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.

APPEARANCES:

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

On behalf of the Defendants
Reminger & Reminger
BY: STEPHEN S. CRANDALL, ESQ.
The 113 St. Clair Building
Cleveland, Ohio 44114

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

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

EXAMINATION OF DANIEL GOLDBERG, M.D.

BY MR. MISHKIND:

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

A. Daniel Goldberg.

Q. You are a physician?

A. I am.

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

A. Correct.

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

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

Q. Is it current?

A. It's not.

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

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

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

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

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

A. That's right.

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

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

Q. And what are those, please?

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

Q. Tell me about that.

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

Q. Where is this at?

A. Located at Case Western.

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

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

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

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

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

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

Q. Is this for cosmetic surgery?

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

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

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

Q. And you are heading up this research?

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

Q. Are there other physicians that work

in the lab with you?

A. There are.

Q. Who are those physicians?

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

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

A. About three working days a month.

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

A. No, I don't.

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

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

Q. So you are now a full-time legal

resident of the U.K.?

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

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

A. It's listed on the curriculum vitae.

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

A. My home address.

Q. Do you have a clinical office?

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

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

A. I am.

Q. And in what area?

A. A plastic surgeon, plastic and reconstructive surgeon.

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

A. No.

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

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

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

A. September '98.

Q. Do you have family in England?

A. Just my wife.

Q. Your wife is a --

A. She is Dutch.

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

A' Completely.

Q. Is she a physician?

A. No.

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

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

doctorate in art history.

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

A. I wish.

Q. No, okay. She is a commoner?

A. She is a commoner, yes.

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

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

Q. Tell me what association you have.

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

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

assistant professor or otherwise at Case Western Reserve University?

A. I don't know.

Q. That's uncertain?

A. It's uncertain.

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

A. Yes.

Q. And what have you indicated?

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

Q. There being Case Western Reserve University?

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

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

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

plastic surgery.

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

A. That's right.

Q. And give me his title.

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

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

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

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

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

A. It's incorrect.

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

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

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

A. Yes, it is.

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

A. It does.

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

A. It is.

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

A. Correct.

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

A. Correct.

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

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

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

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

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

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

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

A. I was out of town.

Q. It wasn't England, was it?

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

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

A. Yes.

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

A. Uh-huh.

Q. That's a yes?

A. Yes, it is.

Q. Was he a resident?

A. He is a resident.

Q. Is he still at University Hospitals?

A. No, he has graduated.

Q. Do you know where he practices now?

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

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

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

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

A. He was.

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

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

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

A. That's right.

Q. What or who is this entity?

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

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

A. I was.

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

A. I was not.

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

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

commercial and part political and part professional and educational.

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

A. Yes, it is.

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

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

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

titles.

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

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

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

A. I didn't.

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

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

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

my status there at all.

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

Q. Why were you such a special case?

A. From my point of view or theirs?

Q. Whichever you feel more comfortable addressing.

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

Q. You said that this has never happened before.

A. Yes.

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

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

Firstly, there has been a significant

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

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

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

So I think it was a combination of

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

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

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

A. I don't.

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

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

A. That's correct.

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

recall receiving that request?

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

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

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

Q. And that would have been who?

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

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

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

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

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

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

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

MR. CRANDALL: Do you have a policy?

THE WITNESS: No.

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

A. No.

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

A. Correct.

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

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

Q. Of course.

(Pause.)

A. Are you referring to something in particular?

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

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

Q. That's what I was referring to.

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

a. Yes, I can

(Pause.)

Q. Just for the record, Plaintiff's

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

A. Yes, it does.

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

A. It may in some way touch on it.

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

A. Yes, I have.

Q. On how many occasions?

A. Once.

Q. Was that in the Robert Walker case?

A. Yes, it was.

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

A. It was not.

Q. That case was dismissed; correct?

A. It was.

Q. Is the Robert Walker case still pending?

A. It's not.

Q. Bid that matter go to trial?

A. It didn't.

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

A. We settled for some amount of money.

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

MR. MISHKIND: That's fine.

