COMMON PLEAS COURT

MONTGOMERY COUNTY

STATE OF OHIO

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EDWARD L. WATKINS,
INDIVIDUALLY AND AS THE
ADMINISTRATOR OF THE ESTATE :
OF DOROTHY A. WATKINS,
DECEASED,

PLAINTIFF, :

VS. CASE NO. 91-5239

RICHARD G. SCHARRER, M.D., :
ET AL.,
:
DEFENDANTS.

- - -

DEPOSITION OF

STEPHEN J. DEVOE, M.D.

FEBRUARY 10, 1994

- - -

E & A REPORTING SERVICE, INC.
915 SOUTH FRONT STREET
COLUMBUS, OHIO 43206
(614) 445-6300

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DEPOSITION OF STEPHEN J. DEVOE, M.D., AN EXPERT WITNESS CALLED BY THE PLAINTIFF AS IF UPON CROSS-EXAMINATION, TAKEN BEFORE ME, DENISE SHOEMAKER, A REGISTERED PROFESSIONAL REPORTER AND NOTARY PUBLIC WITHIN AND FOR THE STATE OF OHIO, AT THE OFFICES OF THE DEPONENT, 3555 OLENTANGY RIVER ROAD, COLUMBUS, OHIO, COMMENCING AT 4:10 P.M., SAID DEPOSITION TAKEN PURSUANT TO THE STIPULATIONS HEREINAFTER SET FORTH.

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APPEARANCES:

DAVID B. SHAVER, ESQ., OF THE LAW FIRM OF WOLSKE & BLUE, 580 SOUTH HIGH STREET, COLUMBUS, OHIO 43215, APPEARING ON BEHALF OF THE PLAINTIFF.

PATRICK K. ADKINSON, ESQ., OF THE LAW FIRM OF JACOBSON, MAYNARD, TUSCHMAN & KALUR, SUITE 900, ONE CITIZENS FEDERAL CENTRE, DAYTON, OHIO 45402, APPEARING ON BEHALF OF THE DEFENDANTS.

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PLAINTIFF'S EXHIBITS

DESCRIPTION	MARKED
1) DIAGRAM OF THE PERITONEUM	17
2) GREATER OMENTUM AND ABDOMINAL VISCERA	17

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STIPULATIONS

IT IS AGREED AND STIPULATED BY AND BETWEEN COUNSEL FOR THE RESPECTIVE PARTIES HEREIN THAT THIS DEPOSITION MAY BE TAKEN IN SHORTHAND BY DENISE SHOEMAKER, WHO MAY LATER, OUT OF THE PRESENCE OF THE WITNESS, TRANSCRIBE OR CAUSE SAID SHORTHAND NOTES TO BE TRANSCRIBED; THAT THE FORMALITIES AS TO THE TIME AND PLACE OF THE TAKING OF THE DEPOSITION ARE PURSUANT TO AGREEMENT; AND THAT THE QUALIFICATIONS OF THE OFFICER BEFORE WHOM TAKEN AND THE READING OF THE TRANSCRIPT BY THE DEPONENT SHALL BE EXPRESSLY WAIVED.

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THEREUPON,

STEPHEN J. DEVOE, M.D.

BEING BY ME FIRST DULY SWORN,

AS HEREINAFTER CERTIFIED,

TESTIFIES AS FOLLOWS:

CROSS-EXAMINATION

BY MR. SHAVER:

Q COULD YOU, DR. DEVOE, STATE YOUR FULL NAME.

A STEPHEN JOHN DEVOE.

Q AND YOUR PROFESSIONAL ADDRESS IS HERE AT 3555 OLENTANGY RIVER ROAD?

A THAT'S CORRECT.

Q YOU'RE A MEDICAL DOCTOR, OF COURSE.

A THAT'S CORRECT.

Q AND YOU PRACTICE OB-GYN?

A THAT'S CORRECT.

Q CAN YOU TELL ME A LITTLE BIT ABOUT YOUR PRACTICE. DO YOU CONSIDER YOURSELF A GENERALIST?

A I'M A GENERALIST, BUT I DO KIND OF EMPHASIZE HIGH-RISK OBSTETRICS. I DID A FELLOWSHIP IN HIGH-RISK OBSTETRICS. IN THE LAST FEW YEARS THE PENDULUM HAS SWUNG TOWARD HOSPITAL-BASE, HIGH-RISK PEOPLE. SO MY PRACTICE IS BASICALLY A GENERAL

PRACTICE IN OBSTETRICS AND GYNECOLOGY, MAYBE A LITTLE MORE HIGH-RISK STUFF THAN MOST PEOPLE ARE WILLING TO BITE OFF.

Q ARE YOU A PERINATOLOGIST?

A THAT'S THE SAME THING.

Q SO YOU'RE BOARD CERTIFIED IN BOTH O.B. AND MATERNAL-FETAL MEDICINE?

A I NEVER TOOK THE BOARD IN PERINATOLOGY. I PASSED THE WRITTEN THE ONLY TIME I TOOK IT, BUT I NEVER DID THE RESEARCH TO QUALIFY FOR THE ORAL, SO I NEVER TOOK THE ORAL. ABOUT 20 PERCENT OF THE PEOPLE WHO HAVE FELLOWSHIPS ARE IN THAT BOAT, DIDN'T TAKE THE ORAL.

Q DID YOU BRING A COPY OF YOUR C.V.?

A NO, I DIDN'T.

MR. ADKINSON: I FORGOT TO ASK HIM.

BY MR. SHAVER:

Q THAT'S OKAY. DOCTOR, I TAKE IT SINCE THE LAST TIME I HAVE DEPOSED YOU, YOU HAVEN'T HAD YOUR LICENSE REVOKED OR SUSPENDED OR ANYTHING NASTY.

A THAT'S CORRECT.

Q AND THE SAME IS TRUE WITH YOUR HOSPITAL PRIVILEGES?

A THAT'S CORRECT.

Q DO YOU HAVE ANY PUBLICATIONS THAT ARE PERTINENT TO THIS PARTICULAR CASE?

A NO.

Q YOU DO, I IMAGINE, YOU DO LAPAROSCOPIC SURGERY.

A YES.

Q AND FOR THE LYSIS OF ADHESIONS SUCH AS IN THIS CASE?

A THAT'S CORRECT.

Q COULD YOU TELL ME A LITTLE BIT ABOUT YOUR ANNUAL EXPERIENCE WITH THAT TYPE OF SURGERY.!

A ALL LAPAROSCOPIES, I PROBABLY DO 75 TO 100 A YEAR. A LOT OF THEM ARE FOR TUBAL STERILIZATION. MAJORITY ARE FOR THAT. SMALLER PART WOULD BE FOR PAIN AND FERTILITY, THIS KIND OF THING, PELVISCOPIC SURGERY.

Q IS THAT TYPICAL OF WHAT MOST OB-GYN'S WOULD BE DOING?

A I REALLY CAN'T SPEAK FOR THEM. I DON'T KNOW. I DON'T HAVE ANY ACCESS TO THAT.

Q THE TUBALS OR FERTILITY PROBLEMS, THE TECHNIQUE, AS FAR AS WHAT IS CONCERNED IN THIS CASE, IS THE SAME, IT'S NOT LIKE WE'RE DEALING WITH A DIFFERENT TECHNIQUE OR ANYTHING LIKE THAT?

A THAT'S CORRECT.

Q I WILL SAVE SOME WRAP-UP QUESTIONS ABOUT YOUR EXPERIENCE, MEDICAL-LEGAL MATTERS AND STUFF UNTIL THE END. WHY DON'T WE JUMP RIGHT TO THE HEART OF THE MATTER AND THAT'S THIS CASE.

HOW DID YOU HAPPEN TO BE CONTACTED IN THIS CASE?

A I GOT A PHONE CALL, ACTUALLY A CONVERSATION AND THEN A FOLLOW-UP LETTER ABOUT THIS CASE FROM GREG GIBSON, WHO IS AN ATTORNEY IN DAYTON.

Q I IMAGINE HE TOLD YOU A LITTLE @IT ABOUT THE CASE.

A RIGHT.

Q DID HE SEND YOU ANY WRITTEN MATERIALS ABOUT THE CASE?

A HE DID IN FOLLOW-UP AFTER THE CONVERSATION A COUPLE MONTHS LATER SENT ME SOME MATERIALS.

Q WERE THE MATERIALS ACCOMPANIED BY ANY CORRESPONDENCE?

A BOILERPLATE, FOLLOW UP ON OUR CONVERSATION, HERE'S THE STUFF, CALL ME WHEN YOU LOOK THROUGH IT.

Q NOTHING SPECIFIC ABOUT THE CASE?

A CAPSULE SUMMARY.

Q NOTHING YOU WOULD RELY ON?

A EXACTLY. READ IT AND THROW IT AWAY.

Q THAT'S TRUE FOR MOST PHYSICIANS, THEY GET GIBBERISH FROM ATTORNEYS, THEY DON'T PAY ANY ATTENTION TO IT AND JUST DO THEIR OWN REVIEWS.

A ABSOLUTELY.

Q I IMAGINE YOU LOOKED AT THE MEDICAL RECORDS. COULD YOU TELL ME WHAT MEDICAL RECORDS YOU LOOKED AT.

