Doc. 138

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

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IN THE COURT OF COMMON PLEAS

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VIRGINIA DURFEE,
plaintiff,

vs. : Case No. 155034.

RICHMOND HEIGHTS GENERAL HOSPITAL, et al.,
Defendants.

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Deposition of MELVYN I. DINNER, F.R.C.S., a witness herein, called by the defendants for the purpose of direct examination, taken via videotape and court reporter, pursuant to the Ohio Rules of Civil Procedure, taken before Michelle M. Myers, a Notary Public within and for the State of Ohio, at the office of Melvyn I. Dinner, F.R.C.S., 3755 Orange Place, Beachwood, Ohio, on Monday, the 9th day of July, 1990, commencing at 1:30 p.m., pursuant to agreement.

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Also Present:

Len Gavlen, Videotape Technician

I-N-D-E-X

WITNESS: MELVYN I. DINNER, F.R.C.S.

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DEFENDANTS' EXHIBITS	MARKED
A - Dr. Dinner's Curriculum Vitae	7
B - Letter dated June 26, 1989, to Mr. Warner from Dr. Dinner	7
C - copy of report in reference to actual examination	7
D - Dr. Dinner's office notes	7
E - photograph of plaintiff's leg	7
F - photograph of plaintiff's leg	7
G - photograph of plaintiff's leg	7

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INDEX OF OBJECTIONS

CONTINUED INDEX OF OBJECTIONS

CONTINUED INDEX OF OBJECTIONS

- - - - -

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(Defendants' Exhibits A through G marked for identification.)

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MR. WARNER: Today is July the 9th, 1990. We are at the office of Dr. Dinner for his videotaped deposition in the matter of Virginia Durfee versus Dr. Classen, Case Number 155034, before Judge Tim McMonagle.

Would the court reporter please swear in Dr. Dinner.

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MELVYN I. DINNER, F.R.C.S.

of lawful age, a witness herein, called by the Defendants for the purpose of direct examination pursuant to the Ohio Rules of Civil Procedure, being first duly sworn, as hereinafter certified, was examined and testified as follows:

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DIRECT EXAMINATION

BY MR. WARNER:

Q. Doctor, for the ladies and gentlemen of the jury, would you please state your whole name, please?

A. Dr. Melvyn Ivan Dinner.

Q. All right. Would you run me through your

educational background, starting with college a bringing us up to the present date?

A. I'm originally from South Africa some 15 years ago and trained as a medical student at the University of Witwatersrand in Johannesburg, South Africa, trained as a general surgeon in South Africa. I then trained as a plastic surgeon in England, following this up with post-graduate studies in the United States of America, completing these studies in 1971.

Q. In specific you were at the Cleveland Clinic; is that correct?

A. Correct.

MISS STARR: Objection.

Q. How long were you at the Cleveland Clinic?

A. I was recruited from South Africa by the Cleveland Clinic in October of 1975 and the beginning of 1976. I was there for about eight and a half years, at which time I was chief of the plastic surgery for a little over seven years.

Q. If you would, and specifically when you were at the -- apparently you graduated from the Royal College of Surgeons, you did a fellowship there; is that correct?

A. The Royal College of Surgeons is the examination

body for board certification in general surgery, and I became a fellow of the Royal College of Surgeons both of England and of Scotland, and subsequently of Canada.

Q. You were board certified in plastic surgery?

A. Yes, I am.

Q. Just tell the ladies and gentlemen of the jury what it means to be board certified?

A. Board certification is the peer specialty approval, and once a physician is a licensed physician to practice the broad practice of medicine, one subspecializes in an area of medicine.

For example, in my case plastic surgery, and is an examination of peer approval whereby they approve your training. You then undergo an examination, oral and written examinations, to become certified by your peers.

Q. You are a physician licensed to practice medicine in the State of Ohio?

A. I am.

Q. In what other states do you have medical privileges?

A. Currently in California.

Q. As I understand we are currently at your office, the Center for Plastic Surgery here in -- this is

Beachwood, Ohio?

A. Beachwood, Ohio. Yes.

Q. You have another office where, Doctor?

A. I have an office, a surgery center similar to this, in La Jolla, California.

Q. Also apparently you are an assistant clinical professor at Case Western Reserve?

A. Yes, I am.

Q. What does that entail?

A. This allows one the opportunity of interacting with a trainee plastic surgeons in the training program of the university itself, and they rotate their residents through our center.

Q. When you were the chief of plastic surgery at Cleveland Clinic --

A. Yes.

-- tell the jury what you did on a day-to-day basis when you were at the Cleveland Clinic?

A. Well, my function was twofold. I was the director of the entire service, which included the directorship of the training program. We were a residency training program for training young, aspiring plastic surgeons. And then I was the chairman of the department of five plastic surgeons. I was responsible for the administrative aspects of a

large surgical department.

Q. Doctor, showing you Defendants' Exhibit A, this is a copy of your CV; is that correct?

A. Yes.

Q. I looked through it, Doctor. It looks as if I have counted them, and apparently there were 57 publications that you had publicized; is that correct?

MISS STARR: Objection.

A. I don't count them. That may well be right.

Q. Then I also counted, and there is apparently over 168 presentations --

MISS STARR: Objection.

Q. -- that you have made throughout your career?

A. If it's documented here, that's probably what it is.

Q. What type of -- in reference to the presentations, in what different areas and what states and what type of media have you given presentations before?

A. I have presented clinical work to both lay and medical, scientific programs across the United States and across the world.

Q. Both in England and South Africa?

A. In England, South Africa, and United States and Canada.

Q. In fact I know, to be specific, you even appeared on T.V. and I noted an article, you even appeared on the Phil Donahue Show and other media type of --

A. Yes, I have.

MISS STARR: Objection.

Q. Doctor, can you just briefly tell us about any awards or honors that you have received in your career?

A. These are mentioned in my curriculum, and the medical school awards were most distinguished student in forensic medicine, which is medical, legal aspects of medicine.

In my fifth year of medical student I was most distinguished surgical student of the year, which must have been 1964 or '65. And in my final medical student year, 1965, the most distinguished surgeon in gynecology and obstetrics.

Q. So you've had your licenses and have been a physician for how long now, Doctor?

A. Since 1965.

Q. Doctor, you were approached by our office in reference to review this matter in reference to the defense of Dr. Classen. In specific, I think you were provided with the office records of

Dr. Classen, the Richmond Heights General Hospital records, St. John's emergency records, depositions of Dr. Classen and Dr. Vogt, and records of the other physicians, Dr. Heji and Dr. Thomas.

After having had an opportunity to look at these, you're familiar with the events that had surrounded Virginia Durfee's admissions into Richmond Heights Hospital?

4. That's correct, except for one thing. I did not review any of Dr. Heji or Dr. Thomas' records, only those pertinent to Dr. Classen.

2. What's your understanding of the accident that occurred to Virginia Durfee, I think the date is February the 24th, 1987?

A. 1987.

2. Yes. What is your understanding of how that accident occurred?

A. Briefly from what I'm able to assess from the notes that I had seen, that the individual in question was crushed between the bumpers of two motor cars, sustaining a crush injury to her leg. In this case I believe it's her left lower leg.

She was treated in emergency room, seen in emergency room, then seen for a period of 14 to 17 days by four physicians, including emergency

room physicians and orthopedic surgeons. And then admitted to hospital initially for consultation and subsequent treatment by the plastic surgeon in question, Dr. Greg Classen.