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

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

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

A. It was.

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

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

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

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

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

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

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

A. No, I haven't seen it.

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

A. It was.

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

A. I can't remember his name.

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

A. It is.

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

A. It's not.

Q. How many times have you been named?

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

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

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

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

A. Yes, they are.

Q. How many?

A. Three are still open.

Q. Are all of them -- strike that.

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

A. Edna's would be the fourth.

Q. Are the other three here in Cuyahoga County?

A. They are.

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

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

A. No, they weren't.

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

A. That's correct.

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

A. They are.

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

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

MR. CRANDALL: Yes.

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

I am going to stop.

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

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

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

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

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

A. I am.

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

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

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

A. I'm not.

Q. Have you ever?

A. I haven't.

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

A. I have.

Q. On how many occasions?

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

Q. Have you written reports in those cases?

A. I have, yes.

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

A. That's right.

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

A. I don't recall that there were.

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

A. He was.

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

post mastectomy reconstruction?

A. Yes.

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

A. I had.

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

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

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

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

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

MR. MISHKIND: Not yet, no.

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

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

MR. MISHKIND: Right, yes.

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

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

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

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

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

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

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

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

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

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

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

A. It might have been, yes.

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

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

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

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

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

A. No, not that I recall.

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

A. Yes. In general, his response was

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

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

A. No, I don't.

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

A. No, I don't.

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

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

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

A. Not that I can recall, no.

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

A. Yes, correct.

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

A. Yes.

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

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

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

A. Yes.

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

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

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

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

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

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

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

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

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

A. I don't recall a specific conversation.

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

A. Correct.

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

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

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

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

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

Q. What were those demands?

A. Aesthetic demands?

Q. Yes, sir.

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

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

A. I thought they made her care more challenging.

Q. But not unrealistic?

A. What do you mean by unrealistic?

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

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

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

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

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

A. I did.

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

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

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

A. Yes.

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

A. Can you ask me that again?

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

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

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

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

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

A. Yes.

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

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

MR. MISHKIND: I am.

A. 1 think, within reason, they accurately reflect the medical information that was disseminated.

Q. When was the last time you reviewed

your notes?

A. This morning.

Q. And before that?

A. Maybe a few months.

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

MR. CRANDALL: Objection. Go ahead.

A. Can you ask your question again?

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

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

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

MR. MISHKIND: I am not suggesting that.

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

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

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

MR. CRANDALL: Again, I need to

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

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

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

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

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

A. He wasn't.

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

A. I don't believe so.

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

A. Yes.

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

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

Q. Is Coleen -- does she go by Coleen?
A. She does.
Q. What does the M stand for?
A. I don't know.
Q. Not that it's really terribly important. But is she still affiliated with the group?
A. She is.
Q. What is her title other than RN?
A. What is her title? Officially, I couldn't tell you what her title is. I don't know.
Q. What was her responsibility?
A. Her responsibility is patient care, patient liaison, patient teaching for patients of University Plastic Surgery Associates.
Q. Have you had an opportunity to talk to Coleen since this lawsuit was filed?
A. I have had the opportunity to, yes. I don't recall if I have discussed the lawsuit with her.
Q. You know Dr. Melvyn Dinner; correct?
A. E know him, yes.
Q. Is he a well-respected plastic surgeon, in your opinion?

A. Yes.

Q. You sort of hesitated when you said that.

Does he maintain a good reputation amongst plastic surgeons?

A. From my point of view, he does.

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

A. I haven't.

Q. You haven't seen any of that?

A. I have not.

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

A. No.

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

A. No.

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

A. Yes.

Q. I take it you have never had your

hospital privileges suspended or revoked or called into question?

A. That's correct.

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

A. I have not.

Q. Ever applied for licensure and been denied?

A. Never have.

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

A. Never have.

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

A. I do.

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

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

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

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

A. No, not in particular.

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

A. Correct.

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

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

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

A. Yes.

Q. Which books or journals, if you will,

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

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

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

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

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

A. Yes.

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

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

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

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

A. Yes.

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

A. Yes.

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

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

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

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

I consider those to be very good ones.

