DOC. 162

THE STATE OF OHIO, )
) SS:
COUNTY OF CUYAHOGA. )

IN THE COURT OF COMMON PLEAS

FRANCES SMITH, Administratrix of the Estate of Alvester Smith, Sr., Deceased,

Plaintiff,

v.

ST. LUKE'S HOSPITAL, et al.,

Defendants.

Case No. 100877

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Deposition of AVRUM I. FROIMSON, M.D., taken by the Plaintiff as if upon cross-examination before Kerry L. Paul, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at The Mt. Sinai Medical Center, One Mt. Sinai Drive, Cleveland, Ohio, on Tuesday, the 10th day of November, 1987, commencing at 3:45 p.m., pursuant to notice.

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APPEARANCES:

Charles Kampinski Co., L.P.A., by:
Charles Kampinski, Esq.,
and
Christopher M. Mellino, Esq.,

On behalf of the Plaintiff.

Reminger & Reminger, by:
Marc W. Groedel, Esq.,

On behalf of the Defendants Timothy L. Stephens, Jr. & Curtis W. Smith, M.D.

Arter & Hadden, by:
Kris H. Treu, Esq.,

On behalf of Defendant
St. Luke's Hospital.

Jacobson, Maynard, Tuschman & Kalur, by:
William D. Bonezzi, Esq.,

On behalf of Defendant S.J. Lee, M.D.

Kitchen, Messner & Deery, by:
Eugene B. Meador, Esq.,

On behalf Defendant Agnes Sims, R.N.

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that this deposition may be taken in stenotypy by Kerry L. Paul; that her stenotype notes may be subsequently transcribed in the absence of the witness; and that the reading and signing of the deposition by the witness were expressly waived.

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AVRUM I. FROIMSON, M.D.,

a witness herein, called by the Plaintiff for the purpose of cross-examination as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposes and says as follows:

CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Doctor, my name is Charles Kampinski and I represent the Estate of Alvester Smith. I have got a number of questions to ask you this afternoon. If you don't understand, please tell me. I'll be happy to rephrase them. Have you reviewed any materials in addition to what is set forth in your report of December 17, 1986?

A. What is set forth in that report?

Q. The medical records and the x-rays basically. Do you have a copy of your report in front of you?

A. I have a copy of that report. That's right here. That was done almost a year ago; and since then, I have looked through some other depositions. I can't remember the titles of them, but they are here. There are various things here.

Q. Have you provided any other reports to

Mr. Groedel or anybody else?

A. No.

Q. Did you receive any material from Mr. Groedel, other than the depositions that you referred to now and the inatters referred to in your report, that you relied upon in any manner?

A. No.

Q. Did you receive any oral communication from Mr. Groedel which you relied upon in providing any opinion?

A. No.

Q. Doctor, in your report on the very last page, the last paragraph, you indicate that you did not feel cardiological consultation, other than Dr. Jackson's examination of the patient, was required before returning him to the operating room for the second procedure?

A. That's correct.

Q. Is that still your opinion today?

A. That's right.

Q. Is it your opinion that Dr. Jackson did examine the patient for the purpose of clearing him for surgery?

A. Dr. Jackson examined the patient. Whether or not it was for the purpose of clearing

is neither here nor there. You can examine the patient. You can make observations and then you can derive whatever judgments you want from the examination. The examination for purpose of clearing for surgery is no different than the examination for determining his medical status.

Q. Would it matter to you if Dr. Smith was aware of whether Dr. Jackson saw him on the day of surgery; that is, November 17, 1984?

A. Would it matter to me?

Q. Sure, in terms of rendering an opinion that Dr. Smith didn't do anything wrong here?

A. It was my impression, from reading the information correctly or not, that Dr. Smith did know that Dr. Jackson saw the patient.

Q. Okay. If he didn't know that, would that make any difference to you for purposes of your opinion?

A. No, because there's another line of inquiry in terms of relying upon the anesthesiologist as well, so we don't rely on just one person.

Q. All right.

A. We rely upon a number of people in the treatment team.

Q. Would you rely on the anesthesiologist to give medical clearance?

A. We generally do, as a matter of fact.

Q. So whether Dr. Jackson saw him or didn't see him or whether clearance was obtained from Dr. Jackson just doesn't matter as far as you are concerned; is that correct?

A. That's right. It doesn't matter inasmuch as in that circumstance he has the anesthesiologist to fall back on and to rely upon, which is what we do everyday.

Q. Then why did you even suggest that no cardiological consult was required other than Dr. Jackson's examination?

A. I don't know why I wrote that. I mean, that's just a way of phrasing what I perceived to to be an issue after reviewing the various depositions and the various records.

Q. Doctor, in your CV you set forth that you are a board examiner for the American Board of Orthopedic Surgery?

A. That's true.

Q. Were you an examiner for any of Dr. Smith's examinations when he took the boards?

A. No.

Q. You are aware of the fact that he has failed them three times?

A. No.

Q. What is your belief with respect to the responsibilities of an attending physician vis-a-vis medical problems other than those within the specialty of the attending?