A SURE. I LOOKED AT THE RECORD FOR THE HOSPITAL ADMISSION ON **3-13, 3-14-91,** THE HOSPITAL ADMISSION THAT BEGAN ON **3-15-91.** I LOOKED AT THE AUTOPSY RECORDS ON THE DECEASED. I LOOKED AT THE OFFICE RECORDS FROM DR. SCHARRER, DR. KRAUS, DR. PETERS, SOME CORRESPONDENCE FROM DR. O'HARA. DEPOSITIONS FROM CORSON, THE PATIENT'S HUSBAND AND DR. SCHARRER. A SUMMARY, I BRIEFLY LOOKED AT A SUMMARY OF THE DEPOSITION FROM MR. SCHARRER -- CORRECTION, MR. WATKINS. I THINK THAT COVERS IT.

Q BUT YOU DID HAVE A CHANCE TO LOOK AT THE DEPOSITION OF THE HUSBAND HIMSELF?

A VERY BRIEFLY.

Q WHAT WAS YOUR UNDERSTANDING F THE

SIGNIFICANT MEDICAL HISTORY THAT BROUGHT THIS WOMAN TO DR. SCHARRER?

A SHE HAD CHRONIC RECURRENT SEVERE PELVIC PAIN. SHE HAD A HYSTERECTOMY IN 1974. SHE HAD RECURRENCE OF HER PAIN IN THE LATE EIGHTIES, HAD A LAPAROSCOPY IN 1988 FOR PAIN, SUBSEQUENT LAPAROTOMY IN 1989 FOR PAIN, AT WHICH TIME ENDOMETRIOSIS WAS DIAGNOSED AND CONFIRMED PATHOLOGICALLY WITH TISSUE TAKEN FROM THE PERITONEAL CAVITY. SHE HAD EXTENSIVE ADHESIONS NOTED AT THAT TIME.

AFTER THAT TIME SHE INTERMITTENTLY HAD PAIN. SHE HAD A G.I. EVALUATION IN SEPTEMBER OF '90, AND THEN A UROLOGIC EVALUATION THE SUMMER, MAYBE EARLY WINTER OF '91, IVP URINALYSIS, THAT SORT OF THING. SEVERAL PELVIC EXAMS. SEVERAL VISITS WITH DR. SCHARRER. SEVERAL VISITS TO HER FAMILY PHYSICIAN FOR DEMEROL SHOTS AND OTHER THINGS.

Q YOU WERE AWARE ALSO PROBABLY THAT SHE HAD HAD AN APPENDECTOMY IN THE PAST?

A I KNOW SHE HAD HER GALLBLADDER OUT IN '66. I DON'T KNOW ABOUT THE APPENDECTOMY.

Q DO YOU RECALL WHAT TYPE, FOR THE LAPAROTOMY, WHAT TYPE OF INCISION THAT SHE HAD?

A SHE HAD A PFANNENSTIEL INCISION FOR THE

PELVIC LAP AND A VERTICAL MIDLINE FOR THE GALLBLADDER.

Q WAS THE PFANNENSTIEL OVER THE OLD PFANNENSTIEL FOR THE HYSTERECTOMY?

A THAT'S MY UNDERSTANDING.

Q YOU ACTUALLY WERE ABLE TO SEE THE LAPAROSCOPY REPORT FROM '88 AND THE LAPAROTOMY REPORT FROM 1989?

A RIGHT.

Q I TAKE IT YOU DIDN'T HAVE A CHANCE TO CONVERSE WITH THE SURGEON, DR. WATSON.

A THAT'S CORRECT.

Q DID ANYTHING STRIKE YOU ABOUT THE LAPAROSCOPY OF 1988? YOU CAN GO AHEAD AND TAKE A LOOK.

A NOTHING OFF THE TOP OF MY HEAD. I HATE TO SAY THAT IF I'M MISSING SOMETHING IMPORTANT. SHE HAD ADHESIONS, WHICH PEOPLE DO AFTER SURGERY.

Q THAT'S NOT UNEXPECTED?

A RIGHT.

Q OKAY.

A I SCANNED THE OP NOTE FROM THE LAPAROSCOPY OF AUGUST OF '88.

Q DOES ANYTHING STRIKE YOU AS UNUSUAL?

A I DON'T THINK SO.

Q THEN IN 1989 SHE HAD A LAPAROTOMY?

A CORRECT.

Q COULD YOU TURN TO THAT OPERATIVE REPORT, THE OPERATIVE REPORT FOR 1989. LET'S START WITH A DISCUSSION OF THE APPROACH. THE PFANNENSTIEL INCISION, IS THAT THE USUAL INCISION FOR A LAPAROTOMY?

A YES. ESPECIALLY WHEN SOMEONE HAS THE SAME INCISION FROM A PREVIOUS SURGERY. YOU TEND NOT TO PUT TWO SCARS IN THE BELLY IF YOU CAN AVOID IT. THAT'S VERY STANDARD.

Q SO YOUR ASSUMPTION IS HE WENT THROUGH THAT INCISION SIMPLY BECAUSE THAT INCISION ALREADY EXISTED?

A WELL, I THINK IT'S A STANDARD GYNECOLOGIC INCISION FOR BENIGN DISEASE.

Q YOU MENTIONED THAT ONE OF THE CONSEQUENCES OF ANY ABDOMINAL SURGERY WOULD BE THE DEVELOPMENT OF ADHESIONS.

A THAT'S CORRECT.

Q DOES ANYONE QUITE UNDERSTAND WHY ADHESIONS DEVELOP?

A THERE ARE ALL KINDS OF THEORIES. IT'S MORE THEORY THAN ACTUAL FACT ABOUT WHY THEY DEVELOP, WHY SOME PEOPLE GET MORE OF THEM THAN OTHERS, WHY SOME

PEOPLE HAVE SYMPTOMS AND BOWEL OBSTRUCTIONS FROM THEM AND SOME SEEM TO FORM A GREAT EXUBERANCE AND SOME OF THE OTHER PEOPLE HAVE NONE OF THE ABOVE.

Q DO THEY TEND TO BE SITE SPECIFIC, IN OTHER WORDS, IF SOMEBODY HAS AN ADHESION AT ONE SPOT, WILL THEY TEND TO GROW ADHESIONS AT THE SAME SPOT?

A THEY TEND TO GROW ADHESIONS WHERE THE SURGERY IS DONE RATHER THAN SPECIFIC SITES WITHIN THE ABDOMEN, FOR EXAMPLE. ONCE THEY ARE FORMED, THEY DO TEND TO RECUR AT THAT SPOT, BUT IT'S NOT PARTICULARLY HARD AND FAST. THEY ALSO WILL OCCUR AT OTHER AREAS THAT ARE SUPPOSEDLY NOT TRAUMATIZED IN THE SURGERY. SO YOU CAN'T ALWAYS SAY I KNOW WHERE THE ADHESIONS ARE GOING TO BE BECAUSE I KNOW WHAT WAS DONE AND I KNOW WHERE THE INCISION WAS DONE. THEY ARE UNPREDICTABLE, IN OTHER WORDS.

Q BUT IT IS SOMETHING THAT'S RELATIVELY WELL-KNOWN THAT ONE OF THE PROBLEMS WHEN YOU CUT DOWN SOME ADHESIONS, THEY ARE LIKELY TO GROW BACK IN THE SAME SPOT?

A THAT'S CORRECT.

Q NOW, THERE ARE SEVERAL TERMS USED -- LET ME FIND MY COPY OF THE OPERATIVE REPORT. DID THIS WOMAN HAVE PERMANENT RELIEF OF SYMPTOMS FROM THE

SURGERY IN 1988?

A NO.

Q DID SHE HAVE PERMANENT RELIEF OF SYMPTOMS FROM THE SURGERY IN 1989?

A NO.

Q IS THAT A PROBLEM WITH ADHESIONS?

A THAT'S WHAT I WAS ALLUDING TO A FEW MINUTES AGO. ADHESIONS AND THE SYMPTOMS THEY CAUSE ARE VERY, VERY UNPREDICTABLE.

Q DO YOU HAVE ANY OPINION, GOING INTO THE THIRD SURGERY, AS TO THE PERCENTAGE OF CHANCE OF SUCCESS FOR PERMANENT ALLEVIATION OF THIS WOMAN'S PAIN GIVEN THE PAST HISTORY OF THE PAST TWO SURGERIES?

A FIFTY PERCENT PROBABLY.

Q IS THAT BASED ON ANY STUDY OR JUST YOUR OWN PERSONAL EXPERIENCE?

A IMPRESSION. ADHESION WORK IS HIGHLY VARIABLE AND THE RESULTS ARE HIGHLY VARIABLE. THAT'S JUST -- THERE ISN'T GOOD DATA OUT THERE.

Q THERE WERE SOME TERMS USED IN THE SURGERY OF 1988 -- 1989 THAT YOU CAN PERHAPS HELP ME WITH. HE TALKS ABOUT --

MR. ADKINSON: YOU ARE IN '89?

BY MR. SHAVER:

Q THE '89 SURGERY. ADHESIONS INVOLVING THE RECTOSIGMOID TO THE CUL-DE-SAC. WHAT IS THE CUL-DE-SAC?

A THE CUL-DE-SAC IS A POUCH BEHIND THE UTERUS IN MIDLINE, KIND OF AT THE BOTTOM OF THE ABDOMINAL CAVITY.

Q IS WHAT HE IS SAYING IS THE SIGMOID, RECTOSIGMOID COLON, A PORTION OF THE COLON IS ATTACHED TO THE CUL-DE-SAC?

A YES. THE COLON RUNS THROUGH THE PELVIS AND EXITS. IT OBVIOUSLY CONNECTS TO THE ANAL OPENING AT THE BOTTOM OF THAT AREA CLOSE TO THAT AREA DIRECTLY BEHIND THE CUL-DE-SAC, AND APPARENTLY THERE WERE ADHESIONS OF THAT AREA OF THE COLON TO THE CUL-DE-SAC TISSUE ITSELF.

