IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

Doc 118 part I of II

THOMAS WILLIAMS, JR., etc., et al.,

Plaintiffs,

-vs-

JUDGE FRIEDLAND
CASE NO. 258,274

YOEL S. ANOUCHI, M.D., et al.,

Defendants.

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Deposition of ROBERT C. CORN, M.D., taken as if upon cross-examination before Aneta I. Fine, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Robert C. Corn, M.D., 850 Brainard Road, Highland Heights, Ohio, at 2:30 p.m. on Wednesday, July 20, 1994, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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On behalf of the Defendants
Yoel S. Anouchi, M.D. and Ohio
Permanente Group.

ROBERT C CORN M D of lawful age. called by the Plaintiffs for the purpose of cross-examination. as provided by the Rules of Civil Procedure. being by me first duly sworn, as hereinafter certified. deposed and said as follows:

CROSS-EXAMINATION OF ROBERT C. CORN, M.D.

BY MR. ZUCKER:

Q Would you state your name. please?

A My name is Robert Curtis Corn. C-O-R-N

Q. And your profession is that of a physician, is that correct?

A I'm an orthopedic surgeon

Q And you specialize in orthopedic surgery You have been identified as an expert for the defendant in this matter, is that correct?

A Yes

Q And you're appearing here today as an expert witness on behalf of the defendant in this case. is that correct?

A Yes

Q Doctor. you have had your deposition taken before. correct?

A Yes.

Q As we met a few minutes ago. you know that my

name is Dale Zucker, and I represent the plaintiff in this court action, and I'm here to ask you some questions and determine or attempt to determine each and every one of your expert opinions in this case and the basis for your opinions. You know that there's certain ground rules in these depositions. Before you answer any questions --

MR. GOLDWASSER: I think he's had his deposition taken more often than you and I have taken depositions, in fairness.

Q. Well, for the record, you understand that I would like you to make sure that you understand my question before you answer my questions. Mr. Goldwasser may have told you for example that from time to time in one sentence I may ask more than one question, and I don't want you to hesitate to stop me and ask me to clarify that if Mr. Goldwasser doesn't do that on your behalf.

If you answer a question I will assume that you intended to answer the question that was asked, and that you were answering it truthfully. Is that fair?

A. Yes.

Q. You're Board-certified in orthopedic surgery, is that correct?
A. Yes.
Q. What year did you obtain your Board-certification?
A. 1980.
Q. And you began practicing medicine in what year?
A. I started my office practice in orthopedics in 1979.
Q. Okay. Do you happen to have an updated CV here present?
A. Is that an old one that you have?
Q. It is. Well, it is. It is something that I obtained from one of the exchanges and I will show it to you. You can tell me if it is. First give this to Mr. Goldwasser.
A. Other than the home address, it appears to be relatively current.
Q. Okay. Doctor, if you would, on page two of your curriculum vitae, have any of your hospital affiliations changed?
A. The only changes are that I retired as chief of orthopedics at Huron Road in November of 1992, and then I am also on the staff at University Hospitals, Bedford Medical Center.

Q. Okay. Have you ever been affiliated with St. Luke's Medical Center?
A. Never.
Q. Kaiser?
A. No. Never.
Q. Okay. Doctor, I see on your CV that you continue to hold faculty positions at Case Western Reserve University and at the Ohio College of Podiatric Medicine, is that correct?
A. That's correct.
Q. Further on in your CV I see on page three that you have been the recipient of several awards, one of which was the Pennsylvania Heart Association Cardiovascular Research Award in 1975, correct?
A. Yes.
Q. Could you tell me what the topic of that, was this a paper, I assume, or --
A. The topic was prevention of venous, deep venous thrombosis through the use of external pneumatic compression.
Q. Okay. Would you have a copy of that available to give to Mr. Goldwasser?
A. The original article?
Q. Yes.

A. I don't know. I'll try. I'm not sure if I have a copy of that.
Q. Okay. Again, further down the list of awards, I see that in 1977 you were the recipient of the American College of Surgeons Resident Essay Contest, 1st Prize, correct?
A. Yes.
Q. Can you tell me what the subject matter of that presentation was?
A. That was on comparative analysis of various knee braces for unstable knee situations.
Q. And finally, the William E. Lower Award which was a clinical research paper in June of 1977. Can you tell me what the subject matter of that paper was?
A. I'm not sure. I had two papers that were submitted. One was for the actual formal paper, the same as the American College of Surgeons, and the other was a research work that was done on biological pin growth of centers of biomaterials, looking at various total joint implant coatings and the body's ability to grow into those coatings.
Q. Okay. On page four at the top, the 1975 presentation, The Prevention of Venous

Thrombosis by External Limb Compression.

Is that the same paper that was submitted to the Pennsylvania Heart Association?

A. That's correct.

Q. And again, I would ask that if you could find that paper, I would like to have that.

A. I'll make a valiant attempt to look for it.

Q. Okay. Let me ask you this, regarding that paper and the presentation. Did the subject matter of the paper and the presentation include the detection, prevention and treatment of deep venous thrombosis and/or pulmonary embolism?

A. Just to give you a little discussion on that. What the project was was a senior medical student, surgical research project in which I designed a way of reproducibly producing a blood clot in a dog. In other words, what we were trying to do is trying to prevent a blood clot from forming in a situation that would universally create a blood clot and that involved an electrical implant placed around a blood vessel that 100 percent of the time would cause a blood clot. Obviously something that does not have a lot of clinical significance, but in order to test a prevention, means of

prevention, we had to develop a means of creating a blood clot. And essentially, we did this on a number of dogs, I think we did 25 dogs, about 50 limbs, where we universally produce the clots in the nonstimulated leg, that is, stimulated by the electrical pulsation which really was the second research project ever in the development of the sequential stockings which are currently used. This was done back in 1975. And we found that universally, with the use of external compression, we prevented a clot that would normally form from forming, and that's essentially what the project was.

Q. Did it go --

A. It didn't involve detection, because we were looking, you know, we physically cut the artery open and looked for the clot.

Q. And in terms of resultant pulmonary embolism or prevention of deep venous thrombosis, you only went to the extent of treating with the pneumatic compression technique?

A. In other words, we were looking at the efficacy in a situation which would universally produce a clot to prevent a clot from forming which was one of the basis of the sequential pneumatic

compression stockings which are clinically used now.

Q. So beyond the stockings, the test had nothing to do with the heparin for example?

A. No. It had nothing to do with anticoagulants or nothing like that.

Q. Okay. On page six, doctor, continuing along in your presentations, in 1987 you made a presentation to the, at the Meridia Huron Hospital at a trauma conference entitled Fractures of the Pelvis.

Did the subject matter of that presentation include detection, prevention and treatment of either DVT or pulmonary embolism?

A. Not to my recollection.

Q. How about the 1988, Chronic Refractory Low Back Pain presentation? Or the Current Concepts of Total Joint Replacement Arthroplasty? Same question.

A. Not specifically. In other words, it was on, mostly not the complications of joint replacements, but the new technologies.

Q. The performance of the procedure itself?

A. Well, the new concepts in implant fixation, not specifically or not at all dealing with

complications of different plasties.

Q. Finally on the bottom of page six, the CME Conference that you indicate, you presented at Meridia Euclid Hospital, Current Concepts of Current Joint Replacement Arthroplasty.

Same thing, doctor?

A. Approximately.

dealing with the prevention, detection or treatment of DVT or PE?

A. No.

Q. And finally, the last presentation indicated on your CV on page seven entitled Fractures About the Hip Joint, which was a Geriatric Review Course, CME lecture at Meridia Huron Hospital. Did that presentation include subject matter dealing with the detection, prevention or treatment of DVT or PE?