A. The responsibilities of the attending orthopedist?

Q. Let's just leave it as the attending first and then we will narrow it down to the orthopedic surgeon.

A. The responsibility of the attending physician is basically to care for his patient and take those steps necessary to treat the condition for which he's consulted.

Q. Well, does that require assuring that other specialists are caring for him if he has problems that would involve those other specialist?

A. Yes. He has a duty to consult, sure.

Q. Does he also have an independent duty to be apprised of his patient's status, even though that information might also be within another specialist's knowledge?

A. I don't think I would say he has a duty.

I think he has a need to be advised. In other words --

Q. Okay.

A. -- people have to give him information as necessary.

Q. All right. Can he assume that he's getting it all or does he have to make some affirmative attempt to make sure that he's getting it, especially if there are residents involved?

A. When there are residents involved in the structure of a teaching program, it is assumed in the chain of the organization that the residents will provide the attending with the necessary -- with the pertinent necessary information.

There are a number of people treating the patient, including the residents and the nurses and the various other respiratory therapists, whoever it may be and the structure of the organization is that those people should report to the attending physician those pertinent items.

Q. I understand that. Maybe that's the structure, but is there an independent responsibility upon the attending to make sure that is being done to the extent it is a teaching

environment? Does he have some responsibilities to insure that that aspect of the teaching is being attended to?

A. He does, yes.

Q. All right.

A. The issue is not by each individual case. Just to insure the structure is intact, that he told, for instance, as you ask the question, be sure to tell me before we do this and that whether such-and-such has taken place.

Q. Okay. Does he have an independent duty to look at the record to insure that he's being toId?

A. No.

Q. He does not?

A. No, because it's not the standard of practice in teaching institutions or others for the attending to look at the record each day or at each contact.

Q. In your opinion?

A. In my opinion; and as professor and director of a teaching program, this is the standard which we set forth.

Q. Does that not leave the potential, Doctor, that you will not be apprised by the

residents and that you will miss something in the care of the patient?

A. It does have that risk, as in any calling, in any profession.

Q. But this is a profession involving life of people, Doctor.

A. The same as an airline pilot. It is the same thing. As corollary it would depend on receiving information from subordinates; and in failing to do so, he's exposed to risks, as well as all of the passengers on the airplane and this is a corollary situation. We depend on a certain system taking place.

Q. And in your analogy if, let's say, the navigator failed to give him crucial information, wouldn't it devolve upon him as the captain of the ship to be responsibile for the failure of the navigator for not giving him that information?

MR. GROEDEL: Objection.

A. If he knew in time.

Q. (BY MR. KAMPINSKI) Well, if he didn't know, isn't it his responsibility ultimately for the safety of the passengers?

MR. GROEDEL: Objection.

A. It would be the responsibility of the

employer of the navigator as well, the airplane.

Q. (BY MR. KAMPINSKI) I agree with you.

A. To make sure he hired a navigator that knows what is going on.

Q. Sure.

A. It's not an exact correlation, but this is exactly what happens in all professional encounters.

Q. That is fair. Is the attending responsible for the conduct of the residents in addition to the employer of the residents; that is, the hospital?

MR. GROEDEL: Objection. Go ahead.

Q. (BY MR. KAMPINSKI) More specifically, while dealing within that specialty of the attending.

A. As much as possible. As much as possible. He's responsible to see that the residents perform under his supervision in the manner in which they are supposed to.

Q. Do you have any opinions, Doctor, with respect to the cause of death of Mr. Smith?

A. My opinion as an orthopedist is limited to orthopedics.

Q. All right.

A. From what I have perused in the record, it is the opinion of others -- I mean, I'm just reading from others, that he had a heart attack or he had some cardiovascular collapse of some kind.

Q. Do you have any independent opinion of that?

A. No. I'm not competent to make that opinion.

Q. Do you have any opinion with respect to the conduct of the anesthesiologist, Dr. Lee, either in preop, during the operation or postoperatively with respect to his care of Mr. Smith?

A. Yes.

Q. Okay. What are your opinions regarding Dr. Lee's actions?

A. From what I can garner from the records, this is all of the information that I have, from the various depositions, that Dr. Lee was less than fully aware of the patient's condition prior to administering the anesthetic.

Q. Do you believe that the orthopedist, in this case Dr. Smith and/or the residents, had any independent duty to make him aware of the condition of the patient?

A. To the extent that they knew that information.

Q. Well, shouldn't they have?

A. Dr. Smith, from the record, did not know the information.

Q. Shouldn't he have, Doctor?

A. Ideally, yes.

Q. Whether --

A. Practically in the circumstances, not necessarily. I mean, in hindsight, it is very simple to say that he should have done this and that; but in the proper conduct of the care of these patients, Dr. Smith depends upon the residents or the cardiologist or somebody telling him things, which it appears did not occur.

Q. All right. Should Dr. Oliver, for example, the intensivist who was in the instensive care unit apprised, in your opinion, Dr. Smith of Mr. Smith's condition?