Q. Have you contributed to any of those texts?

A. No.

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

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

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

something?

A. I will.

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

A. Yes.

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

A. It does.

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

A. That's correct.

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

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

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

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

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

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

Q. Please, go ahead.

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

Q. Okay. Did you discuss various other

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

A. We did.

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

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

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

A. Yes.

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

A. They would be.

Q. Did you recommend one over the other?

A. I recommended that she have a TRAM flap.

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

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

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

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

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

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

A. Yes.

Q. And are these premastectomy photographs?

A. They are.

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

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

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

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

Q. Mow, do you know where the originals are of these photographs?

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

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

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

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

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

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

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

MR. MISHKIND: Specifically, the photos.

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

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

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

A. No, they don't.

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

A. Yes.

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

A. 35 millimeter.

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

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

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

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

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

THE WITNESS: Slides.

MR. MISHKIND: Which is a negative, so

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

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

A. It appears that the oblique view shows hyperpigmentation.

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

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

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

A. It was.

Q. And was Edna against having a TRAM flap?

a. She was.

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

A. She did.

Q. Tell me, please.

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

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

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

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

is lessened by having the latissimus muscle added to it.

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

A. It was.

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

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

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

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

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

Q. Okay. And I guess subsumed in my

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

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

MR. MISHKIND: Yes.

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

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

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

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

another.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

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

patient makes the choice. Perhaps you can remember.

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

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

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

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

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

much committed to going that route?

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

Q. From a medical point of view.

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

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

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

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

A. That's is true.

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

A. That's true.

MR. CRANDALL: Can we take a break?

(Thereupon, a recess was taken.)

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

A. Yes.

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

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

First, did I read that accurately?

A. You did.

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

A. Yes, it does.

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

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

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

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

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

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

A. It was.

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

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

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

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

A. Yes, it appears to be.

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

A. It is my understanding.

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

A. It was not.

Q. This is a hospital consent form?

A. It is.

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

A. I don't.

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

A. Yes, it is.

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

A. Correct.

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

A. Correct.

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

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

A. Correct.

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

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

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

A. I do not recall.

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

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

present the consent form and obtain the signature.

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

A. I do not recall specifically.

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

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

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

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

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

A. It is.

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

A. Correct.

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

A. Yes.

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

A. I don't recall.

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

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

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

A. I would have.

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

A. True.

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

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

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

To your knowledge, were either or both

of these documents provided to Edna Williams?

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

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

A. It would.

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

A. No.

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

A. They were.

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

A. Yes.

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

A. No.

Q. Did you have any photographs that you

would show a patient on stages of reconstruction?

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

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

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

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

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

A. I don't recall.

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

A. Yes.

Q. You were the attending?

A. I was.
Q What aspect did he perform?
A. What aspect? He was the assistant.
Q. What aspect did he assist you with?
A. What particular aspects of the operation?
Q. Yes.
A. I don't recall.
Q. Were you satisfied with the outcome? This is the first phase of the procedure; correct?
A. Yes.
Q. Were you satisfied with what you were able to accomplish at that particular time?
A. I was.
Q. Okay. No untoward complications that occurred at the time of your surgery?
A. None.
Q. And notwithstanding the radiation and notwithstanding all of the concerns, the risks that are inherent, the first phase of your surgery was successful?
A. At the time of surgery did I deem it that way?
Q. Yes.