A. Not specifically.

Q. Not at all?

A. I don't recall but it wasn't specifically designed for that.

Q. And on page nine, the third publication down from the top, The Prevention of Venous Thrombosis by External Limb Compression, is that

the same paper and presentation that we just discussed before regarding the dogs?

A. Correct.

Q. Okay. Doctor, as an instructor at Case Western Reserve University in orthopedic medicine, I assume, did you author or co-author any writing that was included in any textbook, the subject matter of which included detection, prevention, or treatment of DVT or PE?

A. No.

Q. And getting back to the publications for one moment, are there any publications that are listed that I didn't ask you about that dealt with prevention, detection, treatment of DVT or PE?

A. Not that I can recall.

Q. Are there any publications not listed that would have dealt with those subject matters?

A. Not that I can recall.

Q. Do you know Dr. Edward Chester?

A. Yes.

Q. Okay. Are you aware that Dr. Chester was an instructor at Case Western Reserve University during part of the time that you were?

A. I don't know.

Q. You don't recall being on the staff with him at Case Western Reserve University?
A. No.
Q. Okay.
A. I know him through Hillcrest.
Q. Doctor, could you describe for me any background that you have in pulmonary medicine or pathology?
A. Other than the specific rotations taken as a medical student and in training, I have had no specific postgraduate training in pulmonary medicine.
Q. Okay. Can you tell me what medical journals you subscribe to at the present time?
A. Yes. The Journal of Bone and Joint Surgery, The Clinical Orthopedics and Related Research. Gee, there's a number of journals. Those are the main ones. Orthopedic Clinics of North America, a journal called Orthopedics, Journal of Arthroplasty, and a number of other ones.
Q. May I ask how long you have subscribed to the Journal of Arthroplasty?
A. Since its inception, since I believe only a couple years.
Q. I see you have some textbooks here in your

office. Is that Campbell's I see up there?
A. Yes. Second to the last version of Campbell's.
Q. The second to the last?
A. There's a more recent edition which I have at home.
Q. Okay. The red, the new red one?
A. I think it's green.
Q. Okay. You're correct, it's green. You consider Campbell's to be authoritative in your field?
A. I don't consider any book or publication to be authoritative.
Q. Have you ever considered Campbell's to be authoritative?
A. Campbell's is a reference textbook, it is constantly undergoing revision and is therefore not authoritative.
Q. Okay. Do you keep any other textbooks up there besides Campbell's?
A. There are quite a few textbooks up there.
Q. Any that you consider authoritative?
A. I don't consider any textbooks authoritative.
Q. Are there any particular authors of any medical literature that you subscribe to or otherwise read that you consider to be authoritative in your area of medicine?

MR. GOLDWASSER: What do you mean, the authors authoritative?

MR. ZUCKER: Yes.

A. There are a number of authors who have very subspecialized expertise, but their opinions vary from patient to patient and from problem to problem so I'm not really sure any particular individual is authoritative.

Q. Are there any orthopedic specialists that come to mind that you would consider to be authoritative in the area of prevention, detection, and treatment of DVT or pulmonary embolism?

A. No.

Q. Doctor, do you have a file on this case?

A. Yes.

Q. May I see that for a moment, sir?

A. Sure.

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(Thereupon, Plaintiff's Exhibits 1 through 4 were marked for purposes of identification.)

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MR. ZUCKER: And I will ask that the originals be sent back to the doctor or

to Mr. Goldwasser.

MR. GOLDWASSER: I'm sorry, you want to keep those?

MR. ZUCKER: No. I want them as exhibits. If you want to get copies.

MR. GOLDWASSER: We'll get you copies. You're not taking anything away from this office but you can use it today to question him.

Q. Doctor, you issued a report to Mr. Goldwasser dated April 12th, 1994, is that correct, sir?

A. Yes.

Q. Okay. I'm handing you what has been marked Plaintiff's Exhibit 3. Would you identify that, please?

A. This is a copy of the letter of April 12th, 1994.

Q. Okay. Did you discuss this case with Mr. Goldwasser before issuing that report?

A. I don't recall.

Q. You don't recall if you discussed the form or the content of the report with Mr. Goldwasser?

A. I probably would not have discussed the content. I probably would have discussed the necessity or when he needed the report by.

Q. Relative to the form of the report, were you requested to write a short report, not a very detailed report?

MR. GOLDWASSER: All right. First of all, doctor, I would ask you not to answer these questions.

You are not entitled to know what I have discussed with my witness in a case. You are entitled to know what the basis of his opinions are in a case. ***So*** whether you like it or not I'm going to ask the doctor to refrain from answering any questions that he and I may have orally, or any issues he and I may have orally discussed or anything we orally discussed, so that's noted on the record. You may continue.

Q. Doctor, you mentioned that you reviewed some documents prior to writing this report. In paragraph one you indicate that you reviewed the St. Luke's admission records, the EMS run, and the St. Luke's, and the St. Luke's medical records for March 24th, correct?

A. Right.

Q. As well as the autopsy report?

A. Yes.

Q. You did not review any other records prior to

A. That's correct.
Q. Okay. **You** didn't review any medical literature?
A. No.
Q. You had not reviewed any records of her past medical history?
A. The only records are the records that I stated.
Q. And of course, not to be redundant, but you did not examine any of the expert reports in this case prior to issuing the letter?
A. Correct.
Q. Okay. Have you reviewed any documents since you wrote the report of April 12th, 1994?
A. Yes.
Q. And can you tell me what you've reviewed since then?
A. Essentially it was your expert's report.

MR. GOLDWASSER: Just so you will know, just within minutes of this deposition started, I presented to Dr. Corn the report of Dr. Tavernetti, T-A-V-E-R-N-E-T-T-I, which he read, as I have indicated for the first time, about 15, 20 minutes ago.

Q. Doctor, I have submitted several expert reports to Mr. Goldwasser just to be certain you have reviewed today Dr. Tavernetti's report. Have you reviewed the report of Edward Chester?

A. No.

MR. GOLDWASSER: Just to try to save time and for that purpose alone --

MR. ZUCKER: Okay.

MR. GOLDWASSER: -- and I can vouch professionally, he has seen nothing more than he's told you, Dr. Tavernetti's report.

Q. A few minutes ago you said, doctor, since writing the report of April 12th, all you have reviewed are the plaintiffs' expert report or reports. Are you saying that the only one you've read is Dr. Tavernetti, is that correct?

A. Yes.

Q. And you have reviewed no other documents including documents that would have information about her past, the medical records?

A. I think I answered that already but the answer is yes.

Q. Since then?

A. That's correct.

Q. Doctor, does the report of April 12th, 1994, contain all of the opinions that you have in this case?

A. It has all the opinions that I was addressing at that time. I'm not sure what other opinions I'm going to be asked about that, but essentially the basic questions and the letter that you have received, that you have marked as an exhibit is the only issues that I was asked to discuss, and the only opinions that were rendered were those of the questions that have been asked so far.

Q. So the opinions that you have rendered thus far in your letter of April 12th, 1994, there have not been any changes in your opinion?

A. That's correct.

Q. Doctor, I'd like to ask you some questions regarding your medical-legal reviews. How many medical-legal reviews do you do in a course of a year?

A. I am not sure what you mean by medical-legal reviews.

Q. A medical-legal review in terms of being contacted by an attorney, a medical malpractice case, and asked to review the case, and render an opinion?

A. I would say -- and get involved with a case or just review the case?
Q. Just review the case.
A. Probably a hundred a year.
Q. A hundred a year?
A. Mostly from plaintiffs' attorneys.
Q. And you -- that's in medical malpractice?
A. Correct.
Q. And you do review approximately 100 cases?
A. I would say about a hundred cases.
Q. Just so I'm clear, you are not saying you're contacted 100 times, you're saying that you do approximately a hundred a year, is that correct?
A, I'm not sure what the difference in that is.
Q. Well, the difference is, doctor, I may call you and ask you to review a case, you'll say no.
A. Oh, I see what you mean.
Q. What I'm asking you is --
A. I usually review, the attorneys that I am, feel comfortable working with, I will review what they want me to review, what they feel would be appropriate if I could help them out with a case to see whether this is something that is reasonable to, for them to pursue or something that's a waste of time for them to pursue.