A. It would have been appropriate.

Q. And should the residents have apprised Dr. Smith of Mr. Smith's condition prior to the second surgery?

MR. TREU: Objection.

A. In my opinion if they knew that he was --

his condition was precarious, yes.

Q. (BY MR. KAMPINSKI) Are there other things with respect to Dr. Lee's conduct that you believe to be inappropriate, either preop, during the operation or postop?

A. I'm not, you know, an anesthesiologist and I rely, as do other orthopedists, upon the skill and conduct of the anesthesiologist to safely get our patients through this kind -- through all operations and this is just one of them, but I'm not skilled to analyze his treatment.

Q. Would that also be true with respect to his treatment of Mr. Smith in the recovery room?

A. Yes. I would not want to analyze that from a medical standpoint.

Q. Do you have any opinion with respect to Dr. Smith's conduct at the time that Mr. Smith was transferred to the recovery room?

A. Yes, I do have an opinion. I have read what I analyzed to be the sequence of events.

Q. What is your opinion about whether or not his conducts in leaving the hospital at that time and not checking back on his patient was appropriate?

A. He checked on -- from what I can tell

from the anesthesia record, he went in and checked on the patient. There was a note -- I just reviewed that a few minutes ago -- that he was there and he checked on the patient.

Q. What record are you talking about in the recovery record?

A. The recovery note and he left the patient in the hands of the anesthesiologist and did whatever else he was doing

Q. What condition was Mr. Smith in at the time that he left?

A. He was unstable.

Q. And should he have, as the attending, checked back to determine what the condition was later on of the patient?

A. Should is not -- I wouldn't answer it as he should have. I would say that it would have been of interest to him to find out. When we leave a patient in the recovery room as the orthopedist or in the intensive care unit, we leave them in the care of people far better skilled in taking care of them than ourselves.

I think it would have been appropriate for him to inquire, but he couldn't personally have been the one to take actions.

Q. I understand what you are saying, but aren't we really talking about someone wearing two hats in that context, one, as an orthopod and, two, as an attending?

A. While the patient is in an intensive care unit, it is the practice, at least as I understand it in our institution and St. Luke's, where I was formally on the staff, I know that when a patient is assigned to a recovery room or intensive care unit he is not directly under the care of the attending doctor, but under the care of those that are in charge, specifically if -- we don't write medical orders on the patient in an intensive care unit.

An orthopedist does not write orders on a person in the intensive care unit with regard to life support. Others do. To go further, if I give orders even in terms of positioning the patient or ambulating the patient or sitting the patient, those orders take the power of consultation, but the intensivist will override them.

He will say, we can't do that. That's inappropriate, so the patient really is under the care of the intensivist in the intensive care unit

or the anesthesia team in the recovery room. There's nothing from a medical standpoint that an orthopedist would do or in the case of many of us know how to do, because we are highly specialized.

Q. Well, if you saw that the patient wasn't receiving appropriate care, regardless of your specialty, as the attending would you not insure that he would then receive it at such time as you became aware?

A. Yes.

Q. All right. And that would be done more as the attending than as the orthopedic surgeon, right?

A. Yes.

Q. Do you know Dr. Smith personally?

A. I know him. We are not friends. I know him because he's been in the community for some time. He's a member of the orthopedic club, the Cleveland Orthopedic Club.

Q. And are there other organizations that you are both members of?

A. Not that I know of. I think that's the only one where we would see one another, at an occasional meeting of the Cleveland Orthopedic Club.

Q. You have testified for him before, have you not, Doctor?

A. I believe I did in another matter.

Q. And how often have you testified for Reminger & Reminger, let's say, in this particular year?

A. This year?

Q. Yes.

A. Two times, three times. I don't do a lot of this type of review and testimony thing. This is unusual in the course of my professional life.

Q. How about in 1986?

A. I don't have any accurate statistics. This is not a thing that I spend a great deal of hours in the year doing.

Q. How many times have you been consulted, let's say, in the last five years by just Reminger's office?

A. Six, eight. I don't know. I really don't know. I don't keep any independent record of that, so I don't have any way --

Q. I assume that you charge them?

A. I charge.

Q. Therefore, you get some kind of 1099

from them at the end of the year reflecting what they paid you?

A. Well, I might. From what I know from my bookkeepers, the checks don't necessarily come from them in their name. It might come from the people whom they represent, so I really have a great deal of difficulty ferreting out the answer to your questions.

Q. What were the two cases that you testified in in this particular year?

A. I remember doing a case that involved Dr. Smith in a wrist problem, but I don't remember the details. I remember it was somewhere during the last year. Maybe it was longer.

Q. Did you actually testify in that case?

A. I don't even know. I can't remember, whether I wrote a report or testified or did a deposition.

Q. My question is -- I guess I wasn't as clear as I should have been. How many times have you testified in the past year?

