

IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

EDNA WILLIAMS,)
)
Plaintiff,)
)
vs) Case No. **381815**
) Judge Boyle
DANIEL P. GOLDBERG, M.D.,)
et al.,)
)
Defendants.)
)

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DEPOSITION OF DANIEL P. GOLDBERG, M.D.

FRIDAY, FEBRUARY 11, 2000

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The deposition of DANIEL P. GOLDBERG, M.D.,
the Defendant herein, called by counsel on behalf
of the Plaintiff for examination under the
statute, taken before me, Vivian L. Gordon, a
Registered Diplomate Reporter and Notary Public
in and for the State of Ohio, pursuant to
agreement of counsel., at the offices of Reminger
& Reminger, The 113 St. Clair Building,
Cleveland, Ohio, commencing at 9:00 o'clock a.m.
on the day and date above set forth.

1 APPEARANCES:

2
3 On behalf of the Plaintiff
4 Becker & Mishkind Co., LPA
5 BY: HOWARD D. MISHKIND, ESQ.
6 The Skylight Office Tower Suite 660
7 1660 W. 2nd Street
8 Cleveland, Ohio 44113

9
10 On behalf of the Defendants
11 Reminger & Reminger
12 BY: STEPHEN S. CRANDALL, ESQ.
13 The 113 St. Clair Building
14 Cleveland, Ohio 44114

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2 (Thereupon, GOLDBERG Deposition
3 Exhibits 1 thru 10 were marked for
4 purposes of identification.)

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6 DANIEL GOLDBERG, M.D., a witness herein,
7 called for examination, as provided by the Ohio
8 Rules of Civil Procedure, being by me first duly
9 sworn, as hereinafter certified, was deposed and
10 said as follows:

11 EXAMINATION OF DANIEL GOLDBERG, M.D.

12 BY MR. MISHKIND:

13 Q. Good morning. I am Howard Mishkind.
14 Would you tell me your name.

15 A. Daniel Goldberg.

16 Q. You are a physician?

17 A. I am.

18 Q. You are a defendant in the lawsuit
19 that has been filed against you by Edna Williams;
20 correct?

21 A. Correct.

22 Q. I am going to show you what has been
23 marked as Plaintiff's Exhibit 1 and ask you if
24 you could identify for the record what that is?

25 A. It's a copy of my curriculum vitae.

1 Q. Is it current?

2 A. It's not.

3 Q. What needs to be added to make it
4 current?

5 A. The U.S. address listed on here is no
6 longer mine. Hospital affiliations in London,
7 England which are current are not listed. My
8 title in the United Kingdom is not listed. The
9 status of my U.K. medical licensure is absent.
10 The status of other particular certificates in
11 the U.K. recently obtained is not added. A few
12 publications, most recent publications are not
13 added. Invited review, at least one I know of is
14 not here. Some further presentations also are
15 missing.

16 Q. When was this CV, this Exhibit 1,
17 prepared?

18 A. Well, the most recent date I see on
19 here is March 1999.

20 Q. All of what you have just summarized
21 has taken place since March of 1999?

22 A. That's right.

23 Q. Tell me if you would what percentage
24 of your professional time do you spend in the
25 U.S. versus in the U.K.?

1 A. Well, as far as the clinical practice
2 of medicine at this time, 100 percent of the time
3 is spent in the U.K. I have other professional
4 endeavors outside of the clinical practice that
5 bring me here.

6 Q. And what are those, please?

7 A. Academic endeavors related to plastic
8 surgery at the university. I am in charge of a
9 research lab.

10 Q. Tell me about that.

11 A. The research lab is called the Plastic
12 Surgery Tissue Engineering Research Lab. It's a
13 basic science research lab funded by a couple of
14 sources, and I am the one who originated the
15 lab. I am in charge of it and there are members
16 in there that carry out basic science
17 experiments.

18 Q. Where is this at?

19 A. Located at Case Western.

20 Q. Is this research private research that
21 you are doing?

22 A. I don't understand what you mean
23 private.

24 Q. I mean, there is nothing confidential
25 about the research that you are doing, is there?

1 A. Oh, no, there is nothing confidential
2 about it.

3 Q. What is the nature of the research
4 that you are doing currently?

5 A. Tissue engineering, which is, in
6 essence, the growth, creation and growth of
7 tissues and complex tissues in the laboratory,
8 working toward the creation of replacement parts.

9 Q. Is this for cosmetic surgery?

10 A. Well, really mostly for what we would
11 call reconstructive surgery, I think. Ultimately
12 its applications would apply to probably
13 congenital, post oncologic and post traumatic
14 deformities.

15 Q. And limited to any particular area of
16 the body?

17 A. No. But the focus of my research is
18 on heart tissues, basically growing bone and
19 cartilage in prefabricated shapes, of
20 prefabricated flaps, with a design toward their
21 clinical application of replacing missing parts.

22 Q. And you are heading up this research?

23 A. I am. I am the head of this
24 laboratory, anyway.

25 Q. Are there other physicians that work

1 in the lab with you?

2 A. There are.

3 Q. Who are those physicians?

4 A. There is a Ph.D. named David Dean, who
5 is officially titled in the department of
6 neurosurgery. There is an another physician
7 named Christine Neneghetti. She is a plastic
8 surgery resident. And there are a couple
9 technicians who give part-time effort. They are
10 involved in other projects, as well. I can't
11 give you the names off the top of my head because
12 they are always changing.

13 Q. How much time do you spend in the U.S.
14 in connection with this research activity?

15 A. About three working days a month.

16 Q. Do you have any other professional
17 activities that bring you to the U.S. other than
18 the research lab?

19 A. No, I don't.

20 Q. Do you maintain a residence in the
21 U.S.?

22 A. I do. I have a summer house in New
23 England, but I don't have a residence in
24 Cleveland anymore.

25 Q. So you are now a full-time legal

1 resident of the U.K.?

2 A. That's right. My status is called a
3 nondomiciled resident. It's a U.K. term. That
4 means that that's where I spend the bulk of my
5 time.

6 Q. And what is your U.K. address?

7 A. It's listed on the curriculum vitae.

8 Q. Oh, it is, okay. That's the address
9 in London?

10 A. My home address.

11 Q. Do you have a clinical office?

12 A. I do. It looks like that's not listed
13 on there. I can give it to you. It's number 10,
14 Harley Street, H A R L E Y, London, W-1-N-1-A-A,
15 United Kingdom.

16 Q. And when you are in the United
17 Kingdom, are you practicing in the clinical area
18 as a physician?

19 A. I am.

20 Q. And in what area?

21 A. A plastic surgeon, plastic and
22 reconstructive surgeon.

23 Q. Do you have any other professional
24 pursuits that you are involved in in the U.K.
25 other than as a plastic surgeon?

1 A. No.

2 Q. When did this change take place that
3 you moved and became a nondomiciled resident with
4 100 percent of your clinical practice outside of
5 the U.S.?

6 A. The 100 percent of my clinical
7 practice outside the U.S., to answer the question
8 put that way, it probably would have been
9 September '99.

10 Q. And up to that point, you had some
11 aspect of a practice in the U.S., though. It was
12 decreasing, and that would have started to
13 decrease sometime earlier in 1999?

14 A. September '98.

15 Q. Do you have family in England?

16 A. Just my wife.

17 Q. Your wife is a --

18 A. She is Dutch.

19 Q. Is that what took you to the U.K.?

20 A. Completely.

21 Q. Is she a physician?

22 A. No.

23 Q. What type of work does she do, if
24 anything?

25 A. She doesn't work now. She has a

1 doctorate in art history.

2 Q Whenever I think of anyone from
3 England, or that area, I always think of
4 royalty. Any royalty in her?

5 A. I wish.

6 Q. No, okay. She is a commoner?

7 A. She is a commoner, yes.

8 Q. Are you totally, I guess,
9 disassociated then with the clinical practice
10 group that you were involved in when Edna
11 Williams was your patient?

12 A. No, I'm not totally disassociated from
13 them.

14 Q. Tell me what association you have.

15 A. Well, I am still considered a partner
16 in the group at this time, but I think because of
17 this peculiar position that I now occupy, it
18 might have to be redefined. But I am still an
19 assistant professor of surgery at Case Western
20 Reserve Medical School and am still on the tenure
21 track.

22 Q. Do you have any intentions in the
23 foreseeable future of reestablishing either a
24 clinical practice here in the U.S., other than
25 your research activity, or teaching either as an

1 assistant professor or otherwise at Case Western
2 Reserve University?

3 A. I don't know.

4 Q. That's uncertain?

5 A. It's uncertain.

6 Q. Have you established or made known to
7 anyone either at University Plastic Surgery
8 Associates or Case Western Reserve University
9 what your intentions are?

10 A. Yes.

11 Q. And what have you indicated?

12 A. That I would like to maintain a status
13 there that is largely academic; that I am going
14 to abandon clinical practice there.

15 Q. There being Case Western Reserve
16 University?

17 A. That's right. And that the future is
18 uncertain.

19 Q. The physicians that you were
20 associated **with** in whatever way that association
21 existed when Edna was a patient of yours, who
22 were they?

23 A. Well, at this time, my partner, if you
24 will, at least defined by sharing practice
25 experiences, was Edward Luce, the chief of

1 plastic surgery.

2 Q. That's L-UT-C-E?

3 A. That's right.

4 Q. And give me his title.

5 A. He is chief of the division of plastic
6 surgery at Case Western Reserve and University
7 Hospitals.

8 And then there was a different kind of
9 association with other members of our academic
10 group, a full-time faculty in plastic surgery at
11 Case made up by Dr. Luce and myself and three
12 physicians at Metro; Roderick Jordan, Steven
13 Bernard and Mark Wells.

14 Q. Dr. Jordan was involved in the final
15 surgery that you performed on Edna?

16 A. Right. Actually he performed it, not
17 me. I was out of town then.

18 Q. Although your name is listed on the
19 operative report?

20 A. It's incorrect.

21 Q. Let me just jump to that even though
22 it's obviously getting way ahead of things. But
23 if I don't, I will forget to ask you about it, so
24 I will do that now.

25 - - -

1 (Thereupon, GOLDBERG Deposition
2 Exhibit 11 was marked for
3 purposes of identification.)

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5 Q. Showing you what has been marked as
6 Plaintiff's Exhibit 11 -- and I am presenting
7 this to you not to try to confuse you in any
8 way. I intend to go back and go through matters
9 pretty much chronologically with you. But
10 Exhibit 11 is a copy of the operative note that
11 you and I just chatted about; correct?

12 A. Yes, it is.

13 Q. And it has on the operative note the
14 surgeon being Daniel Goldberg, and that's you;
15 correct?

16 A. It does.

17 Q. And then it is signed by you; correct?

18 A. It is.

19 Q. But what you are telling me is that
20 you didn't do the surgery?

21 A. Correct.

22 Q. You weren't assisting Dr. Jordan or
23 Dr. Lawrence Weider?

24 A. Correct.

25 Q. Can you tell me why it is that if you

1 didn't participate in the surgery or assist in
2 the surgery why you signed the operative note?

3 A. Two plausible reasons. One, they are
4 presented to me in a stack of usually 40 or 50
5 operative notes and I scan through the bottom and
6 if my name is there, I just sign them.

7 Or two, it's also possible for one
8 colleague to sign an operative note for another,
9 especially one who doesn't work in that
10 building. So it could have been one of the two.
11 Likely it was the first.

12 Q. Okay. And in fact, when you signed an
13 operative note, isn't it fair to say that you are
14 attesting that the procedure as described is a
15 procedure that you either participated in or
16 supervised the performance of?

17 A. In general, that would be true, yes.

18 Q. Do you recall why it is that you
19 didn't participate in this last surgery?

20 A. I was out of town.

21 Q. It wasn't England, was it?

22 A. No. Nothing to do with England at
23 that point. I think at that time it was a time
24 of a national meeting of ours and I was probably
25 there presenting a paper or something.

1 Q. The assistant surgeon that is
2 referenced on here is Lawrence Weider. Am I
3 pronouncing it correctly?

4 A. Yes.

5 Q. He also was an assistant to you, I
6 believe, in one or possibly -- at least one other
7 surgery; correct?

8 A. Uh-huh.

9 Q. That's a yes?

10 A. Yes, it is.

11 Q. Was he a resident?

12 A. He is a resident.

13 Q. Is he still at University Hospitals?

14 A. No, he has graduated.

15 Q. Do you know where he practices now?

16 A. I don't know off the top of my head,
17 I'm sorry.

18 Q. When is the last time you had any
19 contact with him?

20 A. Well, I probably would have been at
21 the Past resident graduation dinner, which would
22 have been the middle or the end of June of '99.

23 Q. And at that time, was he finishing his
24 residency?

25 A. He was.

1 Q. Do you recall what his stated plans
2 were as to where he was planning on practicing or
3 whether he indicated that he had a commitment?

4 A. He did have a commitment, and I
5 believe he was going into private practice. And
6 I can't recall where, I'm sorry.

7 Q. Okay. Now, the professional
8 negligence policy that you maintained was
9 maintained through University Faculty Practice
10 Associates?

11 A. That's right.

12 Q. What or who is this entity?

13 A. This entity is a group that represents
14 all the full-time faculty at University Hospital.

15 Q. Were you an employee of university
16 Plastic Surgery Associates?

17 A. I was.

18 Q. Were you also an employee of
19 University Faculty Practice Associates?

20 A. I was not.

21 Q. So this was just sort of an entity for
22 purposes of providing malpractice coverage?

23 A. That was one of the purposes. I think
24 it provided a forum, if you will, for full-time
25 faculty there. I think the group was, in part,

1 commercial and part political and part
2 professional and educational.

3 Q. At all times while you were treating
4 Edna, is it fair to say that you were operating
5 under your position as an employee of University
6 Plastic Surgery Associates?

7 A. Yes, it is.

8 Q. I made some notes as to some of the
9 changes that you indicated on the CV. I think
10 one of them was U.K. hospitals and U.K. medical
11 licenses and certifications. Can you just sort
12 of give me a summary of what all needs to be
13 stated to cover the U.K.

14 A. Of course. I have a full registration
15 with the General Medical Council of the United
16 Kingdom. I don't know my registration number
17 offhand. I could provide that, if it's
18 necessary. It's an unencumbered license to
19 practice medicine in any venue, now in the entire
20 EU. But by law I can practice anywhere in
21 Europe.

22 My title is consultant plastic surgeon
23 practicing at two hospitals; one at Cromwell
24 Hospital at London, England and the other is
25 Harley Street Clinic. At present those are my

1 titles.

2 And the other certification, I also
3 hold a position on the Specialist Register in
4 plastic surgery, which is a government approved,
5 maintained and approved list of plastic surgeons
6 that requires practicing through a rigorous type
7 of criteria in order to be placed on that list.

8 That kind of concept doesn't exist in
9 the United States, but that list in a certain
10 specialty only holds members that have been
a1 reviewed by the government and found to be
12 trained and certified appropriately and they get
13 this placement on this official list. So I have
14 that, as well.

15 Q. Okay. Did you have to take any type
16 of a formal exam to acquire your licensure?

17 A. I didn't.

18 Q. Just having practiced a certain number
19 of years in the United States?

20 A. No. That wouldn't be good enough
21 either.

22 I made a special petition to the Royal
23 College of Surgeons and I was a special case and
24 had a special hearing and a special committee
25 formed for me. So there is nothing regular about

1 my status there at all.

2 I am the only American that is fully
3 licensed to practice plastic surgery there, the
4 only American that maintains a place on the
5 Specialist Register. So there is no system in
6 place to accommodate someone like me; either
7 before me or after me, I believe.

8 Q. Why were you such a special case?

9 A. From my point of view or theirs?

10 Q. Whichever you feel more comfortable
11 addressing.

12 A. Why do I think they considered me a
13 special case or why do I think I was a special
14 case?

15 Q. You said that this has never happened
16 before.

17 A. Yes.

18 Q. And I am just wondering, how it is in
19 your mind you believe that you accomplished what
20 you did and apparently no one else has prior to
21 or since been able to accomplish?

22 A. I think in retrospect it was a
23 combination of multiple factors, some having to
24 do with me in particular and some not.

25 Firstly, there has been a significant

1 pressure on the British medical establishment as
2 of late by the European Economic Union to codify
3 certain regulations and come into line with the
4 way physicians are licensed and credentialed in
5 other European countries, and it was
6 particularly, that pressure was particularly high
7 at the time that I applied.

8 That in combination with the fact that
9 I married a European woman, so I was legal to
10 work there, I wasn't just an American coming
11 there. I already declared intention to settle
12 there, so I wasn't going to be an itinerant
13 physician, I was going to be permanently settled
14 there.