Q. Do you do medical-legal reviews outside the area of medical negligence?
A. Oh, probably much more so in personal injury than in medical negligence. I do very little medical negligence review.
Q. So you don't do 100 medical negligence reviews per year, is that correct?
A. No.
Q. You are saying you do 100 combined between medical malpractice and general injury cases, correct?
A. Correct.

MR. GOLDWASSER: Just so the record is clear, the question, doctor, you misheard it, was he was talking about medical negligence, that is, when physicians are sued in medical malpractice.

A. I'm sorry, I thought you were talking about medical-legal reviews.
Q. Your answer was quite clear to me.

And doctor, you indicated that, you volunteered that most of the reviews you do are on behalf of plaintiffs' lawyers, is that correct?

A. I would say a vast majority of those types of reviews.
Q. Okay. Relative to the medical negligence reviews that you do, can you tell me of the 100 per year how many you do?
MR. GOLDWASSER: Of the medical negligence. I think the doctor just clarified he doesn't do 100. Didn't we just go through that?
MR. ZUCKER: Excuse me, Gary. The question was, of the 100 he does per year, how many are medical negligence.
MR. GOLDWASSER: That's not the way the question was posed. Do you want to read the question back?
Q. Let's go on with the question now stated, that was about to be posed when you interrupted me.
A. I would say I review one new defense case a month and about four or five plaintiff cases per month, purely medical negligence.
Q. Thanks, doctor. What is the average length of time it takes you to review these cases?
A. It's an impossible question to answer. As you know, there's some cases that have a much more significant complexity which are not compatible

with a superficial review. Some of them take hours and some of them will take minutes.

Q. And, of course, some of the cases, there are voluminous medical records and in some cases there are a small amount of medical records, correct?

A. Correct.

Q. Doctor, do you recollect if you have ever reviewed a case having to do with a deep venous thrombosis or pulmonary embolism, whether it be for plaintiff or defendant?

A. I can't recall.

Q. Can't recall if you have ever reviewed a DVT or a PE case?

A. I can't recall. I don't remember from doing any.

Q. Have you provided expert testimony for Mr. Goldwasser's clients in the past?

A. I don't think I have seen Mr. Goldwasser for almost ten years, so if I did, I don't remember what case it might of been involved with. It's certainly not something I do on a regular basis.

Q. Okay. Medical negligence is not something you do on a regular basis?

A. No. I'm a practicing orthopedic surgeon and I

do that as an assistance for certain plaintiffs' attorneys and certain defense firms. And they are highly selected.

Q. Doctor, did you ever sit on the review, peer review committee for Physicians Insurance Exchange?

A. I sat on the review committee for a three month period of time in the mid 1980's, I think 1985 to 1986.

MR. GOLDWASSER: I'm going to object to that question because there's just no relevancy whatsoever between this lawsuit and PIE.

Q. Doctor, do you know the name of the doctor who admitted Lillie Mae Williams to St. Luke's Hospital and performed surgery on her in March of 1993?

A. Yes.

Q. What is his name?

A. Dr. Anouchi.

Q. Okay. Do you know his first name?

A. Yoel.

Q. Okay. Do you know the names of the residents who assisted the doctor in Mrs. Williams' care?

A. Not off the top of my head.

Q. Do you know the date of her surgery?
A. I assume it was around March 16th of 1992.
Q. And you know that because you just looked at your report, is that correct, doctor?
A. Correct.
Q. You do not have an independent recollection of that, correct?
MR. GOLDWASSER: Doctor, you don't have to have an independent recollection of anything in this case and Mr. Zucker knows that full well. You may refer to any medical records you care to in this deposition.
Q. And doctor, can you tell me what surgical procedure was performed on Mrs. Williams?
A. She had a total hip replacement, arthroplasty.
Q. Do you know what hip?
A. Not without reviewing the records. Right hip.
Q. Doctor, without looking at the medical records, would you know Mrs. Williams' age at the time of her surgery?
A. I don't remember.
Q. Okay. Would you know what her weight was without looking at the medical records?
MR. GOLDWASSER: Wait a minute.

Why isn't he allowed to look at the medical records? He's not the treating physician. He's an expert witness who is relying upon records I provided him to evaluate this case. Those questions are outrageous.

MR. ZUCKER: I never said that he wasn't allowed to. I asked him.

MR. GOLDWASSER: You know what you're going to do, Dale. You're going to go in front of a jury in this case and try to suggest the doctor doesn't know anything about this case because he doesn't know about the ages. That's absurd. There's no reason to ask that question.

MR. ZUCKER: Gary, allow me to take the deposition.

MR. GOLDWASSER: I'm not going to allow you to take the deposition.

MR. ZUCKER: If I step outside of the rules, let me know --

MR. GOLDWASSER: I'm letting you know right now.

MR. ZUCKER: -- I'll comply. What you're trying to do is disrupt the deposition and not allow me to ask the

questions that I'm permitted to ask.

Q. Doctor, without looking at the medical records, do you know what Mrs. Williams' weight was at the time of her surgery?

MR. GOLDWASSER: Objection.

A. I have no idea.

Q. You have no idea. Did you know her weight when you issued your report on April 12th, 1994?

A. Not to be examined on, but it was clearly available for review when I reviewed the medical records.

Q. Okay. Would that have been something that you would have found pertinent in issuing your opinions in this case?

A. Not necessarily.

Q. Her age?

A. Her age was in the mid 50's.

Q. Her weight?

A. Her weight had little or no relevance. She may have been a little overweight from the diabetes, but other than that, I really don't know.

Q. Okay. And do you now know or have knowledge of what her past medical history was?

A. Other than the fact that she had, she was an insulin-dependent diabetic, I don't recall

anything else specifically.
Q. At the time of writing your report, you did not know what past medical history was?
A. If it was in the medical records, I had that available. I didn't commit it to memory.
Q. Okay. Doctor, do you know if Mrs. Williams had any post-operative prophylaxis following her total hip replacement?
A. Yes.
Q. And can you tell me what it was?
A. According to the medical records, she had, she had dosages of heparin, she had a compression stocking, and she had elastic stockings, and she was also mobilized rather rapidly.
Q. Okay. Any other prophylaxis that you're aware of?
A. I'm not sure if there is any other prophylaxis available.
Q. Okay. Do you know what her preoperative EKG status was?
A. I don't know.
Q. Do you know if her preoperative EKG indicated a sinus tachycardia?
A. I don't remember.
Q. Okay. Do you recall what her preoperative PO2

was?
A. Yes. It was low. It was in the mid 70's, 77, 75, something like that.
Q. And it's your testimony that 77, a preoperative PO2 of 77 was low in a woman such as Lillie Mae Williams?
A. I believe that is not -- I believe most people are a little bit higher unless you have some sort of lung disease, chronic obstructive long disease. I would hope mine's not 77.
Q. I would hope not either, doctor. How about your oxygen saturation. Do you know what Lillie Mae Williams' 02 saturation was?
A. I don't know if they did one preoperatively.
Q. Okay.
A. It wouldn't be the normal thing to necessarily do. They do it during anesthesia but they wouldn't necessarily do it preoperatively.
Q. Do you know what it was postoperatively in the recovery room?
A. At that specific time, no, not without looking at the records.
Q. Okay. Doctor, I'd like to ask you some question now about, some questions now about Mrs. Williams' post-operative complications, and

symptoms.

