questioning the signature on the form or the fact that she is the one who actually looked at and signed these forms?

A No, not at all.

Q Okay. Whose responsibility on the medical staff is it to review a consent form with a patient?

A The physician.

Q And in this case, I believe, if you read Dr. Cain's testimony, he did indicate that he reviewed the forms with Ms. Shonk, and Ms. Shonk also testified in her deposition that he reviewed the form with her; is that correct?

A Yes.

Q Okay. So you're not critical of that process either, correct?

A No. My only criticism is that any patient who's undergoing a laparoscopic

procedure needs to be made aware that the procedure could end up being an open procedure, where they have a significantly larger incision than what they're anticipating, and that any consent for a laparoscopic procedure should include the fact that the patient has been told about the possibility of conversion, which was not done in this case, or it certainly was not documented.

Q Okay. Now, are you saying there has to be actual language in the consent form itself?

A Yes, that's my opinion.

Q And what specific language has to be in the consent form, based on your opinion?

A Well, my standard consent for a laparoscopic cholecystectomy would say -- when I was saying the procedure, I would say laparoscopic cholecystectomy slash possible open cholecystectomy, so they would consent. Or if I was doing a diagnostic laparoscopy, it would be laparoscopy slash possible open laparotomy. So the patient was clearly

consenting to the possibility that the procedure could have to be converted.

Q Now, is this something -- is this a form that is provided to you through the hospital that you would use?

A No, this is something that I would write in when I -- when you write in what the operation is that they're consenting for.

Q Okay. So do you have the consent for operation procedure form in front of you that Sandra Shonk signed?

A Yes, I do.

Q Okay. So I want to understand you correctly. Are you saying, then, that on the one line that Dr. Cain wrote in "laparoscopic tubal ligation," you would have written something different?

A I would have, or when he wrote in the things that could happen, for example, damage to uterus, tubes, ovaries, or surrounding structures, e.g., bowel, bladder, ureters, he should also have written in possible need for open

procedure --

Q Okay.

A -- or something to that effect.

Q Now, when you -- you read the words damage to uterus, tubes, ovaries, or surrounding structures, for example, he has bowel, bladder, ureters, what does that mean to you?

A Well, it would mean something different to me as a surgeon than it would to the average patient.

Q What would it mean to you as a surgeon?

A Well, to me, it would mean that injury to those structures would probably necessitate an open procedure, but that would not be intuitive for the average patient.

Q And when it says damages to those, what does that mean, the word "damages"?

A It means injury.

Q Pardon?

A Injury.

Q And what does "injury" mean?

A Well, it could mean cauterization burn, it could mean tearing them, it could mean cutting them with an instrument.

Q Infection?

A Well, I wouldn't think that infection would really be part of damage.

Q When you have a consent form that you write on, is this a consent form that you put together in your own office, or is this a consent form that has been put together by the institution that you're performing the surgery in?

A We use the institutional consent forms.

Q Okay. So any additional information that is placed on the form by you is in addition to whatever that institution has on the form; is that correct?

A Yes.

Q Okay. And when you go through a consent form with your patient, do you read it verbatim to them?

A No.

Q How do you go through it?

A I tell them what procedure that they're consenting to. Then I tell them what the most likely significant complications are. And then I ask them if they have any questions.

Q And do you have all of those things listed on the form that you explain to them because you didn't read it to them verbatim, or are some of the things just addressed verbally?

A Well, the things that are written on the form that I think are very -- that are essential are gone over verbally. Anything that I think is important to discuss with them verbally is also written on the form.

Q So essentially every part of your verbal communication with the patient is handwritten out as you speak?

A No.

Q Was that a yes?

A No, that was a no.

Q Okay.

A I mean, I don't transcribe my conversation.

Q Okay. So is it possible that some of your conversation is not written on that form?

A Yes, but anything -- any part of the conversation that was important would be also written on the form.

Q Doctor, on this form, I think it's in the fourth paragraph, and I think Dr. Cain's name is written on the one line in that paragraph -- do you see that?

A Yes.

Q -- it states, "If any unexpected condition occurs during the operation or procedure which, in my doctor's opinion, needs treatment in addition to or different from that to which I give consent, I will allow my doctor to do at that time whatever he or she believes is in my best interest."

What does that mean to you?

A Well, it's a blanket consent to do whatever's necessary in an emergency situation.

Q Okay. And what would an emergency situation be?