A. Yes.

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

A. I have.

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

A. Poor healing, increased rate of capsular contraction.

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

A. About 50 percent.

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

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

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

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

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

A. Yes.

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

A. And I did.

a. And certainly in order to comply with

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

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

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

A. There is.

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

A. Correct.

Q. As opposed to rapid expansion?

A. Correct.

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

A. There are two ways that are written about.

Q. Okay.
A. Yes.
Q. In Edna's case, was the gradual expansion the preferable route if one is going to use tissue expanders?
A. Yes.
Q. The reason being?
A. I don't believe the other way works, frankly. I don't believe there is such a thing as immediate tissue expansion. It's written about, but true physiology that describes tissue expansion does not really occur with immediate expansion. Probably only a phenomenon of skin stretching happens then. I don't believe there is such an entity as immediate tissue expansion.
Q. In September of '96, if you would take a look at your office note for that date --
MR. CRANDALL: Are you talking about the September 10th?
MR. MISHKIND: Yes.
Q. You have a note there that her expander is very firm, as might have been guessed under radiated skin, I believe?
A. Yes.
Q. Was it more or less firm than what you

had anticipated occurring preoperatively?

A. I don't understand your question.

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

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

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

A. Let me take a look.

Q. Please.

A. Yes, it appears that way.

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

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

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

A. Yes, it appears that way.

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

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

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

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

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

A. Correct.

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

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

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

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

A. There wasn't.

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

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

Q. January 9, 1997.

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

Q. Yes.

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

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

A. Yes.

Q. Would that be information that would

be -- strike that.

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

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

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

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

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

A. No.

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

A. As I recall, it was.

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

May of 1997?

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

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

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

A. No.

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

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

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

A. They did.

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

A. They are.

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

A. Can I examine them?

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

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

Q. And that's Exhibit 4; correct?

A. This is Exhibit 4.

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

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

photograph.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. I don't recall.

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

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

Q. Okay.

A. As I observe here in my record, there

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

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

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

Q. Notes.

A. I can review them.

(Pause.)

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

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

A. Correct.

Q. Do you type the notes yourself?

A. I don't, no.

Q. You dictate them yourself?

A. I do.

Q. Do you walk around with a dictating machine?

A. I do.

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

A. It is.

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

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

Q. Let me give you a for instance.

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

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

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

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

A. No.

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

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

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

A. Yes.

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

A. Yes.

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

A. That's right.

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

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

Q. Did you recommend against doing nipple reconstruction?

A. I did.

Q. When did you recommend against doing nipple reconstruction?

A. When did I?

Q. Yes.

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

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

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

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

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

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

Q. Pushing the envelope, so to speak?

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

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

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

Q. Right.

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

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

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

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

THE WITNESS: I was going to say that.

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

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

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

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

A. Of performing a nipple reconstruction?

Q. Yes, sir.

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

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

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

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

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

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

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

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

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

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

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

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

Q. Okay.

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

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

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

A. Yes.

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

A. I do.

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

MR. CRANDALL: Do you mean specifically those terms?

Q. Or anything that paraphrases what you

just said to me.

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

Q. I'm sorry, maybe I misunderstood you. I thought you told me you felt --

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

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

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

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

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

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

A. That's correct.

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

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

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

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

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

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

Q. Let me ask you a question then.

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

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

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

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

A. That is true.

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

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

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

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

Q. Do you follow me, doctor?

A. I do.

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

explain things.

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

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

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

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

Q. And certainly this patient -- strike that.

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

June of 1997; correct?

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

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

A. Correct.

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

A. I have to refer.

Q. Go ahead.

(Pause.)

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

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

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

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

A. I can't.

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

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

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

A. Yes.

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

A. Correct.

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

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

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

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

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

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

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

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

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

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

A. Yes.

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

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

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

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

MR. CRANDALL: I am concerned about that.

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

Q. How many different methods would you

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

A. Would I use?

Q. Right.

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

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

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

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

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

there was no reason not to do the nipple reconstruction.

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

A. Correct.

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

A. Yes.

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

A. Yes.

MR. MISHKIND: Fair enough?

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

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

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

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

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

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

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

- - - -

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

- - - -

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

that; correct?

A. Uh-huh.

Q. That's a yes?

A. Yes, it is.

Q. And what does CV stand for?

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

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

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

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

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

maintained like that.

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

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

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

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

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

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

A. It's showing the blood supply into the

flap, yes.