15 And that's the back drop for a
16 situation where I think I explored extensively
17 the requirements for what it took to be a
18 certified plastic surgeon there and addressed
19 those particularly. And I think I made a
20 particularly compelling case comparing my
21 background, training and credentials versus what
22 they usually require. And I had just a little
23 bit of legal assistance there just to make sure
24 that I complied all the way around.

25 So I think it was a combination of

1 making a compelling -- being a good candidate,
2 making a compelling case, being married to the
3 right person and having shown up at the right
4 time.

5 Q. Okay. Now, before this lawsuit was
6 filed, I believe you provided Edna, pursuant to a
7 request that she had made to your office, with a
8 copy of your office records.

9 Do you recall receiving a request from
10 her and providing a copy of her records?

11 A. I don't.

12 Q. The only reason I say that, contained
13 within your chart are a number of items,
14 including an authorization that was signed by
15 Edna for the release of a copy of her records.

16 And based upon that being in the
17 chart, you have no reason to believe that your
18 office wouldn't have released a full copy of the
19 office records to her, do you?

20 A. That's correct.

21 Q. And also, before my office, and
22 specifically, myself, on behalf of Edna filed a
23 lawsuit, an authorization was sent to you signed
24 by Edna, which is part of the file requesting a
25 complete copy of your office records. Do you

1 recall receiving that request?

2 A. I don't recall receiving it, but I saw
3 it in there.

4 Q. Okay. And on my letter to you, which
5 is dated June 5, there is a little note sent June
6 18, 1998 and then there is initials on there.
7 Would that have been a secretary in the office?

8 A. It would have been the office manager
9 at that time.

10 Q. And that would have been who?

11 A. Lorna Kotlin K-O-T-L-I-N.

12 Q. Would she have cleared the okay from
13 you before going ahead and sending the records?

14 A. She likely would have, but it's
15 possible that they were sent without talking to
16 me.

17 Q. In any event, when an authorization,
18 whether approved by you or otherwise, is provided
19 and records are sent, a complete copy of the
20 records are sent; correct?

21 MR. CRANDALL: You are asking to his
22 knowledge; right? I don't think he stated that
23 he actually does the copying.

24 Q. The procedure in the office is once
25 the authorization is approved and the okay,

1 whether it's been the office manager or by the
2 physician is given, the procedure is to send the
3 entire record. If a request is made for a
4 complete copy of the records, everything is to be
5 sent.

6 MR. CRANDALL: Do you have a policy?

7 THE WITNESS: No.

8 Q. Would you believe that anything other
9 than a complete copy of the records should be
10 sent?

11 A. No.

12 Q. Okay. In reviewing your CV, I
13 noticed that you have done some writing and
14 presented some presentations in the area of
15 aesthetic breast reconstruction; correct?

16 A. Correct.

17 Q. And in fact, in your CV, just glancing
18 at it, having just seen it for the first time
19 before the deposition started, there appears also
20 to be some information that you have disseminated
21 that has to do with nipple reconstruction, as
22 well, correct, or techniques?

23 A. Can I take a look at my own CV?

24 Q. Of course.

25 (Pause.)

1 A. Are you referring to something in
2 particular?

3 Q. I'll direct you to it once I find it
4 again. That was in my quick read through I saw
5 something.

6 A. Here is an article in here under
7 publications about three-fourths of the way
8 through, immediate nipple reconstruction
9 tatooing.

10 Q. That's what I was referring to.

11 And I guess what I am going to do just
12 to try to save some time is ask you as you look
13 at your CV, if you could, on Exhibit 1, if you
14 could just put your initials to the left of any
15 of the publications or reviews that you believe
16 contain any information that may be relevant to
17 the manner in which you approach breast
18 reconstruction in a post mastectomy patient as
19 well as nipple reconstruction techniques;
20 anything that may be relevant or touch on some of
21 the issues that pertain to Edna Williams. Can
22 you do that for me?

23 a. Yes, I can

24 (Pause.)

25 Q. Just for the record, Plaintiff's

1 Exhibit 1 is your CV and it now contains your
2 initials in 11 different locations on the CV; is
3 that correct?

4 A. Yes, it does.

5 Q. And that relates to articles or
6 presentations that in some way touch on matters
7 that may be relevant to Edna Williams' case;
8 correct?

9 A. It may in some way touch on it.

10 Q. All right. Have you had your
11 deposition taken before, sir?

12 A. Yes, I have.

13 Q. On how many occasions?

14 A. Once.

15 Q. Was that in the Robert Walker case?

16 A. Yes, it was.

17 Q. Your deposition was not taken in the
18 Mary Jane Hall case, was it?

19 A. It was not.

20 Q. That case was dismissed; correct?

21 A. It was.

22 Q. Is the Robert Walker case still
23 pending?

24 A. It's not.

25 Q. Bid that matter go to trial?

1 A. It didn't.

2 Q. Do you know what the resolution of
3 that case was?

4 A. We settled for some amount of money.

5 MR. CRANDALL: I would like an
6 objection to any reference to prior lawsuits,
7 other than this one.

8 MR. MISHKIND: That's fine.

9 Q. What was the subject matter, very
10 briefly? I don't need you to go into great
11 detail, but as you understood it, what was the
12 procedure or the accusation as it related to your
13 involvement?

14 A. Mr. Walker had a scalp flap done for
15 baldness, an aesthetic operation. A portion of
16 that flap died, a complication that was described
17 to him and reviewed before the surgery and he
18 felt that the aesthetic result was unacceptable.

19 Q. Was it your position that it was a
20 recognized complication?

21 A. It was.

22 Q. And did you feel that it was an
23 unavoidable complication?

24 A. I'm not sure I understand your
25 question.

1 Q. Had you ever had that complication
2 occur before Mr. Walker's?

3 A. Have I ever seen a portion of a flap
4 die before?

5 Q. Had you personally ever had the same
6 type of complication occur that occurred to
7 Mr. Walker?

8 A. Again, I am not sure of your
9 question. Have I seen a portion of a flap that I
10 have raised personally or a portion of a scalp
11 flap or a portion of a scalp flap designed like
12 his was? I am not sure of the question.

13 Q. Specifically a portion of the skin
14 flap die that was designed like his.

15 A. No, I haven't seen it.

16 Q. That was a case here in Cuyahoga
17 County; correct?

18 A. It was.

19 Q. Do you happen to remember who the
20 plaintiff's attorney was in that case?

21 A. I can't remember his name.

22 Q. This is now the second time that
23 you've had an opportunity to have your deposition
24 taken?

25 A. It is.

1 Q. Is this the third occasion in your
2 career that you have been named as a defendant in
3 a medical negligence case?

4 A. It's not.

5 Q. How many times have you been named?

6 A. I have been named, to my recollection,
7 three others.

8 Q. So this is now the fifth time, the
9 Edna Williams case -- I'm sorry, the sixth time?

10 A. This would be the sixth time that I
11 have been named.

12 Q. Are any of the cases, aside from
13 Edna's case, still open as far as you know?

14 A. Yes, they are.

15 Q. How many?

16 A. Three are still open.

17 Q. Are all of them -- strike that.

18 Does the three include Edna or would
19 Edna's be the fourth?

20 A. Edna's would be the fourth.

21 Q. Are the other three here in Cuyahoga
22 County?

23 A. They are.

24 Q. Do any of them have to do with
25 complications -- I'll use that as a generic

1 term, not implying whether the complication was
2 due to negligence or otherwise -- complications
3 associated with any aspect of reconstruction
4 following mastectomy?

5 A. No, they weren't.

6 Q. Those other cases that are open,
7 Edna's aside, your deposition has not been taken
8 in those as of yet?

9 A. That's correct.

10 Q. Are they relatively -- are they more
11 recent, to your knowledge?

12 A. They are.

13 Q. Can you tell me briefly either the
14 name of the patient or what the subject matter of
15 the procedure was that is in controversy, or
16 both?

17 THE WITNESS: First of all, can I ask,
18 is it appropriate that I list the names?

19 MR. CRANDALL: Yes.

20 Q. As long as a lawsuit has been filed,
21 you are permitted to do so. I am not going to go
22 into any specifics of that because it's pending
23 litigation and your deposition hasn't been
24 taken. I just want to know the name of the case
25 and what the procedure involved and that's where

1 I am going to stop.

2 MR. CRANDALL: I need an objection on
3 the record for any of the lawsuits filed after
4 this Williams' lawsuit also. Go ahead and tell
5 him the name and the brief subject matter.

6 A. One involves a Mary Elliott, a patient
7 who is dissatisfied with the outcome of a face
8 lift.

9 Another patient is named Joseph
10 Keffer, dissatisfied with the outcome of a brow
11 lift.

12 The last patient is named Caroline
13 Pruitt, who is dissatisfied with the outcome of
14 an injection, a sclerotherapy injection.

15 Q. Are you represented by the Reminger
16 firm in those other cases?

17 A. I am.

18 Q. Are you currently scheduled to give
19 deposition testimony in any of those cases?

20 A. No, I'm not. Not that I know of
21 anyway.

22 Q. Are you currently serving as an expert
23 witness in any medical negligence cases?

24 A. I'm not.

25 Q. Have you ever?

1 A. I haven't.

2 Q. Have you ever reviewed records and
3 provided an attorney with an opinion on whether
4 or not the standard of care was or was not
5 complied with?

6 A. I have.

7 Q. On how many occasions?

8 A. About three or four, I believe,
9 something like that.

10 Q. Have you written reports in those
11 cases?

12 A. I have, yes.

13 Q. But never got to the stage where your
14 testimony was elicited?

15 A. That's right.

16 Q. Did any of those cases have to do with
17 issues surrounding complications following
18 mastectomies, following reconstructive surgery?

19 A. I don't recall that there were.

20 Q. Dr. Shenk was the surgeon that
21 performed the mastectomy on Edna?

22 A. He was.

23 Q. You consulted with Edna prior to her
24 mastectomy to determine with her whether or not
25 she was an appropriate candidate for immediate

1 post mastectomy reconstruction?

2 A. Yes.

3 Q. Had you worked with Dr. Shenk on cases
4 previously?

5 A. I had.

6 Q. Since this lawsuit was filed, have you
7 had occasion to talk to Dr. Shenk at all about
8 any aspect of Edna's criticisms of you?

9 A. Criticisms of me. I am not sure I
10 understand that question.

11 Q. Fair enough. And I should say since
12 you have not testified a lot, if I ask you
13 anything that may to me seem clear, but to you it
14 is garbled, don't answer it. Tell me just as you
15 did and I will rephrase it.

16 Simply put, I am asking you whether
17 you have talked to Dr. Shenk at all since this
18 lawsuit was filed concerning any of the
19 criticisms or the things that Edna has said in
20 the lawsuit or anything that you understand her
21 to be unhappy about you concerning the outcome?

22 MR. CRANDALL: Can I just object and
23 ask a question of you, Howard? Has an expert
24 report ever been given by the plaintiff in this
25 case yet?

1 MR. MISHKIND: Not yet, no.

2 MR. CRANDALL: I don't know if Dr.
3 Goldberg is aware exactly what your client is
4 complaining of.

5 Are you asking him whether or not he
6 has talked to Dr. Shenk about this case
7 whatsoever?

8 MR. MISHKIND: Right, yes.

9 MR. CRANDALL: I think that's a
10 different question, but go ahead and answer.

11 A. About this medical case or about this
12 legal case?

13 Q. Well, since Edna left your practice --
14 and that would be sometime after the last surgery
15 in 1997, towards the end of 1997, she
16 disassociated herself from your: practice. From
17 that time forward, the end of 1997 up to the
18 present date, have you had occasion to talk to
19 Dr. Shenk at all about Edna Williams?

20 A. Probably. I mean, I am not sure of
21 the date. I talk to Dr. Shenk about all the
22 patients we shared in common at one time or
23 another.

24 Q. Would this have been an in-person
25 discussion?

1 A. Yes. It would have taken the form of
2 verbal or likely written at some time, as well.

3 Q. Again, since 1997, do you have any
4 correspondence that you wrote, have written to
5 Dr. Shenk or he to you concerning Edna Williams?

6 A. Well, if it's not in the chart, I am
7 going to make the assumption that I haven't. So
8 the correspondence with him, if not in this
9 chart, probably was verbal.

10 Q. Do you remember the substance, either
11 specifically or in general, of any of the
12 discussions that you had with Dr. Shenk about
13 Edna Williams? Again, after she left your
14 practice.

15 A. After she left my practice. Well, I
16 certainly may have discussed with him either
17 before or after she left my practice what her
18 ongoing course was. And I believe I discussed
19 with him at some time that I received a letter
20 saying she was going to take legal action against
21 me.

22 Q. And might that have been then the 180
23 day letter that I issued to you in October of
24 1998?

25 A. It might have been, yes.

1 Q. Okay. Did you then have a discussion
2 about -- you get this letter and you said that
3 she is considering or contemplating taking legal
4 action against you. What was discussed between
5 you and him at that point?

6 A. Again, I'm not sure of the timing with
7 regard to your letter. But I do recall saying to
8 him that I have become aware that Edna Williams
9 is considering or is taking legal action against
10 me.

11 Q. Okay. And tell me what, if anything
12 else, you said to him then or at any time as it
13 relates to legal action by her.

14 A. I don't recall exactly. I just recall
15 the substance of the conversation, which
16 basically was what I just said to you; that Edna
17 Williams -- either I think, or Edna Williams is
18 considering or is taking legal action against me.

19 Q. Anything further that you recall
20 saying to Dr. Shenk then or at any time as it
21 relates to the contemplated legal action?

22 A. No, not that I recall.

23 Q. Do you recall what Dr. Shenk's
24 response was to you?

25 A. Yes. In general, his response was

1 something on the order of that conveyed his
2 disbelief, frustration, and said something like
3 if I can help you or if you need my help, let me
4 know, something like this.

5 Q. Do you remember anything else
6 substantively or in general that he said to
7 you --

8 A. No, I don't.

9 Q. -- other than what you just told me?

10 A. No, I don't.

11 Q. Did he ever explain to you what he
12 meant when he said that he was expressing his
13 disbelief or his frustration with the information
14 that you had just given to him?

15 A. Well, he may have added something
16 like, in general, that referenced the fact that
17 because she was such a difficult patient and
18 required an extreme high level of attention and
19 care, I believe that is what underlined his
20 surprise.

21 Q. Anything else that he said to you
22 specifically or in general with regard to his
23 disbelief or his frustration of the news you gave
24 to him?

25 A. Not that I can recall, no.

1 Q. The business that you are in as a
2 plastic and reconstructive or aesthetic surgeon,
3 you frequently encounter patients that have high
4 aesthetic demands; correct?

5 A. Yes, correct.

6 Q. And when you are dealing with a
7 patient, especially reconstructive surgery
8 following mastectomy, do you have to balance the
9 patient's aesthetic demands versus the vascular
10 demands of the patient's body; correct?

11 A. Yes.

12 Q. And if you feel as if a patient has
13 demands which are unrealistic or demands which
14 you believe to be not in the patient's best
15 interest, what action as a surgeon should you
16 reasonably and prudently take?

17 A. It would depend on the situation, of
18 course. But I would like to believe that I
19 wouldn't do an operation that I didn't feel was
20 appropriate.

21 Q. And that, can we agree, is what a
22 reasonable and prudent aesthetic surgeon
23 operating in this area should do?

24 A. Yes.

25 Q. I want to move away from Dr. Shenk,

1 but before I do that, I want to find out whether
2 there is anything else that you recall having
3 discussed with him about Edna after you learned
4 that she was contemplating bringing legal action?

5 A. No. As I stated, there is nothing
6 else I recall.

7 Q. Were you having any communications
8 other than perhaps sending copies of portions of
9 your chart, operative notes, perhaps, to Dr.
10 Shenk as you were going through the various
11 stages of the tissue expander and the injection
12 of the saline and then the exchange of the
13 implant? Were you having any meetings or talking
14 with him at all about any aspect of her
15 reconstructive course?

16 A. Yes, I am sure I was. As I stated,
17 all my communication with him was either verbal
18 or written. And I am going to make the
19 assumption if it was written, it's in her chart,
20 and if it was verbal, it is not.

21 Q. Okay. As it relates to those verbal
22 communications that were occurring along the
23 course of time, beginning from the time that you
24 started your relationship with Edna back in April
25 of 1996, up to the time that it ended towards the

1 end of 1997 -- this is obviously now before any
2 lawsuits are contemplated or communications from
3 any attorneys -- do you recall any of your
4 discussions that you had, verbal discussions with
5 Dr. Shenk about Edna Williams?

6 A. Not in particular. I could recall the
7 type of thing that I would have been very likely
8 to discuss with him about a patient such as
9 this.

10 MR. CRANDALL: I don't want you to
11 guess, okay? If you recall a conversation with
12 him, I want you to tell Mr. Mishkind. If you
13 don't, I don't want you to presume based on any
14 other --

15 A. I don't recall a specific
16 conversation.

17 Q. You mentioned based upon a patient
18 like this. Obviously in the area of aesthetic or
19 reconstructive surgery with patients that may
20 have high aesthetic demands or otherwise, you may
21 encounter patients, perhaps different than a
22 general surgeon or an internist may encounter,
23 and certain demands different upon you than other
24 physicians; correct?