Are you aware of any complaints post surgery that Mrs. Williams indicated?

A. I have to review the medical records. I don't remember. I know she had some dysphagia problems, some swallowing problems preoperatively and postoperatively. She had some episodes of unusual feelings in the ribs and in front of the chest. She had the appropriate level of pain after the total hip replacement as reported. She had unusual sensations, the feeling of a lump in her lungs, whatever that means. There were some episodes of shortness of breath that were short-lived and improved. I'd have to read through every single nurses' note and every single doctors' record to make a list of them for you.

Q. But at the time you issued this report you were aware of those factors?

A. Yes.

Q. Is that correct?

A. Correct.

Q. And can you tell me if to your knowledge any testing was done postsurgical in Mrs. Williams' case?

A. Yes.

MR. GOLDWASSER: Testing for what, just so we know what we're talking about?

Q. Any tests that were done?

MR. GOLDWASSER: Any laboratory tests, is that what you --

Q. Any laboratory tests that were performed subsequent to her surgery.

A. She had the normal battery of postoperative testing, including blood level monitoring, that is, hemoglobin, hematocrit, looking at the various lab chemistries. She had a transfusion, I think one or two units of blood after the surgery. She had a ventilation perfusion lung scan after her surgery. I believe she had one blood gas prior to the lung scan, and the appropriate x-rays, chest x-rays and hip x-rays.

Q. Do you recall if she had an EKG done subsequent to her surgery?

A. I believe she had an EKG done, yes.

Q. Doctor, you do have a copy of the medical chart in front of you, is that correct?

A. Yes, I do.

Q. Do you know what the results of her EKG were?

A. Not without looking at the chart.

Q. Well, why don't you take a look at the chart? On March 19th, doctor, a battery of tests were run, is that correct, including EKG, ABG, chest x-ray, lung perfusion scan?
A. Yes.
Q. Okay. I'd like to discuss the results of those tests with you. First of all, doctor, can you tell me who ordered those tests for Mrs. Williams?
A. I don't know.
Q. Can you tell me the results then starting with the EKG?
A. I don't know offhand. It's going to take me a couple minutes to read through. If you have those pulled it would make my life a lot easier if you just want me to recite what the medical records say. I have to --
Q. Well, Mr. Goldwasser would have to offer you his --

MR. GOLDWASSER: Doctor, you have a tab there that says EKG. It's the fourth tab from the front.

A. Okay. EKG says sinus tachycardia, increased RS ratio, and V1, consider early transition or posterior infarct abnormal, EKG.

Q. You agree that that EKG is abnormal?
A. I don't know. I don't normally read EKG's.
Q. You agree that the EKG indicates sinus tachycardia?
A. I am not an expert in reading EKG's.
Q. Doctor, my question was do you agree that that report that you have in front of you indicates sinus tachycardia?
A. It says sinus tachycardia.
Q. What was her heart rate?
A. I don't know. I don't even know how to tell on these things. 112 beats per minute.
Q. Okay.
A. I think.
Q. You'll agree that 112 heart beats per minute is a sinus tachycardia, won't you?
A, I'm not sure what the definition of sinus tachycardia is. When I went to medical school it was anything over 110. That may have changed so 112 is slightly over 110 and therefore would warrant a clinical opinion of sinus tachycardia.
Q. In order for you to determine whether or not that EKG is abnormal, you would need to consult with another physician?
A. I'm an orthopedic surgeon. I don't look at, I

haven't looked at an EKG in 15 years to interpret it myself. I would have to depend on the cardiologist's interpretation and I have no idea if that's correct or incorrect.

Q. Very good. Doctor, do you have a tab also for radiology or chest x-rays?

MR. GOLDWASSER: It's the last tab, I think, doctor, in the order of things there.

A. Yes.

Q. Okay. Doctor, I want to ask you to look at the AP chest x-ray that was done on the 19th.

Do you have that in front ***of*** you?

A. Yes.

Q. Can you tell me what the interpretation was?

A. It says, heart size is normal, there may be minimal lineal atelectasis in the left lower lobe with the lungs otherwise clear.

Q. Doctor, I have the actual x-ray here. Would you be able to read this?

A. I probably would not be able to add anything more than the radiologist would.

Q. If what that report indicates is on this x-ray, would you be able to see it?

A. I don't know.

Q. Let's take a look. And my question to you, doctor, in interpreting this, or in looking at that x-ray is whether or not you see any signs of minimal lineal atelectasis?
A. Well, first of all, this looks like a recumbent laying down view because the lungs are not fully expanded.
Q. It's an AP view, isn't it, doctor?
A. Correct. And I don't know.
Q. You're not capable of interpreting that?
A. Yes. I'm not sure.
Q. Okay. Doctor, is there a tab for the arterial blood gas test that was done that would help you locate that test?

MR. GOLDWASSER: It's under the lab results, doctor. And it should be the last page under the lab result.

A. Okay.
Q. Okay. Do you see any abnormal findings on that arterial blood gas?
A. Yes.
Q. Which ones do you find to be abnormal?
A. Her 02 saturation is low and her PO2 is low.
Q. Her P02 is 57, is that correct, doctor?
A. That's what it says.

Q. Now, you testified before that you felt 77 was low, is that correct?
A. 77 is, according to this, this scale, 75 is their low normal.
Q. But you believe that 77, you testified that 77 was low?
A. Absolutely.
Q. Correct? Okay. Would you consider 57 to be significantly low for a PO2?
A. It's lower than the normal value.
Q. But you wouldn't consider it to be significantly low?
A. I'm not sure what you mean by significant. I'm not a pulmonary person. I would recognize this as something that was lower than, lower than normal range.
Q. Would this be a red flag for you, doctor?
A. I think below 50 is the critical stage but this is certainly lower than 77, which I think was her pre-op value.
Q. Okay. Would you consider that Lillie Mae Williams with a PO2 of 57 on March 19th, 1993 was hypoxemic?
A. I'm not really sure what the definition of hypoxemia is. She certainly has a lower lab

value than she had preoperatively.
Q. You don't know the definition of hypoxemic?
A. You know, hypoxemia means low oxygen level.
Q. Right.
A. I mean that has a range. So I would consider 77 hypoxemic but they consider 75 low normal so -- so you're really asking an orthopedic surgeon to keep up with what is currently viewed in pulmonary medicine as whether this is significant or not. It's certainly not in the danger zone from what I understand which is below 50, but at least at that one time when that one blood test was taken, that's the values that were written, that were achieved.
Q. Okay. Can you locate the lung perfusion scan, doctor?
MR. GOLDWASSER: It would be under x-ray.
A. I had it before. We keep bouncing around the records here.
MR. GOLDWASSER: It's under the x-ray.
A. Okay.
Q. And can you tell me the results of that lung perfusion scan that was done on March 19th?

A. It says, Impression, low probability for pulmonary embolism.
Q. Okay. And finally in conclusion on this battery of tests that was done on the 19th, I would ask you to look at the laboratory blood work. From the 19th, if you would.
A. Okay.
Q. And were the blood results from the 19th normal or abnormal?
A. Well, there are a number of tests that were done on the 19th. There was a random blood glucose which was very high.
Q. Excuse me, doctor. I would just refer you to the CBC at this point.
A. Okay.
Q. And I would specifically ask you the question, if the results of the CBC done on the 19th would have indicated that Mrs. Williams was suffering from anemia?
A. Yes, I believe she is anemic at that time.
Q. Okay. Doctor, at the time you reviewed this record, I'm assuming that you reviewed the doctor's order portion of the chart as well as the progress note portion of the chart, is that correct?