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

A. Named artery.

Q. And then the arrows above would be what?

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

Q. Fair enough.

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

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

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

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

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

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

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

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

A. Free flaps?

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

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

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

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

A. Less likely.

Q. Tell me why.

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

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

A. Yes.

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

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

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

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

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

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

A. It is.

Q. Okay.

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

Q. Other than Howard Mishkind?

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

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

Q. Fair enough.

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

A. It's a skin flap.

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

A. Perforating the implant?

Q. Perforating the implant.

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

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

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

Q. You are talking about back in --

A. I am.

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

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

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

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

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

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

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

practice to list that specific risk before nipple reconstruction.

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

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

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

A. Correct.

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

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

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

A. I was.

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

A. I was.

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

A. I did.

Q. -- who caused the perforation?

A. As I recall, I think he did.

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

A. No, it doesn't.

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

A. He was.

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

A. I was.

Q. With epinephrine solution?

A. I was.

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

A. As I recall, it was him.

Q. But the records don't reflect that?

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

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

A. Yes, I am.

Q. Had you ever had that happen before?

A. Never have.

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

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

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

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

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

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

MR. CRANDALL: Same objection.

Do you understand what he is asking you?

THE WITNESS: I do.

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

Q. Yet you never had it happen to you?

A. Correct.

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

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

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

A. Not one that I think is likely.

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

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

Q. Any other reasons?

A. Those are the only two reasons.

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

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

A. That's right.

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

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

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

A. I do.

Q. Tell me what you remember.

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

And I felt comfortable at that time

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

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

A. She was.

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

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

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

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

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

Q. Did you have to expand the incision?

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

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

A. That I didn't expand the incision?

Q. How you went about replacing the implant.

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

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

A. Well, I don't describe it. So I therefore presume that I didn't --

Q. Okay.

A. -- make another incision.

Q. Are you critical of Dr. Weider in any respect?

A. I'm not.

Q. Are there steps taken to avoid or to minimize the likelihood of penetrating the implant at the time that you do the injection before starting the nipple reconstruction?

A. Other than try not to put the needle in too deep, I can't think of any.

Q. You are aware that the skin is thin; correct?

A. Yes.

Q. And you are aware that there isn't a lot of muscle in that area of the chest wall because of the radiated skin; correct?

A. Well, there is not a lot of muscle. The implant is submuscular, so technically there is skin, subcutaneous tissue, thin muscle and capsule. The thinned muscle is not due to the radiation. It's due to the fact that it's expanded over a period of time.

Q. Every time that an injection is made into a patient that has radiated skin, the implant is not perforated, is it?

A. No.

Q. And there has to be care taken not to go too far with the injection, otherwise you increase the likelihood of perforating the implant; correct?

A. That's true.

Q. Do you know whether appropriate care was taken in this case to avoid going too far with the injection?

In other words, were appropriate techniques used to realize the anatomy and to prevent injecting the needle into the implant?

A. Yes, I believe they were.

Q. Why then did this happen?

A. Because I think despite the fact that appropriate care was taken, the needle penetrated the implant.

Q. August 13th, when you saw Edna in your office, you had an office meeting with Edna and she was quite upset with you, wasn't she?

A. Upset with me? I think she was upset.

Q. What did you mean when you said

raising the flaps turned out to be technically difficult?

A. The flaps were thinner, even thinner than I expected.

Q. You state that there was no way that you can tell that the skin was as thin as it was over the implant.

A. That's correct.

Q. Yet you knew full well that you were dealing with thin skin just by having dealt with her along the various phases. ? You knew you weren't dealing with normal skin?

A. Correct.

Q. And you knew the skin was going to be thin?

A. Correct.

Q. And you knew that raising the f aps to form the nipple with the thin skin, not only was it going to be technically difficult, but that it was a risky procedure from the standpoint of the healing and the vascularity of that site; correct?

A. Well, I have to ask you to ask me your question again so I can give you a clear answer, I'm sorry.

Q. You knew in addition to it being thin, in addition to it being a technically difficult procedure, you knew that because of the radiation, the vascularity in that area was compromised so that the healing potential was reduced over normal skin?