Q THEN HE TALKED ABOUT THE OMENTUM BEING ADHERED TO THE ANTERIOR ABDOMINAL WALL. I THINK I UNDERSTAND ANTERIOR ABDOMINAL WALL. THAT'S THE TOP OF THE STOMACH?

A THE FRONT. THE WHOLE THING FROM THE PUBIC BONE TO THE RIB CAGE IS THE ANTERIOR ABDOMINAL WALL.

Q WHAT IS THE OMENTUM?

A THE OMENTUM IS A FATTY APRON-LIKE

STRUCTURE THAT HANGS OFF THE ANTERIOR CURVE OF THE STOMACH AND THE TRANSVERSE COLON, AND IT MAY BE REAL SMALL OR REAL LARGE DEPENDING ON THE INDIVIDUAL VARIATION AND FREQUENTLY IS INVOLVED IN ADHESIONS.

Q IS THE OMENTUM ATTACHED TO ANY INTERNAL STRUCTURES?

A I JUST MENTIONED THEM.

Q IT'S ATTACHED TO THE COLON AND TO THE STOMACH?

A RIGHT.

Q I BROUGHT ALONG A COUPLE PICTURES. IF YOU CAN BE KIND ENOUGH TO --

A IF THIS IS AN ANATOMY QUIZ, I MIGHT NOT DO SO WELL.

Q THIS IS OUT OF DORLAND'S, SO IT'S NOT THE BEST PICTURE. WOULD THAT BE A FAIRLY ACCURATE DRAWING OF THE ANATOMY?

A YES.

Q AND WHERE IT'S MARKED "OMENTUM," THAT IS WHERE THE OMENTUM WOULD LAY?

A YES. IN A PATIENT STANDING, IT WOULD HANG DOWN LIKE THIS. IT'S HIGHLY VARIABLE IN SIZE. I'VE SEEN SOME PEOPLE THEIR OMENTUM IS ONLY TWO OR THREE INCHES, OTHERS IT WILL COME ALL THE WAY DOWN

BELOW WHERE THIS ILLUSTRATION HAS IT.

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THEREUPON, PLAINTIFF'S EXHIBITS NOS. 1 AND 2 WERE MARKED FOR THE PURPOSE OF IDENTIFICATION.

- - -

BY MR. SHAVER:

Q THAT IS ALSO, OF COURSE, JUST A DRAWING OF THE OMENTUM AND OTHER STRUCTURES IN THERE.

A YES.

Q SO TELL ME, JUST SORT OF IN LAYMAN'S TERMS, WHEN DR. WATSON IS DESCRIBING THE OMENTUM BEING ADHERED TO THE ABDOMINAL WALL, WHAT DOES HE MEAN?

A WELL, AGAIN, I'M INFERRING WHAT HE MEANS.

Q SURE.

A WHAT I THINK HE MEANS IS THAT THE OMENTUM WAS STUCK TO THE AREA WHERE THE GALLBLADDER INCISION WAS MADE IN THE UPPER ABDOMEN FROM THE 1966 OPERATION.

Q WHY DO YOU SAY THERE, JUST BECAUSE THAT'S WHERE THE GALLBLADDER --

A THAT'S THE MOST LIKELY SPOT GIVEN WHERE THE OMENTUM ORIGINATES AND THE FACT THAT HER ONLY OTHER INCISION IS DOWN LOW, THE PFANNENSTIEL SUPRAPUBIC INCISION.

Q COULD HE ALSO MEAN THE OMENTUM WAS ENTIRELY STUCK UP TO THE WALL?

A THE WALL WHERE?

Q THE ANTERIOR ABDOMINAL WALL.

A IT'S THE WALL EITHER WAY. IT'S STUCK TO THE WALL EITHER WAY. EITHER DOWN LOW OR WHERE I'M SAYING IT IS.

Q OR JUST IN MORE SPOTS THAN ONE, IT COULD BE STRUCK IN MULTIPLE LOCATIONS?

A YES. BUT I THINK IF IT WERE STUCK DOWN LOW, HE WOULD SAY THAT IN MORE DETAIL. HE DESCRIBES THE PELVIC ADHESIONS FAIRLY EXTENSIVELY. I THINK IF THE OMENTUM WAS PART OF IT, HE WOULD MENTION IT WAS STUCK DOWN THERE, ALTHOUGH I DON'T KNOW THAT.

Q THEN HE DESCRIBED A DENSE ADHESIVE WHITE BAND RUNNING FROM THE COLON TO THE PELVIC SIDE WALL. DO YOU KNOW WHAT HE MEANS BY A DENSE ADHESIVE WHITE BAND OR IS THAT JUST --

A IT'S NOT A SPECIFIC TERM. IT'S JUST HIS DESCRIPTIVE TERM.

Q DR. WATSON OBVIOUSLY PERFORMED A LAPAROSCOPY IN '88. DO YOU HAVE ANY IDEA WHY HE PERFORMED A LAPAROTOMY IN 1989 RATHER THAN A LAPAROSCOPY?

A WELL, SHE'S ACUTELY WORSE. SHE HAS LONG-STANDING PELVIC PAIN AND HE FELT THE PAIN HAD EXACERBATED ENOUGH THAT HE WANTED TO ATTEMPT TO REDUCE THESE ADHESIONS AND GET RID OF THEM. THE PRE-OP DIAGNOSIS WAS ACUTE PELVIC PAIN.

Q I IMAGINE DR. WATSON WOULD BE A PRETTY GOOD PERSON TO KNOW WHAT HER INSIDES LOOKED LIKE.

A THAT'S A STATEMENT.

Q IT'S A QUESTION.

A IT SOUNDED LIKE A STATEMENT TO ME.

Q WOULD YOU AGREE WITH THE STATEMENT?

A I WOULD SAY ANYBODY WHO WAS THERE WHO WAS DESCRIBING THIS HAD A PRETTY GOOD IDEA WHAT THEY LOOKED LIKE.

Q DO YOU HAVE ANY EVIDENCE THAT DR. SCHARRER MADE ANY ATTEMPT TO CONTACT DR. WATSON BEF RE PERFORMING HIS SURGERY?

A I THINK HE HAD THESE RECORDS FROM BEFORE THAT. THEY'RE IN HIS OFFICE CHART.

Q HAVE YOU EVER CONTACTED A SURGEON BEFOREHAND TO ASX THEM THEIR THOUGHTS ABOUT A PERSON'S ANATOMY SINCE THEY HAD BEEN IN THERE BEFORE?

A NOT REALLY. TO BE HONEST WITH YOU, VERY FEW PEOPLE I THINK REMEMBER DETAILS IN ADDITION TO THE

OP NOTE A COUPLE YEARS LATER. FINE NUANCE-TYPE THINGS MIGHT BE WORTH PICKING UP.

Q LET'S DIVERT FROM PARTICULAR TO GENERAL. IN GENERAL, ARE THERE ANY CONTRAINDICATIONS TO THE PERFORMANCE OF LAPASCOPIC SURGERY FOR CHRONIC ABDOMINAL PAIN?

A WHEN YOU LIMIT IT TO CHRONIC ABDOMINAL PAIN, ARE THERE ANY CONTRAINDICATIONS?

Q I WANT TO LIMIT IT TO THE TYPE OF PAIN THIS WOMAN HAD.

A I WOULD SAY NO.

Q EXCEPT IF SHE CAN'T UNDERTAKE THE RISK OF GENERAL ANESTHESIA?

A UNDERSTANDING THOSE KINDS OF THINGS.

Q ARE THERE ANY INDIVIDUALS WHO FEEL THAT REPEATED ABDOMINAL SURGERY WOULD BE A CONT~INDICATION?

A I'M SURE THERE ARE. I MEAN THE LITERATURE IS FULL OF OPINIONS. I THINK THE CONSENSUS IS THAT REPEATED ABDOMINAL SURGERY IS NOT A CONTRAINDICATION TO A LAPAROSCOPY.

Q ARE THERE ANY DANGERS THAT ARE ASSOCIATED WITH REPEATED ABDOMINAL SURGERY?

A AS A GENERAL QUESTION, OF COURSE,

THEORETICALLY THERE ARE.

Q I GUESS 1 WILL MAKE IT MORE SPECIFIC. THE PERFORMANCE OF A LAPAROSCOPY, ARE THERE ANY DANGERS ASSOCIATED WITH A PAST HISTORY OF REPEAT ABDOMINAL SURGERY?

A THEORETICALLY, BOWEL INJURY IS A POSSIBILITY, INABILITY TO ACCOMPLISH ANYTHING BECAUSE OF ADHESIONS. THOSE WOULD BE TWO DANGERS.

Q ONE OF THE DANGERS WOULD BE THE DANGER OF INSTRUMENTATION, SUCH AS A TROCAR, PERFORATING THE BOWEL?

A TRUE, THAT'S INHERENT IN THE PROCEDURE.

Q IS THAT RISK INCREASED BY THE FACT THAT THERE HAS BEEN EVIDENCE OF EXTENSIVE ADHESIONS IN PAST SURGERIES?

A ACTUALLY THAT'S CONTROVERSIAL. THERE'S A LOT OF EVIDENCE TO SUGGEST THE RISK IS NO HIGHER IN SPITE OF PAST SURGERY. THE RISK OF A BOWEL INJURY IS NO HIGHER IN SOMEBODY WHO HAS HAD SURGERY THAN SOMEBODY WHO HASN'T HAD ANY. IT'S POSSIBLE TO PULL ANECDOTES OR CASE REPORTS OR STUDIES THAT WOULD SAY, YES, THE RISK IS MUCH HIGHER IN PEOPLE WHO HAVE HAD PREVIOUS SURGERY, BUT THERE ARE OTHER CASE REPORTS THAT DON'T SUPPORT THAT. I THINK THE CONSENSUS IS

LITTLE OR NO INCREASE IN RISK.