Q. As I understand, you happen to know Dr. Classen; is that correct?

A. Yes, I do. Yes, I do.

Q. Just tell the ladies and gentlemen of the jury, now is it that you know him?

A. He is a young man who trained under my services for a period, and I mentioned before, somewhere between six months and year, and I can't remember. This was back in the early, very early '80s, at the Cleveland Clinic.

Q. That's when he was a resident in training at the Clinic, you were also there?

A. He did a portion of his training for six months to a year. I think it was a year, but I stand to be corrected on that.

Q. The fact that you knew him, does that influence you in rendering your opinions that you are going to give in this litigation?

A. It doesn't alter my opinion as to the treatment. It peaked my interest to see what had transpired, and this is the only reason I offered to evaluate the

initial papers that your office sent to me.

Q. Doctor, in reference to the crush injury received by Virginia Durfee, can you explain to the ladies and gentlemen of the jury what happens, based on your experience to, example, the leg of Virginia Durfee when it was trapped between the two automobile bumpers as to the mechanism of what happened in the crush injury and the sequela that occurred after that?

A. When living tissue becomes crushed between the two bumpers of a motor car, the tissue sustains an injury which affects primarily the blood supply to the portions of the limb that are injured. Namely to the skin, to the underlying tissue, which may include the fatty tissue, may include the muscle, and may include the bone.

It becomes evident that in this particular patient this affected only skin and fatty tissue. The deeper vital structures were not injured.

From the time the injury occurs, there is a protracted period of time that the affected circulation manifests and ends up or culminates in death of the tissue, and the skin and its underlying fatty tissue, or so-called subcutaneous or under underneath the skin tissue, dies.

And this happened in this particular

patient over a period of two to three weeks, ending in the situation of dead tissue on the skin of the leg, requiring surgical removal of dead tissue and replacement with healthy tissue, so-called skin graft, from a distant site to repair the defect that had been created.

Q. In this particular case you know that Dr. Gregory Classen did debridements on three separate occasions, March the 20th, March 27th and April 3rd.

Is that unusual, Doctor, to have to do more than one debridement of dead tissue?

A. I would say in my experience it is not unusual at all, and it should probably be more the usual in this situation to take more than one debridement before one is able to finally clear the area of dead tissue prior to reconstruction.

Q. Just so the jury understands, what exactly are we talking about when we say "debridement"?

A. The debridement -- the term "debridement" merely refers to removal of dead tissue. The reason that I put this forth to you is that it's not all that simple to differentiate between living, dying and dead tissue. The dead tissue is usually evident.

However, the tissue which is not quite dead and is not quite living and one is unable to

assess in which direction it is going is the tissue that manifests with time after the first debridement, maybe after the second. So it may take one or even more debridements before you're really sure that the area is completely cleaned of dead tissue.

Q. Doctor, since the crush injury occurred on February 24th, 1987, why is it that during the initial time, or at least the first 17 days after that accident, that those physicians were having difficulty identifying live versus dead tissue?

A. Sir --

MISS STARR: Objection.

A. Sir, I can't attest to what happened between day 1 and day 17 because I have not reviewed any records relative to that. What I have reviewed is from the time Dr. Classen became involved, and I can give you some speculation if this is of interest to you.

MISS STARR: Objection.

Q. You have had experience with other types of crush injuries, why is it sometimes difficult to identify living versus dead tissue?

A. What I perceive as having occurred in a crush injury is not a matter of a tissue just automatically dying. The tissue is injured. It becomes bruised.

It becomes discolored. It becomes -- it dies gradually over a period of time. The diagnosis of crush injury is not simple. There is a differential. There are other factors that mimic a crush injury.

For example, mere bleeding or hematoma. The presence of a large amount of blood underneath living tissue can mimic the early stages of crush injury. The situation, as I -- as I read the notes of Dr. Classen is they appear to be a diagnosis of vein, or what we call deep venous thrombosis, where the underlying veins are clotted which manifests a very similar picture.

So it may have been that these individuals were diagnosing something else, and it only became evidence after a period of 14 to 17 days that tissue was dead.

And even when it's dead, I mentioned earlier, it's not a matter of there just being dead tissue and healthy tissue. There are -- there is a spectrum between dead and living, so-called dying tissue, and it's that tissue which is extremely difficult to differentiate in a crush injury.

MISS STARR: Objection. Move to strike.

Q. Doctor, what's your understanding of the scope

of treatment that Dr. Classen used in treating Virginia Durfee, what did he do for the patient?

A. What he did originally when he saw the patient was admitted -- I believe she was in hospital and he was consulted -- but I believe his treatment was, Number 1, to require bed rest, elevation of the limb to reduce the swelling, place the patient onto antibiotics, place the patient on two -- I recall Heparin, which is a blood thinner -- and he applied support bandages.

After a period of evaluation, which in this case took about five to seven days, I believe, he cook the patient to surgery and started the debridement process, which is the removal of dead tissue process.

When this was complete after a period of three separate debridements, he then took the skin graft from a distant site, which is free tissue skin, placed it into the site where the dead tissue had been removed from to repair the defect.

Q. Doctor, when you do a debridement, what's the goal in reference to being conservative and trying to distinguish as to taking live versus dead skin?

A. The point you are getting is the initial question, what is the goal of the debridement. The

initial goal of debridement is to remove all dead tissue. Then, second goal, to repair the created or the surgical defect by putting in new, healthy skin.

Now, what you are asking me is how do you obtain that goal. That goal can be attained zither by a single debridement process or by a series of debridement processes, depending upon the circumstances involved.

One -- you are talking about radical versus conservative debridement. The goal is to remove as much or all of the dead tissue. As I attested to earlier, it's not that simple just to say chat tissue is alive and that's dead.

It probably, in my way of thinking and in my practice, makes more sense to remove areas which are obviously dead, remove areas or maintain areas which you think maybe viable or still alive.

If you were wrong and that tissue went on from questionable living to dying, go back and remove a little more, a little at a time, to prevent you removing too much in the way of healthy tissue at one stage.

Q. In essence, if you're removing live skin once you remove it, in essence, it's gone?

A. Whatever you remove is gone.

Q. Doctor, in this particular case the patient, Virginia Durfee, from the various notes, is noted to be obese, that is I think over 100 pounds overweight.

MISS STARR: Objection.

Q. Does that have any effect in reference to the crush injury itself and how occurred, or in reference to her recovery period in any way?

A. When you mention the term "obese," I'm not familiar with a definition of obese being X amount of the pounds of your ideal weight. But the heavier the individual, the more fatty tissue anybody has, the higher the surgical risk because fatty tissue is relatively poor in blood supply.

It just makes the situation slightly more difficult, but I don't think impacts greatly on the amount of debridement or greatly on the amount of reconstruction. It makes it slightly more difficult from a healing point of view. Heavy people, obese people, don't heal as well as normal weight people do.

Q. What's your understanding in reference to the graft that Dr. Classen put on in reference to -- was it successful or unsuccessful?

A. It was 100 percent successful.

Q. Doctor, in looking through your report, you were making some comments in reference to -- that the

surgery done by Dr. Classen was purely limb saving --

MISS STARR: Objection.