A. I did know that.

Q. Okay.

A. The skin I expected to be thin, it was thin, but I didn't expect it to be this thin.

Q. Why not?

A. I don't think there is any way someone could know.

Q. The nipple ultimately necrosed, didn't it?

A. Part of the flap did, yes.

Q. Did you make any recommendations to Edna on this August 13th, '97 visit in terms of whether she should have the implant removed and closed over or use an immediate tissue expander?

A. Can I take a look at my note?

Q. Absolutely.

(Pause.)

A. We discussed two options that I discussed here. One of which I favored was

taking the implant out, but an unreasonable alternative was not taking the implant out or taking the implant out but putting something in there to maintain the space. Mind you, this is a 15 months after we started this operation. Just taking the implant out would essentially put us back to the beginning.

Q. So what recommendations did you make to her at that point?

A. Well, I recommended to her that we remove the implant, irrigate the pocket, close the wound over a drain. But another alternative was to place a spacer. For that I would use a tissue expander. So there was a potential to be reinflated later into the pocket to maintain the space. This is knowing that the space is contaminated, by definition, because there is a communication between the air and the pocket in there. And there is an increased chance of this spacer, the expander becoming infected.

Q. Certainly you had -- did I cut you off?

A. Yes.

Q. I did cut you off. Go ahead.

A. And the downside of that is that if

this thing gets infected, we have to go ahead and remove it. The up side is removing it is not a particularly difficult thing; that it was not needlessly risky in her in leaving it and if we did win, then we saved at least most of what we had accomplished in 15 months. If we lost, we would take it out and we would be where we were if we had taken the other choice.

Q. Based upon those options, did you ultimately recommend to her that you proceed with the tissue expander, recognizing the risks?

A. We decided together that is what she would do. I let her think about it.

Q. But you felt, because you are the surgeon, you felt that weighing and balancing the various risks that it was reasonable and prudent to proceed with the tissue expander as the next step in the process of giving her a reconstructive breast?

A. I felt it was reasonable.

Q. Okay. And was it reasonable in your professional opinion to proceed with the tissue expander at the time that it was done, which we ultimately learned was done in September or October?

A. Are you asking me what the date was that it was done?

Q. That's sort of a combination. That wasn't my intended question. But whenever it was done, was it reasonable to proceed at that point with the tissue expander?

A. I believe it was. This conversation here anyway is documented on **8-13-97** and the exchange was done on **8-15-97**, so I think the recommendation would be if we are going to do it, we should get on with it.

And I also recall discussing with her that I was willing to go along and do this thing because I thought the risks here were not unreasonable. If we had to take the implant out, we would. But if I felt at any time, like if I saw pus or felt at some time that this was indeed an infected wound, I would not knowingly put a prosthetic into that. She understood that issue and weighed her two choices.

Q. We know ultimately that while you were on vacation the tissue expander had to be removed; correct?

A. That's correct.

Q. And that's because an infection

developed?

A. Yes. It appears so, yes, from the notes here.

Q. And that was an infection that you knew prior to doing this was a risk associated with putting the tissue expander in so early after removing the implant; correct?

A. Well, the earliness is not what determines the risk of infection, I don't believe. What determined the risk of infection was the fact that the wound was contaminated and the implant was going into a known contaminated wound. And that does increase the risk of infection. I don't think the timing is the issue there.

Q. Okay. What about proceeding with latissimus or TRAM flap at this point given the fact that you had to do something? Was that an option, as well in August?

A. Was that an option? It was an option the whole time.

Q. Was it an option in August of 1997?

A. That she and I discussed undertaking one of these large operations at this time?

Q. Yes.

A. We did not do it for breast reconstruction. We discussed the latissimus for chest wall reconstruction, for filling in this hole, if you will. But latissimus would not be used for breast reconstruction, as it would have to have had a buried implant with it.

Q. A TRAM would be?

A. A TRAM in general is a reasonable alternative. At this point, a TRAM is still theoretically possible, yes.

Q. Did you ever at any point consider telling Edna before you proceeded with the nipple reconstruction or the attempted nipple reconstruction in July of 1997, did you ever consider telling Edna that she should get another opinion, go to see somebody else; that you just felt that her aesthetic demands were more than what you felt comfortable with?