A Well, it would be an instance such as occurred in this case, a major vascular injury or bowel injury that would require a different incision. On the other hand, if this patient had been told that she might require an open procedure, she might say, well, I don't want to have a tubal ligation so badly that I am going to risk having a 6- or 10-inch incision on my abdomen. I'm not going to have the procedure at all. I mean, for example --

Q If she wanted to have a complete sterilization -- and I know you're not an ob/gyn -- what other alternatives would she have had?

A A whole variety of birth control methods.

Q Okay. But if she didn't want to take birth control and she wanted something permanent, what options would she have?

A Well, there wouldn't be any other permanent options other than this, but she -- but all I'm saying is that it's entirely possible that a patient would say,

well, I don't want a big incision. I'm very vain about my appearance. I'm just not going to do this. If this is a possibility, I'm not going to do it. For example, there are patients who, under no circumstances, will allow you to transfuse them. And if you say to them it's a possibility that during this operation, you may need to be given blood, they may say, well, then I'm not having the operation. So that's why you need to cover these things with the patient, so they can make an informed decision.

Q Is it possible, Doctor, that information can be covered verbally that is not written on the form?

A Yes. But there's no testimony that the discussion of converting to an open procedure was specifically discussed with the patient. And that's -- I didn't find any evidence of that in Dr. Cain's deposition or in Ms. Shonk's.

Q So you didn't see anything yourself when you went through them?

A No.

Q Okay. If this testimony was there, would you have a different opinion?

A Well, if he said that I specifically talked to her about the possibility of conversion to open, and she said that he didn't, then I guess that's something for a jury to decide.

Q Okay. If he did have that conversation but it's not specifically written out on the form, is that a breach of the standard of care?

MR. HENRETTA: Objection.

A I'm not sure that I know the answer to that. I think the important thing is what's conveyed to the patient, whether it's verbally, you know, or in writing.

Q Okay.

A I mean --

Q If it was presented verbally, it would not be a breach of the standard of care?

A I think that's correct. But I think Dr. Cain said that he didn't specifically do that.

Q Doctor, are you also prepared to give opinions with regard to issues of proximate causation in this case?

A Yes.

Q And what are those opinions?

A Well, the opinion, I guess, is several fold. One is that as a result of the injury to the vessel, she required a significantly prolonged hospital stay compared to what she would have had had it not occurred. She was intubated for a period of 24 hours, which is unpleasant and would not have been required absent the injury. She received four or five units of blood and a couple units of fresh frozen plasma, which she would not have required, although there's no evidence at all that she had any complications from that.

Q Okay.

A It's my belief that the wound infection, the wound abscess, would not have occurred to a degree of probability if it had just been a laparoscopic procedure and the operative field hadn't been contaminated

by the intestinal injury. So she wouldn't have required the second and third operative procedures that she had to drain the abscess and to deal with the infected suture.

Q Let me go back a little bit. I want to talk about what you just said. You mentioned the intubation.

Is intubation common in a laparotomy?

A Before I answer that, can I go back to another question?

Q A question I asked you?

A Yeah.

Q Okay.

A Well, I mean, we were discussing the informed consent issue and as to whether there had been verbal discussion of conversion to an open. And in Dr. Cain's deposition, on Page 36, Line 1, the question was asked: "Did you tell her that? Did you give her an option of a laparotomy?" Answer: "We didn't discuss laparotomy."

Q Okay. And that's what you're basing your opinion on?

MR. HENRETTA: Which opinion? I guess let me just object to that question.

Q Doctor, did you answer?

A The answer's yes.

Q Okay. Can we go back to my other question?

A Sure. About intubation?

Q Yes. For a laparotomy, is intubation common?

A Yes. If you're going to have a laparotomy, the patient's intubated during the procedure, just as the patient is for a laparoscopy.

Q Okay.

A But the -- in the absence of major complications, patients are extubated either in the operating room or in the recovery room shortly after the procedure.

Q Is that with a laparotomy also?

A Yes.

Q Okay. Were there any complications from the intubation?

A No, other than having an endotracheal tube down your windpipe is very

unpleasant for most patients.

Q And how long was that in?

A 24 hours.

Q Is that a standard amount of time, a short amount of time, or what, with regards to intubation in this type of case?

A Well, in a patient who suffered a major complication like this and large volumes of transfusion, it certainly is not an excessive time for a patient to be intubated. But it's -- it is very excessive for a standard laparotomy or laparoscopy.

Q And you said there were no complications from the transfusion; is that correct?

A That's correct. And there were no complications either from the intubation. I mean, she hasn't ended up with a tracheal stenosis or anything like that.

