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

- - -

IN THE COURT OF COMMON PLEAS

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MARTIN T. McCUE,
Plaintiff,

v.

PARMA COMMUNITY GENERAL HOSPITAL, et al.,

Defendants.

Case No. 326206

- - -

THE DEPOSITION OF RICHARD A. GITTINGER, M.D.

WEDNESDAY, DECEMBER 10, 9997

- - -

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APPEARANCES:

On behalf of the Plaintiff:

DAVID B. MALIK, ESQ.
8228 Mayfield Road
Chesterland, Ohio 44026
(440) 729-8260

MARK RUFF, ESQ.
Hoyt Block Building
700 West St. Clair
Cleveland, Ohio 44113
(216) 687-1999

On behalf of the Defendants Southwest Orthopedics and Dr. Gittinger:

STEPHEN E. WALTERS, ESQ.
Reminger & Reminger
The 113 St. Clair Building
Cleveland, Ohio 44114
(216) 687-1311

On behalf of the Defendant Parma Community General Hospital:

JOHN W. JEFFERS, ESQ.
Weston, Hurd, Fallon, Paisley & Howley
2500 Terminal Tower
Cleveland, Ohio 44113
(216) 687-3214

On behalf of the Defendant Dr. Lopez-Valez:

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JOHN P. SLAGTER, ESQ.
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Cleveland, Ohio 44114
(216) 621-5300

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Q. Doctor, my name is David Malik. I have some questions to ask you regarding Martin McCue.

If there's anything that you want me to rephrase for any reason, let me know, okay?

A. Okay.

Q. It's not the grand inquisition and just give me straightforward answers as best you can.

For the record would you please state your full name?

A. Richard Alan Gittinger.

Q. Your business address?

A. 6681 Ridge Road, Parma, Ohio.

Q. Your occupation?

A. Orthopedic surgeon.

Q. Briefly tell us about your education.

A. Undergraduate study at John Carroll University, medical school at Case Western Reserve, my residency at St. Luke's Hospital in Cleveland, Ohio.

Q. Brief description of your employment the last 10

years.

A. 1989 started with Southwest Orthopedics, which is the -- at the 6681 address. And that was directly from our residency.

Q. Okay. Your social security number?

A. 290-66-7644.

Q. Marital status?

A. Married.

Q. Office phone number?

A. 842-1570.

Q. Okay. Have you ever had your deposition taken before?

A. I have.

Q. At the times when you had your deposition taken before were you a plaintiff, a defendant or a witness?

MR. JEFFERS: objection.

I want time to get my objections in, and I will object to this line.

A. Expert witness.

Q. Okay. Can you tell me the cases in which you were an expert witness?

A. I don't recall the details.

Q. Were any of them medical malpractice cases?

A. No.

Q. Were they all personal injury cases?

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A. I would suspect they were, yes.
Q. Were they in Cuyahoga County?
A. Yes, they were.
Q. Have you ever testified at a trial?
A. No, I have not.
Q. Have you ever had your deposition taken by videotape?
A. Yes, I have.
Q. Have you testified for both plaintiff and defendant?
A. I don't understand the question.
Q. Have you been an expert witness for the plaintiff side in any of those cases?
A. I have always been the expert witness for the patient that I treated.
Q. Have you ever been named as a defendant in a medical malpractice case other than this?
MR. JEFFERS: Objection
A. I have been given several 180 day letters and I may have been named in one or two suits. Again, the details I'm not sure of.
Q. In Cuyahoga County?
A. Yes.
Q. Have you ever been named as a defendant in any type of litigation?

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MR. JEFFERS: Object.
MR. WALTERS: other than malpractice?
Objection, go ahead.
A. No.
Q. Have you ever been a plaintiff in a case?
A. I don't understand what plaintiff is.
Q. Have you ever sued anybody?
A. I have not, no.
Q. That's refreshing.
During 1995 and through 1996 did you have privileges at Parma Community Hospital?
A. Yes, I did.
Q. And did those privileges extend to the emergency room?
A. Yes, they did.
Q. Were there any limitations on those privileges?
A. None.
Q. Did those privileges include the authority to perform surgery at Parma?
A. Yes, they did.
Q. In 1995 how long had you had privileges?
A. Since 1989.
Q. What is Southwest Orthopedics?
A. Southwest Orthopedics is a corporation which currently involves four orthopedic surgeons who practice solely orthopedic surgery based out of Parma Hospital.
Q. Is Dr. Karns in that?
A. Yes, he is.
Q. Did Dr. Karns treat Mr. McCue?
MR. JEFFERS: I couldn't hear you.
MR. MALIK: Did he treat Mr. McCue.
A. Not directly.
Q. What was his involvement.
A. Dr. Karns was taking weekend call for me while Mr. McCue was in the hospital during his post-op period.
Q. Was his involvement in Mr. McCue's treatment limited to telephone conversations?
A. That, and he would round on Mr. McCue on Saturday and Sunday of the weekend he was in. He made rounds meaning he went in and visited him, made sure, physically saw him.
MR. WALTERS: Post-op, can we get him dismissed? Go ahead.
BY MR. MALIK:
Q. Are you an employee of Southwest Orthopedics?

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Page 9

A. Technically I am, yes.
Q. Are you an employee of Parma Community Hospital?
A. I am not.
Q. Were you ever an employee of Parma Community Hospital?
A. I was not.
Q. Does Southwest Orthopedics issue you a W-2?
A. Yes, they do.
Q. Are you an employee of any other entity?
A. I am not.
Q. Is there a contract that exists between Southwest Orthopedics and Parma Hospital?
A. None.
Q. Is there a contract that exists between you as a physician and Parma Hospital?
A. None.
Q. Is there a contract that exists between you as a physician and Southwest Orthopedics?
A. Yes.
Q. Would you at some point in the near future give your attorney a copy of that?
A. Yes.
MR. WALTERS: We won't necessarily give it to him, but we will make a decision in that regard as to its

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relevance, but go ahead.
BY MR. MALIK:
Q. Did there come a time when you received a request for consultation regarding Martin McCue?
A. Yes.
Q. And how did that come about?
A. Mr. McCue was seen in the emergency room the morning or the day of his injury. He was actually treated by the emergency room physician and then the extremity was -- the affected extremity was splinted and he was discharged home from the emergency room with instructions to follow up, to give my office a call, make a follow-up appointment.
The same day through the answering service Mr. McCue got in touch with me. I happened to be on call for the group that night so I called Mr. McCue at home and basically he said he was in so much pain that he felt something needed to be done. And I wasn't sure of the situation seeing as I never met the gentleman or knew the specifics, so I asked that he return to the emergency room and I met him there that same evening and evaluated him then.
Q. The referral from the emergency room, was that normal procedure for the emergency room to refer cases to you?

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A. Yes.
Q. Are you aware of whether or not Southwest Orthopedics is the exclusive referral network for Parma Community Hospital?
A. We are not.
Q. Do you recall what day of the week this was?
A. Monday.
Q. And when you received the phone call where were you?
A. I don't recall.
Q. But you weren't at the hospital?
A. I suspect I was at home.
Q. When you got to the hospital and you saw Mr. McCue what occurred?
A. Again, from review of my records, I don't remember specifically, but from review of my records I examined him, I actually took a history from him, I examined him, reviewed x-rays and then splinted the extremity and he was again discharged home with plans to follow up in the office within a week's time.
Q. Do you recall whether or not Mr. McCue was cooperative?
A. Yes, he was.
Q. During the course of your treatment was there ever a time when he wasn't cooperative?