A. Yes.
Q. Do you recall seeing any diagnosis that was made after this battery of tests was run?
MR. GOLDWASSER: Diagnosis on the order sheets?
Q. In either the doctor's order sheets or the progress notes?
A. Well, there were a number of entries on the 19th. It looks like in the morning Dr. Anouchi saw her and felt that she had probable costochondritis. Later they did the ABG's and EKG and scans, and there's really no other diagnosis listed on the 19th.
Q. Doctor, are you aware from your review of the chart that Dr. Anouchi diagnosed Mrs. Williams' condition on the 19th as atelectasis?
A. There's nothing on the chart to indicate that.
Q. Other than the chest x-ray, correct?
A. Correct.
Q. Are you aware that Dr. Anouchi determined that Mrs. Williams' hypoxia was a result of the atelectasis?
A. I'm sorry. You're asking me was I aware of that? No, I was not specifically aware of that.
Q. Doctor, do you feel that you can make an honest

evaluation in this case without having read the deposition of the attending physician who was treating the woman on a day-to-day basis, who ordered and interpreted the tests and who made the diagnosis?

A. I believe I can draw my own opinions and my own conclusions reading the same data that he looked at.

Q. You can draw your own conclusions regarding what?

A. Any questions that you have to ask me.

Q. Okay. So if Dr. Anouchi made a statement in his deposition that would have a direct bearing on any diagnosis he made in this case or any treatment that he offered in this case, that information would not be necessary to you in order to determine whether or not he met the applicable standard of medical care in this case?

A. From what I understand, my opinions are on the basis of review of the medical records only. I'm not the defendant in the case, and I am not aware of what the defendants' opinions were in the case.

Q. Okay. Then aside from Dr. Anouchi's deposition

or anybody else's deposition, did you recognize when you reviewed this chart that Mrs. Williams was having pleuritic chest pains on March 19th and complained of other symptoms, and as a result of those complaints, and a physical examination by one of the doctors that a battery of tests was ordered?

MR. GOLDWASSER: Wait.

A. I'm not sure that anybody ever said she had pleuritic chest pain. I don't remember seeing that.

Q. From your review of the chart you did not note that Mrs. Williams suffered pleuritic chest pain?

A. I don't remember anybody ever using that term, pleuritic chest pain.

Q. Pleuritic --

A. That usually has a specific meaning to it.

Q. Correct me if I'm wrong, pleuritic chest pain means chest pain which worsens on inspiration, is that correct?

A. Well, pleuritic chest pain is pain that is worsened by breathing, not necessarily by inspiration. It could be expiration or coughing.

Q. And you don't recognize that Mrs. Williams suffered from pleuritic chest pain in this case?
A. I don't know if she has pleuritic chest pain or not.
Q. You don't know that now and you didn't know that at the time you issued your opinion?
A. There's no indication in the medical records that she had pleuritic chest pain. Nobody used that diagnosis or that term.
Q. Well, if you read in the nurses' note, a note that the patient is complaining about pain worse on breathing, would that indicate pleuritic chest pain to you?
A. Not necessarily.
Q. From your review of the medical records, from what you glean from those records, why was the battery of tests ordered on March 19th?
A. I think the battery of tests were ordered because there was a difference in her clinical appearance on the 19th.
Q. And can you tell me what the difference in her clinical appearance was on the 19th, as opposed to prior to the 19th?
A. Well, she had the same problem with swallowing. I believe she was short of breath. I have to

check the nurses' notes because I don't remember, but there was a higher index of suspicion that there may be something else going on on the 19th that was different than prior to the 19th.

Q. And also subsequent to the 19th do you know if this clinical, this change in her clinical picture continued past the 19th?

A. It was improved almost immediately, improving almost immediately.

Q. It was?

A. That's what my understanding of it is.

Q. Okay. Doctor, do you know if any follow-up testing was done subsequent to the 19th, specifically any other EKG's?

A. I do not believe that the, on the basis of what was the clinical appearance, that any additional testing was necessary.

Q. I didn't ask you that question, but --

A. No, there wasn't another done.

Q. But I appreciate you volunteering that information.

Were there any further chest x-rays obtained?

A. No.

Q. Any further arterial blood gases?
A. No.
Q. And was there another lung perfusion scan?
A. No.
Q. Was there any pulse oximetry that you are aware of?
A. No.
Q. So to your knowledge, there was no tests to determine whether or not Mrs. Williams still had a low PO2 and/or whether or not she still had the atelectasis, is that correct?
A. I think I already answered that question. There were no other diagnostic tests that were performed.
Q. Do you think that that was in accordance with good and sound medical practices not to do any further testing to determine whether she was still hypoxemic and whether or not her atelectasis had resolved prior to her discharge?
A. Well, there's a number of issues. I don't think it's necessary if the clinical picture doesn't demand it being necessary. She started off with a low P02. She is used to living with a low P02. If she is not short of breath and is not complaining clinically of any of those types of

symptoms that would be suspicious, I see no reason to do the same tests that you did that were normal already and have them repeated again.

Q. Didn't you just state you weren't sure if there was any complaints of shortness of breath?

A. Well, the chest pain that she was complaining of, which was a sternal chest pain, this pain was less after that point in time, and there was absolutely no clinical suspicion that would necessitate any further investigation.

Q. Doctor, from your recollection of reviewing the medical records, it is your testimony as stated a few minutes ago that her complaints resolved almost immediately after the oxygen was administered and the blood was given?

A. No. I didn't say that.

Q. What did you say then?

A. I don't remember. I just remember over the next day or two --

Q. They resolved?

A. The complaints that she --

Q. You did say they resolved immediately before?

A. They resolved within a very short period of time. Immediately has different connotations.

Q. I would refer you to the nurses' notes now of the 20th, doctor. If you would turn to the nurses' notes, narrative notes of the 20th I'd like to ask you a few questions there.
A. Go ahead.
Q. Do you see where Mrs. Williams was complaining of being weak, dizzy, the nurses' notes that there was general malaise and that she was diaphoretic?
A. That's what it says here.
Q. Would you consider that to be a resolution then of her complaints and symptoms from the day before?
A. No. To me that sounds more like she's got a difference in blood sugar. It doesn't sound like the same, it's a pretty generalized complaint. It doesn't sound like chest pain to me.
Q. I would ask you then doctor to take your time and look through the narrative notes for each and every day of Lillie Mae's admission and tell me whether or not if she didn't complain at least daily of continuing chest pain?
A. She complains of a pain that is very reminiscent of a hiatal hernia, which she has, an esophageal

type of chest pain. She certainly doesn't have what I would consider pleuritic chest pain or cardiogenic chest pain.

Q. No cardiopulmonary implications to her chest pain. Is that what you're saying?

A. From, you know, you're asking me to draw an opinion on a nurse's opinion, and, you know, there is a level of, that it's, I'm basically trying to interpret what a nurse meant. And I don't know if that's fair to anybody.

Q. And what the patient meant, correct?

A. Well, you know, this is like whispering down the lane. The nurse tells the doctor or the patient tells the nurse and the nurse writes it down and you are supposed to get what the nurse meant. Obviously the nurses can't write down everything. Nurses' notes are usually not the most enlightening portion **of** the medical records.

Q. You will agree with me, doctor, that a nurse's observation of a patient and/or a nurse's writing regarding a patient's complaint is not really a high technology situation; she is merely stating what the patient told her and/or what she is observing. Isn't that correct?