Q. -- and reconstructive in nature. What do you mean by the words "Limb saving"?

A. What I meant by that statement was that a woman had come in with a severe injury. A crush injury is a very severe injury. The extent of dead tissue was debrided and her limb was reconstructed without mishap.

If these are not handled appropriately, it is possible for the dead tissue to become progressive. I have seen them extend up an entire limb. I have seen a limb succumb from secondary complications such as infection, none of which occurred in this.

So what I meant was here was a severe injury, it was treated surgically, it was reconstructed surgically, and a woman has a successful result from a functional point of view.

Q. Showing you Defendants' Exhibit B, it's a letter dated June 26th, 1990 -- is it '89, I think -- can you tell us what that is for the jury?

MISS STARR: Objection.

A. This is a letter written by myself to yourself, which is a summary of my findings and feelings about

the treatment administered by Dr. Classen to the patient involved.

Q. As I understand on March the 6th, 1990, an appointment was made for Virginia Durfee to actually come to your office, and I think Dr. Foglietti -- am I pronouncing that right?

A. Foglietti.

Q. Foglietti, thank you. The doctor here saw the patient.

First of all, who is Dr. Foglietti?

A. Dr. Foglietti is one of my associates. And due to some misunderstanding that occurred in my office -- and the patient's attorney was here, apparently she was referred to see me -- and due to some administrative error in my staff, was referred to see Dr. Foglietti.

I was called in at the time to render an opinion, not realizing the patient had initially been sent to see me, as a second opinion to Dr. Foglietti.

Q. I'm showing you Exhibit D, which apparently are your office notes, that is of your center here, in reference to the exam done on the patient; is that correct?

A. Correct.

MISS STARR: Objection.

Q. Also showing you Exhibit C, which is a copy of a report from your office in reference to the actual examination, what did the --

MISS STARR: Objection.

MR. WARNER: Thank you.

A. May I ask, what are the objections? Am I entitled --

Q. She is going that for the legal purposes. The judge will rule on that at a later time.

A. I mean, I'm not sure what the objection is. Am I entitled to know what the objection is?

Q. The judge will rule on her objections, if they are appropriate, and decide whether or not your answers --

A. It's not related to what I'm saying or doing?

Q. It probably is, but that's just plaintiff's counsel's difficulty at the present time.

Doctor, if you could --

MISS STARR: Move to strike.

Q. If you could give us your reference in reference to seeing the patient at that time with Dr. Foglietti and reviewing your office centers' notes and the report, what's your understanding of her present condition?

MISS STARR: Objection.

A. I think one must clarify also that between the time that Classen operated on her and the time that I saw, her she had had interval surgery by another plastic surgeon, and that was an attempt to do further reconstruction.

At the time that I saw her, the lady had an extensive wound, healed wound, on her lower leg, a depressed area was skin grafting. She complained of pain and discomfort in the area, but this was a fully functional, fully mobile limb with a Large, at this stage, cosmetically deformed limb with pain and discomfort.

My assessment and my advice was to leave well alone, not to do anything further from a surgical point of view, and that any further treatment would be symptomatic, by which I mean to manage the pain and discomfort.

And secondly, that I advised the patient to lose weight because I feel on an injured Limb the total heaviness of the body habitus was aggravating the situation.

Q. I note in the report it talks about the weight Loss and also physical therapy, what was the goal or purpose of physical therapy --

MISS STARR: Objection.

Q. -- that was recommended in reference to things that Virginia Durfee should be doing?

MISS STARR: Objection.

Q. I think on the first page, last paragraph, it talks about physical therapy and weight loss as a program to improve function, how could that have assisted?

MISS STARR: Objection.

A. If I may read my paragraph, what I said was is in my opinion the affected area is well healed. She has achieved functional ability that would be consistent with the severity of the injury, from which I meant the patient was able to walk, she was able to bend her knee, she was able to to her daily activities.

From a cosmetic point of view, all that I could recommend would be to take tissue from one area of the body to this area, what we call free tissue transfer, but I thought that would be overkill for this particular patient. I think that's too radical a treatment.

And that I had advised and hoped that by going to physical therapy she could strengthen the limb, exercise would reduce weight, and thereby

hopefully reduce any of the symptoms that she was experiencing.

Q. Doctor, showing you Exhibits G, E and F, I will purport to you that these are photographs of Virginia Durfee's leg that were taken at my office during her deposition, and just describe for the jury what you see there in those photographs?

A. What one is seeing is the left lower leg from the knee down to the ankle and foot. On the outside of the leg is a large depressed or dish-like deformity, and one can notice the nature of the skin differs markedly from the normal skin. That is, the skin graft that had been removed, probably I think in this particular case, from the opposite leg or buttock and replanted to the site (indicating).

The reason it is dish-like is that the underlying fatty tissue, or the cushion of underlying so-called subcutaneous tissue which we had referred to earlier, had been died and removed during the debridement.

And the residual deformity is well healed, all be it with scar and skin graft, constituting at this stage a cosmetically deformity, ahich is evident, but functionally from the actual novement of the limb there was no functional deficit

that he was able to assess.

Q. From the records you were able to realize that Dr. Classen was successful in that no muscle was lost on the patient. Why is it, Doctor, that in these types of injuries -- is that a complication that could have occurred?

MISS STARR: Objection.

A. Well, a number of questions here, sir. The point that muscle died or did not die was not related either to good or bad treatment of Classen. Classen treated what was meant to be treated.

The muscle wasn't injured. The bone wasn't injured. What was injured was skin and fatty tissue. That tissue was debrided, and the affected areas were successfully and adequately reconstructed.

Q. Doctor, I note from the records of Dr. Vogt and from his deposition, he claims -- he was a subsequent treating physician you mentioned earlier.

His records in his deposition indicate that the original graft is put on by Dr. Classen. I think was 10 centimeters by 12 centimeters, and that when your office measured the graft it had not actually -- it was enlarged. It was 12 centimeters versus 13 centimeters.

MISS STARR: Objection.

Q. Between those two intervals we had the surgery done by Dr. Vogt, why is it that the surgery done by Dr. Vogt required the actual graft to be made larger?

MISS STARR: Objection.

A. May I ask at this stage that the measurements from my office be revealed to me, because I don't recall --

Q. Sir, in your report of March 6th, 1990.

A. Okay. I have that. I have that.

Q. In the second paragraph, first sentence --

A. Right. I have that.

MISS STARR: Objection.

A. The note reveals that examination reveals a well healed skin graft that we attested to, measuring 12 by 13 centimeters, and you say that Dr. Vogt said how much?

Q On October 14th, '88 at his deposition he talked about it being 10 by 12.

MISS STARR: Objection.

A. No. This is one of two explanations here. I can't tell you whether we are accurately measuring or he is accurately measuring, but there is another explanation in that between the time that he measured the defect and that we saw her, there has been two or maybe three other surgeries.

When the patient went to see Dr. Vogt she had this large defect, and they were attempting to do two things, from what I understand. Number one, to treat her pain, and the pain was due to nerve or Little nerve endings called neuromas, and he removed these successfully.

The second thing was to reduce the dimensions of the deformity in her leg by inserting expanders. Expanders uses the concept of skin stretching, much like a pregnancy. A pregnant abdomen cannot accommodate a ten-pound baby immediately, but over a period of months can stretch.

So we as plastic surgeons have used this concept by putting a balloon underneath the skin, filling it with water gradually to stretch up the skin, then once the skin is stretched and lax, remove the balloon and cover the site of the skin graft.