A. Testified for the Reminger office?

Q. Yes, sir.

A. I don't honestly know. Maybe once or twice. Depositions. I haven't been in the

courtroom for years. That I would probably remember a little more clearly, but what goes on here occasionally I can't keep track of.

Q. You remember testifying in a case involving one of my clients years ago for Reminger's office, don't you? You said you would remember court appearances more clearly, but you don't remember that?

A. Testifying in your office?

Q. No, in court.

A. In court?

Q. That's correct.

A. How long ago? I honestly don't remember. I remember seeing you somewhere, but -- a nice looking man, but I don't remember what the issue was.

Q. How about for other law firms, Doctor?

A. Occasionally I review cases of special interest to me and do depositions or give opinions, but it's not -- I would say that at the most maybe 1 percent of my professional work.

Q. And what other firms have you been retained by?

A. That's a good question. Who else do I --

Q. Jacobson, Maynard?

A. I have done a case for Jacobson. I have done cases For Fred Weisman. I have done cases for Larry Stewart. I have done cases -- I mean, just reviewing cases for people whom I know.

Q. Have you ever testified --

A. Arter & Hadden, Squire, Sanders, different people over the years. I have been in practice for 25 years. I got to know most of the people in town that are doing this kind of thing.

Q. Has your practice been primarily with the hand? Is that what you are --

A. No, the hand is a special area of my practice. I'm in general orthopedics. I do hip replacements. I did one this morning. I did one yesterday. I do major orthopedic surgery and I do arthroscopies. I do back surgery. I do hand surgery. Hand surgery was something that I derived -- have a special interest in. I had special training in and I have been a leader in, but I do the others as well.

Q. All right. Are there potential adverse consequences of the use of methacrylate in someone having a heart condition?

A. There are potential reactions in everybody. There's a potential for dips in blood

pressure when it is being administered. Usually once everybody is aware -- they are not permanent. As long as everybody involved knows that it is going to happen, it can be monitored. It passes very quickly.

Q. All right. Is that something that you, as the orthopod, would then tell the anesthesiologist so that he would be aware of that potential so he could monitor and deal with it?

A. Sure. This morning the anesthesiologist said, where are you going? Do you plan to use methacrylate? I said probably not, but we will let you know. That's how it is done.

Q. And as a teacher of residents, I assume that is something that you would apprise them of, that potential adverse effect?

A. Yes, that's well-known.

Q. There is the potential of dislocation after a hip replacement; is that correct?

A. Yes.

Q. And that can happen for a number of reasons?

A. Unfortunately, true.

Q. And from what I understand you to say, you, as an orthopod, rely on the anesthesiologist

to apprise you whether or not the patient is medically capable of undergoing a closed reduction in a situation where there is --

A. Yes.

Q. -- a dislocation?

A, Yes. I would expect him to veto or to postpone or take special precautions if he felt those were necessary.

Q. And you wouldn't check on any values that he put down in his pre-anesthetic assessment of the patient to insure that those values were correct?

A. Not necessarily.

Q. Would you sit down and talk to him about the status of the patient to insure that he was medically stable to proceed, especially if you hadn't received a medical clearance from someone else?

A. Not specifically I wouldn't. I would assume -- this is another one of those implied relationships. The implied relationship is that I would assume that he would tell me, that he would be duly diligent in taking care of the patient and let me know if there was something that I should know.

Q. Could he also assume that you were being duly diligent in knowing the status of the patient and apprising him of any problems that you were aware of that he might miss? Would that also be a fair assumption on his part?

A. They don't as a rule. The anesthesiologists don't as a rule rely upon that. I mean, they take it independently as a rule, an assessment of the record and the history and whatever else.

Q. Do you have any opinion as to whether or not the anesthesiologist's failure to become fully apprised of the patient's status had any contributing effect in his death? Do you have any such opinion?

A. I really don't have an opinion on that.

Q. Do you have an opinion as to whether anybody's conduct contributed to Mr. Smith's death?

A. Actually not. I can't arrive. He had medical problems and I don't -- I'm not competent to analyze all of the intricacies of the laboratory and clinical studies.

Q. As I understand it, your involvement is merely to comment on Dr. Smith's conduct and whether or not that was appropriate in the

circumstances?

A. Yes. That's all I can do as an orthopedist.

MR. KAMPINSKI: That's all I have.

MR. GROEDEL: Gentlemen?

MR. BONEZZI: Are you through?

MR. KAMPINSKI: Yes.

CROSS-EXAMINATION

BY MR. BONEZZI:

Q. Doctor, my name is William Bonezzi and I represent Dr. Lee, the anesthesiologist. I have some questions for you and I will try to be brief and to the point. If during my examination I ask a question that is inartfully phrased so that you do not understand, please tell me. I will assume, rightfully or otherwise, that if you answer the question, you understood what I was asking.

A. Fine.

Q. Now, you have indicated, I believe, just a moment ago to Mr. Kampinski that the orthopod relies upon the anesthesiologist for purposes of either vetoing or postponing a surgery and that would be based upon the anesthesiologist's review of the record; is that correct?