Q HOW ABOUT IN INDIVIDUALS SUCH AS MRS. WATKINS WHO HAD A KNOWN HISTORY OF ADHESIONS ADHERING HER OMENTUM TO THE ABDOMINAL WALL?

A I'M NOT IMPRESSED WITH THAT. WHAT ARE YOU ASKING ME? MAYBE --

Q MAYBE I'M BEING TOO COMMON SENSE ABOUT IT. IF THE OMENTUM IS ADHERING TO THE ABDOMINAL WALL, IT'S ALSO GOING TO TAKE THE COLON UP TO THE ABDOMINAL WALL?

A NOT NECESSARILY.

Q CAN IT, THOUGH?

A WELL, MY HYPOTHESIS IS THE PART OF THE OMENTUM THAT IS ATTACHED TO THE ANTERIOR ABDOMINAL WALL WOULD BE THIS AREA UP IN HERE. IN THIS DRAWING YOU CAN SEE IT ORIGINATES FROM THE STOMACH AND COLON. IT'S REDUNDANT ENOUGH, THERE IS ENOUGH OMENTUM THAT IT WOULDN'T MOST LIKELY PULL THE COLON TO THE UPPER ABDOMEN. THE OMENTUM ITSELF WILL STRETCH AND MOVE AND COULD TURN UP ANYWHERE.

Q BUT SINCE WE DON'T KNOW EXACTLY WHERE IN DR. WATSON'S REPORT HE DESCRIBED THE OMENTUM BEING ATTACHED, THERE IS A POSSIBILITY THAT THE OMENTUM COULD BE SECURING THE COLON TO THE ABDOMINAL WALL?

MR. ADKINSON: OBJECTION.

A IT'S A POSSIBILITY, SURE. IT TURNED OUT NOT TO BE THE CASE APPARENTLY, BECAUSE HE DIDN'T SAY THAT.

BY MR. SHAVER:

Q NOW, IN PERFORMING A LAPAROSCOPY, OBVIOUSLY THE PLACEMENT OF THE TROCAR IS A BLIND PROCEDURE.

A YES, IT IS.

Q BY "BLIND," MEANING YOU CAN'T SEE WHERE YOU'RE GOING?

A THAT'S CORRECT.

Q ARE THERE ANY SURGICAL TECHNIQUES THAT YOU CAN UTILIZE TO DECREASE THE RISK OF PLACING THE TROCAR, I.E., WHERE YOU CAN VISUALIZE A LITTLE BIT BETTER?

A HASSON INTRODUCED A PROCEDURE, AN OPEN LAPAROSCOPY, ON THE THEORY TO REDUCE THE CHANCE OF INTRA-ABDOMINAL INJURY. THAT HASN'T PANNED OUT TO BE THE CASE AND THE PROCEDURE HASN'T FOUND A WIDE FOLLOWING. THE RISK OF COMPLICATION IS ABOUT AS COMMON OR THE INCIDENCE OF COMPLICATION IS ABOUT AS COMMON WITH AN OPEN LAPAROSCOPY AS IT IS WITH A CLOSED LAPAROSCOPY.

Q BUT DR. HASSON, 1 BELIEVE THEY CALL IT THE HASSON CANNULA --

A RIGHT.

Q -- DOES BELIEVE THAT IF YOU OPEN UP -- TELL ME WHAT HIS THEORY WAS, HOW HE EXPECTED THE SURGERY TO WORK.

A HIS THEORY IS BASED ON THE IDEA THAT YOU WILL MAKE AN INCISION, SLIP THE TROCAR, A BLUNT TROCAR RATHER THAN ONE WITH A TIP, INTO THE ABDOMINAL CAVITY, SEW THE ABDOMINAL WALL TO THE SIDES OF THE TROCAR, THE SLEEVE OF THE TROCAR, PULL OUT THIS BLUNT CANNULA AND INTRODUCE A SCOPE VERY GRADUALLY. RATHER THAN PUNCTURING WITH A BLIND SCOPE, THE IDEA IS YOU MAKE A SMALL INCISION AND SLIP THE SCOPE FROM HERE AND LOOK AROUND. BUT IT TURNS OUT THE COMPLICATIONS ARE JUST ABOUT AS FREQUENT WITH THAT AS THEY ARE WITH THE TRADITIONAL LAPAROSCOPY. IT DOESN'T HAVE A WIDE FOLLOWING.

Q LET'S TAKE THE PERSPECTIVE IF A HASSON CANNULA HAD BEEN USED IN THIS CASE, WHAT DO YOU THINK WOULD HAVE HAPPENED?

A I HAVE NO IDEA. THAT'S PURELY SPECULATIVE. I THINK IT'S REASSURING FROM DR. SCHARRER'S STANDPOINT THAT WATSON WAS ABLE TO CARRY

OUT HIS LAPAROSCOPY IN '89 WITHOUT ANY COMPLICATIONS. THAT WOULD TEND TO MAKE ME THINK EVERYTHING WILL BE OKAY TOO.

Q LAPAROSCOPY OR LAPAROTOMY?

A BOTH.

Q OF COURSE THERE'S ANOTHER TECHNIQUE THAT COULD BE UTILIZED AND THAT WOULD BE THE LAPAROTOMY.

A IT'S A STATEMENT AGAIN.

Q IT'S A STATEMENT. IS THAT FAIR?

A YES, THAT'S A FAIR STATEMENT. YOU COULD GO TO A STRAIGHT LAP. WE MIGHT BE SITTING HERE ARGUING ON A LAPAROTOMY TOO, WHY WASN'T A LAPAROSCOPY DONE.

Q WOULD YOU BE CRITICAL OF ANY DOCTOR WITH HER PAST HISTORY PERFORMING A LAPAROTOMY?

A LET'S THROW OUT A HYPOTHETICAL. WE HAVE A PULMONARY EMBOLUS RECOVERING FROM A LAPAROTOMY AND THERE'S INDICATIONS THAT SHE SHOULD HAVE HAD A LAPAROSCOPY, I'D BE CRITICAL. SHE HAD A LAPAROSCOPY. IT DOES HAVE SOME RISK INHERENT EVEN TO PEOPLE WHO HAVE HAD MULTIPLE OPERATIONS, BUT THE CONSENSUS IS IT'S STILL A SAFE PROCEDURE BY AND LARGE. THERE'S COMPLICATIONS PART AND PARCEL OF THE PROCEDURE, BUT THE RISK OF IT IS REAL LOW, THE FREQUENCY IS REAL LOW

Q BEAR WITH ME FOR A MOMENT. LET'S ASSUME THAT A LAPAROTOMY HAD BEEN THE TECHNIQUE OF CHOICE AND A LAPAROTOMY HAD BEEN PERFORMED. IS IT FAIR TO SAY UNDER THAT SCENARIO THE INJURY TO THE BOWEL WOULD HAVE BEEN AVOIDED?

A OF COURSE THAT'S SPECULATIVE. THE PARTICULAR INJURY TO THE BOWEL THAT HAPPENED HERE WAS THROUGH A LAPAROSCOPE. SURE, IF HE DOESN'T USE A SCOPE, HE'S NOT GOING TO STICK THE SCOPE IN THROUGH THE SMALL BOWEL. OTHER INJURIES ARE CERTAINLY MUCH MORE COMMON, OTHER COMPLICATIONS ARE MUCH MORE COMMON AFTER LAPAROTOMY AND RECOVERY THERETO FROM A LAPAROSCOPY.

Q IS ONE OF THE OTHER BENEFITS OF A LAPAROTOMY THAT IF THERE IS INADVERTENT PERFORATION OF THE BOWEL THEY'RE EASILY TO DISCERN AT THE TIME OF THE ORIGINAL SURGERY?

A I THINK THAT'S PROBABLY TRUE.

Q YOU MENTIONED SEVERAL TIMES THE STUDIES ABOUT HASSON CANNULA COMPLICATIONS VERSUS LAPAROSCOPIC COMPLICATIONS. ARE THERE ANY STUDIES YOU HAVE IN MIND?

A I CAN'T QUOTE ANY. I LOOKED THEM UP SEVERAL MONTHS AGO AND I CAN'T GIVE YOU SPECIFICS.

BUT IT IS PRODUCIBLE. YOU COULD FIND IT.

Q ALONG THE SUBJECT OF CONTRAINDICATIONS AND INDICATIONS FOR THE PERFORMANCE OF THIS TYPE OF SURGERY, ARE THERE ANY TEXTS OR ARTICLES THAT YOU CONSIDER AUTHORITATIVE?

MR. ADKINSON: OBJECTION.

A IN AN AREA -- I DON'T KNOW WHETHER YOU'RE TALKING ABOUT ADHESION SURGERY OR --

Q ADHESION SURGERY.

MR. ADKINSON: LET ME OBJECT TO THE USE OF THE TERM "AUTHORITATIVE" BECAUSE IT HAS A LEGAL MEANING AND NORMAL MEANING.

MR. SHAVER: YOU CAN EXPLAIN IT TO HIM IF YOU WANT.

MR. ADKINSON: THAT'S ALL RIGHT. YOU CAN DO WHAT YOU WANT. I JUST WANT TO GET MY OBJECTION ON THE RECORD.