It was unsuccessful in this particular patient due to a number of reasons. One being, I believe, the obesity or the amount of fatty tissue. And second of all the lower limb, the lower extremity, is the poorest area of blood supply in the entire body from a surgeon's point of view.

So when he took the expanders out, which had become infected, that tissue could have

contracted, due to infection and scar, and retracted, thereby creating slightly bigger dimensions than is reported in his individual measurement versus ours.

But this again, as I say, is dependent upon the accuracy of the measurements reported by himself and ourselves.

MISS STARR: Objection. Move to strike.

Q. Doctor, I note in the history taken by your office in reference to Virginia Durfee, it talks about her smoking one pack daily of cigarettes, did that have any effects?

A. That's an extremely --

MISS STARR: Objection.

A. -- important situation.

Q. What effect does the plaintiff, Virginia Durfee's, smoking a pack of cigarettes a day have on her recovery period, if anything?

A. I will go so far as to say -- and I had completely overlooked the situation of smoking -- smoking is one of the most deleterious problems that we as surgeons face when operating on soft tissue.

To the extent that in our practice for elective surgery, we will not operate on the patient who is currently smoking. And the reason is we are,

as lay people, very well aware of the effects of smoking on the heart circulation, but this is not confined to the heart. It affects the entire circulation of the body, including skin and its underlying tissue.

When the surgeon is creating the surgical injury or surgical insult in attempting to repair tissue, it is very important that the patient not be smoking because whatever inhalation of nicotine and tobacco, every blood vessel in the body goes into constriction, reduces the blood supply, thereby impairing the healing.

So it may have played a part in the problems that were encountered with the expanders and theoretically play a part in the extent of the injury, or the extent of the injury that has been developed.

Q. Can it also --

MISS STARR: Objection. Move to strike.

Q. Can it delay or impair the recovery process also?

A. From the point of view --

MISS STARR: Objection.

A. Not so much a point of view of skin graft as such, but more in the situation of skin flaps. Skin

flaps being large segments of full thickness skin and underlying tissue, subcutaneous tissue. I don't believe it impacted on the success or take of the skin grafting, or free skin grafting procedure.

Q. Doctor, if I would refer again to the photographs of Virginia Durfee's leg, Exhibits E, F and G which were photographed before the surgery done by Dr. Vogt, can you again, based on your background, your training, your education, give us your opinion, Doctor, in terms of medical probability and certainty as to whether those -- that skin graft is adequate or not in reference to meeting standards of care in reference to its final product?

MISS STARR: Objection.

A. There is absolutely no question that what he has here is 100 percent take of the skin graft. The wound is fully healed. The result is an excellent result given the severity of the injury.

Q. Doctor, based on your education, your training, your background, your review of the medical records, your review of the depositions, can you give us your medical opinion in terms of medical certainty and probability as to whether or not Dr. Classen met the acceptable standards of care in treatment of Virginia Durfee?

First of all, Doctor, do you have an opinion?

MISS STARR: Objection.

Q. Yes or no?

A. I have an opinion.

Q. Doctor, what is your opinion?

A. My opinion is that --

MISS STARR: Objection.

A. -- every standard has been met culminating in the successful result and successful reconstruction of the very serious injury.

Q. Doctor, Virginia Durfee and her attorney have brought this lawsuit against Dr. Classen. In your opinion, based upon your experience as the plastic surgeon, what was the cause of Virginia Durfee's problems?

MISS STARR: Objection.

Q. What's your understanding based on all the records as the cause?

A. Let's --

MISS STARR: Objection.

A. Let's evaluate the situation here. Dr. Classen didn't cause this injury. This injury has been caused by the crush between two motor vehicles. This is where the problem arises. Somebody catches their leg,

for whatever reason, between two bumpers of a motor vehicles. This is an extremely serious situation.

The patient has the result in injury' which needs to be cleared up, debrided, and then reconstructed. The origin of the injury is where the problem therises, not with this physician.

MISS STARR: Objection. Move to strike.

MR. WARNER: Thank you, Doctor.

MISS STARR: Can we take the short recess, please?

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(Recess had. I

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CROSS-EXAMINATION

BY MISS STARR:

Q. Dr. Dinner, you would agree, wouldn't you, that you would have done surgery earlier on Virginia Durfee?

MR. WARNER: Objection, Go ahead.

A. I think you're referring to my initial deposition, that optimally had one made a diagnosis earlier, the earlier you do it, the preferable.

Q. You would have done it earlier?

A. Had I made the diagnosis. I'm not saying I necessarily would have made the diagnosis. It's easy to look back retrospectively and say, "This is the situation," but I feel that I may have been involved in a similar dilemma as to what the diagnosis was.

Q. You would agree that Dr. Classen was dealing with a crush injury in this case?

A. Yes.

Q. You are aware that Dr. Classen made that diagnosis on the first day he saw Virginia Durfee on March 13th, 1987?

A, Yes.

Q. You would agree that when Dr. Classen began treating Virginia Durfee on March 13th, 1987, she was in stable health with a sick or dying portion of her extremity?

A. Yes.

Q. You would agree that your objective as a plastic surgeon is to get the patient into her pre-injury state as soon as possible?

A. Yes.

Q. You would do that to prevent further damage from occurring, wouldn't you?

A. The situation optimally, when the definitive diagnosis is made to clear the damaged tissue as soon

as possible, repair it as soon as possible so that the patient may return to their pre-injury state as soon as possible.

The error here that we're making is the term "Crush injury" is a generic term. It doesn't mean crush injury, operate, reconstruct.

MISS STARR: I am going to object.

Q. You are not being responsive to my question.

A. I am being responsive because you said "Wouldn't you," and my answer is no, and I'm giving you my snswer there. You answered question before me by saying "Wouldn't you," and my answer to your question is no.

Q. So the answer is no, Dr. Dinner?

A. No, yes.

Q. You would agree that if you see a black area of skin it tells you that the tissue is dead?

A. Yes.

Q. And that the patient had a crush injury?

A. Yes.

Q. Skin turns black when it dies, doesn't it?

A. Yes.

Q You would agree that in a wound with necrotic tissue you will take the necessary steps to control

the spread of necrotic tissue --

A. Correct.

Q. -- and secondary infection?

A. Correct.

Q. You would institute certain treatment to prevent any further deterioration, wouldn't you?

A. Yes.

Q. The primary treatment for dead tissue, the cure for dead tissue, is debridement, isn't it?

A. Correct. Correct.

Q. Local treatment being debridments is the most important treatment for this type of injury?

A. Well, it is a most important, correct.

Q. Debriding or cutting away of dead tissue is necessary because the organisms thrive on dead tissue, don't they?

A. It depends. It depends whether you have what's called a dry gangrene or a wet gangrene, gangrene being the term for dead tissue. Where the situation -- the situation is dry, dead tissue is there and their organisms can't thrive on completely dead tissue. They thrive in the presence of moisture.

I gave you an example when we spoke before, frostbite is the typical example. The tissue dies and the body can spontaneously amputate the

affected area without there being any other consequences. So --

Q. Dr. Dinner, so that the organisms --

MISS STARR: Let him finish his snswer.

Doctor, you are allowed to finish your answer.

A. So the situation is so that organisms will thrive, it doesn't necessarily mean that these wounds necessarily become infected because the body is able of localizing the wound itself.