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A. None that I can recall.
Q. Did you seem to be able to communicate well with him?
A. Yes.
Q. So is it a fair statement to say you were comfortable with the dialogue that occurred between the two of you?
A. Yes.
Q. Now, you indicated that you took a history from Mr. McCue. Feel free to refer to your note, but can you briefly tell me what that history was?
A. Sure.
MR. WALTERS: still in the emergency room?
A. Still in the emergency room, correct, I even have a written copy of it here. A 38-year old maintenance worker who had a granite gravestone fall on the lateral aspect of his right knee in the afternoon, that afternoon. He recalled the tearing sensation about the medial aspect of that knee. The leg was trapped under the gravestone for about 30 seconds.
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complaints of severe knee, calf and ankle pain with a numb feeling from the thigh to the foot. And then just that his current medications include several medications for asthma.
Q. I want to ask you a little bit about the asthma.
MR. JEFFERS: The what?
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Q. Other than the patient telling you that he had asthma was there any other dialogue about the asthma in the emergency room?
A. None that I could recall.
Q. Was there any reason at that time for you to be concerned at all --
A. No.
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A. Pain medication.
Q. And who prescribed that?
A. I know I had prescribed it once I had seen him in the office, but apparently I have at the bottom of

Page 14

my notes that he has Vicodin at home. I don't know who prescribed that.
Q. And which note is that, what's the date on that note?
A. This is 09-25-95, my initial emergency room visit with him.
Q. So you're not aware of whether or not it was Dr. Markowitz that prescribed the Vicodin at that time?
A. No, I'm not.
Q. Okay. Now, the records indicate the first office visit was on 10-02 of '95; is that correct?
A. Correct.
Q. And was that visit at your offices at Southwest Orthopedics?
A. Yes, it was.
Q. I was unable to read the handwritten portion of the chart; could you read that?
A. Sure. It says medial knee, posterior calf, posterior ankle, venous ultrasound, one week.
MR. JEFFERS: You're reading from that date now.
THE WITNESS: October 2, 1995.
BY MR. MALIK:
Q. I assume you've had the opportunity to review

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the entire note?
A. Yes, I have.
Q. And you did that prior to your deposition?
A. I did, yes.
Q. Other than your office notes what else did you review?
A. I reviewed the hospital chart and I reviewed our entire office chart of Mr. McCue.
Q. When you say the hospital chart, is that the hospital chart from Parma?
A. Correct.
Q. Did you review any University Hospital records?
A. I did not.
Q. There was an indication in one of your notes during one of your office visits that Mr. McCue had asked you to send a letter -- or to contact Dr. Gillota?
A. M-hm.
MR. MALIK: This is Victoria, she is our paralegal.
BY MR. MALIK:
Q. Did you ever send Dr. Gillota a letter?
A. In fact I had on several occasions. I usually made a notation to that effect at the end of each of my office notes. In fact, on January 15, send letter to

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Dr. Gillota, and that was the one time, correct.
Q. Okay. *Your* attorney sent me a copy of that letter which I misplaced; do you have another copy of it?
A. When we send letters to Dr. Gillota, basically what we are doing is including a letter, basically a face sheet, and then we send a copy of these actual office notes with it, so that's basically what gets done.
Q. Okay.
A. These would be the face sheets that go along with the office notes.
Q. Okay.
MR. JEFFERS: I would like copies of those.
BY MR. MALIK:
Q. I just want to make the January 18th Southwest Orthopedics letter Exhibit A and the April 4, '96 exhibit B.
Is everything that you reviewed with you today?
A. Yes.
Q. And we will go through that a little bit later.
Why is part of the chart handwritten and part of the chart typed?
A. You're making reference to this?

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Q. Yes, the office notes, right.
A. What I typically do is when I am seeing a patient in the office I will take this portion in with me such as this. While I'm talking I will make just small notes, handwritten notes, basically just cues so that I can come back and dictate the note, formal note, and that's what the handwritten portion is.
Q. Do you have a tape recorder with you?
A. I do not, no.
Q. So I'm a little unclear. The basis of the typewritten note is the handwritten part?
A. These are nothing more than small mental cues as to my longer formal dictation that I do after the patient leaves the office.
Q. And what period of time generally lapses between the time you write your office note?
A. Could be anywhere from minutes to hours. Always the same day.
Q. So then what the patient tells you you transform into mental cues which are your handwritten portion, correct?
A. Correct.
Q. And then I'm still unclear, how does it get typed?
A. There is a dictation machine on my desk in my

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office that I sit down at and then dictate the notes, and then there's a transcriptionist in our office who will from that tape recording type the notes.
Q. Who is the transcriptionist or who was the transcriptionist?
A. We have several that work in our office and I would -- their initials are always at the end of the note, so I can see here there's at least two that had worked on this particular chart.
Q. Who was that?
A. One of them would be Lee Kitanic and the other would be Pat Ovan.
Q. What happens to the dictation?
A. The actual tape itself?
Q. Yes, sir.
A. Gets erased to be reused.
Q. Other than your office notes and what you brought with you today, are there any other extraneous materials, tapes, documents, notes pertaining to Mr. McCue?
A. Perhaps some x-rays.
Q. Okay.
A. But other than that I'm not aware of anything.
Q. X-rays taken in your office?
A. Those x-rays I actually have. X-rays taken at

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Parma Hospital I don't have.
Q. I'm assuming when you were in the emergency room with Mr. McCue at Parma that you reviewed x-rays?
A. Yes, I did.
Q. In terms of the presentation of his injury was there anything out of the ordinary or unusual? Was it pretty straightforward?
A. M-hm, yes.
Q. In terms of access to your notes in your file on Mr. McCue, other than yourself, who has access to the file?
A. The employees of the office.
Q. Are there any written policies or procedures as to the format which the notes are supposed to take?
A. No, sir.
Q. Any special written directions to the typist at all?
A. None that I'm aware of.
Q. Do you expect the transcriptionist to record the information verbatim as you dictate it?
A. I expect that, yes.
Q. When you do your dictating are you specific in the sense that you dictate where a period is when a sentence ends?
A. I tend to do that, yes.

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MR. MALIK: Is this a [illegible] course or are we going to get [illegible]
MR. MALIK: We are going to get there.
MR. WALTERS: I'm sorry. As I get older --
MR. MALIK: There's a method to my madness.
MR. WALTERS: I understand.
BY MR. MALIK:
Q. Let's go to the next visit on 10-09 of '95. What I want you to do is summarize the highlights of that note.
A. Two weeks from his injury, improvement in his pain, the initial splint was removed, he had ecchymosis of the knee and lower leg. Still remained markedly tender along the medial aspect of the knee, as well as the posterior calf. His neurologic exam was intact and there was no obvious instability, but that was considered secondary to muscle guarding.
Basically I felt he was improving and I wanted him to start working on knee motion. I asked that he maintain his nonweight bearing status and was to return in one week.

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At [illegible] time did you still feel comfortable in communicating with him what your wishes were?
A. Yes.
Q. Was he able to communicate what his condition was?
A. Yes.
Q. Let's go to the next visit. I believe that's 10-11.
A. No. 10-16.
Q. Is there a note on 10-11?
A. 10-11 was that Vicodin, 30 tablets, had been called into his pharmacy.
Q. 10-16, can you summarize the highlights of that, please?
A. Mr. McCue was three weeks from his injury, still having pain mainly at night. Admitted he was probably more afraid of his pain than actually experiencing pain. Still ecchymosis about the knee and calf, still tender.
Diagnosis remained unchanged and he was started on physical therapy at that time.
Q. Any problems communicating with Mr. McCue?
A. None.
Q. Let's go to the next visit on 10-30 of '95, please, would you summarize the highlights?

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A. About five weeks from the injury, had progressive improvement. Pain was now isolated to the medial aspect of the knee and some about the ankle.

Exam of the leg showed some muscle atrophy, still tender along the medial side, moderate knee motion. X-rays of the ankle were done and shown to be negative for fracture.

And then basically the plan was to start him on anti-inflammatory medication, continue with physical therapy, return in one month.