25 A. Correct.

1 Q. When you say a patient like Edna
2 Williams, what kind of patient was she or what
3 expectations or demands fit within this
4 description of Edna Williams?

5 A. I'm not sure I understand what you are
6 asking.

7 Q. Okay. You said before a patient like
8 Edna Williams. Actually you have said it a
9 couple times. I want to understand from you what
10 you mean by a patient like Edna Williams, as
11 specifically as you possibly can.

12 A. Okay. Well, first of all, in the most
13 general sense I would discuss a patient like Edna
14 Williams, a breast reconstruction patient, with
15 him. Every patient has a particular to their
16 case. Some patients may have more particulars
17 than others. They may require more discussion or
18 more planning or something.

19 This patient has particulars about her
20 that were probably included in discussions with
21 him, such as a history of radiation, certain
22 aesthetic demands that she communicated to me
23 that might make the operation more challenging,
24 might make her care more challenging, let's say.

25 Q. What were those demands?

1 A. Aesthetic demands?

2 Q. Yes, sir.

3 A. That she wanted, as I recall, in her
4 words, a perfect, beautiful breast, a minimum of
5 scars, a minimum of operative risk, a minimum of
6 operative time, a minimum of recovery time, a
7 minimum of postoperative time, postoperative
8 risk.

9 Q. And did you feel that those demands
10 were unrealistic, any one or more of them?

11 A. I thought they made her care more
12 challenging.

13 Q. But not unrealistic?

14 A. What do you mean by unrealistic?

15 Q. Well, you said that there were certain
16 demands. I want to know -- realistic or
17 unrealistic to me means demands that you may or
18 may not be able to achieve.

19 Did you feel that any one of more of
20 those demands were unrealistic things that you,
21 challenging or otherwise, could not reasonably
22 expect to be able to achieve?

23 A. Well, within reason, there was no way
24 to give her a perfect, beautiful breast -- her
25 words.

1 Beyond that, I don't know if it was
2 unrealistic as much as it was challenging.

3 Q. Okay. Did you convey to her that you
4 could not provide her with a beautiful, perfect
5 breast in light of the fact that you are dealing
6 with a patient that's post radiation and then
7 mastectomy on top of the post radiated skin?

8 A. I did.

9 Q. And did she seem to understand that
10 given that she had perhaps this radiation
11 dermatitis or radiated skin that she could not
12 expect to have a perfect breast?

13 A. Well, she seemed to understand at the
14 end of each conversation, but the conversation
15 came up more than once.

16 Q. Okay. The conversation that she
17 wanted a perfect breast?

18 A. Yes.

19 Q. Other than the conversation about
20 wanting a perfect breast, were there any other
21 aspects of her demands, that albeit challenging,
22 you felt were unrealistic?

23 A. Can you ask me that again?

24 Q. Other than the issue of the perfect
25 breast, which came up on more than one occasion,

1 were there any other demands that Edna had that,
2 albeit challenging to you, were unrealistic?

3 A. It's a difficult question to answer.
4 Because her perception of accepting something
5 less than perfect may not still, may not have
6 still mirrored what I thought was possible.

7 So though she may have come to accept
8 or may not have come to accept the idea of
9 something less than perfect, it's conceivable
10 that what she envisioned was still not what I
11 explained she could get.

12 Q. Okay. You have had a chance to review
13 your office notes; correct?

14 A. Yes.

15 Q. Do your office notes in your opinion
16 accurately reflect the exchanges that you had
17 with Edna on each and all of the visits that are
18 recorded?

19 MR. CRANDALL: I assume you are
20 indicating a summary form, not word-for-word?

21 MR. MISHKIND: I am.

22 A. I think, within reason, they
23 accurately reflect the medical information that
24 was disseminated.

25 Q. When was the last time you reviewed

1 your notes?

2 A. This morning.

3 Q. And before that?

4 A. Maybe a few months.

5 Q. As you reviewed them, either this
6 morning or a few months ago and you read through
7 any particular office note -- and putting aside
8 the operative note of September 1997, which we
9 have already talked about -- is there anything
10 that you would, had you to do it over again in
11 terms of recording things, you would have added
12 something that you remember taking place that is
13 not reflected in the office notes?

14 MR. CRANDALL: Objection. Go ahead.

15 A. Can you ask your question again?

16 Q. Sure. Is there anything, when you
17 look at your office notes, or the operative
18 notes, that had you an opportunity to add to or
19 correct anything in the records, is there
20 anything that you would add to the records based
21 upon specific events that you recall that are not
22 either accurately reflected in the records, or
23 it's accurate up to a certain point but there is
24 additional information that you remember that
25 just isn't in the record?

1 MR. CRANDALL: I need to object. I
2 just need to say I am confused because it seems
3 to me what you are asking him is does he have
4 some independent recollection beyond the
5 records.

6 But my concern is it seems like we are
7 getting into some situation where I would go back
8 in and write things in the record and I don't
9 like that.

10 MR. MISHKIND: I am not suggesting
11 that.

12 Q. And Steve put it probably the best, as
13 he normally does. And that is, is there anything
14 independent that you recall from any one of the
15 visits or any one of the operations that when you
16 looked at the records, you just said to yourself,
17 gosh, I remember such-and-such, and right or
18 wrong, I don't have it reflected in the records?

19 A. From the point of this being a record
20 of her medical care, the answer is no.

21 Q. From any other point of view, is there
22 something you wish you had put into the records
23 that you remember that is not contained in the
24 records?

25 MR. CRANDALL: Again, I need to

1 object, because the "wish that he put in there"
2 is what I am confused about or concerned about.

3 I think what he is asking is do you
4 have an independent recollection of other things
5 that occurred beyond what is in the record;
6 conversations with her, things of those
7 magnitude?

8 A. If that's the question, the answer is
9 no.

10 Q. Okay. In the interrogatory answers
11 that were provided, you have Dr. Roderick Jordan
12 as one who has information relative the care and
13 treatment of Edna. And Dr. Jordan, we know, is
14 involved in THE September of '97 surgery.

15 Was he involved in any other aspect of
16 Edna's surgical intervention before?

17 A. He wasn't.

18 Q. Have you talked to Dr. Jordan since
19 this lawsuit was filed?

20 A. I don't believe so.

21 Q. M. Coleen Neely, am I pronouncing it
22 correctly?

23 A. Yes.

24 Q. N-E-A-L-Y?

25 A. N-E-E-L-Y.

1 Q. Is Coleen -- does she go by Coleen?

2 A. She does.

3 Q. What does the M stand for?

4 A. I don't know.

5 Q. Not that it's really terribly
6 important. But is she still affiliated with the
7 group?

8 A. She is.

9 Q. What is her title other than RN?

10 A. What is her title? Officially, I
11 couldn't tell you what her title is. I don't
12 know.

13 Q. What was her responsibility?

14 A. Her responsibility is patient care,
15 patient liaison, patient teaching for patients of
16 University Plastic Surgery Associates.

17 Q. Have you had an opportunity to talk to
18 Coleen since this lawsuit was filed?

19 A. I have had the opportunity to, yes. I
20 don't recall if I have discussed the lawsuit with
21 her.

22 Q. You know Dr. Melvyn Dinner; correct?

23 A. E know him, yes.

24 Q. Is he a well-respected plastic
25 surgeon, in your opinion?

1 A. Yes.

2 Q. You sort of hesitated when you said
3 that.

4 Does he maintain a good reputation
5 amongst plastic surgeons?

6 A. From my point of view, he does.

7 Q. Have you had an opportunity to review
8 the records as it relates to the subsequent
9 surgeries that he performed?

10 A. I haven't.

11 Q. You haven't seen any of that?

12 A. I have not.

13 Q. So you have no idea then -- or do you
14 have an idea as to what the aesthetic outcome has
15 been following Dr. Dinner's surgeries?

16 A. **No.**

17 Q. I provided photographs to your
18 attorney -- have they been shown to you -- that
19 Dr. Dinner took?

20 A. **No.**

21 Q. Is Dr. Dinner, in your opinion,
22 considered an expert in the area of breast
23 reconstruction?

24 A. Yes.

25 Q. I take it you have never had your

1 hospital privileges suspended or revoked or
2 called into question?

3 A. That's correct.

4 Q. Have you ever had your license in any
5 way restricted?

6 A. I have not.

7 Q. Ever applied for licensure and been
8 denied?

9 A. Never have.

10 Q. Or applied for privileges at a
11 hospital and had them denied?

12 A. Never have.

13 Q. You do maintain an active license in
14 the State of Ohio?

15 A. I do.

16 Q. Have you had occasion in connection
17 with this lawsuit to review any medical
18 literature that relates to techniques used for
19 reconstructive surgery on a patient that has
20 compromised vascularity, secondary to radiation,
21 that's undergoing reconstructive surgery?

22 A. I review medical literature about this
23 kind of thing all the time, ongoing.

24 Q. Are there any particular articles or
25 book chapters that you reviewed in connection

1 with this case? In other words, with Edna
2 Williams in mind, just to see what is in the
3 literature and what you did and what occurred in
4 this case?

5 A. No, not in particular.

6 Q. Certainly we know that you have a
7 number of articles that you have written that
8 touch on various things that have some relevance
9 to Edna Williams; correct?

10 A. Correct.

11 Q. Do you personally own any texts that
12 deal in large part with breast reconstruction
13 following mastectomy on a patient that has
14 radiation dermatitis or compromised vascularity
15 secondary to radiation therapy?

16 A. I own texts that discuss the issue of
17 breast reconstruction. To my recollection,
18 that's the most accurate I can answer the
19 question.

20 Q. And is it likely that those texts have
21 aspects of the issues that a surgeon such as
22 yourself faces in doing reconstruction on a
23 radiated chest wall?

24 A. Yes.

25 Q. Which books or journals, if you will,

1 are the ones that you look to most frequently in
2 that area of reconstruction post mastectomy on a
3 patient that has had radiated chest wall?

4 MR. CRANDALL: I am going to object.
5 I don't know if he told you that he looks at
6 these books frequently when dealing with these
7 issues, but go ahead.

8 THE WITNESS: I did. I said before
9 that I read the literature on an ongoing fashion,
10 not in relation -- certainly here not in relation
11 to any one case, certainly here not in relation
12 to this case.

13 A. You asked me earlier what books I have
14 on my shelf, which I am going to list for you.
15 My familiarity with the literature is not limited
16 to those books nor in any way particularly is my
17 practice particularly based on what is said in
18 those books.

19 Q. But you keep up to date on various
20 techniques that are written about the peer
21 reviewed articles and journals and texts which
22 are considered to be standard textbooks; correct?

23 A. Yes.

24 Q. Okay. And in terms of peer reviewed
25 articles or peer reviewed journals, which ones do

1 you, in order to keep up to date on the thought
2 process as it relates to standard and accepted
3 techniques, which journals do you typically look
4 to for information of this type?

5 A. Plastic and Reconstructive Surgery,
6 British Journal of Plastic Surgery, Journal of
7 Aesthetic Surgery, a journal called Breast
8 Diseases, Clinics and Plastic Surgery.

9 Q. Are these generally considered
10 reliable sources of information that are peer
11 reviewed by surgeons that practice in this area?

12 A. Yes.

13 Q. And sources that you from time to time
14 will look to for reliable information?

15 A. Yes.

16 Q. Okay. Now, the texts -- and I don't
17 need you to give me every single text that you
18 have, but the ones that you consider to be
19 perhaps the leading texts that you own that would
20 be most relevant to topics dealing with aesthetic
21 or reconstructive surgery following mastectomy.

22 A. It's difficult to name one book, but I
23 can name you a few that I think are relevant.

24 Q. These would be the ones that would be
25 like at the top of your list?

1 A. Yes. Aesthetic and Reconstructive
2 Breast Surgery by Bostwick. Reconstruction of
3 the Cancer Patient by Kroll K-R-O-L-L. I don't
4 remember exactly what it is called, but it's a
5 book by Scott Spear, Breast Surgery or
6 Reconstructive Breast Surgery or something like
7 that. S-P-E-A-R.

8 I consider those to be very good ones.

9 Q. Have you contributed to any of those
10 texts?

11 A. No.

12 Q. Let's talk about Edna. Feel free to
13 refer to the records as we go through it, because
14 it's not a memory contest. If there are items --
15 what I was saying is please feel free to refer to
16 the records. It's not a memory contest.

17 On the other hand, if you talk about
18 things, if there is something that does come back
19 to you, oh, yeah, I remember such-and-such taking
20 place as we talk about a particular visit or a
21 particular surgery, please tell me.

22 In other words, I don't want you to
23 hold back when we talk about a particular entry.
24 If there is something that is not reflected in
25 the record, will you tell me that you remember

1 something?

2 A. I will.

3 Q. Okay. Going through the records, I
4 note that the first visit that you had with her
5 would have been April 17th, 1996; correct?

6 A. Yes.

7 Q. Now, for that visit, all I have and
8 all I have seen is a letter that you wrote to Dr.
9 Shenk, two pages in length. Does that constitute
10 your office note for that visit?

11 A. It does.

12 Q. Thereafter when you see the patient in
13 the office, you have specific dictated notes;
14 correct?

15 A. That's correct.

16 Q. Was there a reason that this one was a
17 letter as opposed to a clinical note like we have
18 thereafter?

19 A. Well, there is a lot of information to
20 record after the first visit, and that's a rather
21 time efficient way, as well as courteous way of
22 recording all the information and communicating
23 with the referring or primary physician about the
24 visit and perhaps the direction that the care
25 might go.

1 Q. Okay. And I am not suggesting it's
2 not courteous or efficient, I am just curious as
3 to whether it's your practice to maintain simply
4 the letter itself as the office note as opposed
5 to something else by way of dictation?

6 A. As long as I feel the letter I
7 dictated contains the information that is
8 relevant and important, then I feel that the
9 letter is sufficient. There are other cases
10 where I would dictate a separate note if I hadn't
11 covered it in the letter.

12 Q. The decision to use a tissue expander
13 with subsequent saline injections followed by
14 subsequent exchange with a saline implant was
15 your recommended course of treatment, assuming
16 Edna chose to have you as her reconstructive
17 surgeon? Is that an accurate statement?

18 A. I think the statement is accurate
19 provided that it's qualified.

20 Q. Please, go ahead.

21 A. That at the end of our meeting, given
22 the set of circumstances in this case, that was
23 the decision to which Edna and I had come to
24 mutually.

25 Q. Okay. Did you discuss various other

1 modalities that you could use to reconstruct her
2 breast following the mastectomy?

3 A. We did.

4 Q. What were the other potential surgical
5 procedures that you discussed and considered with
6 her?

7 A The options that we reviewed **as** listed
8 here were to do nothing in the way of
9 reconstructing the breast, to use some kind of
10 implant, either as an expander or an implant
11 placed primarily after surgery to reconstruct the
12 breast from her own tissue or to use some
13 combination of the two.

14 Q. In terms of using her own tissue,
15 would you be considering either latissimus muscle
16 or abdominal muscle?

17 A. Yes.

18 Q. **So** that consideration would be for a
19 TRAM flap or a latissimus?

20 A. They would be.

21 Q. Did you recommend one over the other?

22 A. I recommended that she have a TRAM
23 flap.

24 Q. Okay. And what was the reason that
25 you recommended the TRAM flap over the others?

1 A. Well, the reason -- there is two
2 answers to your question and there is a reason
3 that I would recommend a TRAM flap for the
4 general patient and there would be reasons I
5 would recommend a TRAM flap for Edna.

6 In the general way I would recommend a
7 TRAM flap because the use of osteogenous tissue
8 provides a reconstructive breast that in general
9 is the most aesthetically pleasing, has the least
10 complications over the long term, probably is the
11 most durable, likely is the most resistant to
12 effects of radiation, and in general, in those
13 studies that have been done, patient satisfaction
14 over the long term seem to be very high with a
15 TRAM flap and perhaps higher with a TRAM flap
16 though with implant reconstruction, although that
17 is not proven. It's implied in the literature.

18 In Edna's case, I think the TRAM flap
19 is particularly useful in that she has a radiated
20 bed in the area where she had the previous breast
21 cancer treatment. And though implants are known
22 to carry certain risks, those risks are increased
23 with the use of prosthetic material there.

24 Q. Okay. I am going to show you
25 Plaintiff's Exhibits 2 and 3 and ask you whether

1 these two exhibits which are photographs with a
2 date stamped of April 17, 1996 are photographs of
3 Edna?

4 A. Yes.

5 Q. And are these premastectomy
6 photographs?

7 A. They are.

8 Q. Do these photographs show to a certain
9 degree the radiation dermatitis or the radiation
10 injury to the left chest wall?