Q. Okay.

A. The critical portion is not -- we are not arguing whether or not debridement should be performed or not. The concern is when do you perform it and how much is performed.

We have no argument with you, you and I, with that the fact that debridement is a most important part of the management of localized dead tissue.

Q. Dr. Dinner, you would agree that if there is drainage and necrotic tissue, that those two factors in combination are an indication to debride the wound?

A. Correct.

Q. The presence of infection also means that one

should debride the wound?
A. Correct.
Q. Timing is therefore important in debriding the wound, isn't it?
A, Yes.
Q. You would also agree with me, would you not, that you can get a different result in a wound by the timing of the debridement?
A. Yes.
Q. The sooner the surgery or the debridement the better the result; isn't that true?
A. Yes. I would say so, in general.
Q. Dr. Dinner, you practice the specialty of plastic surgery and your practice is consistent with the standard of care, isn't it?
A. Correct. Correct.
Q. If you were the doctor taking care of Virginia Durfee you would have done the surgery earlier; wouldn't you have?
A. I think that's an unfair way to put it, say "You would have done this, wouldn't you"? How could I possibly render an opinion one year later that I would have done this on a specific date?
Given the situation that the patient is well, given the situation that the patient has got

a dead tissue, then the optimal situation is to do the debridement at the most earliest and most convenient time. It is not an emergency, It is preferable to do it as soon as you can, thereby avoiding any of the possible sequelae that may occur.

Q. Dr. Dinner, you recall that I took your deposition on Wednesday, June 13th, 1990 in your office?

A. Yes, I do.

Q. Do you remember being placed under oath at that time?

A. Yes, I do.

Q. Do you remember saying to me on page 108 of your deposition, "I did grant you that if it were me" --

MR. WARNER: What line are you on, counsel?

MISS STARR: 25.

MR. WARNER: Thank you.

Q. Dr. Dinner, why don't you read for me line 25?

A. All right. "I did grant you that if it were me that I probably" -- and the word is "probably" -- "Would have intervened earlier," but this is speculation. I would not like you at any stage to say I was under oath or that I am changing my testimony, Miss Starr. That's exactly what I said, and I don't

change that now.

Q. You are not changing that now?

A. I am not changing that, nor should you imply that I was under oath. I think we understand that I'm here to give you the best of my ability and the most truthful situation, and I resent the implication.

Q. Dr. Dinner, you know that compression dressings hinder circulation, don't you?

A. I do not know that.

Q. You do not know that?

A. No. It is dependent upon the degree of compression, and we went into this before.

Dr. Classen had applied an Ace bandage, and I said to you it is impossible to assess how much compression is applied.

What the implication you are saying here is did this dressing or was this dressing applied so tight that it impaired further circulation. It is impossible for me to sit here and say that the Ace bandage, which is an elastic bandage --

MISS STARR: Objection. It is nonresponsive.

MR. WARNER: Go ahead, Doctor. Finish your answer.

A. It is impossible for me to sit here a year later

to say that an elastic bandage was applied with such force and tension or compression that it impaired the zirculation of an already affected limb.

Q. Dr. Dinner, you will agree that an Ace bandage can compress an extremity?

A. Yes, that I will agree to.

Q. You would also agree with me that you can sctually cut off the entire circulation using an Ace bandage; isn't that true?

A. If you apply an Ace bandage in the form of a tourniquet with sufficient tension that the limb -- that you occlude the blood supply, you can amputate she leg. Absolutely.

Q. Dr. Dinner, you would also agree, would you not, that decreased circulation can be caused by a compression dressing?

A. Yes, if inadequately applied. But I will not allow to you imply that a plastic surgeon, preferably one trained in a teaching institution, would apply an elastic bandage that it would act like a tourniquet. Under no circumstances. This is basic that we teach to nurses, let alone to physicians.

Q. You teach this or you have taught this to your residents?

A. It is absolutely basic standard understanding

that the circulation in a limb be elevated, that it doesn't act like a tourniquet or a compression bandage.

Q. You would agree, would you not, that a compression dressing is of no value in a crush injury where you already have decreased circulation?

A. I think what we have to do here is be very careful of this generic term "Crush injury," because a crush injury manifests as a number of different type of syndromes,

The syndrome we are referring to in this particularity is a crush ending up as dead tissue. It has no value under those circumstances, but crush does produce other syndromes, for which I think they thought they were treating either deep vein thrombosis, which is a clothing off of the blood vessels and the leg swells. The application of light compression, as is affected by an Ace bandage, helps significantly. Hematoma.

Q. Dr. Dinner, excuse me. Dr. Classen did not believe that he was treating a deep vein thrombosis, did he?

A. Well, the fact that they placed the patient under Heparin, the fact that they applied Ace, and the fact that they elevated the limb suggests that in

their mind there was a differential diagnosis.

This is the feeling that I have, in reviewing the notes, that they had not come to a final conclusion of crush injury with dead and dying tissue, This is why they didn't institute earlier debridement. These are the areas that I said I felt was gray zones in a diagnosis. There are a number of different diagnoses that occur as a result on crush injury.

Q. Dr. Dinner, I am going to hand you a page from the Richmond Heights General Hospital Record.

Can you identify that record for me, please?

A. This is a Richmond Heights General Hospital consultation report by Greg Classen to Richard Stang.

Q. When is that dated?

A. Dated 13th of March, 2:00 p.m.

Q. Can you read to the jury what Dr. Classen's impression was?

A. Right. "Impression was crush injury, cellulitis, rule outcome compartment syndrome, necrosis of skin, posterior calf."

Q. Thank you.

A. Okay.

Q. So on March 13th, 1987, Dr. Classen recognized that there was a crush injury of the left lower leg --

A. Correct.
Q. -- and necrosis of the skin, posterior calf?
A. Correct. But you want to add there the question of "Rule out" -- what does it say, "Compartment syndrome." That is another one of the manifestations of crush.

There are a number of syndromes in crush. One that causes a lot of edema, one that causes compression of muscles, one that causes dead skin so it's not a single manifestation. It's a wide spectrum of conditions which I suppose they were covering all basis by raising, compression, antibiotics, Heparin, all of these treatments. They were trying cover all basis for this particular crush.

It didn't manifest as single syndrome but as a wide variety of disease processes, which could occur in a different syndromes within the crush element.

Q. Dr. Dinner, you are also aware, are you not, that Dr. Classen ordered a compression dressing on March 13th, 1987 for Virginia Durfee?
A. I saw the order of compression and the dressing, and I think it was related to the drainage. Yes, I am aware of it.
Q. You will agree that a compression dressing does

not increase circulation --

A. Absolutely.

Q. -- wouldn't you?

A. Absolutely. Except it does decrease edema.

Q. But it does not increase circulation?

A. If you will allow me to finish.

Q. If --

A. Progressive -- if you will allow me to finish. think it will answer your question.

Increasing edema, as you will see from Dr. Gaisford's note, produces progressive decrease in zirculation. Thereby, it may be inferred by reducing edema you may prevent the problem of diminishing circulation.

So while I would agree to the fact that by applying a compressing dressing you cannot enhance circulation, you may in fact theoretically reduce the question of edema, being swelling, compressing already compromised circulation.

And I want to make this point very clear to the jury. We are dealing with a severe --

Q. Dr. Dinner --

A. Just let me -- let me make a point. We are dealing with a very severely injured skin and circulation.

Q. Dr. Dinner, you answered my question. We need to move on.

Isn't it a fact that antibiotics are not going to affect a crushed site because there is no circulation to that area?