Q Right.

Now, you mentioned that she ended up having to have a couple of returns as a -- and after she was discharged from the hospital. And those return visits had to do

with, I believe, an abscess; is that correct?

A Yes.

Q What is an abscess?

A An abscess is a collection of pus.

Q How does that occur?

A Well, bacteria enter the tissues and cause an infection.

Q And at what point in time did bacteria enter the tissue?

A At the time of the procedure.

Q And what was -- how was this abscess handled? What did they do?

A It was initially treated by opening it and draining it and packing it, which was the appropriate way to handle it.

Q Okay.

A And then you allow it to heal in, and then my understanding is that she had an area that kept opening and closing, and eventually they operated on that and traced it down to an infected suture that they removed. And once they did that, the infection cleared up completely.

Q Now, how could a suture cause this problem?

A Because it's a foreign body, and it's difficult to eradicate an infection where a foreign body is there, particularly if it's a braided suture. Bacteria get into the intricacies of the suture material, and antibiotics simply won't clear it up.

Q Are sutures supposed to dissolve?

A They -- some do and some don't. I think the type that she had were supposed to dissolve, but they can take months to do that.

Q What causes some sutures not to dissolve?

A Well, some are made of materials that are designed to be permanent, but I can't tell you why this suture hadn't dissolved in six months.

Q Do you have any idea if this was a dissolvable suture? I believe somewhere in Dr. Conklin's note, he did indicate it was a dissolvable suture. Do you have any idea why it would not have dissolved if it was?

A No, I don't. And I agree with you, that I saw in his note that he did say it was a dissolvable suture.

Q Okay. And you don't know why it wouldn't have dissolved in this particular case, then?

A No.

Q Did you answer, Doctor?

A I said no, I don't know.

Q Okay. I'm sorry. Every now and then I can't hear you.

A I'm sorry.

Q I think it's the phone. I don't think it's you.

Are there any other causation opinions that you haven't expressed to me that you plan to express?

A No, other than, you know, she has a -- an incision going from her xiphoid to her pubis that she wouldn't have had absent the vascular injury.

Q Are there any other opinions that you're planning to express at the trial of this matter that you have not expressed yet

today or in your report?

MR. HENRETTA: Let me just object.

Go ahead, Doctor.

A No.

Q Okay. And are you going to be asking for any additional material to review prior to the trial of this matter, Doctor?

A No.

Q Okay.

MR. HENRETTA: There's another expert's testimony.

Q And is it your intention to offer the same opinions at trial that you've offered here today?

MR. HENRETTA: Well, you know, there's going to be -- your expert has not been deposed.

MR. LOESEL: Okay, Tom.

MR. HENRETTA: Right? Isn't there a doctor -- I can't pronounce his name -- Grischkan --

MR. LOESEL: Grischkan.

MR. HENRETTA: -- Grischkan, he has not been deposed.

MR. LOESEL: Okay.

MR. HENRETTA: So if he is -- when he is deposed, I would favor Dr. Cooperman with a copy of that deposition transcript.

MR. LOESEL: Okay. And I guess if Dr. Cooperman's opinions were to change prior to the trial of this matter based on that deposition testimony, I would ask that you please make me aware of that before the trial of this matter.

MR. HENRETTA: Of course.

MR. LOESEL: Is that fair?

MR. HENRETTA: Of course it's fair, and I will.

MR. LOESEL: Doctor?

THE WITNESS: Yes, of course.

MR. LOESEL: Thank you.

MR. HENRETTA: Okay.

BY MR. LOESEL:

Q Doctor, are you familiar with Dr. Cain at all?

A No, I'm not.

Q Okay. Are you familiar with Dr. Grischkan?

A No.

Q Are you familiar with Dr. Method Duschon?

A No.

Q No?

Are you familiar with Dr. Conklin, the vascular surgeon?

A No, I'm not.

Q Okay. And are you familiar at all with Dr. Shalowitz?

A No.

Q Okay.

MR. HENRETTA: Pam, what was the one doctor's name you mentioned?

MR. LOESEL: Method Duchon?

MR. HENRETTA: Yes. Is he set to give testimony?

MR. LOESEL: Yes. He's scheduled also.

MR. HENRETTA: Well, what I said for Dr. Grischkan applies to him, as well.

MR. LOESEL: Okay, Tom.

MR. HENRETTA: All right.

MR. LOESEL: And I guess my same

request as to any testimony from Dr. Duchon stands the same as I asked for Dr. Grischkan, if there's a change in opinion.