11 A. It's a difficult question to answer,
12 but I will try to be accurate. They show a
13 discoloration of the skin that is consistent with
14 changes from radiation dermatitis. Visual
15 inspection, especially from afar, is certainly
16 not the best way to diagnose that.

17 Q. Okay. What is the best way to
18 diagnose the extent of insult or the extent of
19 injury, and the impact it's going to have on
20 reconstruction when you are looking at a radiated
21 chest wall?

22 A. A combination of visual and palpation
23 examination I think is the best.

24 Q. Now, do you know where the originals
25 are of these photographs?

1 A. I don't know. I assume they are in
2 her chart. I hope they are in her chart. There
3 would be no reason that I know of that they would
4 not be in her office chart.

5 Q. And is that office chart back at your
6 office?

7 MR. MISHKIND: Or is that something
8 that Jay has the original of?

9 MR. CRANDALL: I don't believe that we
10 are in possession of it, no.

11 A. I don't know is the answer. But it's
12 probably in my office, and if it is in my office,
13 I will be happy to produce it intact.

14 Q. Okay. What I want to understand is
15 when I am looking at these laser photographs,
16 when is the last time you saw the original of the
17 chart?

18 MR. CRANDALL: Are you talking about
19 the photos or the chart materials?

20 MR. MISHKIND: Specifically, the
21 photos.

22 A. You know, I can't recall is the
23 answer.

24 Q. Can you recall sufficient enough that
25 you can tell me whether or not the originals of

1 the photographs better depict visually the extent
2 of the radiation burns to her chest wall?

3 A. No, they don't.

4 Q. So these laser photos show as well **as**
5 the originals?

6 A. Yes.

7 Q. Now, the originals, were they
8 Polaroids or were they 35 millimeters?

9 A. 35 millimeter.

10 Q. Were they this size, eight and a half
11 by 11?

12 A. Well, they weren't eight and a half by
13 11, but they were in these proportions and they
14 were 35 millimeter slides.

15 Q. Okay. And are the negatives usually
16 kept with the prints?

17 A. Well, they are slides, so you don't
18 get negatives back, you just get slides. And I
19 hope they are in the chart. And if they are in
20 the chart and you want access to them, that's
21 fine.

22 MR. CRANDALL: They are slides but not
23 photographs; right?

24 THE WITNESS: Slides.

25 MR. MISHKIND: Which is a negative, so

1 that would be reproducible in whatever media we
2 would want to.

3 Q. Of Exhibit 2 and Exhibit 3, which best
4 shows the areas that had any type of
5 hyperpigmentation secondary to the radiation
6 burns?

7 A. It appears that the oblique view shows
8 hyperpigmentation.

9 Q. And where, specifically, if you could
10 describe for me anatomically was the
11 hyperpigmentation?

12 A. It looks as though it's an area of the
13 chest wall underneath the breast on the left
14 side, and there may indeed be some
15 hyperpigmentation on the under side of the
16 remaining breast.

17 Q. It was your recommendation to her that
18 a TRAM flap be used for the reasons previously
19 stated?

20 A. It was.

21 Q. And was Edna against having a TRAM
22 flap?

23 a. She was.

24 **a.** And did she articulate to you the
25 reasons that she was against having a TRAM flap?

1 A. She did.

2 Q. Tell me, please.

3 A. She wanted a surgery that was
4 relatively short. A TRAM flap is not that. She
5 wanted the minimum of scars. A TRAM flap does
6 not provide that. She wanted a minimum of
7 postoperative recovery time and a TRAM flap did
8 not provide that.

9 She had some real financial concerns
10 with regard to her ability to return to work and
11 perhaps with regard to her taking care of her
12 medical bills. I don't remember that
13 specifically, but I remember an element of the
14 conversation that she had financial pressures on
15 her and a long recovery time would negatively
16 impact on that. Those were her reasons, as I
17 recall.

18 Q. Why was a TRAM flap more advisable
19 than using the latissimus muscle?

20 A. Well, the latissimus muscle in most
21 women will require the use of an implant, as
22 well. And just because there is a muscle
23 present, there is no literature that shows that
24 the increased rate of complications associated
25 with the use of prosthetics in a radiated patient

1 is lessened by having the latissimus muscle added
2 to it.

3 Q. Based upon your consult with Edna, was
4 a decision then made for her to go the tissue
5 expander route?

6 A. It was.

7 Q. Did you feel that decision on her part
8 was ill advised?

9 A. I'm not sure I understand your
10 question.

11 Q. Was it, in your opinion, in terms of
12 the likelihood of success, was it ill advised or
13 was it a poor decision on her part to select
14 using the tissue expander?

15 A. I would not say it was ill advised.
16 The advice was from me. I don't think that it
17 would be an oversimplification to say that her
18 selection would have been poor.

19 Her selection came with a set of risks
20 that were particular for choosing that route of
21 reconstruction. Some of those risks would not
22 have been associated with the choice of other
23 methods. I wouldn't have done the operation that
24 I thought was doomed to failure.

25 Q. Okay. And I guess subsumed in my

1 question was how you would approach something if
2 a patient is insisting upon proceeding in a
3 course that in their mind seems to be a positive
4 step aesthetically, but in your mind from a
5 technical standpoint, you realize that it has a
6 high risk of being doomed to failure. What do
7 you say to a patient under those circumstances?

8 MR. CRANDALL: We are talking
9 generally now? You are outside of this case?

10 MR. MISHKIND: Yes.

11 THE WITNESS: In general, I can answer
12 that. That's how I was going to.

13 MR. CRANDALL: I want to make sure
14 that's clear.

15 A. I don't think that it's useful to
16 discuss risk unless it's weighed against
17 perceived benefit, because the risk of one
18 operation versus another may be higher or lower.
19 But that's not a fair way to judge one operation
20 against the other unless it's weighed in balance
21 against the particular benefits for that
22 operation.

23 So I think what needs to be weighed in
24 choosing one procedure versus another is the
25 risk/benefit ratio of one operation versus

1 another.

2 In terms of real risk, TRAM flap is
3 probably riskier -- to use a vernacular term not
4 a medical one -- than an implant. It's probably
5 riskier. It's a bigger operation. As I describe
6 it to patients, it's an operation about five
7 times longer than putting an implant in. But in
8 terms of risk/benefit analysis, the risk/benefit
9 equation of a TRAM flap weighed against the
10 risk/benefit equation of an implant in most
11 patients makes that the favorable choice. That's
12 most patients.

13 Every patient, of course, comes along
14 with their own set of circumstances as far as
15 medical history, present medical situation, level
16 of expectations, other social or emotional
17 factors that also have to get added into that
18 risk balance equation.

19 Q. Help me out with the way that one
20 explains this risk/benefit analysis to a patient,
21 and specifically when you were discussing the
22 risk/benefit analysis with Edna how that
23 discussion would have taken place.

24 a. Every patient at first consultation
25 gets a significant amount of time, about an

1 hour. In general, I do it the same way every
2 time. The discussion does not turn to the
3 patient's particulars, until probably the last
4 third of the conversation, because understanding
5 breast reconstruction in general is salient to
6 any single patient making an appropriate decision
7 for themselves.

8 So the consultation would in essence
9 be structured along the following lines. After I
10 would ask some basic questions about the patient
11 and their history, I would talk about breast
12 reconstruction. First, socially why it's
13 desirable; emotionally why it's desirable;
14 medically what it involves, why patients in
15 general choose to undertake breast
16 reconstruction.

17 And I reinforce the fact that this is
18 elective, completely elective; it will not change
19 her medical course, it will not change the course
20 of her disease. It does have impact on the
21 quality of her life, which is a very subjective
22 entity, of course.

23 Then I review the options that a
24 breast cancer patient has for breast
25 reconstruction that are listed here; in general,

1 the options that they might pick up on a piece of
2 well written literature.

3 And I talk about in the most general
4 way the risks and benefits, the pluses and
5 minuses, the demands on the patient and the
6 perceived benefits and expected benefits from
7 each one of those.

8 After I do that, I try to get a
9 feeling from the patient, either directly or
10 indirectly, which one of those options may appeal
11 to them; and sometimes to the point of asking
12 them which operation do they think they want.
13 And after they tell me where they think they
14 would like it to go, then I will add back in how
15 appropriate I think their choice is.

16 Sometimes their choice is
17 inappropriate and I think we need to discuss
18 why. Sometimes their choice is appropriate but
19 there are other appropriate options and so I
20 reexplore with them the other options that I
21 think is appropriate or sometimes I just
22 reinforce their choice.

23 Q. Let's talk specifically about Edna.
24 She made the choice of going with the tissue
25 expander?

1 A. She made the choice of not having a
2 big operation. From early in the discussion, she
3 made it known that she didn't want to have big
4 surgery, didn't want to have big scars and didn't
5 want to make a commitment to a big operation.

6 Q. Did that then sort of dictate what her
7 choice would be?

8 A. Yes.

9 Q. Did you articulate then that the only
10 choice that you have is to do a tissue expander
11 under those circumstances, Edna?

12 A. I articulated to her that if she chose
13 not to have her own tissue used, that the only
14 option left -- today anyway -- is to use some
15 kind of prosthetic, which in general comes with a
16 set of higher risks in a patient who has been
17 radiated.

18 Q. Okay. Once she indicated her
19 preference and you told her to meet that
20 preference, the only choice was to do it by a
21 tissue expander. Did you approve of her choice?

22 A. I'm not sure what you mean by approve.

23 Q. I think you said once a patient makes
24 a choice, you either will reaffirm or will -- I
25 forgot what the term was you used once the

1 patient makes the choice. Perhaps you can
2 remember.

3 A. If it's a choice that I would have
4 made, then I would reaffirm it.

5 Q. Reaffirm. Once she has made the
6 choice that she wants the small operation or
7 doesn't want to have the big operation and you
8 talked about the only choice then is to do the
9 tissue expander, were you comfortable with
10 proceeding with doing the tissue expander?

11 A. Provided we discussed the issue more,
12 which we did. And we continued to discuss over
13 the course of her care that I don't believe the
14 only choices in a case like this is my first
15 choice or nothing. There is an acceptable course
16 of treatment somewhere in the middle, not my
17 first choice, accompanied by a higher set of
18 risks, but nevertheless acceptable as long as
19 patient and physician understand there are a
20 higher set of risks with that choice. That's the
21 type of discussion we had then.

22 And to the best of my understanding,
23 she understood that.

24 Q. Once you did the tissue expander and
25 started the process along the way, was she pretty

1 much committed to going that route?

2 A. From a medical point of view or in her
3 attitude?

4 Q. From a medical point of view.

5 A. Well, this patient could still go back
6 at any time, and I believe has gone back to have
7 a TRAM flap, So what we did was not undoable, if
8 that's what you mean by commitment.

9 Q. Okay. Now, you say you recognize the
10 patient has had a TRAM flap. On what do *you* base
11 that information?

12 A. I heard that. Honestly, I don't know
13 from where I heard that.

14 Q. But again, your testimony is you have
15 not seen any of Dr. Dinner's records?

16 A. That's is true.

17 Q. You have not seen any of the
18 photographs by Dr. Dinner?

19 A. That's true.

20 MR. CRANDALL: Can we take a break?

21 (Thereupon, a recess was taken.)

22 Q. In referencing this letter that you
23 sent to Dr. Shenk, it says -- I just want to read
24 one sentence -- it says after reviewing the
25 options -- it's in the second paragraph --

1 A. Yes.

2 Q. I believe the best choice in Ms.
3 Williams' case would be a tissue expander with
4 later exchange for an implant.

5 And then you go on, she is very
6 concerned about the scars and minimizing
7 surgery.

8 First, did I read that accurately?

9 A. You did.

10 Q. And does that accurately reflect your
11 opinion as expressed to Dr. Shenk?

12 A. Yes, it does.

13 Q. What risks did you tell Edna she had
14 associated with using the tissue expander route
15 with the sequential saline injections with the
16 ultimate exchange as opposed to doing a TRAM flap
17 or a latissimus muscle?

18 A. Well, first of all, there are general
19 risks associated with any operation. I include
20 infection and bleeding; poor result, need for
21 further surgery. Those are risks that probably
22 apply to any form of breast reconstruction, but
23 those risks that may define use of a prosthetic
24 material from a TRAM flap might include capsular
25 contracture or scar formation around the implant,

1 hardening of the implant, displacing of the
2 implant, need for replacement of the implant;
3 some technical malfunction, a leak, a deflation,
4 a folding of the implant, an impingement of the
5 implant and some other structure causing it to be
6 moved, and a very reasonable chance the implant
7 would need to be exchanged even if it performed
8 reasonably well at some time in the future.
9 These things do not have unlimited durability.

10 Q. Is it because of the radiation damage
11 or the inherent process of using a tissue
12 expander?

13 A. The inherent process. Now, all or
14 let's say most of those complications may occur
15 with a higher frequency in those patients that
16 have been radiated.

17 Q. And was it your duty and
18 responsibility to explain to her the specific
19 risks that were associated with going forward
20 with a tissue expander route in addition to the
21 general risks that apply to all reconstructive
22 surgery?

23 A. It was.

24 Q. In going through the records, I note
25 that there are various consent forms that are

1 signed, and I am going to mark as the next
2 exhibit, which would be Exhibit 12, one of the
3 consent forms. It happens to be the July 18,
4 1997 consent form for the nipple reconstruction.

5 - - -

6 (Thereupon, GOLDBERG Deposition
7 Exhibit 12 was marked for
8 purposes of identification.)

9 - - - -

10 Q. And in fact, is Exhibit 12 what I just
11 stated?

12 A. Yes, it appears to be.

13 Q. In looking at the hospital records and
14 in looking at the office records, it appears that
15 for each of the procedures that were done along
16 the way from May of '96 through September of 1997
17 that each of the surgeries were preceded by this
18 University Hospitals of Cleveland authorization
19 for a medical procedure risk form. Is that your
20 understanding, as well?

21 A. It is my understanding.

22 Q. This is not a form that was provided
23 by you or by your office, was it?

24 A. It was not.

25 Q. This is a hospital consent form?

1 A. It is.

2 Q. Did you have a specific written
3 informed consent form that you used in your
4 office with reconstructive breast patients?

5 A. I don't.

6 **a.** So it's incumbent upon you before a
7 patient makes an informed decision about going a
8 particular route that you disclose to them the
9 material risks and potential complications
10 associated with the procedure; correct?

11 A. Yes, it is.

12 Q. And it's also incumbent upon you in
13 order to meet the standard of care that you
14 explain to the patient the alternatives, the
15 reasonable alternatives to the proposed surgery;
16 correct?

17 A. Correct.

18 Q. So that the patient can make an
19 informed decision as to whether or not to
20 proceed; correct?

21 A. Correct.

22 Q. You further recognize that even if you
23 do provide informed consent, that is, the
24 reasonable risks and alternatives to the
25 procedure, that if the procedure is not performed

1 in accordance with accepted standards, in other
2 words, if you are hypothetically negligent during
3 the procedure, the fact that you have a patient
4 that signs the consent form for a procedure, that
5 doesn't excuse you from responsibility for
6 performing a procedure in a negligent manner;
7 correct?

8 A. Correct.

9 Q. So that I don't have to go through
10 each one of the consent forms, did you ever
11 present any of the consent forms to Edna for her
12 signature or would this have been a process that
13 would have been taken care of by someone at the
14 hospital?

15 A. It could be either. I would have to
16 review them and tell you if I did it myself.

17 Q. Do you have any recollection of
18 presenting any of the consent forms to Edna?

19 A. I do not recall.

20 Q. Was it the usual practice that a nurse
21 or someone at the hospital, either at the time of
22 admission or shortly before surgery, would
23 present the consent form to the patient?

24 A. It would be a practice that the member
25 of the surgical team, i.e., a physician, would

1 present the consent form and obtain the
2 signature.

3 Q. Do you have any recollection of
4 reviewing any of the risks and complications of
5 any of the procedures with Edna immediately
6 before, at the time the consent forms were
7 presented to her?

8 A. I do not recall specifically.

9 Q. Okay. When I look at the consent
10 forms, they seem -- and I don't mean anything by
11 this -- but they seem to be sort of generic in
12 terms of talking about alternative methods of
13 treatment, if any have been explained as to the
14 advantages and disadvantages; the possibility and
15 nature of complications being fully anticipated.

16 But it doesn't appear as if this
17 concept for the nipple reconstruction or any of
18 the others deal with the specific risks that are
19 inherent with the procedures that you were
20 performing; is that correct?

21 A. Well, they don't seem to be enumerated
22 on that piece of paper.

23 Q. This is just sort of a general
24 statement, it's incumbent upon, for the patient
25 to make an informed consent decision, for you to

1 explain to them the material risks and benefits
2 of each of the procedures; right?