A. I think your question was is it what the nurse's observing or what the patient is saying, and the answer to that is yes, that's all it is.
Q. Right. And what you're trying to intimate was that you can't always trust nurses' narrative notes in medical matters, is that correct? Am I right?
A. I'm not, I didn't say anything about trust or distrust. I think that the nurse is certainly entitled to her opinion on what she says she, what she says she heard, and what she has observed. Now, whether that has any relevance to the pure medical aspect of it, or more specifically the orthopedic aspect of it, really may need some interpretation and may not be as accurate.
Q. Okay. Doctor, from your --
A. I don't say I ignore nurses' notes.
Q. Sure.
A. I just say they have to be taken with a grain of salt.
Q. Sure. From your point of view, what was causing Mrs. Williams' chest pain?
MR. GOLDWASSER: Chest pain upon swallowing, which is what the nurses talk

about? Is that your question?
Q. Well, Mrs. Williams complained about chest pain from?
A. A long time. Even preoperatively.
Q. Exactly. Yes?
A. And this was the same type of symptom. At least this is what she told the nurses what she had had before.
Q. She had mentioned that she had had the same type of thing prior to surgery, correct?
A. Yes.
Q. I think that in the admission note Mrs. Williams, in the admission physical Mrs. Williams indicated that she had dysphagia, is that correct?
MR. GOLDWASSER: Did Mrs. Williams say dysphagia?
Q. No. It was written in the admission notes that she complains of what the writer called dysphagia?
A. Dysphagia just means difficulty swallowing. It has a lot of connotations and it's sort of like a, it's like saying headache. It doesn't really qualify it to any way, state or form but, you know, the only chest pain she had was with pain

with swallowing.
Q. That's the only chest pain in the record that's indicated?
A. That's what I'm looking at. This is certainly from 3-20, 3-21, mid chest pain with swallowing.
Q. Are you aware of the diagnosis that was made in this case by Dr. Anouchi of costochondritis?
A. That wasn't 3-19 that on palpation her rib cage was sore. I'm aware --
Q. You are aware of the diagnosis he made of costochondritis?
A. Yes.
Q. And what location would that be in?
A. I'm sorry. What do you mean?
MR. GOLDWASSER: In the body you mean?
A. In the chart note or --
Q. On Mrs. Williams' body, yes. According to the chart where was the, where were the complaints of chest pain, and where were the findings by Dr. Anouchi on physical exam?
MR. GOLDWASSER: Doctor, if you look at the --
A. I know where it is. It's on the right side, right costochondral, ribs three to six.

Q. Doctor, could you point to your body and show me approximately where that is?
A. Three to six would be right in this area here.
Q. So you're pointing about six inches below?
A. I'm talking about mid sternum. Same level as the heart.
Q. Now, is that related to dysphagia, doctor?
A. I don't know.
Q. Okay. Do you know what day Mrs. Williams was discharged? You have to look at the medical records to determine that?
A. She was discharged on March 22nd, 1992.
Q. And you had to look at the record to determine that, correct?
A. Sure.
Q. Can you tell me from looking at the record or otherwise if her heparin was continued prior to discharge?
A. I'm not sure what you mean by that.
MR. GOLDWASSER: Read that --
Q. Was her heparin --
A. Continued?
Q. -- discontinued prior to discharge?
A. Sure.
Q. It was?

A. I believe so. I don't know. I have to go through the medications and see when she had it but the typical thing would be to keep it only for three or four days.
Q. Okay. And do you recollect when her TED hose or her sequential compression stockings were removed?
A. I don't remember.
Q. And you are aware she had blood transfusions, is that correct?
A. Yes.
Q. Do you know when her oxygen by nasal cannula was discontinued?
A. I don't remember.
Q. Doctor, what is DVT?
A. DVT is essentially an eponym which stands for deep venous thrombosis.
Q. And can you tell me what deep venous thrombosis is?
A. This is a condition in which a blood clot forms in the deep venous system.
Q. And what is pulmonary embolism?
A. Pulmonary embolism is an entity in which a blood clot lodges in one of the branches of the pulmonary artery.

Q. How does DVT occur?
A. Nobody really knows. All the etiologies, there's many etiologies for DVT.
Q. How does DVT occur in lower extremity surgery?
A. It probably does not occur during lower extremity surgery, it probably exists prior to lower extremity surgery.
Q. Could you explain that, it probably exists prior to --
A. There are many studies in the literature that were carried out in the late 70's and early 80's, in which they did venograms, preoperatively on people coming in for elective total hip replacement, and they found that in many studies, a very high percentage, sometimes 40 to 60 percent were present asymptomatically prior to their surgery. So --
Q. Now, in those studies that you are referring to, is there an increased risk of the DVT subsequently becoming pulmonary emboli as a result of lower extremity surgery?
A. Just a very low incidence.
Q. Very low incidence?
A. Of pulmonary embolism and an extremely low incidence of the fatal pulmonary embolism.

Q. Is there a high incidence of deep venous thrombosis in general in lower extremity orthopedic surgery?
A. Well, I think there's no statistics in general in lower extremity orthopedic surgery. I think most of the statistics are in people coming in for joint replacements, primarily hip replacements. There's not been a lot of studies --
Q. Let me rephrase my question. Is there a high incidence of DVT in lower extremity joint replacement surgery?
A. In the studies and in the literature, yes, it can be very high in some of the studies, it was quite high.
Q. Are you making a distinction now between DVT that existed prior to the surgery that you referred to in the literature from the 70's and 80's, as opposed to in general?
A. I don't understand your question.
Q. You don't understand my question.

You stated that there's a high percentage of DVT in lower extremity joint replacement surgery, is that correct?
A. I'm saying that in the studies that were

performed, when they took the group of patients and all of them before surgery had venograms, they found in some studies, up to 40 percent had pre-existing blood clots in their legs prior to the surgery which means they must of developed sometime prior to the, prior to the completion of that test so they developed preoperatively.

Q. When a clot breaks off it becomes an embolus or emboli, is that correct?

A. When a clot breaks off from its moorings, so to speak, it is by definition called an embolus.

Q. So you are saying 40 to 50 percent of the people in the literature that you referred to had DVT before they even were placed on the operating table?

A. Absolutely.

Q. How is DVT detected?

A. We have to specifically look for it.

Q. Correct. And to do that, what tests would you employ?

A. There are a number of tests to employ.

Q. Do you know what they are?

A. I know some of them.

Q. Would you tell me what they are?

A. I think the most common ones performed are

invasive or noninvasive.

Q. What are the noninvasive tests?

A. The noninvasive involve something called plethysmography. There's also a newer study involving ultrasound using a Doppler device. Those are basically the only two that I'm aware of. And then, of course, the invasive study is the venogram in which dye is injected into the venous system.

Q. Okay. And relative to the detection of pulmonary embolism do you know what tests are employed to detect pulmonary embolism?

A. Well, I think the standard is the ventilation perfusion lung scan. Now, that gives you indexes of probability. The only actual diagnostic tool for pulmonary embolism is a pulmonary arteriogram. That's a very unusual examination that can be done in very limited institutions, but that is really in essence the only thing that you actually see the blood clots on.

Q. The pulmonary arteriogram is something that's unusual, not done in many institutions? Is that what you said?

A. That's exactly what I said.

Q. Isn't that considered the gold standard in detecting pulmonary embolism?
A. I have been in clinical practice of orthopedic surgery for 15 years. I had four years of training before that and I have never seen pulmonary angiograms done for diagnosis of pulmonary embolism, so if it's the gold standard I'm not sure where it's the gold standard.
Q. Okay. If DVT is detected, how is it treated?
A. Well, I'm not, this is not my area of expertise. I would usually, if it's detected I would probably consult either a vascular surgeon or either a vascular specialist to monitor the patient. But my understanding, the general, the general way of doing it is to anticoagulate the patient. And that doesn't dissolve the existing clot, it basically prevents new additional clots from forming. And what you do is you hope that by no new clot forming, the body will actually lyse the clot. The body will dissolve the clot itself.
Q. Are you aware of any drug or drugs that are used in the prevention of DVT once it's detected?
A. You can't prevent it once it's detected.