A. Yes. I added another phrase to that.

Q. Please.

A. Or taking whatever necessary actions had to be taken to deal with the issues.

Q. All right.

A. That's the relationship.

Q. Are you aware of whether or not Dr. Lee, the anesthesiologist that I represent, was also the anesthesiologist involved in the first surgery?

A. I don't know.

Q. Would that make a difference to you relative to your statement that the anesthesiologist does not rely upon the orthopedic surgeon to go ahead and make him aware of the patient's condition?

A. I really don't understand the question.

Q. I want you to assume that in this case Dr. Smith was aware of certain medical problems that Mr. Smith, the decedent in this case, had and I want you to further assume that Dr. Smith, the orthopedic surgeon, believed that the closed reduction had to be undertaken because of a so-called emergent situation and I want you to further assume that Dr. Lee was not the first anesthesiologist on the case in that he was not in the operating room during that first procedure.

A. Yes.

Q. And that Dr. Smith had information pertaining to the patient's condition. Under that set of circumstances, would you agree with me that Dr. Smith in that situation has a responsibility, ideally other otherwise, to convey whatever information he possesses to the anesthesiologist so that the anesthesiologist can go ahead and make the decision whether or not the surgery should go forward?

MR. GROEDEL: Objection.

A. In my opinion the answer to that is no.

Q. (BY MR. BONEZZI) Why?

A. This all happened in the course of one hospitalization in which all of that information is in the hospital record. The previous anesthesia record, the previous SICU record, everything is in the record and I think it is fair that Dr. Smith would rely upon Dr. Lee to make himself aware of all of that information, which is in the record, and probably also in his department records. That's all available.

If the situation were otherwise, where it was a different hospitalization, it was a difE?Eent hospital or there was some other -- that

information was not actually in hand, very easily in hand in that hospital chart, then I would agree with you.

Q. Are you saying that Dr. Smith is under no obligation to go ahead and impart any information that he may possess relative to the condition of the patient to the anesthesiologist prior to the procedure?

A. To me Dr. Smith's duty would be to tell the anesthesiologist be sure you read the medical record. That would tell it much more clearly than anything he could say.

Q. So at the minimum Dr. Smith has an obligation, in your opinion, to at least inform the anesthesiologist to review the record carefully to obtain whatever information would be necessary to allow the anesthesiologist to make a decision of whether or not there was a clearance for anesthesia?

MR. GROEDEL: Objection.

A. I think he has a right to expect -- you are asking me initially ideally or not. Ideally he could give that statement, but he has a right to expect in the chain of responsibility in the hospital that the anesthesiologist will avail

himself of all of that readily available information, which is right there.

Q. (BY MR. BONEZZI) Depending upon the amount of time that the anesthesiologist has?

A. Well, it doesn't take very long to do that. It is right there. It's not from the record room. It is right there in that same record.

Q. Are you of the opinion then that there does not need to be a give-and-take between the surgeon and the anesthesiologist prior to surgery relative to the condition of the patient, because, in your opinion, the anesthesiologist must read the record and that the orthopedic surgeon does not have either a responsibility or a duty to impart to the anesthesiologist any information that the orthopedic surgeon has relative to the condition of the patient prior to surgery, correct?

A. Ideally, yes. Just to tell him whatever he can tell him that he knows.

Q. So he should tell him?

A. He should tell him; but if he doesn't know, he has a right to assume that it's in the record and that the anesthesiologist will help himself to the information.

Q. Are you saying then that if the orthopedic surgeon doesn't know the information, then, of course, there's no --

A. He cannot tell him.

Q. He cannot impart that; but on the other hand, if he does have information, he should give that information?

A. If he has special information, which, in his judgment, is pertinent, then he should tell the anesthesiologist. To that I agree.

Q. Then there's a responsibility to do it?

A. What?

Q. There is a responsibility?

A. There is a responsibility to do it.

Q. Okay. You have reviewed the records pertaining to this admission?

A. Yes.

Q. And are you of the belief that the second procedure, the closed reduction, was an emergent situation?

A. Yes.

Q. Is there a difference, in your opinion, between an emergent situation and an urgent situation?

A. No. I think they're synonymous.

Q. One and the same?

A. Yes.

Q. So if you have an emergent or urgent situation, then, of course, surgery is indicated?

A. Right.

Q. And in this case surgery was necessary based upon a so-called emergent situation; is that correct?

A. Yes.

Q. Doctor, would you be kind enough to explain to me why this was an emergent situation in your opinion?

A. With a dislocation of a hip joint, a major joint is shocking and potentially it can cause vascular circulation problems irreversibly.

Q. Can I stop you if I might right there?

A. Yes.

Q. Where would the compromise occur, that vascular compromise?

A. In the leg. Nerve injury to the leg, bleeding into the area, which, in turn, can increase the susceptibility to infection and it is extremely painful and, as I say, shocking to the patient to be left with a hip out of joint.

Q. Were you able to determine from a review

of the records whether or not Mr. Smith was in a stable condition on the afternoon of the 17th of November prior to the time of his surgery?