3 A. It is.

4 Q. So this consent form doesn't
5 substitute for your giving verbal detailed
6 informed consent?

7 A. Correct.

8 Q. Dr. Silverman was apparently a doctor
9 at Ireland Cancer Center that was involved in
10 Edna's care?

11 A. Yes.

12 Q. Did you ever talk to Dr. Silverman at
13 all about any aspect of Edna's oncological
14 status?

15 A. I don't recall.

16 Q. Because of the radiation that she had
17 had previously, did she have what is known as
18 radiation small vessel disease?

19 A. First of all, I am not sure that that
20 is actually the name of an official medical
21 disease. And I would think that that diagnosis
22 of such an entity could only be made on
23 histologic examination of radiated tissue. Up to
24 that point I was not aware that she had such an
25 examination.

1 Q. Okay. Let me come at it a different
2 way. Because of the radiation appearance to her
3 chest wall, would you have expected that she
4 would have compromised circulation in the area of
5 the radiation exposure?

6 A. I would have.

7 Q. And inherent in that is the risk of
8 poorer healing than in nonradiated exposed
9 tissue?

10 A. True.

11 Q. The materials that are marked as
12 Exhibits 9 and 10, which for the record were
13 identified, Mr. Crandall will retain until it's
14 determined whether this is responsive to what Mr.
15 Kelly had thought he produced, which wasn't
16 attached to the interrogatories.

17 The first item, Exhibit 9, it says
18 Premier Issue, First Impression. It looks to be
19 a publication from University Hospitals of
20 Cleveland.

21 And then Exhibit 10 is a pamphlet,
22 Breast Reconstruction. It appears to be
23 something put out by University Plastic Surgery
24 Associates, Incorporated.

25 To your knowledge, were either or both

1 of these documents provided to Edna Williams?

2 A. I don't know specifically if they
3 were.

4 Q. Would the normal practice of your
5 office where a patient wants information be to
6 provide one or both of these documents?

7 A. It would.

8 Q. Were there any other items by way of
9 literature or videos, or any other documentation
10 that would customarily be provided to a patient
11 that wanted more information on breast
12 reconstruction?

13 A. No.

14 Q. So these were pretty much the staple
15 items that were used?

16 A. They were.

17 Q. And obviously they are to supplement
18 but not to replace your obligation as the surgeon
19 in terms of explaining to the patient the various
20 risks and benefits of a particular procedure?

21 A. Yes.

22 Q. Did you have any type of video in your
23 office that the patient could watch?

24 A. No.

25 Q. Did you have any photographs that you

1 would show a patient on stages of reconstruction?

2 A. On stages of reconstruction. No. I
3 often had a book that showed typical -- that had
4 a couple diagrams in there and showed typical
5 results, let's say, of implant reconstruction
6 versus a TRAM flap and versus a latissimus flap,
7 as well.

8 Q. From looking at your office records, I
9 don't detect, but maybe this happened. Again,
10 this falls in the category of yes, I remember
11 this happening, so if it is, you tell me.

12 Do you remember showing Edna or her
13 requesting the opportunity to see photographs in
14 an album to see what --

15 A. I don't recall. But it was my usual
16 practice when I met a new breast reconstruction
17 patient to bring these books that just had these
18 couple photographs in there and diagrams.

19 Q. Whether you did in Edna's case or not,
20 you just can't recall one way or another?

21 A. I don't recall.

22 Q. Okay. On the first surgery you were
23 assisted by Dr. Kihter?

24 A. Yes.

25 Q. You were the attending?

1 A. I was.

2 Q What aspect did he perform?

3 A. What aspect? He was the assistant.

4 Q. What aspect did he assist you with?

5 A. What particular aspects of the

6 operation?

7 Q. Yes.

8 A. I don't recall.

9 Q. Were you satisfied with the outcome?

10 This is the first phase of the procedure;

11 correct?

12 A. Yes.

13 Q. Were you satisfied with what you were

14 able to accomplish at that particular time?

15 A. I was.

16 Q. Okay. No untoward complications that

17 occurred at the time of your surgery?

18 A. None.

19 Q. And notwithstanding the radiation and

20 notwithstanding all of the concerns, the risks

21 that are inherent, the first phase of your

22 surgery was successful?

23 A. At the time of surgery did I deem it

24 that way?

25 Q. Yes.

1 A. Yes.

2 Q. You're experienced, doctor, with using
3 tissue expander replacement as a means of doing
4 breast reconstruction in patients that have a
5 history of radiated, radiation damage in the
6 chest wall? What has been your experience? Have
7 you had any problems with subsequent
8 complications?

9 A. I have.

10 Q. Tell me what type of complications you
11 have had.

12 A. Poor healing, increased rate of
13 capsular contraction.

14 Q. What percentage of the time have you
15 had one or both of those complications in that
16 type of a patient?

17 A. About 50 percent.

18 Q. Would you agree that given that high
19 of percentage of complication that that is the
20 type of information that the patient should, a
21 patient such as Edna Williams should be told that
22 up to 50 percent of the time when I have done
23 this type of surgery, using a tissue expander,
24 that I have had poor healing or capsular
25 contracture in half of the cases?

1 A. If it's a number that I would know, I
2 am happy to share it with them. I think it's
3 important that the patient understands that the
4 risk is substantial. I don't think it's useful
5 to give a patient a number that's not accurate.
6 So if I know a number, then I provide it.

7 Q. Okay. You just very readily gave me
8 50 percent. Has that increased since the time of
9 Edna or were you likely having that type of
10 complication rate doing tissue expander on
11 radiated skin back in 1997, 1996 and '97?

12 A. It would be that kind of rate. This
13 procedure is -- this procedure on this patient is
14 very uncommonly done by me.

15 Q. Okay. Do you have a recollection of
16 telling Edna percentages of the frequency that
17 you were encountering, capsular contracture or
18 poor healing in patients similar to her that have
19 radiated skin when you use a tissue expander?

20 A. Yes.

21 Q. Certainly that is something that in
22 order to comply with the standard of care you
23 should have told her; correct?

24 A. And I did.

25 **a.** And certainly in order to comply with

1 the standard of care, you should have told her
2 not only the risks or the percentage of
3 complication, but that this was a very rare
4 surgery -- I think you said rare. When I am done
5 mumbling, correct me -- a very rare procedure
6 that you were doing on a radiated skin for
7 reconstruction?

8 A. I expressed to her that it was not
9 commonly done in my practice because it is rarely
10 at the top of the list as far as alternatives.

11 Q. There is an increased risk of skin
12 necrosis when you perform breast reconstruction
13 on a radiated chest wall?

14 A. There is.

15 Q. We don't need to go through your
16 office notes, but after the tissue expander was
17 put in, you then started a gradual expansion;
18 correct?

19 A. Correct.

20 Q. As opposed to rapid expansion?

21 A. Correct.

22 Q. And there is two ways to approach it;
23 correct?

24 A. There are two ways that are written
25 about.

1 Q. Okay.

2 A. Yes.

3 Q. In Edna's case, was the gradual
4 expansion the preferable route if one is going to
5 use tissue expanders?

6 A. Yes.

7 Q. The reason being?

8 A. I don't believe the other way works,
9 frankly. I don't believe there is such a thing
10 as immediate tissue expansion. It's written
11 about, but true physiology that describes tissue
12 expansion does not really occur with immediate
13 expansion. Probably only a phenomenon of skin
14 stretching happens then. I don't believe there
15 is such an entity as immediate tissue expansion.

16 Q. In September of '96, if you would take
17 a look at your office note for that date --

18 MR. CRANDALL: Are you talking about
19 the September 10th?

20 MR. MISHKIND: Yes.

21 Q. You have a note there that her
22 expander is very firm, as might have been guessed
23 under radiated skin, I believe?

24 A. Yes.

25 Q. Was it more or less firm than what you

1 had anticipated occurring preoperatively?

2 A. I don't understand your question.

3 Q. You recognize that there was the risk
4 of capsular contraction. You recognize there was
5 the risk of poor healing. As you were going
6 along with the various saline injections and you
7 were seeing how firm the expander was under the
8 radiated skin, was it as you had expected or was
9 it firmer than you had expected?

10 A. I was not surprised by the way I saw
11 it at this point.

12 Q. Okay. You completed the saline
13 injections by October of 1996, I believe, is that
14 fair, according to your record, October 15, 1996?

15 A. Let me take a look.

16 Q. Please.

17 A. Yes, it appears that way.

18 Q. At this time, were you satisfied with
19 how things had proceeded?

20 A. Within the parameters of my
21 expectations from the beginning, yes.

22 Q. Now, it appears that we went from that
23 visit in October to May of 1997 before there was
24 the exchange of the tissue expander: with the
25 implant; correct?

1 A. Yes, it appears that way.

2 Q. Was the period of time from October to
3 May a reasonable period of time after performing
4 the saline injection into the tissue expander
5 before doing the exchange?

6 A. I'm not sure what you mean by
7 reasonable.

8 Q. Is there any preferable period of time
9 that one wants to wait once they are done with
10 the injections of the saline before you go ahead
11 and do the exchange with the implant?

12 A. I think one should probably wait at
13 least a couple weeks after the last injection, so
14 that injection can have its effect.

15 Q. Okay. In Edna's case, the exchange
16 didn't take place until May or approximately
17 seven months later; correct?

18 A. Correct.

a9 Q. Did that delay from October to May in
20 your opinion have any negative impact on the
21 exchange and the ultimate outcome in this case?

22 A. No. If anything, it would have a
23 positive effect.

24 Q. Okay. So there is nothing harmful
25 regardless of what the reason was for there to be

1 that period of time? There was nothing harmful
2 by waiting seven months?

3 A. There wasn't.

4 Q. Now, in October -- I'm sorry, in
5 January of '97, there is a note, a phone
6 conversation with M. Coleen Neely. Information
7 sent to Mrs. Williams re implants. Would that be
8 the information most likely that we are talking
9 about in Exhibits 9 and 10?

10 A. I would have to look at that note,
11 first of all.

12 Q. January 9, 1997.

13 A. Is this the note to which you are
14 referring?

15 Q. Yes.

16 A. I don't know what information Coleen
17 sent to her. We have other brochures, some
18 provided by the implant makers and some other
19 brochures similar to these, and I don't know
20 exactly what literature Coleen sent to her.

21 Q. So it's conceivable that in addition
22 to Exhibits 9 and 10, that additional information
23 may have been sent to Edna?

24 A. Yes.

25 Q. Would that be information that would

1 be -- strike that.

2 Do you know how many other brochures
3 or information sheets that you had in the office
4 that you would routinely provide to patients when
5 they had additional questions?

6 A. Routinely. There were none others
7 that were routinely provided to patients.

8 Q. It was only when patients asked
9 additional questions that you would provide
10 additional information?

11 A. If we had additional information
12 available, we were happy to give it to them, of
13 course.

14 Q. I guess my question is, do you know
15 how much more additional information you had in
16 the office that you would give to a patient if
17 they asked additional questions?

18 A. No.

19 Q. I think part of the delay until May
20 was perhaps Edna delaying?

21 A. As I recall, it was.

22 Q. But you are not critical of her in any
23 respect in terms of how the exchange took place?
24 She didn't cause or contribute to any problems
25 that hampered your exchange when you did it in

1 May of 1997?

2 A. I am not sure what you mean I am not
3 critical of her.

4 Q. We are talking about a seven month
5 period from October until May until you did the
6 exchange. You told me before that certainly
7 sometimes the longer, the better.

8 The fact that she may have been the
9 one or perhaps was the one that caused the delay,
10 her delay for whatever reason, financial or
11 otherwise, didn't negatively impact what you then
12 did in May of 1997 when you did the exchange, did
13 it?

14 A. No.

15 Q. Okay. Was there ever a time along the
16 way prior to October of 1996 where you and Edna
17 talked about changing the course of what you were
18 doing and going to a TRAM or a latissimus?

19 A. Not that I recall specifically. We,
20 of course, communicated about her progress, how I
21 felt about it and how she felt about it along the
22 way.

23 Q. And did things, given the
24 circumstances, did they seem to be proceeding
25 along nicely?

1 A. They did.

2 Q. I am going to show you Exhibits 4, 5,
3 and 6. Are these laser photos of three
4 photographs that you took of Edna?

5 A. They are.

6 Q. And are these three photos following
7 the -- well, why don't you tell me what stage
8 these three photographs 4, 5 and 6 were taken.

9 A. Can I examine them?

10 Q. Sure. I don't know how you can answer
11 without looking at them.

12 A. It looks like this photo is dated
13 11-15-96, which would put its timing at the
14 completion of expansion, but prior to exchange
15 with the implant, with the permanent implant.

16 Q. And that's Exhibit 4; correct?

17 A. This is Exhibit 4.

18 Q. Okay. Now, on Exhibit 4, before you
19 move to Exhibit 5 and Exhibit 6, is there any
20 evidence of any type of radiation dermatitis or
21 radiation damage that you depict on the chest
22 wall in that picture?

23 A. Yes. There are changes in the skin
24 that I would say are consistent with radiation
25 damage. A diagnosis could not be made from a

1 photograph.

2 Q. Tell me what you recall about the
3 status of her skin from a clinical perspective
4 regardless or taking into account the picture.

5 In other words, you are done with the
6 saline injections and you have got what is shown
7 in Exhibit 4. Did you have concerns about the
8 vascularity of her chest wall at that point?

9 A. Did I have concerns? I am not clear
10 what -- it's not clear what you are asking me.

11 Q. Were you concerned as to whether or
12 not she would have any problems with successfully
13 being able to have the implant exchange, given
14 her radiation damage or any issues about
15 decreased vascularity in the chest wall?

16 A. I was always concerned. Did I believe
17 at this point from looking at her that the risks
18 outweighed the benefits of proceeding? I did
19 not.

20 Q. We then go to Exhibits 5 and 6. Are
21 these after the saline implant has been
22 exchanged?

23 A. It has been. And it looks as though
24 she also had the augmentation on the right
25 breast, as well.

1 Q. Can you describe for me on either of
2 these photos what we are looking at in terms of
3 there appear to be some darker areas of
4 pigmentation, in both pictures on her left
5 breast. Can you sort of describe for me what it
6 is that you see there?

7 A. Well, I also see dark areas of
8 pigmentation here. Again, a diagnosis of
9 radiation change is difficult to make on visual
10 inspection only by photographs. But certainly
11 what is here is consistent with what one would
12 call radiation damage. It's difficult to say
13 anything specific beyond that.

14 Q. Taking everything into account at this
15 point, having gotten to where you were now in May
16 of 1997, were you pleased with the aesthetic
17 accomplishments?

18 A. Given the parameters inside which we
19 were forced to work, I thought that the result
20 was acceptable to me.

21 Q. Do you have a recollection as to the
22 expressed level of satisfaction that Edna had in
23 terms of how things were proceeding at this
24 point, especially right after you had exchanged
25 the -- put in the implant in May of 1997?

1 A. The answer to that is a little bit
2 complicated. I am not trying to be evasive. I
3 would say the combination of emotions that I got
4 from her were rather typical of a patient coming
5 to terms with having a breast loss to cancer and
6 dealing with the deformity afterwards. And that
7 is to my observation a rather complex mix of
8 relief, disappointment, happiness, anger,
9 frustration, and hope.

10 And I would say that she exhibited
11 these things in this complicated mix in a way
12 similar to other patients.

13 Q. When did you first have a discussion
14 with Edna about proceeding with nipple
15 reconstruction?

16 A. I don't recall.

17 Q. Can you tell from looking at your
18 records, please?

19 A. Well, I know that I discussed nipple
20 reconstruction at the time of the first **visit**
21 with every patient. It may come up on an as is
22 basis during the course of any discussion along
23 the way.

24 Q. Okay.

25 A. As I observe here in my record, there

1 is a note on 6-11-97 in which we specifically
2 discuss reconstruction of the nipple, period.

3 Q. And do you recall any other notes that
4 talk about nipple reconstruction prior to June of
5 1997, prior to June 11, 1997?

6 A. Do I recall any other notes or do I
7 recall any other discussion?

8 Q. Notes.

9 A. I can review them.

10 (Pause.)

11 A. I see no notes in which we discussed
12 it. And I recall a conversation about it,
13 clearly I recall the conversation, and I think
14 the conversation took place on the day of this
15 one note, 6-11-97. And I know, as I stated
16 earlier, as a matter of routine I discussed
17 nipple reconstruction, what is involved in nipple
18 reconstruction at the time of initial
19 consultation.

20 Q. Okay. All of your notes, or at least
21 the majority of your notes are dictated and then
22 typed; correct?

23 A. Correct.

24 Q. Do you type the notes yourself?

25 A. I don't, no.

1 Q. You dictate them yourself?

2 A. I do.

3 Q. Do you walk around with a dictating
4 machine?

5 A. I do.

6 Q. Was it your practice to dictate each
7 of the office notes at or near the time of the
8 office visit?

9 A. It is.

10 Q. Do you know whether all of the office
11 notes, including the June 11, 1997 office note
12 was dictated at the time of the various visits?