A. I have to be very careful how I answer, because you implied before that I gave an answer in my deposition and I was under oath.

What I said earlier in the deposition, that it probably has no advantage in a localized crush injury because the crushed site has no circulation, and you need circulation as a vehicle for which the antibiotic can get to the crushed site.

Q. So your answer is yes?

A. Yes. My answer is yes, but I still -- as I would have told you earlier, I still would have given it.

Q. You still would have given the antibiotic?

A. Yes, as a broad spectrum.

Q. You would agree that only cleaning the area surgically by debridement and cutting away the dead tissue to healthy tissue will enable the antibiotic to be fully effective?

A. Yes. Yes, I would agree. Broadly, I would agree.

Q. Dr. Dinner, you would also agree that you would have given a different antibiotic than Dr. Classen did?

A. No, I won't agree with that. What I said --

Q. You won't agree?

A. No. What I said, if you read the deposition again, that had a specific problem of Pseudomonas infection been diagnosed that Fortaz, which we spoke about, is the specific antibiotic for Pseudomonas infection as opposed to Claforan, which he gave, which is a non-specific antibiotic in this particular case.

But in the initial injury, if a patient came in to me with a crush and I did not have a bacteriological evaluation, I would give a broad-spectrum antibiotic rather than Fortaz, which is specific to Pseudomonas infection.

Q. Dr. Dinner, do you want to turn to your deposition, please?

A. Yes.

Q. Page 110.

A. Yes.

Q. Line 15.

A. Right.

Q. You would agree that Claforan is not the antibiotic of choice for Pseudomonas --

A. Yes, I will --
Q. -- wouldn't you?
A. Yes, I will agree that.
Q. Pseudomonas was identified in Virginia Durfee's wound, wasn't it?
A. Yes.
Q. You would have used Fortaz, wouldn't you?
A. At that particular stage, yes, but that wasn't your question to me.
Q. Dr. Dinner, you have to be very careful of secondary infection, don't you --
A. Yes.
Q. -- in this type of injury?
A. Yeah.
Q. That's the importance of debridement --
A. Correct.
Q. -- to keep the wound clean?
A. Correct.
Q. The viability of the tissue is determined by the impairment of the circulation?
A. Is that a question or a statement?
Q. That's a question.
A. You are going to need to restate. I'm not -- I'm not following you. Say that again.
Q. In terms of tissue being viable, isn't it

determined by the circulation, the level of circulation to the area?

A. Absolutely. Absolutely.

Q. Proper debridement of this type of wound is the prime concern of a plastic surgeon, isn't it?

A. Are these two separate questions or are you following on one from another? I'm not following your thought process.

The answer to your second question is yes.

Q. You cannot hope for antibiotics to be effective until you adequately go in and debride the wound?

A. Against infection it cannot be effective. See, you must understand that, as I tried to explain to you in a crush, the crush is not a pure line of demarcation -- and we used this term before.

There isn't a zone that says, "This is dead and that's alive." There is a whole array of tissue which is partially injured. It's partially asphyxiated. It's breathing a little bit, but it's in a delicate balance.

For this reason, one gives antibiotics in an attempt to prevent that delicate balance in one area from changing from partially alive to or partially dead, either way you look at it -- to fully

dead, so that debridement is responsible for taking away already dead tissue.

The antibiotics that you add as a broad spectrum, not for infection but organisms that may be floating in a normal persons' body, can settle in an area of compromised circulation.

It's that particular case that you give us broad-spectrum antibiotic. Not specific therapy. It's not treating a specific infection, but you're hoping to prevent the organisms that occur when you brush your teeth, or the organisms that are in your nose or under are fingernails.

From those organisms, there are normal organisms in the body from settling into tissue which is already partially compromised. So I think that we need to be a little bit more careful in talking about specific antibiotics for an established infection versus preventive antibiotics which are more broad-spectrum.

Q. Dr. Dinner, you are aware that there were cultures taken out of the wound of Virginia Durfee?

A. Yes. It showed Pseudomonas, yes.

Q. Pseudomonas was identified from that wound?

A. Um-hum.

Q. Dr. Classen did not change the Claforan at that

time, did he?

A. No, he did not. But on the other hand, we mentioned again in my previous --

MISS STARR: Objection.

A. -- deposition that the mere --

MR. WARNER: Go ahead, Doctor: Let him finish the answer.

Q. Dr. Dinner, the answer is yes or no.

A. I have to finish my question. There is no clear-cut yes or no.

MR. WARNER: The judge will rule on this. Give your answer, Doctor.

A. There is no clear-cut yes or no. The fact that they identify an organism doesn't mean anything. You have to say, "Is this a contaminate or is this an infection."

And the way you do that is -- and I didn't see this -- how many organisms. The pathology lab, bacteriology lab, will tell you that is ten to the sixth organism per gram of tissue, then the treating physician knows that this is an evasive organism rather than a contaminate.

So I grant you yes, there was a culture, a surface culture, that tells you that there is an organism. It didn't tell you how many

organisms, how many organisms per tissue, or is this a contaminate or an evasive organism.

That's the only difficulty I have when you say he should have changed the antibiotic. The patient wasn't ill. We mentioned this before. We weren't treating a sick patient, that it was absolutely mandatory that we did identify the correct on for Pseustemic disease. So granted the antibiotic wasn't changed, but I'm not sure of the implication of that.

Q. Dr. Classen did not request the lab to tell him the colony count or the number of organisms, did he?

A. I can't attest to that.

Q. You didn't see any evidence of this record, did you?

A. No. I didn't see any evidence saying specifically "Give a colony count or organism count." I didn't see that.

Q. Dr. Dinner, Pseudomonas, which was identified --

A. Yes.

Q. -- as growing in Virginia Durfee's wound is an organism that likes dark covered dressings and a lot of fluid to grow in, doesn't it?

A. Yes. I attested to that earlier.

Q. The first thing you want to do in treating an

organism like that is to give it light so it won't keep growing --

A. I think what you --

Q. -- isn't that true?

A. No. I think what you are doing -- and I think we went into this again in the deposition. What I thought was important is when you have an organism like Pseudomonas is is to expose it. By exposing is debride the wound. It's important to debride it, and that's what I said to you.

It would have been -- when I said "I probably," and I speculate, would have debrided earlier, because you want to expose it. It's not so much the organisms, it's the matter of dead tissue that this type of organism thrives in. And that's what I was referring to earlier.

Q. In fact, the infection will continue growing with necrotic tissue and in a dry dressing --

A. Yes.

Q. -- isn't that true?

A. In a dry dressing as opposed to a moist dressing, I think it's important to frequently change the dressing so that you don't have soggy dressings which these organisms tend to proliferate in.

Q. But they also proliferate in dry, dark areas,

don't they?

A. You know, we are going through this business again, and I can't say yes to that question except to say I think it's important to debride it rather than the question of a dressing -- putting a dressing on and say the organisms are going to proliferate more in a dark environment.

Whereby what I meant -- and I want to clear that statement, because I know that it's stuck in your mind -- that these organisms do well in an invironment of dead tissue rather than the questions of dressings, and I just wish I could take back that term that I mentioned right in the beginning.