Q. What is it, Lodine?

A. Lodine, a nonsteroidal anti-inflammatory medication, basically cuts down the inflammation, swelling, pain.

Q. I believe the next visit was on 11-02 of '95.

A. No, 11-17-95.

Q. What was 11-02 of '95?

A. A prescription for Vicodin, 20 tabs.

MR. JEFFERS: what was the date of that one?

MR. RUFF: 11-02.

BY MR. MALIK:

Q. Let's go to 11-17 of '95; would you please read the highlights of that note?

A. That was a prescription for Vicodin as well. It

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was not an office visit.

Q. On when?

A. 11-17-95.

Q. Next visit, 11-27-95?

A. Correct.

Q. Would you summarize the highlights of that note?

A. Two months from injury, still not sleeping well because of knee pain throughout the night. Most of his pain still about the medial side of the knee. He is improving and he was able to walk without significant discomfort.

Examination of the leg shows that he has regained good motion, but now he has a positive Lachman's test which is a test we use to diagnosis a tear of the anterior cruciate ligament.

At that time I suggested only nonoperative treatment, with surgery only if necessary, and then he was to continue physical therapy.

Q. Let's talk about physical therapy for a minute. That was the first mention I saw in the records of physical therapy. Did I miss something?

A. I believe so.

MR. WALTERS: Yes, you did.

MR. JEFFERS: He prescribed physical therapy earlier. He testified to

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it.

A. October 9th -- I'm sorry, October 16th.

Q. Okay. What kind of physical therapy?

A. Physical therapy at this time to begin working on joint motion and muscle strength to the affected extremity.

Q. Did you prescribe the place where he should go?

A. Sent to Parma Hospital for therapy.

Q. Next visit is on 12-18 of '95, read your handwritten portion there.

A. I'm sorry, December 18th?

Q. M-hm.

A. Ankle much better, posterior lateral, excellent motion, grade 1 MCL, positive Lachman's, night pain, in one month.

Q. If you could summarize the highlights of the remainder of the note?

A. Continuing to make progress, walking longer distances, constant medial aching about the knee. Physical therapist suggested an anterior cruciate ligament brace because he demonstrates significant instability.

On exam he again had full knee motion. The medial collateral ligament was tightening up nicely and he continued to have his positive Lachman's test and

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muscle atrophy.

Q. Up through this point did you still feel comfortable with your ability to communicate with Mr. McCue?

A. Yes.

Q. And was he able to enumerate what his problems were to you?

A. As I recall, yes.

Q. Let's then go to the January 15th of '96 note. Would you please read the handwritten portion for me?

A. Brace much improved, two and a half to three hours per session, knee pain all night, patellar instability, quad and medial patellar femoral pain, taped. Lodine no help. Vicodin one-half each night and Phil Gillota.

Q. Would you summarize the highlights of that note?

A. Sure. Four months from injury, has obtained his knee brace, noted tremendous improvement in function with the brace, strength therapy.

During the therapy he developed some patellar femoral pain which improved with patellar taping. Continues to use Vicodin each night for pain. Anxious to proceed with ligament reconstruction as soon as possible.

Exam showed he had regained some of his muscle

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mass, full motion, medial collateral ligament was clinically healed, Lachman's test remained positive.

X-rays were taken of the knee and showed complete healing of the fibular fracture. Felt the patellar femoral pain was due to quad muscle weakness and patellar maltracking.

Basically the inflammation in the knee had subsided and he was ready to proceed with anterior cruciate ligament reconstruction. The planned surgical procedure was discussed. The rehab protocol and the associated risks of the surgery were reviewed.

I asked that Dr. Gillota be notified of the upcoming surgery since he has a history of mild asthma, and surgery was scheduled for 02-01-96.

Q. Now, did you ask that Dr. Gillota be notified or did the patient ask?

A. According to my note it says that he asked that I notify Dr. Phil Gillota.

Q. Is this January 18, 1996 letter the notification?

A. Yes.

Q. Was there any other communication to Dr. Gillota other than this?

A. None that I recall.

Q. I'm going to ask you to, and it's a short

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portion, read into the record the portion of the note that starts with planned surgical procedure, rehab protocol to the end.

A. Planned surgical procedure, rehab protocol and associated risks including anesthetic risk, infection, deep vein thrombosis reviewed. Patient is aware he will need to be on crutches once again, six weeks post-op.

He asked that I notify Dr. Phil Gillota of the upcoming surgery since he does have a history of mild asthma. Surgery scheduled for 02-01-96, Parma Hospital, on an extended recovery basis. Vicodin renewed. Theraflu renewed until surgery. Send letter to Dr. P. Gillota.

Q. Now, specifically what was the planned surgical Procedure?

A. Arthroscopic evaluation, anterior cruciate ligament reconstruction using patellar tendon autograft and a meniscal surgery as needed, should there be a meniscus tear found.

Q. Can you define for me rehab protocol?

A. The rehab protocol that I use for anterior cruciate ligament reconstruction involves crutch ambulation with partial weight bearing for six weeks, use of a brace for three months after surgery, and

Page

during that time extensive physical therapy.

Q. Will you define for me associated risks including; anesthetic risk?

A. When I speak to patients regarding anesthesia it is almost -- it is typically my routine that I will say in cases such as this that this procedure can be done under either a general anesthetic or a spinal anesthetic, and that decision is between the patient, between the anesthesiologist and between the physicians, primary care physician, if indicated.

In either case the anesthesia causes stress upon the various systems including the heart, the lungs, the kidneys, whatever, and therefore, again, those are the risks I discuss in regard to the anesthesia.

Q. Okay. Let's role play for a moment. I want you to assume that I'm Mr. McCue.

Other than what you just told me, is there anything else that you're explaining to me about this surgery that --

MR. WALTERS: First of all, let me object to the let's role play for a moment. I *think* if the question is, is there anything else that was said to this patient about the risk, that's a fair question.

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I'm not going to get into role playing, but go ahead, Doctor.

BY MR. MALIK:

Q. If you're not comfortable, that's fine, doesn't matter.

MR. WALTERS: I am. Go ahead, Doctor.

A. I would ask if you had any questions, and if so, I would answer them appropriately. On occasion and most times I do actually bring out models of a knee and even some illustrations that we have in our office.

Q. Okay.

A. To help.

Q. Now, specifically what did you tell Martin McCue?

A. Other than what I have in my notes, I don't recall.

Q. Other than what you have in your written note on January 15th of 1996?

A. No, what I have in my dictated note.

Q. For what period of time?

A. I don't understand the question.

Q. You said other than in your dictated note. Which dictated note are we talking about?

MR. WALTERS: The question

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was what did you tell him on January 15, 1996.
MR. MALIK: well, that's what I want to know.
BY MR. MALIK:
Q. Is that what we are limiting it to, January 15 of 1996?
A. I feel confident that my notes are accurate no matter what date.
Q. Okay. Listen to the question, please.
You explained according to your note associated risks including anesthetic risk to Martin McCue, correct?
A. M-hm.
Q. Other than on January 15th of 1996 did you explain it to him at any other time?
A. Not that I can recall.
Q. Okay. You indicated infection, deep vein thrombosis reviewed.
Can you explain to me what that means?
A. Again, I would tell patients that with any operation, no matter whether it be minor, major, there's also the risk of an infection. And any time there is injury, surgery, trauma to a hip, a knee, a thigh, there is always a chance of a phlebitis or deep

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vein thrombosis developing in that leg.
Q. As we sit here today do you recall the exact words that you used to describe the anesthetic risk to Martin McCue?
MR. WALTERS: He already answered that, but go ahead.
A. The exact words, no.
Q. You indicated in your testimony that you would explain to the patient that they could have a general or a spinal, correct?
A. M-hm.
Q. That was the word you used, or.
A. That this procedure can be done under a general or a spinal anesthetic.
Q. Did there come a time ultimately when you found out the kind of anesthesia that Martin McCue had?
MR. JEFFERS: The kind that he had, in the past tense.
BY MR. MALIK:
Q. During the surgery --
MR. WALTERS: In February?
Q. In February, correct.
A. The question again is?
Q. Did there come a time when you learned the kind of anesthetic that he had in February?