13 A. I don't know the answer to that, but
14 it's my practice to dictate them as close to the
15 time of the visit as possible.

16 Q. Let me give you a for instance.

17 Would it be appropriate for you months
18 later to go back and dictate an office note if,
19 in fact, one wasn't contained in the office
20 record?

21 A. Would it be appropriate? I am not
22 sure what you mean by appropriate.

23 Q. If you looked at records and realized
24 that you didn't have an office note for a
25 particular visit but had no notes reflecting what

1 transpired on that visit, would it be appropriate
2 for you to recreate an office note months
3 afterwards?

4 A. No.

5 Q. Did you recognize, given what you had
6 accomplished as of May 1997 after the exchange
7 that there was a risk associated with performing
8 nipple reconstruction on her chest wall?

9 A. The risks were present from the
10 beginning, and the same risks existed at this
11 time. They were reiterated, I'm sure, many
12 times.

13 Q. Okay. Well, when we look back at
14 Exhibits 5 and 6 -- and again, these are one
15 dimensional, I think -- the skin on the chest
16 wall at or near the area where the nipple
17 reconstruction would be done, because of the
18 radiation, was thinner than healthy tissue that
19 was not radiated; correct?

20 A. Yes.

21 Q. Okay. And with thinner skin, there is
22 a greater risk of skin necrosis, especially if
23 that skin is radiated, has had radiation
24 exposure, if you are going to use that skin or
25 that area for nipple reconstruction; correct?

1 A. Yes.

2 Q. There is decreased blood flow or
3 decreased vascularity in the area where the skin
4 is thin caused by the radiation damage; correct?

5 A. That's right.

6 Q. And you knew all of those things
7 before you proceeded with the nipple
8 reconstruction?

9 A. I did. And so did Ms. Williams.

10 Q. Did you recommend against doing nipple
11 reconstruction?

12 A. I did.

13 Q. When did you recommend against doing
14 nipple reconstruction?

15 A. When did I?

16 Q. Yes.

17 A. Well, I recall this one conversation
18 where we discussed nipple reconstruction, because
19 she brought it up. And I told her that we were
20 going to incur a significant risk if we went
21 ahead and did that. But she pursued it.

22 And so, of course, we went over the
23 risks, and since I disagreed, since I was of the
24 notion we shouldn't do it, I'm sure that I
25 reinforced the risks again of going ahead.

1 Q. Is this the June 11 conversation that
2 you are talking about?

3 A. Well, I don't know that. But I
4 remember a conversation, and I'm assuming that it
5 corresponds with this.

6 Q. Now, is there any way for you -- and
7 in fairness to you, is there any way for you to
8 determine whether this conversation about the
9 nipple reconstruction that you just alluded to
10 occurred other than on June 11, 1997?

11 A. I wouldn't know that for sure. I
12 don't remember the day I had the talk. But I
13 remember the talk very clearly, because I felt it
14 might have been pushing it a little bit, but she,
15 of course, had the very high aesthetic demand.

16 Q. Pushing the envelope, so to speak?

17 A. A little bit. A little bit, yes.

18 Q. Would you have any type of a calendar
19 or any personal notes that you would have made
20 that might tell you that such conversation where
21 you discouraged her from having the nipple
22 reconstruction occurred other than on June 11?

23 A. Would I have it recorded elsewhere,
24 such a conversation?

25 Q. Right.

1 A. No, not that I would know of. I would
2 think it would be in the record, that's where
3 things go.

4 Q. What I am trying to determine is if
5 there is anything else that you will be able to
6 point to where it's memorialized formally or
7 informally where you had this discussion where
8 you said, I think that the risk outweighs the
9 benefit of doing nipple reconstruction and Edna
10 said that she wanted to proceed with it,
11 notwithstanding your discouragement other than
12 the June 11 note?

13 A. No. But I would say that I wouldn't
14 do any operation on a patient where I felt the
15 risk outweighed the benefit.

16 MR. CRANDALL: I don't think he ever
17 testified to that previously.

18 THE WITNESS: I was going to say that.

19 Q. That's fine, I am not trying to put
20 words in your mouth, believe me.

21 A. I want to make it clear, I wouldn't do
22 that. I wouldn't let any patient talk me into an
23 operation. But what the benefit is is a complex
24 issue.

25 Q. Tell me, in Edna's situation, having

1 accomplished what you had accomplished, and
2 obviously, I presume, being fairly professionally
3 satisfied with what you had accomplished, given
4 the limitations that you had, what were the
5 issues that were going through your mind in terms
6 of the risk/benefit analysis for this patient?

7 A. Of performing a nipple
8 reconstruction?

9 Q. Yes, sir.

10 A. What were the risk/benefit issues with
11 regard to nipple reconstruction.

12 Q. On this patient given everything that
13 had been accomplished, et cetera.

14 A. Well, as I explained to her and I
15 recall explaining to her, we reentered this
16 tunnel of risks and high ended risk associated
17 with an implant on a radiated patient. So to
18 some degree we reincur all the same risks that we
19 did before, because her physiology and
20 predispositions remained essentially unchanged.

21 The benefits in my opinion were
22 somewhat mitigated. We had made a breast, she
23 could wear clothing and function in a public way,
24 I think in a reasonably normal fashion, and the
25 medical benefit of making a nipple -- the medical

1 benefit -- the benefit I saw of making a nipple
2 was less than the benefit of making a breast, at
3 least applying my perception to it.

4 But the risks were essentially the
5 same and that I didn't feel from a purely, my
6 perspective alone, the risks outweighed the
7 benefits. She pushed the issue. She wanted a
8 breast that looked perfect.

9 Q. So it's your testimony that in
10 discussing things with her, you would have said
11 to her that the risks, Edna, outweigh the
12 benefits from a medical standpoint?

13 A. Yeah. I don't think it's a good
14 idea. I remember saying that to her.

15 Q. Okay. And certainly explaining to her
16 that the risks outweighed the benefits, given
17 what you had accomplished, given the fact that
18 you would be operating on radiated tissue, thin
19 tissue with decreased vascularity, certainly you
20 would agree with me that in order for the patient
21 to make an informed decision to go ahead with it,
22 that you would need to explain just what you told
23 me the risk/benefit is and also would tell her
24 that you were against doing the procedure?

25 A. I think, yes, she needs to hear the

1 risks listed again. She needed to hear the risks
2 reinforced, which they were.

3 I needed to communicate to her in some
4 way that I thought the risk/benefit equation was
5 less in her favor.

6 Q. Okay.

7 A. That may be a better way of saying
8 that I was against it. I needed to make that.
9 clear to her.

10 Q. Now, in your note, as I read it, it
11 says that Edna would like nipple reconstruction
12 on that side and it is a small procedure, but as
13 I outlined to Edna, the same risks for originally
14 reconstructing the breast remain?.

15 Do you remember telling her that it
16 was a small procedure?

17 A. Yes.

18 Q. Do you remember telling her that it
19 would probably take less than an hour to perform?

20 A. I do.

21 Q. Does the note indicate anything about
22 the risks outweighing the benefits?

23 MR. CRANDALL: Do you mean
24 specifically those terms?

25 Q. Or anything that paraphrases what you

1 just said to me.

2 A. I don't believe the risks outweighed
3 the benefits, so I don't believe that. And the
4 note didn't say that.

5 a. I'm sorry, maybe I misunderstood you.
6 I thought you told me you felt --

7 A. From a medical point of view -- and
8 what I mean, the difference in benefits medically
9 and for this patient are an emotional overlay,
10 all right? What tips the scale is how important
11 it was to her; how she pushed it after I made the
12 risks clear to her, how this particular person
13 still wanted to do it.

14 And because this operation is done to
15 increase self-perception, quality of life from a
16 subjective point of view, a personal point of
17 view, that's hard to measure. So if I list the
18 risks three different ways and the person still
19 wants it, they are going to go to somebody else
20 and have it done.

21 She is my patient. I feel like I want
22 to take care of her the best way I can, of
23 course.

24 Q. Medically, however, though, you felt
25 that the risks outweighed the benefits?

1 A. It was in my judgment that I felt that
2 from a medical point of view the risks outweighed
3 the benefits.

4 Q. Okay. And even though you are dealing
5 with a lot of things, emotional aspects, and you
6 are also her surgeon, that she presumably is
7 looking to you for recommendations and advice?

8 A. That's correct.

9 Q. And if, in fact, medically the risks
10 outweighed the benefits before proceeding with
11 the nipple reconstruction, you had a duty and an
12 obligation to tell her that; correct?

13 A. I did, which I reviewed with her. But
14 that's only part of the equation here.

15 Q. I understand that. But keep with me
16 for just one moment. I am not going to stop you
17 from giving me the entire equation. Just the
18 medical aspect of the risks outweighing the
19 benefits is not reflected in your office note; is
20 it?

21 A. I guess I want to rephrase what I
22 said, if I can, at least for the record to
23 'understand what it is that I think.

24 I think the risk was higher, the risk
25 was substantially higher in proceeding, all

1 right? I don't think that what I did was
2 medically unjustified, despite any emotional
3 additive to it.

4 Q. Let me ask you a question then.

5 When you say the risks were higher, in
6 your note it says, but as I outlined to Edna, the
7 same risks for originally reconstructing the
8 breast remain.

9 Would you agree that your note does
10 not reflect that you told her that the risks were
11 higher?

12 A. No, what I mean to say here is that
13 the risks were at the same level as they were in
14 the beginning of the procedure, and both of those
15 risks were higher than they would have been in
16 someone who wasn't radiated. So her risks
17 started out higher and stayed higher and were
18 higher and were the same at this point as they
19 were in the beginning.

20 Q. But it seems based upon the way you
21 are answering these questions that you were more
22 determined, if you will, to try to discourage her
23 from going forward with nipple reconstruction
24 than you were with her decision to go forward
25 with the tissue expander.

1 A. That is true.

2 Q. Do your records reflect any greater
3 level of discouragement to her about, let's stop
4 while we are ahead kind of thing? I mean, again,
5 in fairness to you, I am reading your note and
6 that's why I asked you if there is anything
7 else.

8 I am just wondering whether your note
9 in your opinion describes this process where you
10 told her, Edna, we have accomplished this. You
11 wanted to have the tissue expander and we have
12 done that. Even though this is a small
13 procedure, we ought not to do the nipple
14 reconstruction because, and being more emphatic
15 with that than you were previously.

16 And in fairness to you, does this note
17 of June 11 say that?

18 MR. CRANDALL: I don't know how he is
19 going to capture everything you just said,
20 Howard.

21 Q. Do you follow me, doctor?

22 A. I do.

23 Q. Take a moment to read it over and
24 respond in whatever way you think you need to.
25 Because I want to give you an opportunity to

1 explain things.

2 A. The answer is yes, I think it does
3 reflect that.

4 Q. What language is there in the note
5 that you believe reflects your level of
6 discouragement to her, if you will, or your level
7 of concern to her?

8 A. Well, your question before was do I
9 think the note reflects that the risk/benefit
10 ratio may be different now than it was before.
11 And I believe it's reflected in the note in that
12 it is a small procedure, but as I outlined to
13 Edna, the same risks exist. So the procedure is
14 smaller, but the same risks exist. So I see that
15 as a greater risk to benefit ratio.

16 Perhaps, of course, the note is not as
17 specific in detail as our conversation, but I
18 recall her conversation plainly.

19 Q. And certainly this patient -- strike
20 that.

21 Exhibit 12, the informed consent
22 document that is signed by her doesn't have the
23 material risks associated with this specific
24 surgery, the nipple reconstruction, to the extent
25 that it needed to be explained verbally by you in

1 June of 1997; correct?

2 A. Right. None of these do, of course.

3 Q. So this does not replace the kind of
4 informed consent that the patient was required
5 before she agreed to have the nipple
6 reconstruction?

7 A. Correct.

8 Q. Now, when you go in to do the nipple
9 reconstruction in the manner that you performed
10 it, what you were doing was you were creating --
11 you did an S-shaped incision; correct?

12 A. I have to refer.

13 Q. Go ahead.

14 (Pause.)

15 A. No, I don't think I did an S-shaped
16 incision. And I can't tell you that -- I do a
17 few forms of nipple reconstruction and I kind of
18 interchange them for a variety of reasons and I
19 can't tell you exactly what the method of nipple
20 reconstruction was that I used on her.

21 Q. Okay. Does your operative report
22 adequately describe the technique that you used
23 to raise the tissue to close the donor site?

24 A. Adequately. I'm not sure what you
25 mean.

1 Q. You say there are several techniques
2 that you use. Can you tell me by looking at this
3 operative note what technique you used?

4 A. I can't.

5 Q. Where would we look to know what
6 technique you used?

7 A. In the records it's not indicated, so
8 I would have to look at her, the patient herself.

9 Q. Okay. In doing the reconstruction of
10 the nipple, what you are doing is you are cutting
11 into this thin tissue in the area where the
12 nipple is to be placed and raising in some
13 fashion, whatever incision you use, you are
14 raising the skin to form the projection for the
15 nipple; correct?

16 A. Yes.

17 Q. And then after making, raising the
18 skin, you then are pulling whatever area -- you
19 are pulling it together and then you close the
20 donor site?

21 A. Correct.

22 Q. Okay. Wouldn't you agree that there
23 is a high likelihood of the necrosis of the
24 raised skin in a patient that has radiated skin
25 that's thin that has the appearance that Edna

1 Williams' skin had, a high likelihood of necrosis
2 following doing that?

3 A. I wouldn't say there is a high
4 likelihood.

5 Q. Tell she how frequently you had done
6 nipple reconstruction on a radiated chest where
7 you used the thin tissue to raise -- whether it's
8 S-shaped or what have you -- where you raised the
9 skin, closed the area, what percentage of the
10 time have you had complications where the skin
11 necrosed?

12 A. Up to this point, I hadn't had any.

13 Q. You are aware from the literature, are
14 you not, that doing nipple reconstruction on
15 radiated chest wall following tissue expander had
16 a high percentage of complication rate, a high.
17 percentage of necrosis?

18 A. I'm aware from the literature that
19 performing nipple reconstruction on radiated
20 tissue had a higher rate of complications than on
21 nonradiated tissue, which is what we discussed.

22 Q. Can you tell me what percentage of the
23 literature talked about it in terms of the area
24 necrosing?

25 A. I don't know off the top of my head.

1 Q. If I were to give you a sheet of
2 paper, a yellow pad here, could you by making an
3 incision into the paper, could you show me the
4 method that you probably used based upon your
5 operative note to create the raised nipple?

6 A. Yes.

7 MR. CRANDALL: I thought you said you
8 weren't sure and you need to see the patient.

9 THE WITNESS: I wasn't sure, but I
10 could draw what I probably would have done.

11 MR. CRANDALL: I am concerned by that,
12 because I am not sure how you now probably know.

13 THE WITNESS: He asked me if I knew
14 and I said I didn't. And he said could you draw
15 what you probably would have done. I can do
16 that. I can draw what I probably would have
17 done. I can't tell you for sure it is what I
18 did.

19 MR. CRANDALL: I am concerned about
20 that.

21 MR. MISHKIND: Before I have him do
22 that, I know you are concerned. Let me have a
23 couple more questions and if you are still
24 concerned, we will deal with that.

25 Q. How many different methods would you

1 use on a patient that has radiation dermatitis,
2 decreased vascularity after having done the
3 tissue expander route? How many different types
4 of surgical incisions?

5 A. Would I use?

6 Q. Right.

7 A. One of two I would use in that case.

8 Q. Okay. And why is it that you feel
9 that while you can't remember specifically,
10 because your operative report doesn't tell you,
11 why is it that you believe that you can probably
12 tell me which of those two you used on Edna?

13 A. One I use more commonly than the
14 other. One renders a little bit of a tighter
15 closure than the other.

16 And I recall at the time making the
17 incisions for the flaps and then discovering that
18 there was a leak in the implant, and probably at
19 that point having to exchange the implant, I
20 wouldn't have gone on and done the nipple
21 reconstruction.

22 But I already had the flaps cut, so I
23 could either cut them off and throw them away or
24 go ahead and make the nipple at that point. So I
25 decided to go ahead and do it. So at that point

1 there was no reason not to do the nipple
2 reconstruction.

3 Q. So the procedure to do the nipple
4 reconstruction that you believe you probably did
5 was the one that had the greatest likelihood of
6 success?

7 A. Correct.

8 Q. Okay. And the one that you most
9 commonly use?

10 A. Yes.

11 Q. And looking at the operative note,
12 other than applying those principles, your
13 operative note is not dictated with enough
14 specificity to permit you to say that you didn't
15 use, or that you did use the other one -- you
16 most likely used the one that has a greater
17 likelihood of success given everything you said?