A I WAS GOING TO ADDRESS AUTHORITY A LITTLE BIT. IN PARTICULAR, ADHESIONS, I MENTIONED A FEW MINUTES AGO, THAT THERE'S SO FEW FACTS AND SO MANY OPINIONS THAT NOTHING, I GUESS, IS AUTHORITATIVE. THERE ARE AS MANY OPINIONS AS THERE ARE AUTHORS.

Q HOW ABOUT FOR THE PERFORMANCE OF LAPAROSCOPIC SURGERY?

A I THINK THERE IS KIND OF A MERGE OF GENERAL CONSENSUS OF HOW A LAPAROSCOPIC TECHNIQUE SHOULD BE DONE IN THIS KIND OF CASE. A MUCH MORE CONTROVERSIAL AREA WITHIN LAPAROSCOPY NOW IS PELVISCOPIC SURGERY AND TAKING OUT ORGANS THROUGH THE SCOPE. THERE IS A GOOD, FAIRLY GOOD CONSENSUS ABOUT HOW LAPAROSCOPY OF THIS KIND, DIAGNOSTIC FOR PAIN AND LYSIS OF ADHESIONS, SHOULD BE DONE.

Q I IMAGINE ONE OF THE REASONS HE WAS NOT ABLE TO SEE THE INJURY IN THIS PARTICULAR CASE IS BECAUSE THE TROCAR WENT THROUGH AND THROUGH THE BOWEL.

A THAT'S WHAT IT APPEARS.

Q CAN YOU TELL FROM THE OPERATIVE REPORT WHAT SECTION OF THE BOWEL WAS PERFORATED?

A NO, YOU CAN'T.

Q LET'S MOVE FROM THIS SPECIFIC CASE TO GENERAL AGAIN, AND GENERALLY WHAT WOULD BE THE SIGNS AND SYMPTOMS OF A BOWEL PERFORATION FOLLOWING LAPAROSCOPIC SURGERY?

A ABSENCE OF BOWEL SOUNDS, ILEUS, IN OTHER WORDS, POSSIBLY VOMITING, DISTENSION, DIRECT AND REBOUND TENDERNESS IN THE ABDOMEN ARE POSSIBLE. FEVER POSSIBLY.

Q I IMAGINE IT'S LIKE ANYTHING ELSE IN

MEDICINE, YOU NEVER EXPECT 100 PERCENT OF THE CLINICAL SYMPTOMS TO SHOW UP; IS THAT FAIR?

A THAT'S FAIR.

Q SOME OF THEM, VARIOUS INDIVIDUALS, SOME DO, SOME DON'T?

A CORRECT.

Q IS ABDOMINAL BRUISING A COMMON FINDING AFTER A LAPAROSCOPY?

A ROUTINE, VIRTUALLY 100 PERCENT OF THE PATIENTS DO.

Q DOES THE BRUISING USUALLY INCREASE OR DECREASE IN SIZE OVER THE 24 HOURS?

A STEADILY INCREASES.

Q UNTIL IT REACHES AN APEX, THEN COMES BACK DOWN?

A RIGHT.

Q IN THIS PATIENT, DOES SHE HAVE ANYTHING UNUSUAL ABOUT HER POST-OPERATIVE COURSE?

A 1 DON'T THINK SHE DID, NO.

Q YOU DON'T FIND THAT SHE WAS IN AN UNUSUAL AMOUNT OF PAIN OR ANYTHING LIKE THAT?

A THIS LADY'S PAIN IS VERY HARD TO EVALUATE BECAUSE IT WAS SO LONG STANDING AND THE REASON THE LAPAROSCOPY WAS CARRIED OUT WAS BECAUSE IT WAS

WORSENING, SUPRAPUBIC PAIN, AND THAT'S WHAT SHE WAS COMPLAINING ABOUT IN THE RECOVERY ROOM. SO IF YOU SAW HER AT THE BEDSIDE, I THINK IT WOULD BE EASY TO CONCLUDE THAT THIS IS THE SAME PAIN THAT BROUGHT HER IN HERE, IT'S THE SAME PROCESS GOING ON.

I DON'T THINK THAT SHE HAD ANY UNUSUAL AMOUNT OF PAIN OR THE USE OF PAIN PILLS REALLY WASN'T EXCESSIVE. SHE CLEARED THE ANESTHESIA AND WOKE UP A LITTLE BIT AND SHE HAD FOUR PERCODANS IN **18** HOURS OR SOMETHING. NOT A LOT.

Q DO YOU ROUTINELY ORDER WHITE BLOOD CELL COUNTS AFTER YOUR LAPAROSCOPIC SURGERY?

A NO.

Q DO YOU KNOW WHY ONE WAS ORDERED IN THIS CASE?

A THIS LADY COMPLAINED OF PAIN AND DISCOMFORT AFTERWARDS. THEY THOUGHT THEY OUGHT TO OBSERVE HER IN THE HOSPITAL POST-OP. AND ONE OF THE WAYS OF LOOKING FOR, IN THEORY LOOKING FOR EVIDENCE OF SOMETHING INTRAPERITONEAL IN THE FORM OF INJURY WOULD BE TO GET A WHITE COUNT, SEE IF IT SHOWS YOU ANYTHING.

Q WHAT WOULD YOU EXPECT THE WHITE COUNT TO SHOW IF THERE HAD BEEN A PERFORATION?

A THE RESULTS ARE VERY GENERAL. WIDE

POSSIBILITY. I GUESS IT'S PERTINENT IT TURNED OUT NOT TO BE NEGATIVE, BUT IT WAS NOT VERY HELPFUL IN THIS CASE BECAUSE IT WAS BASICALLY NORMAL. IT WAS **11,700**. I WOULD BE VERY IMPRESSED IF IT WAS **20,000**. I *AM* SURE THEY WOULD HAVE BEEN, TOO.

Q IT WAS HIGH NORMAL. IN FACT, IT WAS A LITTLE BIT ABOVE NORMAL?

A WITHIN THE ERROR OF THE LAB. UPPER NORMAL IS **11,000**. THIS WAS **11,700**.

Q WAS THERE ANY SHIFT TO IT AT ALL?

A SHE HAD A SHIFT TO THE LEFT.

Q IS THAT OF ANY SIGNIFICANCE TO YOU?

A IT'S NONSPECIFIC. IT CAN BE AS A RESULT OF THE SURGERY ITSELF. WHEN SOMEONE HAS NOTHING OUT OF THE ORDINARY GOING ON, YOU CAN GET A SHIFT TO THE LEFT FROM ANESTHESIA, ANESTHETIC, ALTHOUGH I'M NOT SURE ABOUT THAT.

Q ANYTHING ABOUT THE BANDS?

A SHIFT TO THE LEFT, RIGHT.

Q AT THE BEGINNING OF THE DEVELOPMENT OF THE INFECTION PROCESS, WHAT WOULD YOU EXPECT THE RELATIONSHIP OF THE BANDS TO BE?

A IN THE BEGINNING, IT DEPENDS ON WHAT KIND OF INFECTIOUS PROCESS, WHERE EXACTLY IN THE BEGINNING.

IF YOU HAVE AN INSULT TO THE BODY, BE IT INFECTION, TRAUMA, BLOOD TRANSFUSION, SOME KIND OF THING THAT DISTURBS THE HOMEOSTASIS, WHICH IS THE BODY'S NATURAL EQUILIBRIUM MECHANISM, YOU CAN GET A SHIFT TO THE LEFT. IT'S A REAL NONSPECIFIC FINDING.

Q THERE WAS A NURSING NOTE THAT TALKED ABOUT A DRESSING HAVING DARK DRAINAGE.

A RIGHT.

Q WHAT DID YOU MAKE OF THAT?

A OLD BLOOD. ROUTINE FINDING, ROUTINE OBSERVATION.

Q AREN'T MOST NURSES EXPERIENCED ENOUGH TO KNOW IF SOMETHING IS BLOOD AND PUT IT DOWN AS DRIED BLOOD?

A NURSES ARE NOW COACHED NOT TO DRAW CONCLUSIONS BUT TO DOCUMENT WHAT THEY SEE AND PUT DOWN THEIR OBSERVATION WHICH IS UNDISPUTABLY A FACT AS OPPOSED TO CONCLUDING WHAT IT IS. IN THIS PARTICULAR CASE, OBVIOUSLY IT WAS BLOOD.

Q DID YOU READ THE TESTIMONY ***OF*** THE HUSBAND WHERE HE TALKED ABOUT THE MATERIAL BEING DRAINED NOT BEING BLOOD?

A I DIDN'T SEE THAT. 1 GUESS HE KIND OF SUGGESTED LATER AFTER THE FACT THAT IT WAS NOT BLOOD.

HE DIDN'T SUGGEST THAT AT THE TIME, AND THERE WAS NO EVIDENCE IN THE RECORD THAT IT WAS ANYTHING BUT BLOOD AT THE TIME. IT SEEMS TO HAVE APPEARED LATER.

Q I RECALL ONE TIME HE DESCRIBED IT AT ONE POINT IN THE DEPOSITION AS SEEPAGE. WOULD YOU THINK SEEPAGE AS BEING SOMETHING DIFFERENT THAN BLEEDING?

A SEEPAGE IS ANYTHING. IT'S JUST SOMETHING GOT THERE COMING THROUGH SLOWLY. IT COULD BE ANYTHING.

Q LET'S ASSUME THAT FOR PURPOSES OF A HYPOTHETICAL THAT ALL THE OTHER FACTS IN THE MEDICAL RECORD ARE THE SAME, THAT THERE IS A WHITE BLOOD CELL COUNT, THE WOMAN WAS COMPLAINING OF PAIN AND THAT THERE IS DARK GREENISH MATERIAL COMING THROUGH THE INCISION UMBILICUS. WOULD THAT AFFECT YOUR OPINION ABOUT WHETHER IT WAS APPROPRIATE TO DISCHARGE HER?