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MR. WALTERS: He was there.
A. I was in the room.
Q. And what did he have?
A. He had a general anesthetic.
Q. Did he have a spinal?
A. He had a spinal injection.
Q. A spinal injection of what?
A. Of morphine.
Q. On January 15th of 1996 did you tell Martin McCue that he was going to have a spinal injection of morphine?
A. I did not.
Q. Why not?
A. Because that decision is up to the anesthesiologist.
Q. On January 15th of 1996 were you aware that it was a possibility Mr. McCue would have had a spinal injection?
A. Yes, only in that my patients do receive spinal injections from time to time.
Q. For this particular surgery, correct?
A. For this and many other surgeries.
Q. Okay. Did you explain to Mr. McCue on January 15th of 1996 that he would subsequently be speaking to the anesthesiologist?

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MR. WALTERS: He already said that, but go ahead.
A. I said that the decision as to whether this is a general or spinal anesthetic is between the patient and the anesthesiologist.
Q. Did Mr. McCue have any questions for you on January 15th of 1996?
A. None that I can recall specifically.
Q. Do you know why he asked you to contact Dr. Gillota?
A. According to my note because he had a history of mild asthma.
Q. Why would a history of mild asthma be significant?
A. I'm assuming because of the upcoming surgery.
Q. Would the asthma be significant because he was to receive anesthesia?
A. Yes.
Q. Why would the fact that he had asthma potentially be significant with respect to anesthesia?
MR. WALTERS: If you know, Doctor.
A. I don't pretend to be an anesthesiologist and therefore I don't feel comfortable answering that question.

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Q. In terms of an explanation of the **risks** of anesthesia, you certainly would notify the patient that there are in fact **risks,** correct?
A. Correct.
MR. WALTERS: Are you going beyond what he already said?
BY MR. MALIK:
Q. Now, hold on, in terns of what the specific **risks** are, is that **up** to the anesthesiologist or is that your responsibility?
A. In regard to the anesthesia?
Q. M-hm.
A. Anesthesiologist.
Q. It's the anesthesiologist's responsibility to define the specific **risks?**
A. Of the anesthesia.
Q. **Do** you know when it was decided that Mr. McCue was to receive a spinal?
MR. WALTERS: spinal what?
MR. JEFFERS: objection.
MR. MALIK: Injection.
A. I do not.
(Thereupon, there was a brief recess.)
(Thereupon, Plaintiff's Exhibts A and

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B to the deposition of Richard Gittinger, M.D. were marked for identification.)
BY MR. MALIK:
Q. If it's the anesthesiologist'sjob to explain the specific **risks** of anesthesia, why then did you explain the **risks** according to your notes of January 15th of 1996?
MR. WALTERS: I *think* the question would be more fair, why didn't you tell him what you told him that you already told Mr. Malik, and --
A. These are the general --
MR. MALIK: Just note I like the question the way I asked it.
MR. WALTERS: I want to be fair.
THE 'WITNESS: Can you repeat the question for me, please?
MR. MALIK: Janet, repeat the question.
THE NOTARY: Question:
"If it's the anesthesiologist's job to explain the specific **risks** of anesthesia, why then did you explain the risks according to your notes of January 15th of

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1996?"
MR. WALTERS: Objection.
A. When I explain the risks involved with an operation I realize that anesthesia is one of the areas where risks are involved, and with that I discuss the possible anesthetic risk that is involved. The details of those risks are left to the anesthesiologist.
Q. I guess what I'm trying to get at is, and correct me if I **am** wrong, what I hear you telling me is that there are limitations on what you tell the patient with respect to anesthesia.
MR. WALTERS: objection.
Go ahead, Doctor.
A. I do not pretend to be an anesthesiologist, I did not study anesthesia, I don't feel that it's my place or I'm in the position to discuss the details of aesthetic, simply because I was never educated in anesthesia, and that the discussion of the risks are left to the person who has studied and is educated in anesthesia.
Q. **Is** it a fair statement then to say that you in your practice and in this case in particular delegated the explanation of the specific risks to the anesthesiologist?
MR. WALTERS: Objection.

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MR. JEFFERS: objection to the term delegated.
MR. WALTERS: And it's not even the term delegated because that's not a delegable duty, as you know. They are independent physicians and I think it's a bad question.
It is not a fair question, but go ahead, Doctor, if you think you can answer it.
THE WITNESS: Can you repeat the question again, please?
THE NOTARY: Question:
"Is it a fair statement then to say that you in your practice and in this case in particular delegated the explanation of the specific **risks** to the anesthesiologist?"
MR. WALTERS: same objection.
A. In my practice when I discuss an operation and the risks and benefits, I inform a patient there is a risk involved with the anesthesia. That risk is that the anesthetic is a stress on the entire system. And that is -- and that's where I leave it, that the

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anesthesia is a risk.
And details beyond that I don't get into because I'm not qualified to get into them. I'm not an anesthesiologist.
Q. So let's go back to the question. In fact then the specifics of the anesthetic risk are delegated to the anesthesiologist?
MR. WALTERS: objection.
BY MR. MALIK:
Q. "heir explanation, correct?
MR. WALTERS: objection.
MR. JEFFERS: objection.
Delegated is an improper word because it has certain inferences when one looks at the dictionary as to control and other aspects, and that is why it is an improper use of that term under the circumstances just described by the doctor.
MR. WALTERS: They are not one unit, David, you know that.
Go ahead, Doctor.
A. I leave the discussion of the specifics up to the anesthesiologist.
Q. Okay. In your note you indicated an extended recovery, but then the next note in the chart on

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02-01-96 says surgery, short stay.
Can you reconcile that for me?
A. It's basically just a difference in terminology. At that time the hospitals were basically changing their terminology over. They both mean the same thing.
Q. Short stay and extended recovery mean the same thing?
A. Basically they both mean an overnight stay.
Q. When you use the term mild asthma, can you tell me what mild means?
A. I'm assuming that's how Mr. McCue related his asthma to me.
Q. Specifically you sent Dr. Gillota a letter dated January 18, 1996, and am I correct in understanding you included your notes up through January 15th of '96?
A. To be honest I don't know if it included only the note of January 15th or if it included all of my notes.
Q. Okay.
A. I do not know.
Q. Were there any telephone conversations between you and Dr. Gillota?
A. None that I can recall.
Q. Did Mr. McCue express any concern about anesthesia on January 15th?

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A. None that I recall.
Q. Did he tell you that he didn't want a spinal?
A. Not that I recall.
Q. Did you feel that he understood what you were telling him about anesthesia?
A. Yes.
Q. Am I correct in understanding that on January 15th of 1996, other than saying you could have a general or a spinal, no discovery of the manner in which the anesthesia would be delivered took place?
MR. WALTERS: objection.
A. I don't understand your question.
MR. RUFF YOU used the word discover, you mean discussion.
BY MR. MALIK:
Q. Other than telling Mr. McCue he would have a general or a spinal, am I correct in understanding there wasn't any discussion as to how the anesthesia would be delivered?
MR. WALTERS: object only because he has answered this about four times.
Go ahead, Doctor.
A. I don't recall any discussion.
Q. Tell me if you agree or disagree with the

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following rule of thumb, statement, do you agree or disagree that the duty to disclose pertinent information regarding the manner in which anesthesia is to be delivered to a patient rests with the surgeon.
A. Can you repeat that again, please?
Q. Tell me whether you agree or disagree with the following, the duty to disclose pertinent information regarding the manner in which anesthesia is to be delivered to the patient rests with the surgeon.
A. I disagree with that.
Q. Okay. Do you recall any specific needs of Mr. McCue on January 15th, 1996 with respect to anesthesia?
A. None.
Q. When you said to Mi-. McCue he could have a general or a spinal, did that anticipate the type of injection that he received for pain?
MR. WALTERS: Taking specifically about the morphine injection?
MR. MALIK: Yes, about Duramorph or morphine injection.
A. I suppose it did.
Q. Do you know for sure whether it did?
A. I don't understand your question completely.
Q. We can agree he received a morphine injection, correct?