A. Having reviewed the records, I would say he was in a marginal condition.

Q. What does that mean?

A. His hematocrit was 32 or 34, which is at the lower end of acceptable. It's not unfit, but it's not ideally fit. It is somewhere in between.

Q. Are you aware of whether or not there was a medical doctor involved in reviewing Mr. Smith's condition prior to the time of surgery?

A. Yes. Dr. Jackson saw him in the morning and his concern, as I gleaned from the record, was that the man had vomited and had some bloody material in his stomach, coffee ground material, and he was concerned about that.

Q. Am I correct in stating that it is extremely important, if not vital, to insure that the condition of the patient is stable prior to the time that that individual is taken to surgery?

A. It is important to get the patient as stable as one can given the emergence of the situation. We are not always privileged to have the patient at ideal condition to do the thing we

have to do.

Q. Are you saying in this case, based upon a review of the records and the information that you obtained from those records, that Mr. Smith's condition was so emergent that the procedure performed by Dr. Smith could not have waited until the following morning?

A. I believe that, yes. It should not have waited until the following morning. Irreversible damage could have occurred to the limb, which would have presented another whole reason for our meeting today. It is another problem that should be dealt with. You cannot leave a hip dislocated overnight.

Q. What major vessel would have been compromised from the period of time of, we will say, 4:00 in the afternoon on the 17th of November until the following morning which would have increased the risk of vascular compromise?

A. The major arteries in the area, the femoral artery, the arteries tributary to that. There are a lot of vessels around the hip joint, the major ones, the femoral artery and the deep femoral artery. They are under torque. The hip is dislocated. The blood flow is impaired.

Q. And can you tell me the degree of the dislocation?

A. Well, it is completely dislocated.

Q. And you reviewed the x-ray?

A. Yes.

Q. And when was the last time that you reviewed the x-rays?

A. In 1986 when I saw the x-rays and then returned them.

Q. By any chance were you able to determine from a review of those x-rays as to when the dislocation took place?

A. No. That was a matter -- I think from the medical record it was noted that morning.

Q. Do you recall whether or not in the nursing notes there was any evidence or suggestion that there was vascular impairment of the major vessels?

A. I don't recall.

Q. And I would assume correctly or otherwise that if there was a lack of pulse in the leg at any location in the leg that, of course, would be noted in the nursing notes, correct?

A. If they were looking for it. If the nurse had been specifically instructed to be

checking the pulses in the foot.

Q. Who would do that? Who would give that instruction?

A. That's a matter of order. That's an observation that would have to be specifically ordered for the nurse to check.

Q. By whom?

A. By a physician.

Q. By what type of physician?

A. By an orthopedist.

Q. Would it be good medical practice for the orthopedic surgeon to go ahead and include orders such as what you have just indicated following this type of procedure?

A. No, that is not standard. That is not a standard observation. That's unnecessary, to be checking the pulses at regular intervals after a successful hip replacement. It's not one of the standard orders.

Q. Are you aware of whether or not there was any evidence of circulatory compromise in Mr. Smith's leg prior to the time of the second procedure?

A. As far as I can remember there was none.

Q. Then if that is one of the major

considerations to look at relative to determining or declaring a situation being emergent or urgent and if there is a lack of that information, was the second procedure really an emergency procedure, Doctor?

A. Yes. I think what I have to explain is that one does not wait for something terrible to happen before taking action to prevent it. The fact that there was no documented circulatory impairment doesn't mean that he wasn't at significant risk for that to happen.

One can't wait for it to happen and then take action to reduce the hip. Then you are dealing with a much more complicated issue where vascular intervention would be necessary and perhaps ineffective. It is best -- the ideal treatment is to not let it happen; and by reducing the hip, you have reduced the possibility of that happening.

Q. It is important, though, is it not, to insure that the patient's condition is stable prior to the time that the patient is taken to the operating room?

A. It is important to see that he can tolerate the procedure to be done. There are

different levels of stability, depending upon whether he's going to have a brief anesthetic to reduce a dislocation or whether he's going to have a three-hour hip operation.

There are different levels. He has to be at a different level of health to tolerate one versus the other.

Q. And, in your opinion, his health, his health status, was sufficient enough or stable enough prior to the time of the second procedure to allow that second procedure?

A. I'm not saying that is my opinion, that he was stable enough. I'm just saying --

Q. Well, did the records indicate that?

A. The records indicate that his condition was marginal; that is, with diligence it was permissible to do that. If one were on top of it, one could proceed. One should be aware of what that condition was.

Q. The orthopedic surgeon you are talking about?

A. The anesthesiologist.

Q. And the orthopedic surgeon?

A. And secondarily the orthopedic surgeon. The orthopedic surgeon cannot proceed without the

anesthesiologist giving him an anesthetic. That's the first step and, yes, then to kind of concur in the fact that the procedure is going to be done.