MR. ADKINSON: OBJECTION.

A YOUR HYPOTHETICAL IS DIFFERENT THAN THE FACTS IN THE CASE. IF THE NURSES HAD OBSERVED DARK' GREEN SEEPAGE, I *AM* SURE THE CHART WOULD HAVE SAID DARK GREEN MATERIAL.

BY MR. SHAVER:

Q IF THERE HAD BEEN NONBLOOD SEEPAGE COMING THROUGH THE UMBILICUS, WOULD THAT BE A REASON TO KEEP

THE PERSON IN THE HOSPITAL?

MR. ADKINSON: SAME OBJECTION.

A DARK NONBLOOD SEEPAGE?

Q GREENISH SEEPAGE.

A THIS IS TOTALLY HYPOTHETICAL, BECAUSE AGAIN --

Q NO, I BELIEVE THAT'S THE TESTIMONY OF THE HUSBAND, BUT THAT'S OKAY.

A THE RECORD DOESN'T SUPPORT THAT AS AVAILABLE TO ME AND HE DIDN'T -- SHE HAD A LAPAROSCOPY BEFORE AND NEVER -- THIS WAS DIFFERENT APPARENTLY, WHAT HE IS ALLEGING, YET IT DOESN'T COME UP UNTIL LATER.

SO YOUR HYPOTHETICAL IS IF IT WERE DARK GREEN SEEPAGE, KEEP HER IN THE HOSPITAL? I DON'T THINK SO. I THINK THE PHYSICIAN COMES BY AND MAKES AN ASSESSMENT BASED ON OBJECTIVE DATA, TEMPERATURE, APPETITE, WHAT YOU HAD FOR BREAKFAST, ABDOMINAL FINDINGS. SHE HAD APPROPRIATE TENDERNESS, SHE HAD BOWEL SOUNDS, SHE HAD EATEN ALL HER BREAKFAST, SHE STATED THAT SHE FELT BETTER.

A PHYSICIAN IS OBLIGATED IN HYPOTHETICAL OR IN A REAL SITUATION TO WEIGH ALL THE AVAILABLE FACTORS AND MAKE A JUDGMENT. YOU'RE ASKING ME IF SHE

HAD HYPOTHETICAL GREEN SEEPAGE AND EVERYTHING ELSE WAS LIKE I SAID IT, SHE'S INTELLIGENT, SHE LIVES NEARBY, SHE'D GET THE SAME INSTRUCTIONS SHE GOT, KEEP IN TOUCH.

Q NOW, WHAT COULD THE GREEN SEEPAGE BE?

A I GUESS IT COULD BE BOWEL CONTENTS, IT COULD BE BILE.

Q BUT YOU DON'T THINK THAT WOULD MANDATE FURTHER MAINTENANCE OF THE PATIENT IN THE HOSPITAL?

A AGAIN, THE RECORD DOESN'T SUPPORT THAT, THAT THERE'S GREEN SEEPAGE THERE. I THINK THAT'S IMPORTANT. IF IT WERE GREEN, WHEN THEY SAID DARK, THEY WOULD SAID DARK OR DARK GREEN.

a I TAKE IT HERE YOU'RE MAKING A VALUE JUDGMENT ABOUT THE FACTS, THAT YOU'RE CHOOSING TO BELIEVE THE HOSPITAL RECORDS OVER THE TESTIMONY OF THE HUSBAND.

A MEDICINE IS JUDGMENT, AND ACTUALLY WHAT I'M SAYING IS THE DOCTOR MADE ALL THE JUDGMENTS BASED ON ALL THE FACTS AVAILABLE AT THAT TIME. HE WAS AT THE BEDSIDE, LOOKED AT THE DRESSING, HAD THE NURSING NOTES, ALL THE INFORMATION AVAILABLE TO HIM AND HE LET HER GO HOME. I THINK IT'S THE CORRECT JUDGMENT.

Q NOW, IN THIS PARTICULAR CASE, SHE CAME

BACK AND SHE WAS SEPTIC.

A CORRECT.

Q OBVIOUSLY THE SEPSIS IS A CONSEQUENCE OF THE BOWEL PERFORATION. WOULD YOU AGREE WITH THAT?

A CORRECT.

Q AND WOULD YOU AGREE THAT HAD IT NOT BEEN FOR THE BOWEL PERFORATION, THAT SHE WOULD HAVE SURVIVED, SHE NEVER WOULD HAVE DIED?

MR. ADKINSON: OBJECTION.

Q I'M TAKING IT STEP BY STEP.

MR. ADKINSON: NEVER WOULD HAVE DIED IS KIND OF A BROAD STATEMENT.

BY MR. SHAVER:

Q EVENTUALLY SHE WOULD HAVE DIED. WE'RE ALL GOING TO DIE. SHE WOULDN'T HAVE DIED AT THAT TIME PERIOD.

A I UNDERSTAND.

Q OKAY.

A WITHOUT THE SEPSIS AND THE BOWEL INJURY SHE WOULDN'T HAVE DIED, THAT'S CORRECT.

Q LET'S ASSUME THAT FOR WHATEVER REASON SHE HAD BEEN RE-EXPLORED AT THE TIME ON THE SAME DAY THAT SHE WAS DISCHARGED AND THE PERFORATION HAD BEEN FOUND AND REPAIRED. IS IT MORE LIKELY THAN NOT THAT SHE

WOULD HAVE SURVIVED?

A MORE LIKELY THAN NOT IN MY OPINION SHE WOULD HAVE SURVIVED. THERE WERE NO INDICATIONS FOR EXPLORING HER AT THAT POINT THOUGH.

Q IS THERE ANY POINT IN TIME IN WHICH YOU THINK HER COURSE BECAME IRREVOCABLE?

A THAT GETS INTO REAL OPINION HERE BECAUSE IT'S CLEAR -- I'M NOT AN INTENSIVIST OR EXPERT ON SEPTIC SHOCK. IT'S CLEAR THAT SHE WAS IN EXTREMIS WHEN SHE WAS ADMITTED. SOMEWHERE BACK THERE IN THE PRECEDING 36 HOURS SHE CROSSED THE LINE WHERE SHE WAS STABLE AND WHERE SHE WASN'T, AND I DON'T KNOW WHERE THAT IS.

Q IN THE SECOND OPERATIVE REPORT THERE WAS SOME CONCERN ABOUT NECROTIZING FASCIITIS. DO YOU FIND THAT OR DO YOU FIND THEY RULED IT OUT?

A I THINK THAT IS REAL IMPRESSIVE. I THINK THIS LADY HAD A COMPLICATION PART AND PARCEL OF THE LAPAROSCOPY AND SHE HAD THE EXTRAORDINARY MISFORTUNE TO DIE FROM IT FROM SOME UNUSUAL MECHANISM OR UNUSUAL INFECTION THAT HER BODY OR UNUSUAL WAY HER BODY RESPONDED TO THIS INFECTION, BECAUSE THE COLON PERFORATION AND THE BOWEL PERFORATION ARE PART AND PARCEL OF A LAPAROSCOPY, YET THIS LADY JUST COLLAPSED

IN 36 HOURS.

I DON'T THINK YOU SHOULD INTERPRET A WHOLE LOT OUT OF THE AUTOPSY. THEY DIDN'T FIND NECROTIZING FASCIITIS. I THINK IT'S VERY IMPRESSIVE WHEN THE GENERAL SURGEON DESCRIBED THE ABDOMINAL WALL AND THE AUTOPSY SURGEON DID ALSO FIND NECROSIS OR CHANGE IN THE FAT. THERE WAS SOMETHING BIZARRE GOING ON IN THIS LADY.

Q WHAT YOU'RE SAYING, FOR WHATEVER REASON SHE WAS MORE SUSCEPTIBLE TO INFECTION?

A SOMETHING HAPPENED. SHE HAD A COMPLICATION THAT'S PART AND PARCEL TO LAPAROSCOPY INFREQUENT, BUT SHE HAD AN EXTRAORDINARY, BIZARRE, UNUSUAL REACTION TO THE INFECTION AND WAS NOT SALVAGEABLE.

Q YOU ARE OBVIOUSLY NOT CRITICAL OF THE CARE OF ANY OF THE PHYSICIANS WHO TREATED HER ONCE SHE BECAME HOSPITALIZED AGAIN.

A NO, I'M NOT.

Q YOU'RE NOT GOING TO COME IN AND SAY, WELL, THERE IS SOMETHING THEY DID WRONG WHICH CAUSED HER TO --

A ABSOLUTELY NOT.

Q FOLLOWING A SURGERY SUCH AS A LAPAROSCOPY

THAT WAS PERFORMED BY DR. SCHARRER, HOW WOULD YOU EXPECT URINE OUTPUT TO REACT?

A THAT'S A LOT MORE GENERAL QUESTION. IT HAS A LOT TO DO WITH HOW MUCH FLUID SHE GETS, HOW QUICKLY SHE STARTS DRINKING AGAIN POST-OP. ALL THOSE KINDS OF THINGS. I WOULD PUT HER URINE OUTPUT, IT'S BORDERLINE NORMAL.

Q A LITTLE LOW?

A A LITTLE LOW. BORDERLINE NORMAL. IT'S LOW NORMAL. SHE WAS A LITTLE BELOW AVERAGE BUT WITHIN THE NORMAL RANGE. YOU HAVE TO REMEMBER SHE WAS NPO FROM THE NIGHT BEFORE.