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A. Yes.
Q. Was that in the form of a spinal?
MR. JEFFERS: Objection.
A. Spinal injection.
Q. When you said you can have a general or a spinal, is that what you were referring to?
A. Referring to a general or a spinal anesthetic.
Q. And is that different than the morphine injection?
A. Yes, it is.
Q. How is it different?
A. General or a spinal anesthetic is a means of basically preparing the patient so that he basically feels no pain during the procedure, whether it's under a general or spinal anesthetic. A spinal injection is given as a means of post-operative pain management.
Q. Is the administration of an anesthetic and the administration of post-operative pain management via a spinal two separate procedures?
MR. JEFFERS: objection.
You keep using the term via a spinal which is a word of art.
BY MR. MALIK:
Q. spinal injection.
Is that two separate and distinct procedures?

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MR. WALTERS: Can you read that back? I'm confused.
BY MR. MALIK:
Q. Is the administration of a general anesthetic a separate and distinct procedure from the administration of a spinal injection for pain?
A. Yes, it is.
Q. Do you have an opinion as to whether or not those distinct procedures require separate informed consents?
MR. JEFFERS: objection.
You're only talking about a spinal injection for pain versus general anesthetic.
MR. WALTERS: Let's look at the consent he is talking about.
MR. MALIK: I don't want him to look at it.
MR. WALTERS: I do.
MR. MALIK: I want him to tell me.
MR. WALTERS: I don't care what you want to do at this point. This is the consent he signed and he wants to know if there's a separate consent

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required for a morphine injection versus a -- and a spinal anesthetic.
A. No, there is not a separate informed consent needed.
Q. Why not?
A. Because these are both actions being done by the anesthesiologist.
Q. So it's your testimony today that anything that's being done by the anesthesiologist is covered under one informed consent.
MR. WALTERS: That assumes -- he doesn't know what the anesthesiologist told the patient, but that assumed the anesthesiologist --
A. I can't answer that without knowing what the informed consent says.
Q. Am I correct in understanding that in your practice you don't believe that there are separate informed consents required to give a spinal injection for pain postsurgery?
MR. WALTERS: Excuse me, are we talking about a document or are we talking about providing information to the patient?
MR. MALIK: I'm talking

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about his practice.
MR. WALTERS: well, no, when you use the term informed consent, from my standpoint I'm now thinking of a document that the patient signs that says he has been informed and consents to the procedure.
Now, it also could mean, and I want to be clear so the record is clear, the fact that the patient is informed and consents to the procedure without a document being generated. I just want to know what we are talking about so the doctor knows.
MR. MALIK: okay.
BY MR. MALIK:
Q. I can rephrase this to clarify it.
Is the patient entitled to know that he is going to receive a spinal injection for pain?
A. Yes.
Q. And at what point is he entitled to know that?
A. Upon discussion with the anesthesiologist.
Q. When should that discussion with the anesthesiologist take place as to the determination of a spinal injection for pain?

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MR. JEFFERS: Objection.
A. That's entirely up to the anesthesiologist.
Q. Would you consider it appropriate for that discussion to take place when you're in the pre-op area prior to surgery on the day of surgery within minutes of surgery?
A. Yes.
Q. And why would you feel that that's appropriate?
A. I'm having a hard time with this question. I'm not an anesthesiologist and it's not one of my duties to do this, to make this discussion, so I feel uncomfortable with the question.
Q. Okay.
A. It's a hypothetical question.
Q. No problem.
Would you agree with me that informed consent is a process as opposed to just the mere signing of forms?
MR. JEFFERS: It's what?
A. Can you define process?
Q. Let me rephrase the question this way, informed consent is not just the signing of forms, correct?
A. Correct.
Q. When I use the term informed consent what does that mean to you?
A. That the patient has been informed and consents

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to the procedure.
Q. Understanding that you're not an anesthesiologist, what is the extent of the information the patient is entitled to receive?
MR. WALTERS: About the anesthesia?
MR. MALIK: About the anesthesia.
MR. WALTERS: David, I don't mean to --
MR. MALIK: If his answer is I don't know, then let that be his answer.
MR. JEFFERS: He said it is outside --
MR. WALTERS: He already stated certain things about what he expects, but in the same respect he has also stated that he doesn't do this and doesn't typically do it. And from that standpoint I mean I feel like we are beating a dead horse a little bit.
MR. MALIK: To some degree we are, but there's a reason.
MR. WALTERS: I guess. Drag

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a horse up here and beat on it.
MR. MALIK: would you repeat the question?
THE NOTARY: Question: "Understanding that you're not an anesthesiologist, what is the extent of the information the patient is entitled to receive?"
A. The patient has to be informed as to what is going to be done and the risks and benefits of that procedure.
Q. What degree of detail of the risks and benefits is required by you?
MR. WALTERS: In regard to what?
BY MR. MALIK:
Q. Regarding the explanation of the risk of anesthesia.
MR. WALTERS: objection. Go ahead.
A. Basically, as stated before, there is risk involved with the anesthesia, that it's a stress on the entire system.
Q. Prior to surgery or at the time of surgery what records did you have in front of you to review for the

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case?
A. I had my -- before the surgery?
Q. M-hm.
A. I had my office notes and any x-rays that I thought were pertinent to the case.
Q. Were you aware at the time of surgery that Mr. McCue had a spinal injection for pain?
MR. JEFFERS: Could I have that back? I want to hear the time sequence in there.
THE NOTARY: Question: "Were you aware at the time of surgery that Mr. McCue had a spinal injection for pain?"
A. Yes.
Q. And at what point did you become aware of it?
A. In the operating room.
Q. When you got into the operating room was Mr. McCue awake, was he out; do you recall?
A. I don't recall the specifics, other than what I have in my notes, upon review of my notes. Since I dictated that in my operative note I must assume I was in the room when Mr. McCue was being given his spinal injection.
Q. At that time did you have any objection to the

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spinal?
A. None.
Q. Did there come a time later on when Mr. McCue saw you after the surgery that he indicated he had had a spinal and that you were surprised by that?
A. None that I recall.
Q. Did you ever tell Mr. McCue he was never supposed to have a spinal injection?
A. No.
Q. Were you aware that the spinal injection was morphine?
A. Yes.
Q. Were you aware at the time that Mr. McCue had asthma?
A. Yes.
Q. I want to go to your progress notes.
A. From the hospital chart?
Q. From the hospital chart, correct.
Other than the entry on 02-01 of '96, this is what I'm looking at right here, is there any other indication in your handwriting, which I have a hard time reading, of any anesthesia?
A. That is all.
Q. And would you read that?
A. Anesthesia spinal, morphine. General with ET

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tube, which means endotracheal intubation.
Q. Did Mr. McCue sign any forms, any so-called informed consents, written informed consent in your office?
A. No.
Q. Does your practice provide any?
A. No.
Q. Did you expect that Mr. McCue would sign an informed consent?
A. In the hospital, yes.
Q. And did you also expect that that would be provided by somebody at the hospital?
A. Correct.
Q. Other than yourself and other than the anesthesiologist, did you expect anybody to explain the risks -- anybody else to explain the risks of anesthesia to Mr. McCue?
MR. WALTERS: Objection.
Go ahead.
MR. JEFFERS: Objection.
A. There's an anesthesiologist who sees the patients in the pre-op holding who would also discuss the anesthesia.
Q. In this case I believe that was Dr. Pacita-Garcia?