18 A. Yes.

19 MR. MISHKIND: Fair enough?

20 MR. CRANDALL: I don't think so. This
21 is my point. I will say it to everyone here in
22 the room.

23 That's all fine and dandy, but you are
24 going to show him a procedure that you think you
25 may have done and there is a chance, whatever

1 that chance is, that it wasn't the one you did.

2 So to me any way you color it, it's a
3 guess or it's a presumption and I don't
4 necessarily think that's a correct thing to do.

5 MR. MISHKIND: He has testified that
6 it's probably the way he did it and it's not a
7 guess. I am going to have him do it anyway.
8 Your objection is noted.

9 Q. What we will do is mark this as
10 Exhibit 13. And then if you want to draw the
11 circumference and maybe draw how you probably
12 made the incision.

13 Do it silently first and then you can
14 cut into the paper. In other words, I don't want
15 you to say, I did this, I did that. Draw it
16 first and then before you make the incision, we
17 will describe what we have, okay, and see if it
18 makes sense.

19 - - - -

20 (Thereupon, GOLDBERG Deposition
21 Exhibit 13 was marked for
22 purposes of identification.)

23 - - - -

24 Q. Thus far you have drawn, you have got
25 a diagram that says modified CV flap right above

1 that; correct?

2 A. Uh-huh.

3 Q. That's a yes?

4 A. Yes, it is.

5 Q. And what does CV stand for?

6 A. It's descriptive, I believe, because
7 part of the flap looks like a C and part of the
8 flap looks like a V. I didn't invent the
9 technique.

10 **a.** I am wondering what the CV stood for
11 in the modified.

12 Now, if you would then show me by
13 making incisions as if the paper was the chest
14 wall how you then make the raised flaps for
15 purposes of forming the nipple projection.

16 A. Well, incisions are made as shown
17 here. Some portion of the subcutaneous tissue,
18 whatever that tissue below the skin would be, is
19 included for added blood supply.

20 In this case it would be subcutaneous
21 fat and I chose to use a bit of the capsule as
22 well around the implant because it has a rich
23 vascularity. The incision is made, the flap is
24 lifted up like this. The blood supply comes in
25 through the base of the flap. This base is

1 maintained like that.

2 Q. Is there a specific blood supply or is
3 it sort of a random blood supply?

4 A. It's random, not axial. There is no
5 named blood vessel that feeds this thing. This
6 wing gets folded in. Each wing gets folded in
7 and the head of this thing gets pulled up in the
8 air away from the paper.

9 So if this is the head, the head comes
10 off the paper like this and each of the wings
11 fold around like two arms hugging.

12 These wings end up rendering something
13 that basically looks like a cylinder like this.
14 And then the top gets folded over as a cap. Each
15 of the donor sites then get closed individually.

16 So in a patient like this, I like to
17 make the scars as minimal as possible, so I do
18 this in the line of the scar. So the resulting
19 scar, this thing would have been raised along the
20 edge, if you will, and that's why the incision
21 was already made by the time I got in there.

22 Q. Now, the arrows that you have below
23 the area where the nipple was being constructed,
24 this is showing the random blood flow; correct?

25 A. It's showing the blood supply into the

1 flap, yes.

2 Q. Which is random as opposed to a
3 specific --

4 A. Named artery.

5 Q. And then the arrows above would be
6 what?

7 A. I am trying to indicate in general the
8 directions of movement of each of the three
9 wings.

10 Q. Fair enough.

11 Now, how long did you tell Edna the
12 recovery from this procedure in July would take?

13 A. Well, provided that everything went
14 well, the recovery is usually quite short, just a
15 few days.

16 Q. In that note on June 11th it says we
17 can organize nipple reconstruction next week or
18 so under local anesthesia at the most convenient
19 facility.

20 Up to this point everything has been
21 at University Hospitals; right?

22 A. I can look at the operative record,
23 but I presume so, yes.

24 Q. What did you mean by the most
25 convenient facility?

1 A. I operate at a lot of or used to
2 operate at a lot of facilities, some designed
3 specifically for outpatient care, such **as** the
4 Wright Surgery Center in the Integrated Medical
5 Campus of Mt. Sinai on the east side of
6 Cleveland. And those seem to be more convenient
7 for patients that have small procedures. So I
8 give them that choice.

9 Q. Were there other methods in terms of
10 free flaps for purposes of creating the nipple
11 projection?

12 A. Free flaps?

13 Q. Maybe a poor choice of terms. But
14 could you have used other donor sites to create
15 the nipple projection other than the skin itself
16 as you just described in terms of raising the
17 existing skin, in other words taking the skin
18 from another area?

19 A. Well, there is a difference in
20 creating the nipple and the areola. There is a
21 grafting procedure for both of those structures
22 which are independent of each other. And there
23 is an older technique described called nipple
24 sharing where one takes a piece out of the
25 opposite nipple and grafts it on to the

1 recipient's site and closes the donor nipple and
2 that is theoretically an option here, yes.

3 Q. Would that have had a greater
4 likelihood of success in Edna's case?

5 A. Less likely.

6 Q. Tell me why.

7 A. Because it's a graft and not a flap,
8 so that the blood supply is challenged here. And
9 a graft needs to parasitize or pick up blood
10 supply from a bed to which it is grafted. And
11 it's a tenet in plastic surgery, you try not to
12 graft something on to a radiated bed. The donor
13 nipple has to be substantially large enough in
14 size and hers really isn't. The deformity in
15 that nipple aesthetically and functionally
16 because of the way the procedure is described, it
17 takes a wedge out of the other nipple and it's
18 closed eccentrically and it doesn't work right
19 and the nipple is closed on itself, so it's a
20 rather old fashioned operation.

21 Q. Exhibit 13 is the diagram that you
22 made showing the probable method that you used in
23 this case, not to 100 percent certainty but more
24 likely than not?

25 A. Yes.

1 Q. That is considered, is it not, a full
2 thickness skin graft?

3 A. No, it's not. A full thickness skin
4 graft, the difference between a graft and flap by
5 definition is a graft is moved from a different
6 location, a distant location and must parasitize
7 the blood supply. It has no independent blood
8 supply on its own.

9 It's akin to planting sod in one's
10 yard. The nutrition must be picked up. A flap
11 by definition carries with it it's own blood
12 supply.

13 Q. This was a full thickness flap, was it
14 not?

15 A. It's a skin flap which involved the
16 full thickness of the skin. I don't know of any
17 skin flaps that do not.

18 Q. So it's a full thickness skin flap,
19 basically called a random pattern flap?

20 A. It is.

21 Q. Okay.

22 A. But actually can I -- in case somebody
23 who actually knows the difference starts to
24 peruse these records --

25 Q. Other than Howard Mishkind?

1 A. Yes. I included the capsule of the
2 flap in this, the capsule around the implant in
3 this flap on purpose, or I do on purpose, let's
4 say, in those patients -- I don't know for sure
5 if I did this here, but when I do this operation
6 on patients that have an implant, I include the
7 capsule. So this thing is lined on the inside of
8 the capsule which is extremely highly vascular
9 tissue. And I think there is no reason to
10 discard the capsule.

11 And I have found that regardless of
12 almost whatever else is going on, when the
13 capsule is included in the way the flap is
14 designed, it ensures the flaps will lift, because
15 the capsule itself has such an incredibly high
16 vascularity despite the status of skin and the
17 capsule is not radiated tissue because it was
18 formed after the time. So for completeness sake
19 that should be included in there.

20 Q. Fair enough.

21 Before you started the nipple
22 reconstruction procedure on July 18th, 1997, you
23 knew that there was a risk by performing the full
24 thickness flap, the random --

25 A. It's a skin flap.

1 Q. The skin flap. You knew that in
2 approaching the surgery on her reconstructed
3 breast that there was a risk of perforating the
4 capsule at the time of operating on her; correct?

5 A. Perforating the implant?

6 Q. Perforating the implant.

7 A. Yes, there is a risk, there is always
8 a risk as described to her of a perforation of
9 the implant.

10 Q. Where did you describe to her that
11 there was a risk of perforating the implant?

12 A. Well, in the original note, from our
13 first consultation, I believe, it's documented.

14 Q. You are talking about back in --

15 A. I am.

16 Q. What is the date? April of '96?

17 A. I am. But if it's documented
18 specifically at the time of nipple
19 reconstruction, I do not see it documented then,
20 but it was part of our discussion.

21 Q. So what you are relying on, unless
22 there is something else, is the letter that you
23 wrote to Dr. Shenk back in April of 1996 to say
24 **that** you had a discussion with her about the
25 risks of perforation of the implant?

1 A. Well, that's not correct. Me had a
2 discussion where I specifically listed all the
3 complications again just before the nipple
4 reconstruction and I believe the way that they
5 were referred to in the note was all the original
6 risks still persist.

7 Q. Certainly it would have been your duty
8 and responsibility to tell her that in forming
9 the nipple, in doing an incision and operating on
10 the breast mound that we run the risk of
11 perforating the implant and basically being in a
12 position where we have to start from scratch;
13 correct?

14 A. I don't know if I can agree that
15 certainly it was my duty to do that. I would
16 guess that common practice would be among plastic
17 surgeons who do nipple reconstruction.

18 Specifically enumerating that the
19 implant could be punctured would routinely be
20 left off the list of perceived risks. **It's** a
21 risk because it is a foreign object and patients
22 understand that an inflated foreign object is
23 always subject to the risk of being perforated by
24 whatever source. I think that's discussed, but I
25 don't know that it would be expected in a

1 practice to list that specific risk before nipple
2 reconstruction.

3 Q. And what you are telling me is that
4 you did not tell her that that was a risk then
5 specifically before doing this nipple
6 reconstruction?

7 A. What I did tell her was that the risk
8 of losing the implant continues to persist.

9 Q. There was a perforation most likely of
10 the implant causing damage to the implant;
11 correct?

12 A. Correct.

13 Q. And that was at the time, at the
14 beginning of the surgery; correct?

15 A. Well, the perforation was found once
16 we entered the space around the implant, and I
17 presume that the damage was caused earlier in the
18 procedure.

19 Q. Okay. And you were the surgeon;
20 correct?

21 A. I was.

22 Q. You were responsible for what took
23 place during the surgery?

24 A. I was.

25 Q. You had an assistant, Dr. Weider --

1 A. I did.

2 Q. -- who caused the perforation?

3 A. As I recall, I think he did.

4 Q. And does it reflect anywhere in the
5 record that he did?

6 A. No, it doesn't.

7 Q. Whatever Dr. Weider was doing, he was
8 doing it under your control and direction;
9 correct?

10 A. He was.

11 Q. Okay. So ultimately you were the one
12 that told him, if in fact he is the one that
13 perforated it, you are the one that told him to
14 infiltrate the area with one percent Xylocaine;
15 correct?

16 A. I was.

17 Q. With epinephrine solution?

18 A. I was.

19 Q. But you are speculating that it was
20 him as opposed to you?

21 A. As I recall, it was him.

22 Q. But the records don't reflect that?

23 A. I don't think that's necessary to put
24 that to dictate into the note. It's under my
25 direction.

1 Q. Okay. And you are ultimately
2 responsible for that complication?

3 A. Yes, I am.

4 Q. Had you ever had that happen before?

5 A. Never have.

6 Q. Is this a complication that with
7 appropriate care should be avoided?

8 A. I don't know what you mean by
9 appropriate.

10 Q. Is this a complication that if the
11 infiltration given the breast mound and the
12 radiated skin is done carefully that perforation
12 of the implant should be avoided?

14 MR. CRANDALL: I'm going to object.
15 You are saying it's strict liability now, the
16 fact that it happened?

18 MR. MISHKIND: I didn't say that,
18 Steve. If you want to object --

19 Q. I am asking if appropriate care is
20 taken to inject the Xylocaine, should the implant
22 be perforated?

22 MR. CRANDALL: Same objection.

22 Do you understand what he is asking
24 you?

25 THE WITNESS: I do.

1 A. And I want to say something that I
2 think reflects something that mirrors the truth,
3 and that is this perforation can happen despite
4 perfectly appropriate care. In the face of
5 perfectly appropriate care, this perforation can
6 happen. So that it happened does not label the
7 act appropriate or inappropriate.

8 Q. Yet you never had it happen to you?

9 A. Correct.

10 Q. And do you know why it happened in
11 this case?

12 A. I speculate that the needle was placed
13 below the level of the skin into the implant.

14 Q. Is there any other explanation for why
15 it happened other than that?

16 A. Not one that I think is likely.

17 Q. Okay. Do you know why it is that you
18 think that Dr. Weider while under your direction
19 and control was the one that injected, did the
20 injection as opposed to you?

21 A. I believe that I recall him doing it.
22 It would have been more likely than not that I
23 would have been letting a senior resident perform
24 the procedure under my direction.

25 Q. Any other reasons?

1 A. Those are the only two reasons.

2 Q. Okay. Do you remember having a
3 discussion afterwards as to -- strike that.

4 So after you raised the skin, you saw
5 that there was a leak and you realized at that
6 point that you had to remove the implant?

7 A. That's right.

8 Q. Did you advise the patient at that
9 point that you had to remove the implant?

10 A. She was asleep or sedated. I didn't
11 discuss it with her at that point.

12 Q. Do you remember having a discussion
13 with her afterwards as to what happened?

14 A. I do.

15 Q. Tell me what you remember.

16 A. I told her that while we were
17 performing the procedure, the implant was -- I
18 told her that I discovered that the implant was
19 ruptured and I presume that it was from a needle
20 that we put in there. And I did indeed find a
21 hole in the implant and couldn't leave it because
22 it would have been deflated, of course, so I
23 replaced the implant and went ahead and did the
24 procedure.

25 And I felt comfortable at that time

1 saying that it didn't change what our plan was
2 going to be. We were able to go ahead and make a
3 nipple and it all worked and the wound came
4 together, and it was actually a bit fortuitous in
5 that I ended up putting a smaller implant in. so
6 if anything, I decreased -- trying to put a
7 little positive spin on it, I decreased the
8 tension on the closure.

9 Q. She, yet, was disappointed with the
10 fact that after the perforation occurred that she
11 now was left with a smaller breast than what she
12 had going into it; correct?

13 A. She was.

14 Q. Was there any reason why you couldn't
15 have put in the same size implant?

16 A. Yes. I couldn't close the wound
17 otherwise.

18 Q. Because of the injury that had been
19 caused by having to remove the perforated
20 implant?

21 A. Well, there wasn't an injury caused by
22 removing the implant. In removing the implant,
23 there is a certain amount of recoil in the skin
24 and it wasn't possible to put an implant in of
25 exactly the same size and get the skin closed

1 without tension. So the safe thing to do,
2 especially in radiated settings, was to put
3 something in there where I get a tensionless
4 closure.

5 Q. Did you have to expand the incision?

6 A. I didn't. I did it all through the
7 incision of the nipple reconstruction, to my
8 recollection.

9 Q. Although your operative report really
10 doesn't describe that, does it?

11 A. That I didn't expand the incision?

12 Q. How you went about replacing the
13 implant.

14 A. I believe it does. The implant was
15 then open, meaning I made a hole in it, drained
16 the rest of the fluid out of it, evacuated the
17 saline, removed it from the wound, presumably
18 from the incision I made up to that point,
19 examined and found it to be a certain size, a
20 slightly smaller implant was selected, 390 cc,
21 repaired, replaced into the wound and filled.

22 Q. Well, you say you presumed you used
23 the same area. You don't describe whether you
24 did use the same area, whether you made a larger
25 incision to put the implant in?

1 A. Well, I don't describe it. So I
2 therefore presume that I didn't --

3 Q. Okay.

4 A. -- make another incision.

5 Q. Are you critical of Dr. Weider in any
6 respect?

7 A. I'm not.

8 Q. Are there steps taken to avoid or to
9 minimize the likelihood of penetrating the
10 implant at the time that you do the injection
11 before starting the nipple reconstruction?

12 A. Other than try not to put the needle
13 in too deep, I can't think of any.

14 Q. You are aware that the skin is thin;
15 correct?

16 A. Yes.

17 Q. And you are aware that there isn't a
18 lot of muscle in that area of the chest wall
19 because of the radiated skin; correct?

20 A. Well, there is not a lot of muscle.
21 The implant is submuscular, so technically there
22 is skin, subcutaneous tissue, thin muscle and
23 capsule. The thinned muscle is not due to the
24 radiation. It's due to the fact that it's
25 expanded over a period of time.

1 Q. Every time that an injection is made
2 into a patient that has radiated skin, the
3 implant is not perforated, is it?

4 A. No.

5 Q. And there has to be care taken not to
6 go too far with the injection, otherwise you
7 increase the likelihood of perforating the
8 implant; correct?

