State of Ohio,)
)
County of Cuyahoga.)

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IN THE COURT OF COMMON PLEAS

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PATTY DOLL, et al.,)
)
Plaintiffs,)
) Case No. 297,828
vs.)
) Judge Kilbane-Koch
UNIVERSITY HOSPITALS OF CLEVELAND, et al.,)
)
Defendants.)

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DEPOSITION OF MICHAEL THOMAS GYVES, M.D.
Thursday, September 5, 1996

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The deposition of MICHAEL THOMAS GYVES, M.D., a Defendant herein, called for examination by the Plaintiffs under the Ohio Rules of Civil Procedure, taken before me, Diane M. Stevenson, a Registered Merit Reporter and Notary Public in and for the state of Ohio, by agreement of counsel, at the offices of Jacobson, Maynard, Tuschman & Kalur, 1001 Lakeside Avenue, Suite 1600, Cleveland, Ohio, commencing at 9:40 a.m., the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiffs:

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On behalf of the Defendant,
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George M. Moscarino, Esq.
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On behalf of the Defendant, Dr. Gyves:

Stephen S. Crandall, Esq.
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ALSO PRESENT:

Shirley Feigenbaum,
University Hospitals

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MICHAEL THOMAS GYVES, M.D.

A Defendant herein, called for examination by the Plaintiffs, under the Rules, having been first duly sworn, as hereinafter certified, was examined and testified as follows:

CROSS-EXAMINATION

BY MR. MISHKIND:

Q. Would you please state your name for the record.

A. Michael T. Gyves, G Y V E S.

(Thereupon, Plaintiffs' Exhibit 1 was marked for identification.)

Q. Doctor, I have marked, prior to the beginning of the deposition, a document with an exhibit sticker that says Plaintiffs' Deposition Exhibit No. 1. It is an 11-page document.

I am told by your attorney that this is a copy of your curriculum vitae. Would you take a look at it and verify it for the record?

A. That is my curriculum vitae.

Q. Is that your curriculum vitae?

A. That is my curriculum vitae. There is one item to be updated, and that is that upon my resignation as department director at St. Luke's, my faculty appointment at the medical school was changed to Associate Clinical Professor of

OB/GYN. So that occurred sometime within the last year.

Q. You are no longer Director of Obstetrics at St. Luke's?

A. Correct, I am no longer the Director of the Department of Obstetrics and Gynecology at St. Luke's. It indicates, I believe on there, 1984 to 1995. I stepped down from that position at the end of June, 1995.

Q. Actually, the copy I have on page two says 1984 to 1996.

A. That is as Director of the Residency Program. As department director, I stepped down in 1995. I continued as Director of the Residency Program until 1996.

Q. Do you have a more current one in front of you now, or is that --

MR. CRANDALL: No, this is the same one.

A. This is the same one. There is only that one change from Associate Professor to Associate Clinical Professor. And I think that change occurred at the last reappointment to the clinical school faculty.

Q. What is the reason that you stepped down as

Director of the Department of Obstetrics and Gynecology?

A. I had been doing the job for 11 years, and I wanted to devote more of my time to private practice.

Q. So it was a decision that you made, a voluntary decision?

A. Yes.

Q. Does the curriculum vitae cover all of your writings in books, bibliography, abstracts, or are there any additions that need to be made to that, as well?

A. There are no additions that need to be made.

Q. At the time that you were treating Patty, were you affiliated with a medical corporation?

A. I was.

Q. What was that?

A. Partners in Women's Healthcare, Incorporated.

Q. You were president of that corporation?

A. I was.

Q. Were there other physicians practicing within that medical corporation?

A. Yes. Do you want to know who they were?

Q. I didn't know whether you were going to tell me that voluntarily, or whether that was going to be

my next question. But yes, I would like to know.
A. Dr. Judith Evans was a member of the corporation at the time, and I think that is all. I had another partner prior to that, and I think he left the corporation in March of 1994. Yes.
Q. Who was that?
A. That was Dr. Robert Edwards. So I don't believe he was still a member of the corporation at this time. He may have been a member when the prenatal care started, but left the corporation in the interim.
Q. Certainly at that time of the cesarean section, he was no longer a member of the corporation?
A. I think that's correct.
Q. At the time that you were handling the late stages, if you will, of Patty's pregnancy, and the cesarean section, and then the admission to St. Luke's at the time that the laparotomy pad was discovered, were you an employee of that corporation?
A. I think I would be considered that, yes.
Q. My understanding from some written discovery that has been provided, that corporation has ceased doing business?
A. Yes.

Q. When did it stop doing business?
A. At the end of March, 1995.
Q. Are you affiliated with a medical professional corporation now?
A. I am. I am now employed by Outreach Professional Services, Incorporated.
Q. I suppose, just to save some time, can you explain to me why the first corporation ceased doing business and how you became affiliated with this current corporation?
A. That was strictly a business decision. In the original private practice corporation, I was being pressured more and more by managed care and finding it more and more difficult to continue the business of practicing medicine. And so I turned over the private practice to Outreach Professional Services, Incorporated, which we refer to as OPSI, and OPSI is essentially a management corporation which purchased the practice and its assets.