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A. I believe so, yes.
Q. Did you ever discuss this case with Dr. Garcia?
A. No.
Q. Did you discuss the case with Dr. Midis?
A. I'm sorry, are you asking after the surgery?
Q. First let's go before the surgery.
A. Just during the procedure itself.
Q. Do you recall what was said?
A. No, I don't.
Q. After the surgery did you discuss the case?
A. On one occasion, had to be shortly after Mr. McCue first noted he was having headaches. I recall actually in the locker room getting ready for another case and the anesthesiologist was there and I just basically mentioned that Mr. McCue is still having headaches and whether he thought they could be related to the spinal injection.
Q. And how long after the surgery was that?
A. Well, Mr. McCue first mentioned the headaches in the fourth week after surgery, so I'm assuming this was shortly thereafter, but I don't know a particular time.
Q. Did you have the opportunity to review the informed consent form from Parma Hospital?
A. Yes, I did.
Q. And that's a form that you signed, right?

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A. Correct.
Q. And that's a form that's not dated, right?
A. It's not dated by myself, correct.
Q. Do you recall when you signed that?
A. I do not.
Q. Do you know why it is not dated?
A. I do not.
Q. Could it have been signed before the form was explained to Mr. McCue?
A. No.
(Thereupon, Plaintiff's Exhibit C to the deposition of Richard Gittinger, M.D. was marked for identification.)
BY MR. MALIK:
Q. Handing you Exhibit C, can you identify that for me?
A. Yes, I can.
Q. what is it?
A. This is the consent to operation and treatment signed by Mr. McCue.
Q. Is that something you would have had prior to the surgery?
A. I am first given access to this at the time of surgery.
Q. Is that prior to surgery or after surgery?

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A. In the operating room.
Q. So then it was sometime in the operating room or sometime afterwards that you signed your name?
A. Correct.
Q. Handing you what I'm marking as Exhibit D, which is called Parma Community General Hospital anesthesia evaluation, is that something that you also saw at the time of surgery?

(Thereupon, Plaintiff's Exhibit D to the deposition of Richard Gittinger, M.D. was marked for identification.)

A. That is not, no. That's one form I tend not to review since it is again an anesthesia evaluation.
Q. Okay. Handing you what I am marking as Exhibit E entitled physician orders, can you explain that, what that is?

(Thereupon, Plaintiff's Exhibit E to the deposition of Richard Gittinger, M.D. was marked for identification.)

A. This is a standing anesthesia pre-op order sheet with basically standing or regularly occurring orders for patients in the preoperative phase.
Q. Did you say this was a Tuesday when the surgery occurred?
A. Thursday.

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Q. Is that your normal operating day?
A. That is my major operating day.
Q. How many cases normally do you have on that day?
A. It varies anywhere from no cases to three or four cases.
Q. Okay. At any time during the surgery did you check any of the anesthesia?

MR. JEFFERS: Check what?
MR. MALIK: Did he check any of the anesthesia.

BY MR. MALIK:
Q. Was it your responsibility --

MR. WALTERS: Monitor.

Q. Thank you.
-- to monitor any of the anesthesia?
A. I don't understand your question, meaning --
Q. In the operating room was it your responsibility to perform any function relating to anesthesia?
A. No, sir.
Q. Was the anesthesiologist in the operating room the entire time?
A. As I recall, yes.
Q. If Dr. Midis had left the operating room would that be noted anywhere?
A. I couldn't answer that question. I don't know.

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Q. Were you in the operating room the entire time?
A. Yes, I was.
Q. At any time did you explain any alternative methods of pain control other than the spinal injection to Mr. McCue?
A. Typically don't make it a routine to discuss pain management.
Q. Tell me if you agree or disagree with the following statement, please, responsibility for obtaining consent rests with the attending physician. It is a matter within the realm of his responsibility to the patient.

MR. WALTERS: I'll object, but go ahead, Doctor.

A. The consent for the particular procedure, yes.
Q. Not the consent for the anesthesia.

MR. WALTERS: There is an attending anesthesiologist as well.
MR. MALIK: I understand.
MR. WALTERS: Are you saying --just so I can clarify in my mind, are you talking about the attending being only one person?
MR. MALIK: I'm talking about the attending being Dr. Gittinger.

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MR. WALTERS: And you're saying the anesthesiologist has no responsibility under that scenario that you read in your little statement there; is that correct?
MR. MALIK: In my little statement I'm asking him --
MR. WALTERS: In fairness there's more than one doctor involved in this case, more than one attending physician involved in this case.
MR. MALIK: I understand. Janet, would you repeat the question?
THE NOTARY: Question: "Tell me if you agree or disagree with the following statement, please, responsibility for obtaining consent rests with the attending physician. It is a matter within the realm of his responsibility to the patient."
MR. WALTERS: Objection.

A. I would have to disagree, not only my responsibility.
Q. The anesthesiologist's responsibility as well?
A. Any physician involved.

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Q. Okay. As one of Mr. McCue's attending physicians, if you want to make that distinction, do you believe he was entitled to have notice of the spinal injection, spinal morphine injection?
MR. JEFFERS: Objection.
A. Yes.
Q. If in fact Mr. McCue was to have a spinal morphine injection would you expect it to be noted on the anesthesia evaluation marked as Exhibit D?
A. No, I would not.
Q. Why not?
A. I suppose I feel uncomfortable with that question, but that is oftentimes a decision made by the anesthesiologist who is doing the case.
Q. Now, Exhibit D is a form that Mr. McCue signed. Is it your testimony today that he shouldn't be notified via this specific form, this anesthesia evaluation form, that he is going to have a spinal injection for pain?
MR. JEFFERS: Objection.
A. I am not familiar with that form. I don't deal with that form.
Q. Do you *think* that Mr. McCue is entitled to notice in writing at all, at all, that he is going to have a spinal injection for pain?

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MR. JEFFERS: objection.
MR. WALTERS: Entitled in writing.
A. No.
Q. Handing you exhibit F, do you know what that is?
(Thereupon, Plaintiff's Exhibit F to the deposition of Richard Gettinger, M.D. was marked for identification.)
A. It's a sheet that we use in our office, basically. It's a face sheet that gets put on the patient's chart when we schedule surgery.
Q. Is that handwriting on there a member of your office staff?
A. One of our nurses.
Q. Do you know who?
A. I do not know.
Q. Do you know when it was filled out?
A. I'm assuming 01-15-96, that's the date that's written at the top.
Q. Did you review that at all?
A. No.
Q. That is just something you would expect to go out as a matter of course?
A. This is basically a checklist that the nurses work off of to make sure they have done all their work.

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Q. And who does that go to?
A. It stays on the front of the chart.
Q. For the pre-anesthesia evaluation does the chart or that document go to the hospital?
A. No.
Q. Let me ask you a couple questions about informed consent and responsibility of parties.
You would agree with me that you do have a responsibility to inform Mr. McCue of the anesthesia risk, correct?
A. Correct.
Q. And would you agree that Dr. Pacita Garcia who did the pre-anesthesia evaluation has responsibility?
A. Correct.
Q. Do you agree Dr. Midis has a responsibility?
A. Yes.
Q. *Are* there any nurses that have responsibility?
MR. JEFFERS: objection.
A. I don't even know if nurses talk to him beforehand about anesthesia.
Q. And Dr. Lopez-Valez who saw Mr. McCue before the pre-anesthesia evaluation?
MR. GUNNING: objection.
MR. JEFFERS: Objection.
A. I'm not sure of her role in this entire case to

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be honest with you.
Q. Let me establish a few things, we are almost done, I have a few questions from Mark.
There existed a physician/patient relationship between yourself and Martin McCue, correct?
A. Correct.
Q. Did that physician/patient relationship cease at any time?
A. I saw him in September of '96 in the office.
Q. Do you still consider yourself his physician?
MR. WALTERS: You mean after he sued him?
Has he been back to see you since he filed a lawsuit.
THE WITNESS: No.
BY MR. MALIK:
Q. You had a duty to provide certain risk information which you indicated on January 15th?
A. Correct.
Q. You provided some of it, correct?
A. Yes. If I might, I provided all the risk information that I felt was my duty.
Q. None of that risk information included discussion about a central spinal fluid leak however, correct?