Q IN THIS TYPE OF SURGERY, WHAT TYPE OF PAIN MEDICATION DO YOU NORMALLY PRESCRIBE POST-OPERATIVELY?

A USUALLY NOTHING. DEPENDING ON WHAT YOU DO, IT'S A JUDGMENT CALL. THIS LADY HAD A LONG-STANDING PERSONAL ACQUAINTANCE WITH A VARIETY OF PAIN MEDICATION.

Q YOU NOTICED SHE COMPLAINED OF CERVICAL PAIN IN THE PAST?

A CERVICAL BEING NECK?

Q RIGHT.

A I WENT THROUGH ALL THAT STUFF. SHE HAD

LOTS OF PAIN.

Q DIFFERENT --

A PSYCHOSOMATIC STUFF AND WAS INVOLVED IN, I GUESS, COUNSELING WITH A PSYCHOLOGIST. ALL KINDS OF THINGS.

Q DID YOU EVER GIVE ANY THOUGHT TO THE IDEA THAT THIS ABDOMINAL PAIN MAY HAVE BEEN PSYCHOSOMATIC ALSO?

A DID I GIVE ANY THOUGHT TO IT, SURE; BUT ADHESIONS, AS I SAID EARLIER, ARE HARD TO UNDERSTAND. SOME PEOPLE HAVE LOTS OF ADHESIONS AND NO PAIN, OTHER PEOPLE HAVE LOTS OF PAIN. YOU GO IN THERE AND CORRECT THEM AND THEY'RE WELL. WE'VE ALL SEEN IT.

Q HAVE YOU EVER USED THE HASSON CANNULA IN ANY SURGERIES?

A TWO OR THREE TIMES SO I WAS ACQUAINTED WITH IT.

Q UNDER WHAT SCENARIOS DID YOU USE IT?

A SELF-EDUCATION.

Q YOU NO LONG USE IT?

A THAT'S CORRECT. I USED IT TWO OR THREE TIMES WHEN IT FIRST CAME OUT. A TOOL FOR WHICH THERE WAS NO NEED.

Q JUST GENERALLY I'M GOING **TO --** TELL ME A

LITTLE BIT ABOUT YOUR PAST MEDICAL-LEGAL EXPERIENCE.

A RIGHT.

Q YOU'VE REVIEWED CASES BEFORE IN ORDER TO TESTIFY IN CASES?

A THAT'S CORRECT.

Q CAN YOU GIVE ME AN IDEA HOW MANY TIMES YOU HAVE BEEN ASKED TO REVIEW CASES?

A THAT WOULD BE GUESSING, PROBABLY SIX OR OR SEVEN OVER A TEN- OR TWELVE-YEAR PERIOD.

Q CAN YOU GIVE ME ANY BREAKDOWN OF HOW MANY OF THOSE HAVE BEEN FOR THE PLAINTIFF AND HOW, MANY FOR THE DEFENDANT?

A TWO OR THREE FOR PLAINTIFFS AND THE BALANCE FOR DEFENDANTS.

Q I KNOW SOME OF THE FIRMS WHO HAVE USED YOU TO REVIEW CASES HERE IN TOWN, MIKE ROMANELLO, I BELIEVE JACOBSON MAYNARD HAS USED YOU IN CASES BEFORE. ARE THERE ANY FIRMS THAT COME TO MIND?

A I HAVE TESTIFIED FOR JERRY DRAPER A COUPLE TIMES, THOMPSON, HINE AND FLORY, I GUESS WHEN HE WAS WITH BRICKER ALSO. I TESTIFIED FOR CRAIG BARCLAY WHEN HE WAS A DEFENSE ATTORNEY.

Q HAVE YOU TESTIFIED FOR HIM SINCE HE HAS GONE WITH JERRY MALOON?

A I HAVEN'T BEEN APPROACH. I KNOW CRAIG SOCIALLY.

Q LANE ALTON?

A I HAVE IN THE PAST. NOT RECENTLY. JOHN ALTON, JACK ALTON. PORTER WRIGHT.

Q THE TWO OR THREE PLAINTIFFS' CASES THAT YOU HAVE DONE IN THE PAST, WERE THEY PLAINTIFFS WHO WERE IN STATE?

A YES.

Q CAN YOU RECALL WHAT ATTORNEYS YOU WORKED WITH ON THOSE CASES?

A TOM TYACK, WALTER RECKLESS AND AN ASSOCIATE OF HIS WHOSE NAME, IT WAS A WOMAN, ESCAPES ME. 1 GUESS A FORMER ASSOCIATE OF **HIS** AND NOW WORKS FOR THE A.G., JOHN MILLER.

Q I'VE NOTICED YOU'VE ALSO GIVEN SEMINARS WITH MIKE ROMANELLO ON HOW TO -- I DON'T KNOW. WHAT IS THE TITLE OF THE NEW SEMINAR THAT YOU ARE ABOUT TO GIVE?

A I GOT ROPED INTO SOMETHING AS A FAVOR **TO** A FRIEND, BY THE WAY. I DON'T KNOW. MIKE CAME UP WITH THE TITLE. IT'S SOMETHING TO DO WITH MEDICINE AND LAW. IT'S AN OVERALL SEMINAR. I ***AM*** TALKING ABOUT A WITNESS -- BEING A WITNESS. IT'S CALLED

MEDICAL-LEGAL COLLABORATION OR SOMETHING.

- - -

DISCUSSION HELD OFF THE RECORD.

- - -

Q HAVE YOU EVER GIVEN SEMINARS LIKE THAT IN THE PAST?

A I TALKED TO THE BAR ASSOCIATION ON TRAUMA AND PREGNANCY A COUPLE YEARS AGO.

Q OBVIOUSLY YOU ARE ENTITLED TO CHARGE FOR YOUR TIME. CAN YOU GIVE ME WHAT YOUR RATES FOR DOING DEPOSITIONS, REVIEWS, TRIAL TESTIMONY?

A I CHARGE **$325** AN HOUR FOR EVERYTHING.

Q I TAKE IT THAT THERE'S NOTHING ELSE YOU INTEND TO REVIEW BEFORE THE TRIAL, ANYTHING YOU THINK PERTINENT.

A NOTHING COMES TO MIND. I'M NOT GOING TO LIMIT THE POSSIBLY I MIGHT REVIEW SOMETHING. I KNOW YOU'RE GOING **TO** DEPOSE SOMEBODY IN CALIFORNIA FOR YOUR SIDE, I WILL PROBABLY REVIEW THAT. I MAY DECIDE, BASED ON WHAT HE SAYS, TO LOOK UP SOMETHING IN THE LITERATURE. I'M NOT GOING TO LIMIT IT TO WHAT I HAVE DONE.

Q I WOULD ASK YOU A QUESTION, IF YOU DECIDE TO DO A LITERATURE SEARCH AND COME UP WITH SOME

LITERATURE YOU THINK PERTINENT BEFORE TRIAL, YOU EXPECT IT WOULD BE PART OF YOUR TESTIMONY, WOULD YOU PLEASE ADVISE MR. ADKINSON OF THAT AND WE CAN MAKE SURE I GET THE CITATION TO IT?

A OKAY.

Q OTHER THAN THAT, I'M DONE.

MR. ADKINSON: WOULD YOU LIKE TO TAKE A LOOK AT THE DEPOSITION?

THE WITNESS: I WOULD RATHER WAIVE BECAUSE OF THE SCHEDULE.

MR ADKINSON: YOU CAN DO WHATEVER YOU WANT. I THINK IT WAS A PRETTY CLEAN DEPOSITION, NOT WHOLE A LOT OF TALKING BACK AND FORTH.

MR. SHAVER: IF SOMETHING COMES UP IN YOUR TRANSCRIPT YOU THINK ISN'T RIGHT BEFORE YOU GET ON THE STAND, TELL PAT SO I KNOW AND I DON'T STICK MY FOOT IN MY MOUTH AND I SAY, DIDN'T YOU SAY THIS AT YOUR DEPOSITION.

- - -

SIGNATURE WAIVED.

- - -

THEREUPON, AT 4:55 P.M.,

THURSDAY, FEBRUARY 10, 1994,

THE DEPOSITION WAS CONCLUDED.

9

C E R T I F I C A T E

STATE OF OHIO)
) *SS:*
COUNTY OF FRANKLIN)

I, DENISE SHOEMAKER, REGISTERED PROFESSIONAL REPORTER AND NOTARY PUBLIC IN AND FOR THE STATE OF OHIO, DO HEREBY CERTIFY THAT BEFORE THE TAKING OF HIS DEPOSITION, THE SAID STEPHEN DEVOE, M.D., WAS FIRST DULY SWORN BY ME TO TELL THE TRUTH, THE WHOLE TRUTH, AND NOTHING BUT THE TRUTH;