A. Well, no.

Q. Would you agree that Edna seemed to trust you?

A. Yes.

Q. If you had to do it over again, would you have done the nipple reconstruction?

MR. CRANDALL: 1 object.

A. I don't think the question is clear. If I had to do it over again?

Q. Well, would you agree that you made an error in judgment in performing nipple reconstruction?

A. No.

Q. Why not?

A. Because given the set of circumstances as I was faced with them then, I think I made the choice that seemed appropriate at the time.

Q. Would you agree that you made an error in judgment in putting a foreign body or the tissue expander into the capsule at the point in time that you did in August of 1997?

A. No, I don't think that was an error in judgment.

Q. Who is Dr. Hocky?

A. LeHocky. Another plastic surgery resident.

Q. Lee is the first name?

A. No, Brett LeHocky.

Q. Looks like Dr. LeHocky saw Edna in September of '97. Were you possibly out of town at that point?

A. I was out of town at that point. I

don't recall where I was.

Q. Any criticism of Dr. LeHocky?

A. In general?

Q. Yes.

A. None.

Q. In specific with regard to this case?

A. None.

Q. There is a note on September 21 that you discussed something with Dr. Jordan. Do you recall what was discussed with Dr. Jordan on September 21?

A. There is a note here from Dr. Weider on September 21st, where he refers to discussed with Dr. Jordan.

Q. Do you know what that discussion involved?

A. I don't.

Q. Are you able to determine from looking at the note what the nature of that discussion was?

(Pause.)

A. Well, the nature of his note says that his clinical opinion, Dr. Weider felt that there is an infection. His assessment reveals an exposed implant, purulent drainage, mild

erythema, for which he administered antibiotics. He thought implant removal was called for and he discussed this with Dr. Jordan.

Q. Do you recall having any discussions with Dr. Jordan after he performed surgery in October of '97?

A. I vaguely do. I recall a discussion -- I know that I discussed it with him. I better recall the details of the discussion with Dr. Weider himself.

Q. Tell me.

A. Dr. Weider said while you were gone, Edna Williams came in and thought she had an infection and he admitted her and Dr. Jordan and I decided to take the implant out the next day.

Q. Anything else that you recall?

A. That is what I recall.

Q. Showing you Plaintiff's Exhibits 7 and 8, can you tell me what -- they are photographs, but can you tell me when these photographs relative to time would have been taken?

A. Well, clearly the photographs represent the wound on the left breast after all implants or expanders are removed. So these photographs depict a period of a time after

September 22nd when the implant was removed and they were taken by me, so they were clearly after the time she was discharged.

Q. Okay. This represents an area that still has not healed; correct?

A. At this point, yes, it had not healed.

Q. Is it likely that her healing is going to be slower than if an incision of that nature had been made on her right breast?

A. In a nonradiated area, you mean?

Q. Yes.

A. Yes, this wound in a radiated area will likely heal slower than a wound.

Q. You last saw Edna November something?

A. My last note is November 19th and there is a note here by Coleen, that Coleen had some contact with her on the 21st.

Q. And what does it say?

A. Coleen's note says call and left message to TJHHC, which is University Hospital Home Health Care that dressing changes could be stopped, as patient stated on 11-20-97 she was doing the dressing changes herself.

Q Do you agree there is a balance between beauty and blood supply in the area of

reconstructive breast surgery?

A. A balance between beauty and blood supply -- beauty and blood supply. I am not sure what that means.

Q. You never heard that?

A. It sounds like a lead off of a chapter.

Q. You never heard that phrase before?

A. No.

Q. It's not a lead off. I am just wondering, in plastic surgery when you are doing reconstructive surgery if there is a balance between the beauty or the aesthetics of the area and the blood supply in the area of the reconstruction?

A. I'm aware of that concept, yes.

Q. And a physician should not let the patient dictate what is done in terms of reconstruction when it comes to the balance between beauty and blood supply?