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MR. JEFFERS: objection.
There's no evidence of that.
MR. WALTERS: Let me just say this, I think we went over what he remembers telling this patient ad nauseam at this point, but go ahead, Doctor, do you remember telling him anything about a central spinal fluid leak?
A. No.
Q. Do you believe that information regarding a central spinal fluid leak as a potential risk of a spinal injection is information a patient should know?
MR. JEFFERS: Objection.
A. I'm not an anesthesiologist. I don't feel comfortable answering that.
Q. Would you agree that it's a fair statement that the patient is entitled to have as much material information, pertinent information about the risks involved in anesthesia in order to make an informed consent?
MR. JEFFERS: objection.
I don't think that's a complete sentence, you left out the center of the sentence. I don't think it's intelligent.
MR. MALIK: Thank you,

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I've been called worse.
Janet, read it back.
THE NOTARY: Question: "Would you agree that it's a fair statement that the patient is entitled to have as much material information, pertinent information about the risks involved in anesthesia in order to make an informed consent?"
MR. JEFFERS: objection.
A. Not being an anesthesiologist I couldn't comment on the extent of the information needed to give a patient.
Q. Dr. Midis is part of the anesthesia group, isn't he?
A. I believe so. I'm not sure of the technicalities of his job.
MR. WALTERS: YOU sued him under Parrna Anesthesia Associates, Incorporated.
BY MR. MALIK:
Q. In terms of your operating room, has he been in your operating room before?
A. Yes.
Q. Is he a regular, so to speak, in your operating

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A. Yes.
Q. Do you feel comfortable with him?
A. Yes.
Q. Did there ever come a time when Mr. McCue told you he didn't want any information about his anesthesia?
A. None that I can recall.
Q. And is it your testimony today because you're not an anesthesiologist you don't feel comfortable commenting on the standard of disclosure in terms of anesthesia risks?
A. Correct.
Q. In terms of probabilities for these kinds of surgeries, what percentage of patients receive a spinal injection for pain in your operating room?
A. I couldn't tell you, to be honest with you. I don't know.
Q. Although you're not an anesthesiologist can you tell me the difference between a spinal and a general?
MR. WALTERS: You're talking now anesthetic.
A. A spinal anesthetic is considered a regional anesthetic or, in laymen's terms, being numb basically from the waist down, whereas with a general anesthetic

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the entire body is affected and they are affected to the point where they have to be placed on a respirator many times because of the entire whole body involvement.
Q. How are those two distinguished from an epidural; if you know?
A. As far as I am aware -- I'm sorry, which two?
Q. The general, spinal, and then I'm categorizing epidural as a third category.
MR. WALTERS: That's assuming it is a third category.
MR. MALIK: Right.
MR. WALTERS: Go ahead, Doctor.
A. Epidural injection is simply an injection of medication given into a different location other than the spinal anesthetic.
MR. WALTERS: still a local anesthetic, correct?
THE WITNESS: It's a regional anesthetic, correct.
BY MR. MALIK:
Q. When you talked to the anesthetist I think you said it was in the locker room about Mr. McCue's headaches, what did he say?

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A. I don't recall specifically other than that he did not believe that his headaches at four weeks out were still related to a spinal injection. And admittedly that's just paraphrasing. I don't remember the details.

MR. MALIK: Can we take a two-minute break?

(Thereupon, there was a brief recess.)

BY MR. MALIK:

Q. Doctor, is it your opinion that the acceptable standard of care requires a physician to fully inform the patient of all material risks prior to performing surgery on the patient, including the risk of both the surgery itself as well as the administration of anesthetic?

A. I as the surgeon, it is my --

MR. WALTERS: object, first. Go ahead, Doctor.

A. It's my duty to discuss the procedure, the rehab and the risks involved. Not with the particulars in regard to the anesthesia.

Q. But in order that the patient be fully informed, the risks of anesthesia need to be explained, correct?

A. The fact there are risks involved, correct.

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Q. Okay. And the specific risks involved, correct?

MR. JEFFERS: And the what?

MR. MALIK: specific risks

A. By whom? Who is discussing these?

Q. Well, regardless of by whom, the specific risks need to be explained to the patient, correct?

A. Yes.

Q. What are the risks of the administration of general endotracheal anesthesia?

A. I don't feel comfortable commenting on that.

Q. And what are the risks of giving a patient a spinal injection?

A. I'm not an anesthesiologist.

Q. Do you agree that you told Martin McCue prior to surgery that when you performed arthroscopic anterior cruciate ligament reconstruction surgery that you would do it with general endotracheal anesthetic?

A. I stated that it could be done under either general or spinal anesthetic.

Q. Did he chose one of the two?

A. I do not recall.

Q. You agree Mr. McCue didn't suffer from severe headaches prior to the surgery of February 1, 1996?

MR. WALTERS: objection.

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There's no way he could know.

A. I never asked him; he never told me.

Q. Would you agree that a physician is prohibited from administering treatment to a patient without the patient's consent, correct?

MR. JEFFERS: I could not hear that.

MR. WALTERS: you're taking an emergency situation out of it.

MR. MALIK: Taking emergency situation out of it.

MR. JEFFERS: would you repeat it?

THE NOTARY: Question: "Would you agree that a physician is prohibited from administering treatment to a patient without the patient's consent, correct?"

MR. WALTERS: object. It happens everyday, go ahead.

A. I agree.

Q. Did Mr. McCue ever bring his fiancee Nancy with him to any of the appointments?

A. Yes.

Q. Was she present in the room during any of the

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appointments?

A. On occasion.

Q. Do you recall whether or not Mi. McCue or Nancy had told you prior to the surgery that Marty did not want a spinal administered?

A. I do not recall.

Q. Do you recall whether or not he told you that he heard of too many complications resulting from the administration of a spinal?

A. I do not recall.

Q. Did you tell Mi. McCue that you perform all of your procedures with endotracheal gas?

MR. JEFFERS: With what?

MR. MALIK: Endotracheal gas

A. I do not recall.

Q. Would you agree that the risks of administering spinal narcotics are different from that of administering endotracheal gas?

A. There are different risks.

Q. Do you agree that general anesthetic does not have the post-operative risk of severe headaches?

MR. JEFFERS: Objection.

A. I can't comment on that.

Q. Would you agree that urinary retention is not a

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A. It went along very nicely.
Q. And how is he today in terms of the function withhisknee?
A. I couldn't comment. I haven't seen him in over a year.
Q. The last time you saw him, how was he doing?
A. I thought he was doing very well. He still had some muscle weakness but was otherwise progressing very nicely.
Q. In terms of the kind of person that Mr. McCue is, you saw him on a number of occasions, correct?
Were you able to formulate an opinion as to his directness and truthfulness with you?
MR. JEFFERS: objection.
MR. WALTERS: object, but as best you can, go ahead.
A. I had no difficulties.
Q. Did you feel that he was forthcoming when he spoke with you?
A. Yes.
Q. Did you feel that he wanted to help himself when he spoke with you?
A. He was willing to participate in therapy and help himself, yes.
Q. Is it a fair statement to say he was a compliant

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patient?
A. Yes.
Q. Did he present you any specific problems?
A. As far as --
Q. As far as his treatment.
MR. WALTERS: You mean not suing him.
MR. MALIK: Correct.
MR. WALTERS: It seems like a problem to me, I'm just a lay person, I don't know. Go ahead.
A. As far as his compliance with my recommendations, he was fine.
Q. Are you on staff at any other hospitals other than Parma?
A. Southwest General Health Center.
Q. Have you had the opportunity to perform surgery at Southwest?
A. Yes.
Q. And are there informed consent forms at Southwest also?
A. I would imagine, but I don't recall the specific form at this point.
Q. Is the procedure for performing surgery at Southwest as it relates to you and informing the

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patient of anesthetic risks any different than it is at Parma?
MR. JEFFERS: objection.
Go ahead.
A. I do the same whether the patient is being done at Parma or Southwest.
Q. After surgery what medications was Mr. McCue on?
A. May I refer to my notes?
Q. Sure.
A. You're talking immediately after surgery?
Q. I'm talking through the time you saw him in September.
A. I couldn't give you the exact details.
MR. WALTERS: You don't want him to go through the hospital record. What you prescribed for him as an outpatient.
A. I prescribed at various times either Vicodin or Darvocet for pain.
MR. MALIK: That's it.
- - -
BY MR. JEFFERS:
Q. Do you have any complaints about any of the care provided by any other medical care providers during the period February 1 through February 4, 1996?