Q. Did you review the operative note of Dr. Smith relative to the second procedure?

A. Yes.

Q. And upon reviewing that document, were you able to determine whether or not the procedure, itself, involved any type of complications or involved any type of effects that were not thought of prior to?

A. I would have to review the record again to avail myself of that. If I can have a moment.

Q. Why don't you take a moment?

A. Yes.

MR. GROEDEL: The second surgery you are asking him?

MR. BONEZZI: Yes.

A. It is a one-paragraph note which indicated that -- I would say that was a routine closed reduction of a hip dislocation.

Q. (BY MR. BONEZZI) What type of force was used?

A. He says a large amount of force.

Q. Is that routine?

A. It can be. I think it's a good sign.

Q. Why is it a good sign?

A. Well, it is a good sign. It means that the hip is not inherently unstable. I think I would put that in a note, that it's not likely to come out again.

Q. Was the hip in such a position as you have just described enough to take a look back at hindsight and determine that the necessity of that surgery was not as emergent as first thought?

A. No, quite to the contrary.

Q. It would be the other way around?

A. The fact that the hip is dislocated is in itself a problem. I mean, that doesn't bear on the necessity of reducing it.

Q. Oh, I never asked you whether or not there was a necessity to reduce it. That was a given. My question always has been directed to whether or not it had to be reduced at that point in time or whether or not the procedure, itself, could have been held back at least until the following morning?

A. The finding in that operative note doesn't answer that question one way or another. The fact that it took a little force or a lot of

force is irrelevant. The man had a dislocated hip. It had to be reduced.

Q. And the amount of force utilized during the procedure, would that in any way cause any type of diminishment in cardiac output or involve any type of cardiac problem?

A. I would not expect that it would. The patient had a spinal anesthetic.

Q. Now, you testified before when Mr. Kampinski asked you questions involving Dr. Lee. I believe you stated in your answer relative to Dr. Lee that he was less than fully aware of the patient's condition prior to the surgery. Is that correct?

A. I believe that's right. You have to review with the court reporter. As I recall, I testified to that.

Q. I don't want to mischaracterize your testimony. Does that sound about right?

A. Yes, I think that would be a fair statement.

Q. Are you aware of whether or not prior to the time that the second procedure commenced if there was any communication between Dr. Jackson, Dr. Smith and Dr. Lee?

A. I don't know the answer to that. It doesn't appear in the record. I don't know.

Q. Are you aware of whether or not there was any communication between Dr. Jackson and Dr. Smith prior to the second surgery relative to the condition of the patient?

A. I don't know.

Q. Would I be correct in stating that if the medical doctor, Dr. Jackson, possessed information relative to the patient's condition, that he should impart that information to the orthopedic surgeon so that eventually it would also get to the anesthesiologist?

A. If, in fact, Dr. Jackson was apprised of the fact that the patient was going to the operating room -- I don't know from the chart. I can't remember if the chart indicates that or not; but if Dr. Jackson knew that he was going to the operating room and if he possessed information to cause concern in his mind, then it would be appropriate for him to tell Dr. Smith and/or the anesthesiologist of his concerns.

Q. And I don't believe the record indicates, does it, if there was any type of conversation between Dr. Jackson and Dr. Smith prior to the

procedure?

A. I cannot recall. I'm trying to separate some things that I have looked at in depositions and what was in medical records. I'm a little -- I'm trying not to interpose the two bits of information.

Q. I believe that the records indicate that both the hematocrit and hemoglobin levels were taken twice on the 17th, one somewhere around 6:30 a.m. or 6:40 a.m. and another one around I think 11:00 if I'm not mistaken?

A. Yes.

Q. And that there appeared to be from those levels a decrease in the hematocrit and hemoglobin levels, correct?

A. Yes.

Q. What is the significance of that?

A. Well, the significance is that he's either bleeding or he's receiving more fluids that dilute the blood that he has or that there's some -- there's a variance in the laboratory values based on technology.

Q. Are you aware of whether or not Dr. Jackson was attempting to keep track of both the hemoglobin and hematocrit levels on the 17th of

November?

A. Yes, it is my recollection, as I said before, he was concerned about the gastric bleeding and that was the signal to him to order these tests.

Q. Do you recall whether or not the records indicate if that information was imparted to Dr. Smith?

A. I don't know.

MR. KAMPINSKI: By imparted you mean verbally as opposed to in the record?

Q. (BY MR. BONEZZI) We will take verbally first.

A. I don't know the answer to that.

Q. Is it the responsibility of the orthopedic surgeon prior to the surgery to take a look at the progress notes and the orders on the day of surgery prior to the time that the surgery commences?

MR. GROEDEL: Objection, asked and answered.

A. Not necessarily in this setting.

Q. (BY MR. BONEZZI) But it would be good medical practice to do it, wouldn't it?

A. It would by ideal; but as I pointed out

in answering Mr. Kampinski, in the teaching hospital structure, the resident is the overseer of the record and it is expected or he has a duty to do that review for the orthopedist.