Q. Dr. Dinner, if I'm understanding you correctly, then you're saying that this is another reason why you want to debride the wound as soon as possible, open it up to the air, and get rid of that dead tissue?

A. Absolutely. I can't disagree with that at all.

Q. The presence of Pseudomonas is further indication to get in and debride that area?

A. I would -- I would grant you that.

Q. As opposed to leaving the wound covered with dead tissue and in a dark environment?

A. Urn-hum.

Q. Doctor, isn't it a fact that you would not have

ordered a dry dressing for Virginia Durfee at that point in time?

A. You know, I mentioned earlier, the dry dressing was there to collect the seepage which you attest to. It wasn't there as therapy, it was there as catchment rather than therapy.

So I'm not going to say to you I would not have put on a dry dressing. I'm not going to allow you to put words in my mouth, either. I probably would have put a dressing on prior to my debridement of the wound.

Q. Dr. Dinner, isn't it a fact that there was no contraindication to take Virginia -- to not take Virginia Durfee to surgery earlier?

A. Miss Starr, we are in this double negative again. And again I'll grant you, as I said in my testimony, that all things being equal, provided you had a clear-cut diagnosis, that optimally to do it as soon as possible. But in answer to your question, there were no clear-cut contraindications precluding the surgeon from debriding earlier.

Q. So there were no reasons --

A. Not to.

Q. -- that Dr. Classen couldn't have done the surgery earlier?

A. Not that I am aware of, no.
Q. Doctor, isn't it a fact that when you observe a necrotic area in a wound you schedule your patient for surgery and you debride that wound?
A. Correct.
Q. Dr. Dinner, presently your practice consists of 80 percent cosmetic surgery?
A. Correct.
Q. And cosmetic surgery is the enhancement or improvement of existing normal structures?
A. Correct.
Q. Reconstructive surgery -- I'm sorry. Plastic surgery is the repair of abnormal damaged structures in an attempt to restore to normal?
A. Correct.
Q. Cosmetic surgery is an elective non-emergency type procedure?
A. Yes.
Q. Isn't it a fact that in the last seven years you have had no experience or treatment of patients with crush injuries?
MR. WARNER: I will enter an objection to the words "No experience."
A. Well, wait a minute. First of all, I mentioned to you earlier on that I am a very experienced plastic

surgeon. The question is not whether you can handle the particular source of injury or is -- are you familiar with the end result --

MISS STARR: Objection.

A. Let me finish, because you're implying that I don't have experience in this treating this particular problem, which is untrue.

MISS STARR: Objection.

Q. Dr. Dinner --

MR. WARNER: Let him finish his answer.

A. Let me finish, because you're making an implication which I resent. You're implying that the fact that I am treating cosmetic surgical patients that I don't see dead tissue. Well, I see any number of dead tissue, because dead tissue of this nature does not only come from a crush, it can come from enumerable different sources, which I see repeatedly.

Once more, the day you were in my office we had a crush injury which I offered to show you and you refused to look at, so that's not the case whether one has experience. I have a vast experience in the management of these situations.

MISS STARR: Objection.

A. I am not currently an emergency room plastic

surgeon, is what you are referring to. I am not a trauma surgeon, but I have an inordinate amount of experience in the management of these wounds.

I'm done.

MISS STARR: Objection, Move to strike.

Q. Dr. Dinner, my question to you is in the last seven years since you have opened your plastic surgery center, you have had no experience or treatments of patients with crush injuries?

A. No experience with -- all right.

Q. No patients?

A. No patients. That's -- that's fair. I'll grant you that.

Q. It's also true, isn't it, that you have not authored any articles or books on the subject of debridments following crush injuries?

A. That's true.

Q. You have not authored any articles or books on the treatment of crush injuries?

A. That is true.

Q. Isn't it a fact that you know the group of lawyers that work with Mr. Warner, Dr. Classen's attorney?

A. That I know them?

Q. You know the group, you know his --
A. I mean, I know of them. But what are you implying, that I work for them or are socially friendly with them, or I am familiar -- once I think we attested to ten years, Goldwasser -- he says, and I don't recall it -- sat on a case with me.
I think that term is grossly inaccurate. I don't know this gentleman sitting here, nor did I know the gentleman who came here last time.
Q. Dr. Dinner, you know Dr. Gaisford --
A. Yes.
Q. -- the plaintiff's expert witness in this case --
A. Yes, I do.
Q. -- don't you?
A. Yes, I do.
Q. You have met him before?
A. Absolutely.
Q. You know of his reputation?
A. Absolutely.
Q. And you personally respect his opinions very much, don't you?
A. Very much.
Q. You believe that he is an excellent and respected plastic surgeon, don't you?

A. Yes, I do. Yes, I do.
Q. You also believe that he is an excellent and respected reconstructive surgeon?
A. Was. I mean, the gentleman is retired, but I do respect his -- and I respect his opinions. I have no idea now, and I'm not sure that he is -- the last I knew he was retired, but I do respect him. That does not detract from my respect of him.
Q. Dr. Dinner, do you know for a fact that he is retired?
A. As far as I was aware, Dr. Gaisford retired from practice in Pittsburgh, from active practice in Pittsburgh. And I stand to be corrected, but I believe it was about five years ago. I believe, but I don't know for a fact. I haven't seen him at any of the meetings. The last time I saw him must have been five or seven years ago at the meeting.
Q. You could be wrong, you don't know this for a fact?
A. I could be wrong. Absolutely. I could be wrong, but I will be happy to review this. But I -- Nevertheless, it doesn't detract from my opinion. I respect him today, and I will always respect him.
Q. Dr. Dinner, Dr. Classen was a student of yours approximately eight, ten years ago?

A. It must be between eight and ten years ago.
Q. During that time you were responsible for teaching him his craft of plastic surgery, weren't you?
A. Well, he trained under me. If you would like to put it that way, yes. I would like to think I was responsible for his training.
Q. I'm sure you put a lot of time and effort into your teaching of your residents, including Dr. Classen; isn't that true?
A. Yes, that's true.
Q. You had a teacher/student relationship with Dr. Classen?
A. Yes, that's true.
Q. As a matter of fact, that's why you agreed to review this case?
A. I resent that, Miss Starr, and you're doing it merely to trick me. I think that's unfortunate that you should stoop to that behavior.

Let me tell you something now that you've said that, and why I agreed to do it, and I think --

MISS STARR: Objection.

A. No. You can object as much as you wish.

Classen was a gentleman and was a good

scholar. When they sent me this, I was interested to see what was happening. When I saw that Classen was being bullied into accepting the responsibility of an -- of an injury of this nature, when the man had done everything within the realms of normal and good standard care of plastic surgery, is when I accepted to stand on his behalf and testify to the situation. Not because I have developed, as you may, a relationship with the man.

If he had done something incorrectly I would rather have denied being here, but that's the answer to my objection to you.

MISS STARR: Objection. Move to strike.

Q. Dr. Dinner, when I took your deposition a few weeks ago you were under the belief that Virginia Durfee was a black woman, weren't you?

A. You know, this was related to photographs that I'd seen and I saw temporarily, but yes, I would say that I thought she had been a black woman, yes.

Q. Dr. Dinner, we looked through your file regarding this case and we didn't see any bill in your file, did we, for Dr. -- for Dr. Classen for the services you have rendered to date in this case; isn't that true?