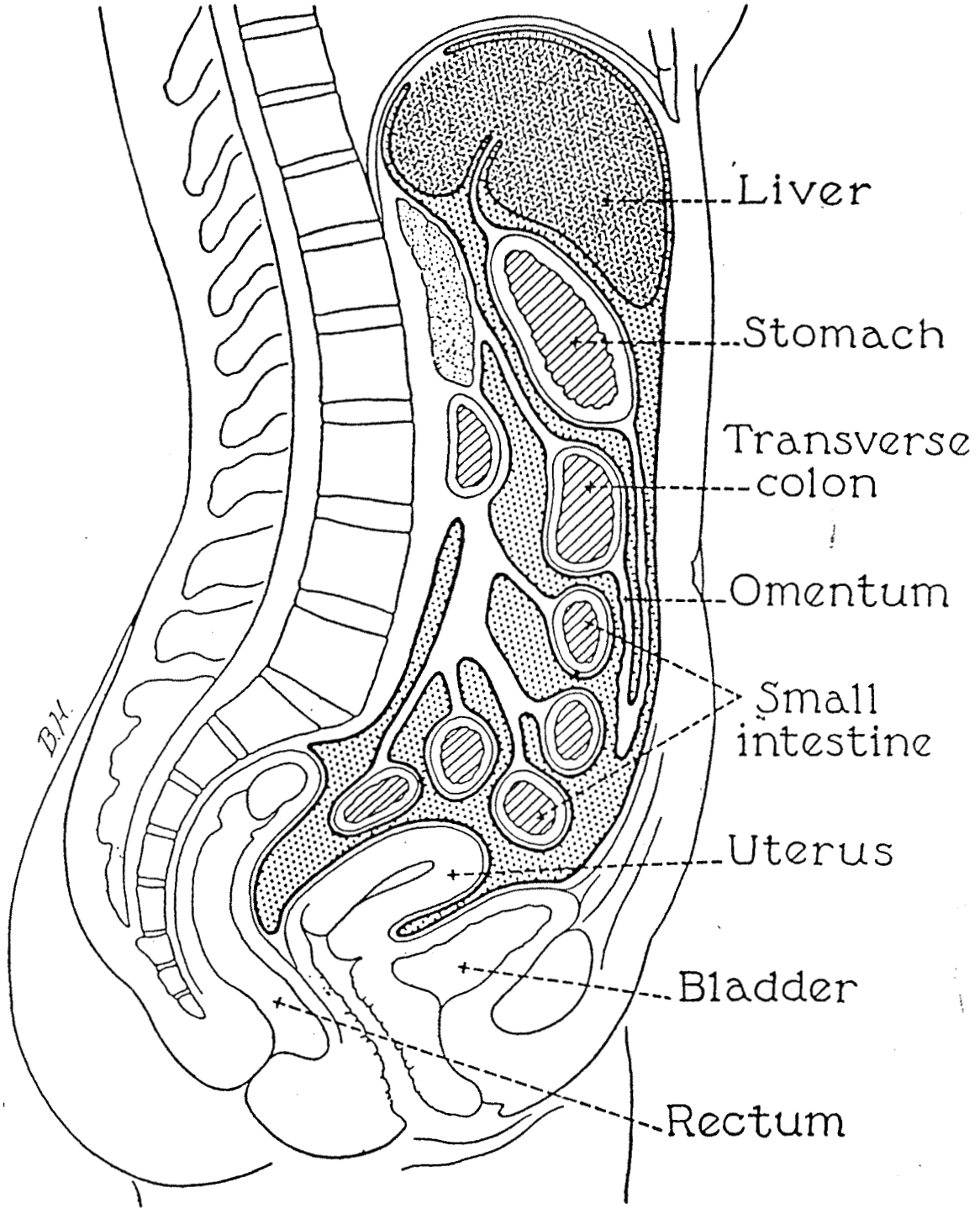
THAT SAID DEPOSITION WAS TAKEN IN ALL RESPECTS PURSUANT TO THE STIPULATIONS OF COUNSEL HERETOFORE SET FORTH AND GIVEN AT THE SAID TIME AND PLACE BY THE SAID STEPHEN DEVOE, M.D.;

THAT I ***AM*** NOT AN ATTORNEY FOR OR RELATIVE OF EITHER PARTY AND HAVE NO INTEREST WHATSOEVER IN THE EVENT OF THIS LITIGATION.

IN WITNESS WHEREOF, I HAVE HEREUNTO SET MY HAND AND OFFICIAL SEAL OF OFFICE AT COLUMBUS, OHIO, THIS 24TH DAY OF FEBRUARY, 1994.

DENISE SHOEMAKER, RPR, NOTARY PUBLIC
IN AND FOR THE STATE OF OHIO.

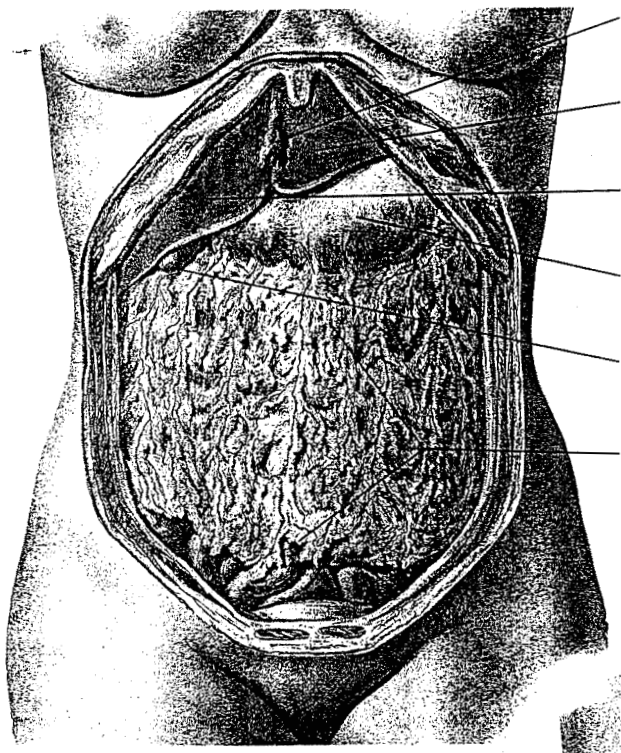
MY COMMISSION EXPIRES: JANUARY 20, 1999.



Course of the peritoneum (heavy black line') in **a** median sagittal section **of a female,**

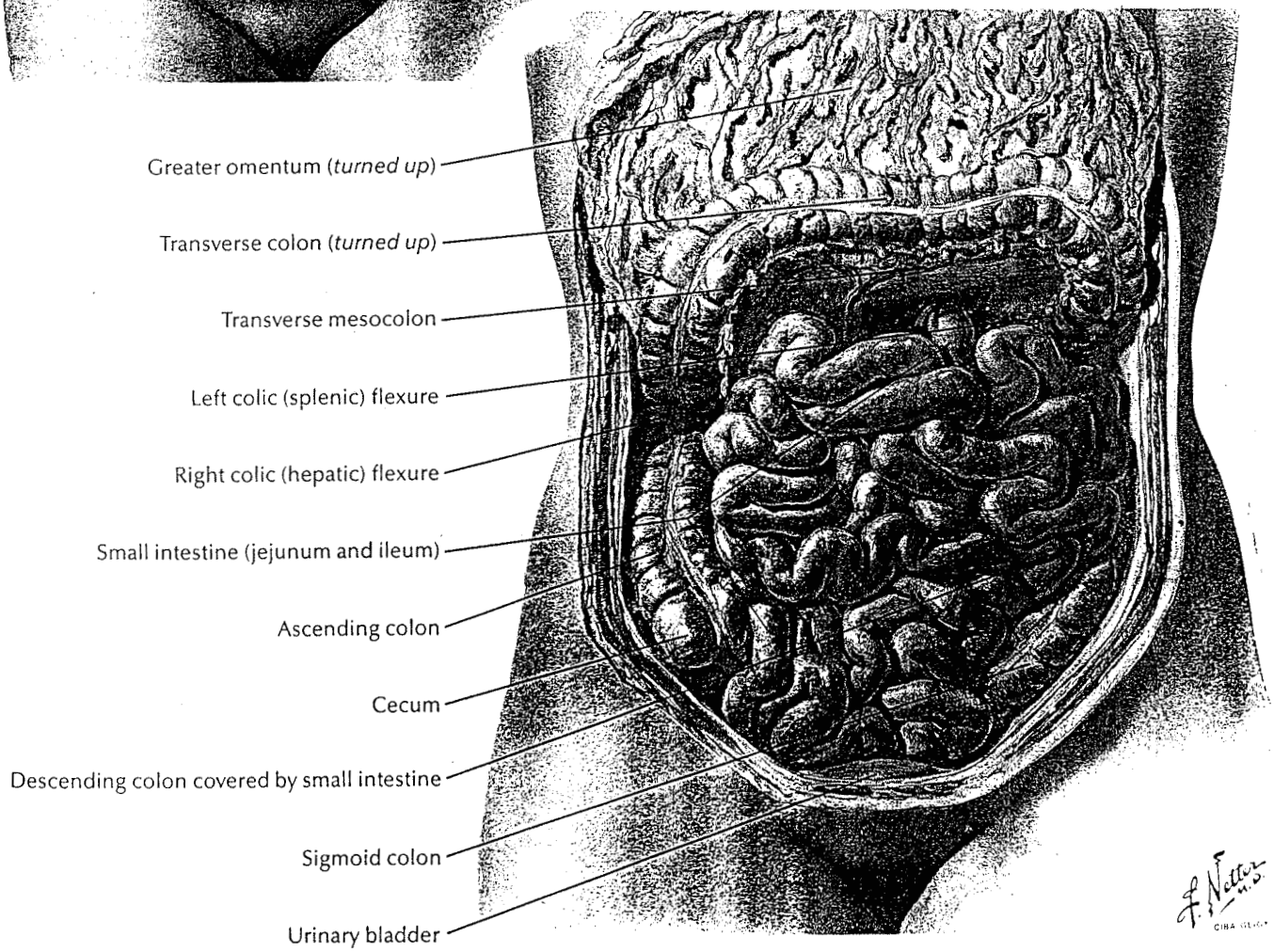
Greater Omentum and Abdominal Viscera

SEE ALSO PLATES 258, 332,333



PLAINTIFF'S EXHIBIT

2



ATLAS OF HUMAN ANATOMY

FRANK H. NETTER, M.D.