MR. HENRETTA: Absolutely.

MR. LOESEL: Okay?

MR. HENRETTA: Okay.

MR. LOESEL: Doctor, I'm going to look at my notes real quick and see if I missed anything. I think I'm done. Just give me a minute, please.

THE WITNESS: Okay. Take your time.

(Break taken.)

MR. LOESEL: I think that's it, Dr. Cooperman. Thank you.

THE WITNESS: Okay. Thank you very much.

MR. LOESEL: Tom?

MR. HENRETTA: He won't waive.

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(Defendants' Exhibits 1 and 2 marked.)

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Thereupon, the testimony of October 2, 2003, was concluded at 12:30 p.m.

*Attach to the deposition of MARC COOPERMAN, M.D.
SHONK ET AL. v DOCTORS HOSPITAL, ET AL.
Case No. 2001 CV 01895

STATE OF OHIO :
SS:
COUNTY OF _____ :

I, MARC COOPERMAN, M.D., do hereby certify that I have read the foregoing transcript of my deposition given on October 2, 2003; that together with the correction page attached hereto noting changes in form or substance, if any, it is true and correct.

_____

I do hereby certify that the foregoing transcript of MARC COOPERMAN, M.D. was submitted for reading and signing; that after it was stated to the undersigned notary public that the deponent read and examined the deposition, the deponent signed the same in my presence on this_____day of_____, 2003.

_____
NOTARY PUBLIC
My commission expires:

CERTIFICATE

STATE OF OHIO :
SS:
COUNTY OF FRANKLIN :

I, Sara S. Fuller, RPR/CRR, a Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named MARC COOPERMAN, M.D. was first duly sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the testimony then given was reduced to stenotypy in the presence of said witness, afterwards transcribed; that the foregoing is a true and correct transcript of the testimony; that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, employee or attorney of any of the parties hereto; that I am not a relative or employee of any attorney or counsel employed by the parties hereto; that I am not financially interested in the action; and further, I am not, nor is the court reporting firm with which I am affiliated, under contract as defined in Civil Rule 28(D).

In witness whereof, I have hereunto set my hand and affixed my seal of office at Columbus, Ohio, on this 8th day of October, 2003.

Sara S. Fuller, RPR/CRR
Notary Public, State of Ohio.

My commission expires: March 19, 2008

CURRIVULUM VITAE
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DATE OF BIRTH: September 30, 1947

DEGREES: B.A. – 1969 Yale University

M.D. – 1973 Stanford University

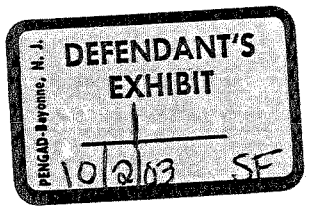
SPECIALTY: General Surgery

LICENSURE: State of Ohio, 1977

BOARD CERTIFICATION:
National Board of Medical Examiners, 1974
American Board of Surgery, 1978
Recertified, 1988, 1996

RESIDENCY: Jr. Assistant Resident in Surgery, 1973-1975
University of Chicago

Sr. Assistant Resident in Surgery, 1975-1977
Ohio State University



CURRICULUM VITAE, PAGE TWO
MARC COOPERMAN, M.D.

APPOINTMENTS:

Assistant Professor of Surgery Ohio State University	1977-1982
Associate Professor of Surgery Ohio State University	1982-1988
Clinical Professor of Surgery Meharry Medical College	1987-1992
Director, Division of Trauma Saint Anthony Medical Center	1986-1990
Chief Of Surgery Park Medical Center	1990-1999
Clinical Asst. Professor Surgery, OSU	2000- .....
Surgical Consultant, VA Med Center	2003-.....

HOSPITAL APPTS:

Ohio State University Hospital East	Active
VA Medical Clinic	Active
Mount Carmel East Hospital	Courtesy
Mount Carmel Medical Center	Courtesy
Riverside Medical Center	Honorary

MEMBERSHIPS:

American College of Surgeons
The Society for Surgery of the Alimentary Tract
Association for Academic Surgery
Society of University Surgeons
Central Surgical Association
Southwestern Surgical Congress
American Gastroenterological Association
Collegium International Cirurgiae
Societe Internationale de Cirurgiae

HONORS:

Outstanding Faculty Service Award Ohio State University	1979

CIRRICULUM VITAE
MARC COOPERMAN, M.D.
GE THREE

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CLIENT INFORMATION PACKET

SANDEE SHONK
Injuries sustained 7/28/00