9 A. That's true.

10 Q. Do you know whether appropriate care
11 was taken in this case to avoid going too far
12 with the injection?

13 In other words, were appropriate
14 techniques used to realize the anatomy and to
15 prevent injecting the needle into the implant?

16 A. Yes, I believe they were.

17 Q. Why then did this happen?

18 A. Because I think despite the fact that
19 appropriate care was taken, the needle penetrated
20 the implant.

21 Q. August 13th, when you saw Edna in your
22 office, you had an office meeting with Edna and
23 she was quite upset with you, wasn't she?

24 A. Upset with me? I think she was upset.

25 Q. What did you mean when you said

1 raising the flaps turned out to be technically
2 difficult?

3 A. The flaps were thinner, even thinner
4 than I expected.

5 Q. You state that there was no way that
6 you can tell that the skin was as thin as it was
7 over the implant.

8 A. That's correct.

9 Q. Yet you knew full well that you were
10 dealing with thin skin just by having dealt with
11 her along the various phases. ? You knew you
12 weren't dealing with normal skin?

13 A. Correct.

14 Q. And you knew the skin was going to be
15 thin?

16 A. Correct.

17 Q. And you knew that raising the f aps to
18 form the nipple with the thin skin, not only was
19 it going to be technically difficult, but that it
20 was a risky procedure from the standpoint of the
21 healing and the vascularity of that site;
22 correct?

23 A. Well, I have to ask you to ask me your
24 question again so I can give you a clear answer,
25 I'm sorry.

1 Q. You knew in addition to it being thin,
2 in addition to it being a technically difficult
3 procedure, you knew that because of the
4 radiation, the vascularity in that area was
5 compromised so that the healing potential was
6 reduced over normal skin?

7 A. I did know that.

8 Q. Okay.

9 A. The skin I expected to be thin, it was
10 thin, but I didn't expect it to be this thin.

11 Q. Why not?

12 A. I don't think there is any way someone
13 could know.

14 Q. The nipple ultimately necrosed, didn't
15 it?

16 A. Part of the flap did, yes.

17 Q. Did you make any recommendations to
18 Edna on this August 13th, '97 visit in terms of
19 whether she should have the implant removed and
20 closed over or use an immediate tissue expander?

21 A. Can I take a look at my note?

22 Q. Absolutely.

23 (Pause.)

24 A. We discussed two options that I
25 discussed here. One of which I favored was

1 taking the implant out, but an unreasonable
2 alternative was not taking the implant out or
3 taking the implant out but putting something in
4 there to maintain the space. Mind you, this is a
5 15 months after we started this operation. Just
6 taking the implant out would essentially put us
7 back to the beginning.

8 Q. So what recommendations did you make
9 to her at that point?

10 A. Well, I recommended to her that we
11 remove the implant, irrigate the pocket, close
12 the wound over a drain. But another alternative
13 was to place a spacer. For that I would use a
14 tissue expander. So there was a potential to be
15 reinflated later into the pocket to maintain the
16 space. This is knowing that the space is
17 contaminated, by definition, because there is a
18 communication between the air and the pocket in
19 there. And there is an increased chance of this
20 spacer, the expander becoming infected.

21 Q. Certainly you had -- did I cut you
22 off?

23 A. Yes.

24 Q. I did cut you off. Go ahead.

25 A. And the downside of that is that if

1 this thing gets infected, we have to go ahead and
2 remove it. The up side is removing it is not a
3 particularly difficult thing; that it was not
4 needlessly risky in her in leaving it and if we
5 did win, then we saved at least most of what we
6 had accomplished in 15 months. If we lost, we
7 would take it out and we would be where we were
8 if we had taken the other choice.

9 Q. Based upon those options, did you
10 ultimately recommend to her that you proceed with
11 the tissue expander, recognizing the risks?

12 A. We decided together that is what she
13 would do. I let her think about it.

14 Q. But you felt, because you are the
15 surgeon, you felt that weighing and balancing the
16 various risks that it was reasonable and prudent
17 to proceed with the tissue expander as the next
18 step in the process of giving her a
19 reconstructive breast?

20 A. I felt it was reasonable.

21 a. Okay. And was it reasonable in your
22 professional opinion to proceed with the tissue
23 expander at the time that it was done, which we
24 ultimately learned was done in September or
25 October?

1 A. Are you asking me what the date was
2 that it was done?

3 Q. That's sort of a combination. That
4 wasn't my intended question. But whenever it was
5 done, was it reasonable to proceed at that point
6 with the tissue expander?

7 A. I believe it was. This conversation
8 here anyway is documented on 8-13-97 and the
9 exchange was done on 8-15-97, so I think the
10 recommendation would be if we are going to do it,
11 we should get on with it.

12 And I also recall discussing with her
13 that I was willing to go along and do this thing
14 because I thought the risks here were not
15 unreasonable. If we had to take the implant out,
16 we would. But if I felt at any time, like if I
17 saw pus or felt at some time that this was indeed
18 an infected wound, I would not knowingly put a
19 prosthetic into that. She understood that issue
20 and weighed her two choices.

21 Q. We know ultimately that while you were
22 on vacation the tissue expander had to be
23 removed; correct?

24 A. That's correct.

25 Q. And that's because an infection

1 developed?

2 A. Yes. It appears so, yes, from the
3 notes here.

4 Q. And that was an infection that you
5 knew prior to doing this was a risk associated
6 with putting the tissue expander in so early
7 after removing the implant; correct?

8 A. Well, the earliness is not what
9 determines the risk of infection, I don't
10 believe. What determined the risk of infection
11 was the fact that the wound was contaminated and
12 the implant was going into a known contaminated
13 wound. And that does increase the risk of
14 infection. I don't think the timing is the issue
15 there.

16 Q. Okay. What about proceeding with
17 latissimus or TRAM flap at this point given the
18 fact that you had to do something? Was that an
19 option, as well in August?

20 A. Was that an option? It was an option
21 the whole time.

22 Q. Was it an option in August of 1997?

23 A. That she and I discussed undertaking
24 one of these large operations at this time?

25 Q. Yes.

1 A. We did not do it for breast
2 reconstruction. We discussed the latissimus for
3 chest wall reconstruction, for filling in this
4 hole, if you will. But latissimus would not be
5 used for breast reconstruction, as it would have
6 to have had a buried implant with it.

7 Q. A TRAM would be?

8 A. A TRAM in general is a reasonable
9 alternative. At this point, a TRAM is still
10 theoretically possible, yes.

11 Q. Did you ever at any point consider
12 telling Edna before you proceeded with the nipple
13 reconstruction or the attempted nipple
14 reconstruction in July of **1997**, did you ever
15 consider telling Edna that she should get another
16 opinion, go to see somebody else; that you just
17 felt that her aesthetic demands were more than
18 what you felt comfortable with?

19 A. Well, no.

20 Q. Would you agree that Edna seemed to
21 trust you?

22 A. Yes.

23 Q. If you had to do it over again, would
24 you have done the nipple reconstruction?

25 MR. CRANDALL: 1 object.

1 A. I don't think the question is clear.
2 If I had to do it over again?

3 Q. Well, would you agree that you made an
4 error in judgment in performing nipple
5 reconstruction?

6 A. No.

7 Q. Why not?

8 A. Because given the set of circumstances
9 as I was faced with them then, I think I made the
10 choice that seemed appropriate at the time.

11 Q. Would you agree that you made an error
12 in judgment in putting a foreign body or the
13 tissue expander into the capsule at the point in
14 time that you did in August of 1997?

15 A. No, I don't think that was an error in
16 judgment.

17 Q. Who is Dr. Hocky?

18 A. LeHocky. Another plastic surgery
19 resident.

20 Q. Lee is the first name?

21 A. No, Brett LeHocky.

22 Q. Looks like Dr. LeHocky saw Edna in
23 September of '97. Were you possibly out of town
24 at that point?

25 A. I was out of town at that point. I

1 don't recall where I was.

2 Q. Any criticism of Dr. LeHocky?

3 A. In general?

4 Q. Yes.

5 A. None.

6 Q. In specific with regard to this case?

7 A. None.

8 Q. There is a note on September 21 that
9 you discussed something with Dr. Jordan. Do you
10 recall what was discussed with Dr. Jordan on
11 September 21?

12 A. There is a note here from Dr. Weider
13 on September 21st, where he refers to discussed
14 with Dr. Jordan.

15 Q. Do you know what that discussion
16 involved?

17 A. I don't.

18 Q. Are you able to determine from looking
19 at the note what the nature of that discussion
20 was?

21 (Pause.)

22 A. Well, the nature of his note says that
23 his clinical opinion, Dr. Weider felt that there
24 is an infection. His assessment reveals an
25 exposed implant, purulent drainage, mild

1 erythema, for which he administered antibiotics.
2 He thought implant removal was called for and he
3 discussed this with Dr. Jordan.

4 Q. Do you recall having any discussions
5 with Dr. Jordan after he performed surgery in
6 October of '97?

7 A. I vaguely do. I recall a discussion
8 -- I know that I discussed it with him. I
9 better recall the details of the discussion with
10 Dr. Weider himself.

11 Q. Tell me.

12 A. Dr. Weider said while you were gone,
13 Edna Williams came in and thought she had an
14 infection and he admitted her and Dr. Jordan and
15 I decided to take the implant out the next day.

16 Q. Anything else that you recall?

17 A. That is what I recall.

18 Q. Showing you Plaintiff's Exhibits 7 and
19 8, can you tell me what -- they are photographs,
20 but can you tell me when these photographs
21 relative to time would have been taken?

22 A. Well, clearly the photographs
23 represent the wound on the left breast after all
24 implants or expanders are removed. So these
25 photographs depict a period of a time after

1 September 22nd when the implant was removed and
2 they were taken by me, so they were clearly after
3 the time she was discharged.

4 Q. Okay. This represents an area that
5 still has not healed; correct?

6 A. At this point, yes, it had not healed.

7 Q. Is it likely that her healing is going
8 to be slower than if an incision of that nature
9 had been made on her right breast?

10 A. In a nonradiated area, you mean?

11 Q. Yes.

12 A. Yes, this wound in a radiated area
13 will likely heal slower than a wound.

14 Q. You last saw Edna November something?

15 A. My last note is November 19th and
16 there is a note here by Coleen, that Coleen had
17 some contact with her on the 21st.

18 Q. And what does it say?

19 A. Coleen's note says call and left
20 message to TJHHC, which is University Hospital
21 Home Health Care that dressing changes could be
22 stopped, as patient stated on 11-20-97 she was
23 doing the dressing changes herself.

24 Q Do you agree there is a balance
25 between beauty and blood supply in the area of

1 reconstructive breast surgery?

2 A. A balance between beauty and blood
3 supply -- beauty and blood supply. I am not sure
4 what that means.

5 Q. You never heard that?

6 A. It sounds like a lead off of a
7 chapter.

8 Q. You never heard that phrase before?

9 A. No.

10 Q. It's not a lead off. I am just
11 wondering, in plastic surgery when you are doing
12 reconstructive surgery if there is a balance
13 between the beauty or the aesthetics of the area
14 and the blood supply in the area of the
15 reconstruction?

16 A. I'm aware of that concept, yes.

17 Q. And a physician should not let the
18 patient dictate what is done in terms of
19 reconstruction when it comes to the balance
20 between beauty and blood supply?

21 A. I think that's true.

22 Q. You have not had a chance to review
23 Dr. Dinner's records?

24 A. I have not looked at them.

25 Q. In November of '97, did you have a

1 discussion with Edna about performing a
2 latissimus flap?

3 A. In November of '97?

4 Q. Yes. October or November, I suppose.

5 A. Right. Yeah, we discussed doing a
6 latissimus flap.

7 Q. Does your record reflect any
8 discussion about doing a TRAM flap?

9 A. The record does not reflect that, no.

10 Q. Do you have any such recollection of
11 having a discussion about a TRAM flap at that
12 time?

13 A. I do.

14 Q. Tell me.

15 A. Really we discussed doing a bigger
16 operation next, the possibility of it. And we
17 discussed latissimus and TRAM came up. At this
18 point, I remember Edna telling me that she had no
19 insurance and she had all these hospital bills.
20 And to do a bigger operation would have left her
21 with a significant number of bills.

22 Not that I wasn't willing to do
23 surgery on her, of course. From the beginning
24 she had no insurance and I was willing to operate
25 on her and wanted to do a TRAM in the beginning,

1 but I reminded her that doing a TRAM flap at this
2 stage, essentially now that she had come around
3 to understand why I wanted to do a TRAM flap in
4 the first place, I think she came to realize that
5 that was the best thing, frankly, but we also
6 discussed the fact that she probably would be
7 paying the bills for this operation now.

8 That wasn't the primary reason we
9 didn't do it, but I recall having that discussion
10 with her.

11 Q. Your record on November 19th says we
12 talked about the latissimus reconstruction of the
13 chest wall. It does not reflect a discussion
14 about the TRAM flap, does it?

15 A. This does not reflect a discussion
16 about a TRAM flap.

17 Q. And the October '97 note, we could
18 close it with a latissimus myocutaneous flap, or
19 if she wanted, we could place a tissue expander
20 underneath the latissimus and try to inflate it.

21 There is no discussion in October of
22 '97 about the TRAM flap either, in the dictated
23 note, is there?

24 A. There is not.

25 Q. This is, again, your recollection of

1 your desire all along, but yet it's not reflected
2 in the October or the November '97 office notes;
3 correct?

4 A. It's not reflected there.

5 Q. Okay. Do you recall offering to do
6 the latissimus reconstruction, given her
7 financial situation, free without charge?

8 A. I don't recall.

9 Q. Do you recall telling her that you
10 would do it without charge to her to the extent
11 that any insurance coverage that she had didn't
12 cover the procedure?

13 A. Well, I don't recall is the answer,
14 but there are other costs involved there besides
15 what I would bill her, meaning the hospital, of
16 course.

17 Q. Is it your testimony that in all
18 likelihood, at least to a probability, that you
19 would not have made such an offer to her --

20 A. I can't --

21 Q. -- free or beyond what insurance would
22 cover?

23 A. No, I can't answer that.

24 Q. You just don't recall one way or the
25 other?

1 A. I can't say in all likelihood I
2 would. I may have.

3 Q. Did you have any communication with
4 her or any contact with her after November of
5 1997?

6 A. Not that I recall, no.

7 Q. We have gone through most of the
8 office visits and we have talked about the
9 surgeries to a lesser extent while the inflation
10 -- while the saline injections were going on,
11 but are there any specific conversations where
12 you discouraged or encouraged her to do one thing
13 or another that you recall that we haven't
14 already touched on that you want to tell me
15 about?

16 A. No.

17 Q. Since '97, other than communications
18 where records were requested or you got lovely
19 letters from me, any other communication that you
20 had with any doctors about Edna's condition?

21 A. Other than what you asked me about
22 earlier, no.

23 MR. MISHKIND: Doctor, I have no
24 further questions for you. I appreciate it.

25 I may need to talk to some other

1 people, certainly Coleen, but I don't have any
2 further questions for you at this point. Thank
3 you.

4 MR. CRANDALL: We will read this.

5 Can I have a waiver on the seven days
6 given his circumstances?

7 MR. MISHKIND: Twenty-eight days is
8 fine.

9 - - - -

10 (Deposition concluded at 12:50 p.m.;
11 signature not waived.)
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AFFIDAVIT

I have read the foregoing transcript from
page 1 through 150 and note the following
corrections:

PAGE LINE	REQUESTED CHANGE
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Daniel P. Goldberg, M.D.

Subscribed and sworn to before me this _____
day of _____, 2000.

Notary Public

My commission expires _____

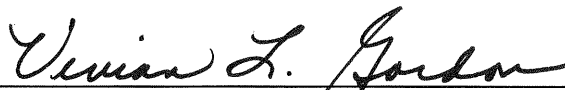
1 CERTIFICATE

2 State of Ohio,)
3) ss:
County of Cuyahoga.)

4
5 I, Vivian L. Gordon, a Notary Public within
6 and for the State of Ohio, duly commissioned and
7 qualified, do hereby certify that the within
8 named DANIEL P. GOLDBERG, M.D. Was by me first
9 duly sworn to testify to the truth, the whole
truth and nothing but the truth in the cause
10 aforesaid; that the testimony as above set forth
11 was by me reduced to stenotypy, afterwards
12 transcribed, and that the foregoing is a true and
13 correct transcription of the testimony.

14 I do further certify that this deposition
15 was taken at the time and place specified and was
16 completed without adjournment; that I am not a
17 relative or attorney for either party or
18 otherwise interested in the event of this action.

19 IN WITNESS WHEREOF, I have hereunto set my
20 hand and affixed my seal of office at Cleveland,
21 Ohio, on this 17th day of February, 2000.

22
23
24
25


26 Vivian L. Gordon, Notary Public
27 Within and for the State of Ohio

28 My commission expires June 8, 2004.

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