A. I think that's true.

Q. You have not had a chance to review Dr. Dinner's records?

A. I have not looked at them.

Q. In November of '97, did you have a

discussion with Edna about performing a latissimus flap?

A. In November of '97?

Q. Yes. October or November, I suppose.

A. Right. Yeah, we discussed doing a latissimus flap.

Q. Does your record reflect any discussion about doing a TRAM flap?

A. The record does not reflect that, no.

Q. Do you have any such recollection of having a discussion about a TRAM flap at that time?

A. I do.

Q. Tell me.

A. Really we discussed doing a bigger operation next, the possibility of it. And we discussed latissimus and TRAM came up. At this point, I remember Edna telling me that she had no insurance and she had all these hospital bills. And to do a bigger operation would have left her with a significant number of bills.

Not that I wasn't willing to do surgery on her, of course. From the beginning she had no insurance and I was willing to operate on her and wanted to do a TRAM in the beginning,

but I reminded her that doing a TRAM flap at this stage, essentially now that she had come around to understand why I wanted to do a TRAM flap in the first place, I think she came to realize that that was the best thing, frankly, but we also discussed the fact that she probably would be paying the bills for this operation now.

That wasn't the primary reason we didn't do it, but I recall having that discussion with her.

Q. Your record on November 19th says we talked about the latissimus reconstruction of the chest wall. It does not reflect a discussion about the TRAM flap, does it?

A. This does not reflect a discussion about a TRAM flap.

Q. And the October '97 note, we could close it with a latissimus myocutaneous flap, or if she wanted, we could place a tissue expander underneath the latissimus and try to inflate it.

There is no discussion in October of '97 about the TRAM flap either, in the dictated note, is there?

A. There is not.

Q. This is, again, your recollection of

your desire all along, but yet it's not reflected in the October or the November '97 office notes; correct?

A. It's not reflected there.

Q. Okay. Do you recall offering to do the latissimus reconstruction, given her financial situation, free without charge?

A. I don't recall.

Q. Do you recall telling her that you would do it without charge to her to the extent that any insurance coverage that she had didn't cover the procedure?

A. Well, I don't recall is the answer, but there are other costs involved there besides what I would bill her, meaning the hospital, of course.

Q. Is it your testimony that in all likelihood, at least to a probability, that you would not have made such an offer to her --

A. I can't --

Q. -- free or beyond what insurance would cover?

A. No, I can't answer that.

Q. You just don't recall one way or the other?

A. I can't say in all likelihood I would. I may have.

Q. Did you have any communication with her or any contact with her after November of 1997?

A. Not that I recall, no.

Q. We have gone through most of the office visits and we have talked about the surgeries to a lesser extent while the inflation -- while the saline injections were going on, but are there any specific conversations where you discouraged or encouraged her to do one thing or another that you recall that we haven't already touched on that you want to tell me about?

A. No.

Q. Since '97, other than communications where records were requested or you got lovely letters from me, any other communication that you had with any doctors about Edna's condition?

A. Other than what you asked me about earlier, no.

MR. MISHKIND: Doctor, I have no further questions for you. I appreciate it.

I may need to talk to some other

people, certainly Coleen, but I don't have any further questions for you at this point. Thank you.

MR. CRANDALL: We will read this.

Can I have a waiver on the seven days given his circumstances?

MR. MISHKIND: Twenty-eight days is fine.

- - - -

(Deposition concluded at 12:50 p.m.; signature not waived.)

AFFIDAVIT

I have read the foregoing transcript from page 1 through 150 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

_____
Daniel P. Goldberg, M.D.

Subscribed and sworn to before me this_____ day of _____, 2000.

_____
Notary Public

My commission expires_____

CERTIFICATE

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

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named DANIEL P. GOLDBERG, M.D. Was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, 1 have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 17th day of February, 2000.

Vivian L. Gordon

Vivian L. Gordon, Notary Public
Within and for the State of Ohio

My commission expires June 8, 2004.

-Q-

-R-