Q. But it would still be good medical Practice to do it, correct?

A. It would still be good medical practice.

MR. BONEZZI: I don't think that I have anything further. Thank you, Doctor.

CROSS-EXAMINATION

BY MR. TREU:

Q. Doctor, just a couple of questions. Let me ask you initially do you have any opinions or any criticisms of the hospital or any of the residents in this case?

A. I don't have an opinion in that regard.

Q. And as I understand your testimony -- let's start like this. There are two ways that a resident can get information to an attending, correct? One is orally and the other is through the record, correct?

A. Yes.

Q. And it's my understanding that it's your testimony that the resident has a duty to impart that information to the attending orally?

A. I think so. That's my opinion.

Q. Putting it in the record is not adequate to your knowledge?

A. It's not entirely adequate. He's serving as the lieutenant in the case. He has a duty under the structure of these programs to tell the attending, to alert him orally, not to wait until he sees it in the record if it is a pertinent item.

Q. And was it your testimony that the attending orthopedic surgeon is responsible for the conduct of the orthopedic residents?

MR. GROEDEL: Objection.

A. As much as he can in the care of that patient.

Q. (BY MR. TREU) Right.

A. The department chairman has overall responsibility, but he has the responsibility as much as he can control the behavior of the residents in the management of that case and to supervise them.

MR. TREU: Okay. Thank you.

MR. MEADOR: I don't have any questions. Thank you, Doctor.

CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Just a couple follow-ups, Doctor. The operative note that you referred to, which is page 153 of the record, that was apparently prepared by the resident, Dr. Gill, and then countersigned by Dr. Smith?

A. Right.

Q. And the last sentence of that, could you indicate what that is for the record, Doctor?

A. "The patient was then transferred to the recovery room in good condition and tolerated the procedure well without intraoperative complications."

Q. From your review, Doctor, of the recovery room record, which is page 155, I think you told me before that -- and I'm sorry, but I'm going to have to paraphrase it, because I don't have it down here, but I think you said that he wasn't in very good condition at that time?

A. Well, yes, upon arrival in the recovery room he was cool and diaphoretic and there was some other changes, but there was another note, the page just before, which is an operating room record, one of a number, which indicates the

condition upon leaving the operating room and that tells us a little different -- gives a little different picture.

The patient's condition is fair and that's the page just before, so I'm trying to reconstruct a picture.

Q. He certainly was not in good condition at the time that he arrived in the recovery room?

A. I agree with that, based on the record.

Q. When you indicated that it was a good sign to use "a large amount of force," I assume you are now referring to a good sign orthopedically in terms of the end result orthopedically and it was not a good sign in terms of what effect using a large amount of force may have on a medically unstable person?

A. Yes, I'm talking about the prognosis of the hip reconstruction, that it is a good sign.

Q. Specifically with respect to the resident's duty to advise the attending of information, would you expect that if there was information relative to an orthopedic patient having sustained myocardial damage, that that information would be imparted to the attending?

MR. TREU: Objection.

A. If the resident knew that, yes.

Q. (BY MR. KAMPINSKI) How about if the other employee of the hospital knew; that is, the intensive care unit specialist? Is that information that you would expect that he would impart to the attending?

MR. TREU: Objection.

A. I would think so.

Q. (BY MR. KAMPINSKI) And how about the evidence of gastrointestinal bleeding, a guiac coffee ground emesis? Is that information that you would expect the resident to impart to the surgeon?

A. Yes.

Q. And information following the hematocrit and hemoglobin? That is also information that you would impart?

MR. TREU: Objection.

A. It is a matter of relatively, if it is a precipitant fall or if it were something unexpected --

Q. (BY MR. KAMPINSKI) How about if it was in conjunction with guiac coffee ground emesis?

MR. TREU: Objection.

A. If it is significant. All patients on

the third day after a hip replacement would show a drop in hematocrit or hemoglobin. If the drop is greater than that expected and if at the same time the patient had some evidence of gastrointestinal bleeding, yes.

Q. In this circumstance that was present, was it not, Doctor?

A. Well, yes.

Q. All right. And you would expect that information then to be imparted by the residents to the attending?

A. Yes.

MR. KAMPINSKI: That's all. Doctor, you have a right to read your testimony. You have a right to waive your signature.

THE WITNESS: I'll waive it.

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THE STATE OF OHIO, )
) SS: CERTIFICATE
COUNTY OF CUYAHOGA. )

I, Kerry L. Paul, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that AVRUM I FROIMSON, M.D. was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above set forth was reduced to writing by me by means of Stenotypy and was subsequently transcribed into typewriting by means of computer-aided transcription under my direction; that said deposition was taken at the time and place aforesaid pursuant to notice; that the reading and signing of the deposition by the witness were expressly waived; and that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I hereunto set my hand and seal of office at Cleveland, Ohio, this 17th day of November, 1987.

Kerry L. Paul

Kerry L. Paul, RPR, Notary Public
Within and for the State of Ohio
540 Terminal Tower
Cleveland, Ohio 441.13

My Commission Expires: October 12, 1988.