Q. In the treatment of DVT once it's detected?
A. Sure. There's basically three types of drugs. There's low molecular weight dextrans. There are the anticoagulants, heparin and Coumadin. There's the platelet aggregation preventers which is the most common one is aspirin, but any of the anti-inflammatories will do that.
Q. In the case **of** pulmonary embolism, if it is strongly suspected or if it is detected, what treatment is normally used?
A. Well, again, this is out of my area of expertise, but I would say the general scheme of things is if it's obviously, if it's nonfatal, if it's not too big, then you place the patient on long term anticoagulation therapy and it's primarily to prevent more clots from forming, more, in other words, prevent additional clots from forming. It doesn't dissolve the present clots or the clots that already went into the lung.

In institutions that have open heart programs, you can do a pulmonary arteriotomy and actually remove the clot although that is done in very, very few institutions worldwide. And that's, the two basic ways of doing acute

pulmonary embolism, that is, you anticoagulate the patient, and you do any sort of respiratory support that's necessary. Sometimes it involves intubation and keeping the patient alive until the clots dissolve. Okay. So that's acute.

Then you get to the chronic stage, in other words, something that you have recurrent pulmonary embolisms or you have recurrent blood clots, documented blood clots, and then you do a vena cava umbrella to prevent the blood clots from coming. There's no indication from what I understand from doing the umbrella procedure without a documented pulmonary embolism or ongoing small emboli.

Q. Doctor, do you do a great deal of total hip replacement surgeries presently?

A. I'm not sure what you mean by a great deal. A large portion of my practice is total hips and total knees and geriatric orthopedics.

Q. In the past year how many total hips have you done if you can probably tell me?

A. Probably 40.

Q. Can you tell me what the incidence of deep venous thrombosis is in total hip replacement?

A. I don't know if anybody knows that. In the

studies that have been performed --
Q. Based on the literature that you read, what is the incidence of DVT in total hip replacement surgery?
A. Preoperatively or postoperatively?
Q. Postoperatively.
A. I have no idea. I don't remember, but it can be as high as 40 percent of, 40 percent before, it can be up to 40 percent afterwards.
Q. You said 40 to 50 percent before it can be for?
A. I don't remember. I don't remember exact figures.
Q. Isn't that an important part of your practice? You're an orthopedic surgeon performing numerous hip replacements; isn't it something you would want to be astutely aware of, the incidence of deep venous thrombosis?
A. I am but it doesn't mean I have to be paranoid when I treat my patients.
Q. I didn't ask you that, I asked you if --
MR. GOLDWASSER: Wait a minute. Dale, that is so outrageously argumentative, and I'm sitting here listening and I'm not sure I'm really

hearing it. The doctor told you he's well aware of the risk of deep venous thrombosis. You're asking him to quote rhyme and verse what the percentage is. Now, that's an insult to a physician to suggest that. I don't think you really mean that but if you listen to yourself that's what you're saying.

Q. Doctor' I don't mean to insult you at all. I hope you know that. But I find that you are perhaps being a bit evasive in some of these questions, and I feel it's necessary to, in order to determine what your opinions truly are for me to probe. So excuse me, and again, I don't mean to be insulting to you.

MR. GOLDWASSER: Well, I think that's an argument for the jury if you think he's being evasive. I don't think he's being evasive at all.

MR. ZUCKER: I think that he is.

MR. GOLDWASSER: Let's get on with it. We'll be here all day. Go ahead. My note's on the record.

Q. Okay. You agree with me, doctor, that it's extremely important for an orthopedic surgeon to

know the incidence of a condition such as deep venous thrombosis in order to properly render care and treatment to his patients. Is that correct?

A. I don't know.

Q. Okay. Doctor' let me ask you about the incidence of pulmonary embolism, status post total hip replacement where there's a low probability on the VQ scan. Are you aware of the Pioped study?

A. No.

Q. You've never read the Pioped study?

A. I have never even heard of it.

Q. Have you recently read medical literature regarding the belief that a finding of low probability on a VQ scan does not mean that there's no probability of pulmonary embolism?

A. That was quoted in your expert's report and I have to agree that low probability doesn't mean nonexistence.

Q. Okay.

A. It just means that there's obviously no significant reaction or if there is a clot it certainly is not anything to worry about it.

Q. The literature that I have reviewed relative to

this case indicates that where in multi-center studies where there is a low probability for pulmonary embolism finding on a VQ scan, that 12 percent of those people ultimately wind up to have pulmonary embolism.

Do you agree with that?

A. I have no idea.

Q. You wouldn't disagree with that?

A. I don't have an opinion.

Q. Okay. Well, hypothetically speaking, if, in fact, it is true that a patient with a low probability for pulmonary embolism result on a VQ scan has a 12 percent chance of having pulmonary embolism, would you agree that it would be good medicine to test for pulmonary embolism beyond the VQ scan?

MR. GOLDWASSER: Objection.

A. I don't know.

Q. You don't know?

A. If given the same situation in my patient with a low probability and an improving clinical picture, I would not pursue it any farther.

Q. Given the same situation as what?

A. Given that situation where there was a low probability scan and this happens, I would say

once every other week, and no further evolution of the clinical picture, in other words, the clinical picture is improving, then I would say there would be absolutely no reason to pursue it any further.

Q. Doctor, do you think that Lillie Mae Williams was in a high risk category for DVT when she had her surgery in March of 1993?

A. I'm not really sure. I don't know what the risk, you know, what the risk, what is high risk, moderate risk, low risk. I'm not really sure of the criteria. I don't really remember.

Q. You don't remember from the literature that you read?

A. I don't --

Q. Pardon?

A. If I had the same situation in the same type of patient, I wouldn't treat it any differently than she was treated, that is, with the same prophylaxis and the same type of monitoring.

Q. Okay. In his deposition Dr. Chester indicated that with a low probability VQ scan -- strike that.

Doctor, is there a classical presentation for DVT?

A. DVT?
Q. Yes.
A. I would say most DVT is asymptomatic.
Q. So you would agree it's a silent presentation, is that correct?
A. It has no symptoms.
Q. Is there a difference in presentation between hospitalized patients and ambulatory patients, generally speaking?
A. I have no idea what your question was.
Q. Relative to classical presentation, which you indicate is normally silent, relative to DVT, is there a difference in the presentation between hospitalized patients and ambulatory patients, those people who are not in the hospital?
A. I imagine it's just as equally silent. I have no idea.
Q. Okay. And how about the classical presentation of pulmonary embolism, doctor? Do you have an opinion as to what the classical presentation is?
A. What I have seen?
Q. Sure. Based on your experience?
A. Have a high index.
Q. Tell me what it is?

A. Patients may or may not, but usually do have some form of chest pain. The symptoms mimic almost precisely what a cardiac, myocardial infarction looks like. Chest pain,' diaphoresis, shortness of breath, extreme anxiety. That's about the clinical presentation. There may be decreased breath sounds, there may be diaphoresis or sweating.

Q. Hypoxemia?

A. You can't judge. We're talking about clinical presentations. You didn't ask me that, about laboratory presentations.

Q. Okay.

A. In other words, if there was a clinical picture that was highly suspicious of a cardiovascular insult, then it would warrant investigation.

Q. I asked you about the clinical presentation.

A. I'm not sure what the textbook says.

Q. I'm asking you based on your experience. The classical presentation including clinical and laboratory, if you could tell me from your experience?

A. There's usually, in addition to what I have said already, there may or may not be EKG changes and

I don't remember what they are. There is usually a significant, significantly lower level of oxygen saturation, and a significantly lower level of oxygen tension, the PO2, *so* to speak. There may be associated respiratory compensation in having a low PC02 as well, because they're breathing more rapidly.

Q. How about atelectasis?

A. Atelectasis usually has nothing to do with pulmonary embolism, at least to my knowledge it doesn't.

Q. You don't normally see a degree of atelectasis with pulmonary embolism in the classic presentation?

A. I don't remember. That's out of my area that I would normally deal with, but I would say virtually every patient that has undergone a major orthopedic procedure who is in the middle age to elderly bracket will have some atelectasis on postoperative x-rays. It's a very, very common finding.