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A. No.
Q. Were you aware that Mr. McCue is obtaining Vicodin and perhaps other prescription drugs from other physicians?
MR. MALIK: objection.
A. I was not.
Q. He did not tell you about that, correct?
MR. MALIK: Objection.
A. No. If I can, the other physicians in my office --
Q. No, outside of your office.
A. No.
MR. MALIK: objection.
BY MR. JEFFERS:
Q. For example, he didn't tell you that Dr. Boswell had been giving him Vicodin?
A. I don't know who Dr. Boswell is.
MR. MALIK: objection.
Q. He did not advise you Dr. Gillota had been providing him with prescription drugs, correct?
A. No.
MR. MALIK: objection.
Q. By the way, I note that in your note of September 25, 1995 you make a comment that you had a call from Marty's wife that evening saying he was in

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excruciating pain. You describe her as Marty's wife.
Did Marty tell you that the woman that has been described as his girlfriend, as Nancy, did he tell you that was his wife?
A. I'll be honest, I had never quite figured out that relationship until later on down the road.
Q. Okay. But he implied apparently or she implied it was Marty's wife when she was calling, correct?
MR. MALIK: Objection.
A. That was my impression of the situation at that time.
Q. Duramorph, another name for morphine, is used for pain control generally speaking, correct, for surgical procedures, correct?
A. Correct.
Q. In terms of post-op urine retention, that is not an unusual occurrence after surgery, correct?
A. It is not unusual.
Q. Were you ever told about any antidepressant medications that Mr. McCue was receiving prior to September 25, 1995?
A. Prior to, no.
Q. Certainly Mr. McCue never told you about that?
A. In fact, in my ER note I have listed just the asthma medications, nothing more.

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Q. Did Mr. McCue ever have a cardiac arrest in recovery after your surgery?
A. Not that I'm aware of.
Q. Have you ever heard that he makes a claim that he did?
A. This is the first.
MR. MALIK: objection to that.
BY MR. JEFFERS:
Q. Were you aware that he had any seizures subsequent to your surgery at Parma Community General Hospital?
A. No.
Q. He never made that claim to you or you were not aware of it by anything that occurred at the hospital, right?
A. Correct.
Q. In fact, it did not occur, correct, at the hospital?
A. Not that I'm aware of, no.
Q. You know he didn't have a cardiac arrest at the hospital.
A. Not that I'm aware of.
Q. Did he ever claim to you that he had a leak in his urethra, Mr. McCue, did he ever discuss that with

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you?
A. Post-operatively?
Q. Yes.
A. Yes.
Q. Did he ever tell you that that was, there was a study done at University Hospital where they did a cystogram and there was no evidence -- I'm sorry.
Did you ever receive information that he was tested for that at University Hospital and it was determined that he had no problem with a urinary problem?
A. If I might refer to my notes, just says that patient reports that the urinary retention may be due to urethral scarring, and this was secondary to evaluation by an urologist at University Hospital.
Q. Do you know if that was Dr. Klein?
A. I do not know.
Q. Did you know they did a cystoscopy on him?
A. He did tell me that, yes.
Q. Did he tell you the results were normal caliber urethra and normal bladder and no lesions in either the urethra or bladder with normal mucosa? Did he ever mention anything about that to you?
A. No.
Q. He left you with the impression that he had a

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problem and it was --
A. Yes.
Q. Now, to go to the cystogram, were you ever aware that they did a cystopuncture and there was no evidence of a leak at all in terms of his urinary problem?
A. No.
Q. I should say in terms of his spinal leak -- alleged spinal leak.
A. I am not aware of that study.
MR. WALTERS: You aren't aware of any follow-up records?
A. What I am aware of is a note from a doctor at Metro who did an evaluation who makes mention of a study, but that was only my review for this person for this case.
Q. Were you aware there was no CSF leak determined?
A. I was not aware of that, no.
Q. When was the last time you saw this patient?
A. September 16, 1996.
Q. Was he still discussing problems that he had with a leak with you at that point or after June 24, 1996?
A. Says in my September note, says in regard to headaches he reports the fluid leak healed, headaches are less but still complains of chronic frontal

headaches.
Q. State that again, please.
A. In regard to headaches he reports the fluid leak has healed, headaches are less but he still complains of chronic frontal headaches.
Q. Did he ever tell you he had a CT of the head?
A. No.
Q. In March of 1996.
A. No.
Q. Did he ever advise you that he had three seizures subsequent to your surgery?
A. I am aware of the reported blackouts only, what the patient reported to me.
Q. You were not aware, if I recall, that Dr. Gillota was treating him for depression as early as 1995?
A. I was not aware of that, no.
Q. Dr. Boswell reports on April 17, 1996 that it was reported to him by Mr. McCue that his post-op course was complicated by questionable seizures six hours post-op with severe post-op vomiting.
Were you aware of either?
A. Again, from review of the notes I noticed at one point he had an emesis of about 150 ccs, minimal, and no mention ever of any seizures in the hospital chart.

Q. So such a statement would not be true if that were the statement made to Dr. Boswell?
A. Correct.
Q. On July 23, 1996 did University Hospital
indicate that he had a spinal at Parma Community General Hospital of morphine as part of the anesthetic process resulting in convulsions and a hole in his spine?
You're not aware of anything to support that claim, correct?
A. No, I'm not.

MR. JEFFERS: That's all.
MR. GUNNING: None for me.

BY MR. MALIK:
Q. Doctor, handing you Exhibit G, I want you to tell me if you can identify this.
(Thereupon, Defendant's Exhibit G to

the deposition of Richard Gittinger, M.D. was marked for identification.)
BY MR. MALIK:
Q. Handing you Exhibit G which is peri-operative patient care record and plan, have you seen that before?
A. Yes, I have.
Q. Is your signature on there anywhere?
A. No.
Q. What does peri-operative mean?
A. It means at the time or around the time of the surgery.
Q. As far as you can recollect and after your review of the records were there any complications whatsoever post-operatively in terms of Mr. McCue's breathing?
A. None.
MR. MALIK: That's it.
MR. WALTERS: Anything else?
MR. JEFFERS: No.
MR. WALTERS: We'll read it if it's typed.
(DEPOSITION CONCLUDED.)

Richard Gittinger, M.D. Date

State of Ohio)
County of Cuyahoga.

I, Janet M. Moffmaster, a Registered Professional Reporter and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, RICHARD A. GITTINGER, M.D., was by me first duly sworn to tell the truth. the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was reduced to stenotypy, and afterwards transcribed by me through the process of computer-aided transcription, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.
I do further certify that this deposition was taken at the time and place in the foregoing caption specified.
I do further certify that I am not a relative, employee or attorney of either party, or otherwise interested in the event of this action.
IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 9th day of January 1998.

Janet M. Hoffmaster, RPR and Notary Public in and for the State of Ohio.
My Commission expires September 12,2002.