A. You looked through my file and you saw no bill to Dr. Classen? Why would I bill Dr. Classen?

Q. To Mr. Warner. There was no bill, was there?

THE WITNESS: Mr. Warner, would you like them to bring in the check for today's videotape?

Q. Dr. Dinner, I'm --

A. Whether you saw a bill or not is not the case. I will bill for my services exactly the same as what you were billed for my services.

Q. But to date, or as of June 13th, there was no bill in your file for the services you had rendered in this case; isn't that true?

A. Whether or not it's in the situation here, they have been billed for my review of the case at a price of 250 to $300 an hour for review! and they will be billed for today's time for testimony exactly the same as your office has been billed.

Q. My office was billed $500.

A. For testimony, yes. They have been billed $1,000 an hour for video testimony and $250 an hour to review the patient -- to review the case.

Q. Dr. Dinner, when Virginia Durfee was seen in your office you did not conduct an independent physical examination of her, did you?

A. No, I did not.

May I ask you a question on that? You had requested that I examine her, why did you ask me to do it?

Q. Dr. Dinner, that is not true,

A. That is -- that is the truth.

Q. That is --

A. Your --

Q. Dr. Dinner --

A. Your office requested. You came here with the patient.

Q. Dr. Dinner, I really do not mean to disagree with you, but I think if you will look in your file, we found letters in your file from Mr. Warner asking that you examine Virginia Durfee, so --

A. May I ask, were you under the impression that I was going to examine her?

Q. Dr. Dinner --

A. May I ask you a question?

Q. No, you cannot at this time.

A. You mentioned in the deposition --

Q. After we go off the tape, we will go off,

A. No. I think it's equally applicable that the judge know that you expected me to be there. I never knew it.

MISS STARR: I am going to object and move to strike this.

Q. Dr. Dinner, isn't it true that you have never, even as you sit here today, read Virginia Durfee's deposition?

A. No, I haven't read it.

MISS STARR: Thank you. I have no further questions.

MR. WARNER: Doctor, just a few questions.

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REDIRECT EXAMINATION

BY MR. WARNER:

Q. What was Dr. Classen's role in this when he was brought in as consult, what's your understanding of what his role was when he was brought in?

MISS STARR: Objection.

Q. Go ahead. The judge will rule on it. What was your understanding of his role?

A. That he was going to render and advise of what he saw and what he thought would be a treatment plan.

Q. Doctor, earlier you made some comment about the injury, the mechanism of injury between the two bumpers, the leg being caught, and that the amount of injury being predetermined. What do you mean by

that --

MISS STAR: Objection.

Q. -- the amount of injury being predetermined?

A. I must assume, Mr. Warner, that these vehicles, at least one of them, was mobile. She did not get crushed between two stationary bumpers.

The size of a bumper, I will go out and look at a car, has a cross-sectional area somewhere in the region of this size (indicating). If you look at the wound on the leg, it's somewhere in the region of that size.

That I would assume -- and it's assumption, this is all we are talking about in this whole case -- is the assumption of the degree of injury to that leg between two moving, or one stationary and one moving vehicle.

MISS STARR: Objection. Move to strike.

A. The question is did -- not whether or not debridement should be performed or not. The question is when, and did the delay period that occurred from the time that Classen came on the case -- and he had the misfortune of having seen the patient 17 days after the injury. Did the delay of that period in any way extend the degree of debridement that needed to be

done, and my answer is categorically not.

I have read Dr. Gaisford's testimony. I have -- I respect the man. I like him, but I don't necessarily have to agree with him, and I disagree with him totally that the area that died is consistent with the degree of injury. The treatment was debridement. He had 100 percent successful take of the graft. I'm not sure what more one can ask of a physician. That's all.

MISS STARR: Objection. Move to Strike.

Q. Miss Starr had a lot of questions about the Pseudomonas and whether or not the right antibiotic was used.

As I understand what significance, if any, did the infection and the taking in reference to taking of the graft play in this patient?

MISS STARR: Objection.

A. The antibiotics had probably no role whatsoever. What was important was the debridement, the dressings, repeated debridement and dressings, and then the graft.

The antibiotic would have played a more significant role, as I had mentioned earlier, if the patient had been sick, infection had gone beyond

the confines of the wound. That's my opinion.

Q. Miss Starr made some comments about no experience in this area.

Doctor, in your training as being chief of surgery there at the plastic surgery of Cleveland Clinic, could you go in detail for the jury what type of experience you have in dealing with these type of crush injuries?

A. I can't go into detail. We were a broad service. We had any time at any stage over 30 patients a day under my care.

This is just a matter of a diversion. I am an experienced plastic surgeon. I know all about the care of these wounds. I have treated enumerable one of these. The point is not whether I treated one in the last year or two or five years, that's not, in my opinion, relevant, because there are principles of treatment that are important. Not whether you treated a particular -- because there is no two wounds that look the same.

Q. How long were you chief of plastic surgery at the Cleveland Clinic, and what years again?

MISS STARR: Objection.

A. Seven a half years, eight years. Somewhere around there.

Q. Doctor, in plastic surgery there are, and in treating this type of crush injury, there were apparently different avenues that a physician can use in getting an end result; is that correct?

MISS STARR: Objection.

Q. You can debride it in different manners?

MISS STARR: Objection.

A. The point you are getting at here, Mr. Warner, is should this have been completed in one debridement, as Dr. Gaisford says, and I disagree with that.

I don't think you can categorically state that "I can clear out every wound with a single sitting." I don't think there is a plastic surgeon in the country who will tell you that he will categorically state that he can clear out every dead wound in a single sitting. I certainly not have been able to do it, and I would challenge anybody else.

The point is the wound was repeatedly debrided until it was clear. When it was clear, a graft successfully took, giving a successful result. I'm not that sure that I understand the controversy here.

Q. Doctor, in spite of all the extensive cross-examination by Miss Starr, that has not changed your opinion about the care and treatment rendered by

Dr. Classen in reference to this case?

MISS STARR: Objection.

A. No, it does not.

Q. Doctor, all of your testimony has been based upon medical reasonability and medical certainty in reference to treatment rendered by Dr. Classen?

A. Absolutely.

MISS STARR: Objection.

MR. WARNER: Thank you. Nothing further.

MISS STARR: I have no further questions.

MR. WARNER: Doctor, just tell them you will waive signature.

THE WITNESS: I will waive signature.

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(Deposition concluded; signature waived.)

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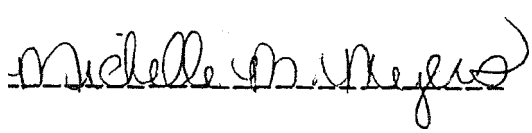
The State of Ohio, :

County of Cuyahoga.: CERTIFICATE:

I, Michelle M. Myers, Notary Public within and for the State of Ohio, do hereby certify that the within named witness, MELWN I. DINNER, F.C.F.S., was by me first duly sworn to testify the truth in the cause aforesaid; that the testimony then given was reduced by me to stenotypy in the presence of said witness, subsequently transcribed onto a computer under my direction, and that the foregoing is a true and correct transcript of the testimony so given as aforesaid.

I do further certify that this deposition was taken at the time and place as specified in the foregoing caption, and that I am not a relative, counsel, or attorney of either party, or otherwise interested in the outcome of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 12th day of July, 1990.



Michelle M. Myers,
Notary Public/State of Ohio.
Commission expiration: 9-14-92.