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(Thereupon, Plaintiff's Exhibit 5 was marked for purposes of identification.)

- - - -

(Thereupon, the deposition was adjourned to be continued.)

- - - -

ROBERT C. CORN, M.D.

C E R T I F I C A T E

The State of Ohio,) SS:
County of Cuyahoga.)

I, Aneta I. Fine, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named ROBERT C. CORN, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ____ day of _____, A.D. 19 __.

_____
Aneta I. Fine, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires February 27, 1996

W I T N E S S I N D E X

PAGE

E X H I B I T I N D E X

EXHIBIT	MARKED
Plaintiff's Exhibits 1 through 4.....	15
Plaintiff's Exhibit 5.....	68

REMINGER & REMINGER CO., **L.P.A.**
ATTORNEYS AT LAW
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CLEVELAND, OHIO 44114
TELEX, 980123
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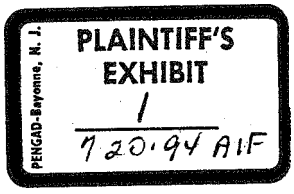
(216) 687-1311



April **6, 1994**

Robert C. Corn, M.D., **F.A.C.S.**
Highland Musculo-Skeletal Associates, Inc.
Highland Medical Center
850 Brainard Road
Highland Heights, OH **44143-3106**

SUBJECT: Estate **of** Lillie Mae **Williams v.** Kaiser Permanente, et al
Cuyahoga **County** Common Pleas Case **No:** 258274

Dear Dr. Corn:

You have graciously agreed to serve as our consultant as pertains to the above-captioned matter. In that regard, you and I missed each other over the course of the last week or so. I am advised that you are on vacation during the week of April **4.** Thus, this letter is submitted merely as a reminder that I will look forward to hearing from you at your earliest opportunity. Time is somewhat of the essence; thus, I would consider it a personal favor if you would give this matter your early attention.

Many thanks.

Yours very truly,

REMINGER & REMINGER CO., **L.P.A.**

Gary H. Goldwasser

GHG:pjo

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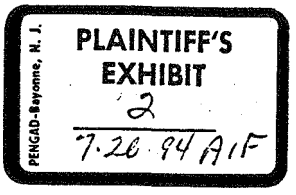


June 23, 1994

Dale P. Zucker, Esq.
1370 Ontario Street
600 Standard Building
Cleveland, OH 44113

COPY

SUBJECT: Estate of Lillie Mae Williams v. Kaiser Permanente, et al
Cuyahoga County Common Pleas Case No: 258274

Dear Mr. Zucker:

This letter will serve to confirm that you will take the deposition of our expert, Robert C. Corn, M.D., on Wednesday, July 20, 1994, at 3:30 p.m. The deposition will be conducted at Dr. Corn's office which is located at:

Highland Musculo-Skeletal Assoc., Inc.
Highland Medical Center
850 Brainard Road
Highland Heights, OH 44143-3106

You will retain the court reporter. This deposition was originally scheduled for July 15, 1994.

Yours very truly,

REMINGER & REMINGER CO., L.P.A.

Gary H. Goldwasser

GHG:man

cc: Robert C. Corn, M.D. ✓
George M. Moscarino, Esq.

BPS -- Dr. Corn, please note your calendar that I will meet with you at your office on Wednesday, July 20, 7994, at 3:00 p.m. for a pre-deposition conference. .

Highland
Musculo·Skeletal
Associates, Inc.

Robert C. **Corn,** M.D., **F.A.C.S.**
Timothy **L.** Gordon, M.D.
Orthopaedic Surgeons

April 12,1994

Gary H. Goldwasser
Attorney at **Law**
The 113th St. Clair Building
Cleveland, OH 441 14

RE: Williams Vs Kaiser Pennanente
Case #258274

Dear Mr. Goldwasser:

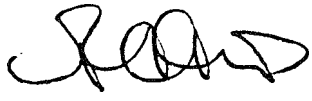
I have had the opportunity to review the medical records which included the Plaintiffs complaint, the St. Lukes admission from March 16, 1992 to March 22, 1992, EMS run on March 24, 1993 and the St. Lukes Medical records from the same date, as well as the autopsy report on the late Mrs. Williams.

After careful review of medical records it is my opinion that the Lilly Mae Williams died from an unpredictable, un-diagnosable pulmonary embolism. The origin of these clots were probably from the abdominal cavity and therefore un-diagnosable by techniques used for diagnosis in the lower extremities.

After careful review of the medical records, in my opinion, this patient was appropriately managed. The development of her fatal pulmonary embolism is **a** known complication of total hip surgery. In my opinion, the care rendered to the late Mrs. Williams post-operatfvely, based on the presenting condition and

circumstances, was in compliance within reasonable and acceptable standards of practice.

Sincerely,



Robert C. Corn, M.D., **F.A.C.S.**

RCC/bn

cc: File

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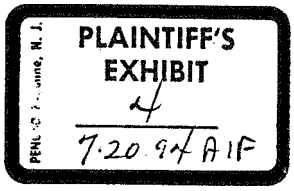

March 16, 1994

Robert C. Corn, M.D., F.A.C.S.
Highland Musculo-Skeletal Associates, Inc.
Highland Medical Center
850 Brainard Road
Highland Heights, OH 44143-3106

SUBJECT: Estate **of** Lillie Mae Williams **v.** Kaiser Permanente, et **al**
Cuyahoga County Common Pleas Case **No: 258274**

Dear Dr. Corn:

This office is privileged to represent Kaiser Permanente and most particular, its staff orthopedic surgeon, Dr. Yoel Anouchi. Your exceedingly fine reputation in our community is well known to me, thus I am herewith making request for your services as our consultant. As always, we seek a frank and candid opinion as to whether or not Dr. Anouchi and his colleagues complied with reasonable and acceptable standards of medical practice given the presenting conditions and circumstances. If so, my clients are entitled to a vigorous defense and if the contrary be true, we have an obligation to seek an amicable out-of-court settlement. Naturally, our client will honor your statement for professional services rendered should you agree to serve as our consultant.

By way of brief summary, the patient, Lillie Mae Williams, presented to St. Luke's Hospital under the service of Dr. Anouchi with complaints of severe right hip pain due to arthritic changes. On March 16, 1993, she underwent a right total hip arthroplasty and appeared to tolerate the procedure without complication. On March 19, the patient complained of right sternal chest pain and on that same date, a VQ lung scan demonstrated low probability of pulmonary embolus. The patient was discharged on March 22. On the very next day, she expired. The coroner's office performed an autopsy diagnosing acute and organizing pulmonary thromboemboli, bilateral.

We are seeking your opinion as to whether or not the care the late Mrs. Williams received postoperatively based upon the presenting conditions and circumstances was in compliance with the reasonable and acceptable standards of practice. In particular, should the attending physicians have done the following:

a. Repeat ABGs with the patient on oxygen;
b. Obtain venous return studies of the lower extremities;
c. Order a pulmonary angiogram?

I am enclosing for your review:

1) Bound and indexed copy of the St. Luke's hospital records for the admission of March 16-March 22, 1993;

2) EMS run sheet;

3) St. Luke's Emergency Room record;

4) Autopsy Report.

As soon as you determine whether or not you will serve as our consultant, I would appreciate it if you would kindly inform my office. If you so agree, please call me after you have had an opportunity to review the enclosed material at which time we can discuss your impressions.

Assuring you we appreciate all courtesies extended.

Yours very truly,

REMINGER & REMINGER CO., L.P.A.

Gary H. Goldwasser /mbd

Gary H. Goldwasser

GHG:man
enclosures
Dictated but not read