And I now function as an employee of OPSI in the same role that I had before in the private practice. That is the same practice continues, but with different ownership and management.
Q. Do you have other obstetricians that are

colleagues of yours within that corporation?

A. Yes. Since joining the corporation, I was able to add a partner to my own practice within the corporation, hire two additional midwives to work in the practice because the management corporation had the working capital to be able to add providers, so that changed the scope, the quality of the practice from working as a solo physician to working as a member of the larger group.

There are also two other OB/GYN practices within **OPSI**, in addition to a number of practices in internal medicine, family practice, and pediatrics.

Q. All that use **OPSI** in the same manner that you use **OPSI**, for the management aspects?

A. All of these practices are OPSI practices, and **OPSI** owns and runs them.

Q. Within your practice currently, not the other obstetrical practice, but just for informational purposes, the other obstetrician that you have been able to hire and the midwives that are affiliated with your practice, tell me their names, please.

A. The other physician is Dr. Sam Liu, L I U. The midwives in the practice are Ellen Margles,

M A R G L E S - - and Ellen Margles was an employee of the previous corporation. She is a midwife. Two other midwives are Judy Nusa, N U S A, and Carolyn Moes, M *o* E *s*. Judy Evans is no longer a member of the practice. She left the employment of OPSI a few months ago.

Q. Where is she practicing now?

A. In another OB/GYN practice in Cleveland.

Q. The other OB/GYN practice that is owned by OPSI, how many obstetricians are in that group?

A. There is one practice with four obstetricians, and another practice with a solo obstetrician.

Q. Your office itself is located in Solon?

A. I have two offices. The main office is in Cleveland at 11201 Shaker Boulevard, and the satellite office is in Solon. The address there is, I believe, 33001 Solon Road.

Q. When you were with your previous corporation, was your office on Shaker Boulevard?

A. I had the same offices in the previous corporation.

Q. The other professional corporation, the other two OB/GYN practices, again, just for information purposes -- and we are going to start talking about more important stuff -- who are the doctors

that are affiliated with or which are owned by OPSI, the obstetrical practice, the one that has four and the one that has just the one?

A. The one with four consists of Dr. John Rozsa, Dr. Shelly Amuh, A M U H, Dr. Andrea Price, and Dr. John Abu, A B U.

The solo practitioner in the third practice is Dr. Penola Jones.

Q. While Patty was being seen by you for prenatal care, and at the time of the cesarean, were any other obstetricians employed by your professional corporation involved in her care either prenatally or at the time of the cesarean?

A. There were no obstetricians involved in her care, either prenatally or at the time of the cesarean. My midwife, Ellen Margles, saw her for one emergency visit in the office early in the pregnancy.

Q. Were any midwives that were or are employed by your professional corporation involved at the time of the cesarean section?

A No.

Q. There was a resident that participated in the cesarean section by the name of Dr. Samudio?

A. Yes, sir.

Q. Had you worked with Dr. Samudio prior to Patty's cesarean section?
A. Yes.
Q. Could you explain to me what your relationship was at the time that the C. section was done as it relates to Dr. Samudio?
A. Dr. Samudio at that time was a resident in training in OB/GYN at University Hospitals, and she still is a resident there.

Residents function as assistants to private physicians in the care of private patients. And that involves both surgical and nonsurgical care of private patients.

So Dr. Samudio was assisting me in the cesarean section as a first assistant would assist in any surgical procedure. I was functioning with her as a supervisor and teacher.

Q. What year was she in her residency at the time of the C. section?
A. She would have been a second-year resident at that time.
Q. The actual physical performance of the C. section itself, was that done by Dr. Samudio, or by you?
A. That was done by both of us. We both perform

roles in that. Both of us are involved in making incisions and in sewing, so it is a combined effort.

Q. I take it you have had a chance to look over your records concerning your prenatal care and the delivery of Patty, correct?

A. Yes.

Q. Can you tell by looking at the operative report or from any independent recollection that you might have as to specifically what you did at the time of the C. section and what Dr. Samudio did from the beginning of the induction all the way to the conclusion of the case?

A. I can't tell you specifically who did what, no, not from the -- no.

Q. Either from the record or from what you can recall, "I remember I did the initial incision. Dr. So and So did the following, I then did this," is there any way that you can tell me at what stages you were involved actually doing a particular procedure as opposed to either supervised her or doing some other aspect of the cesarean?

A. I cannot tell you that from the operative note. I can tell you from the way we usually do it.

Q. I am going to have you do that in a moment. Does the amount of responsibility for the actual performance of the C. section depend upon the experience of the resident?

A. Yes.

Q. Do you know how experienced Dr. Samudio was in terms of performing C. sections at the time that she served as a second-year resident under you?

A. I cannot tell you how many cesareans she had done prior to that. I feel quite sure that I had done cesareans with her previously, and that I was comfortable with her technical ability.

Q. You felt that, as a second-year resident, she was a competent physician?

A. Yes. Dr. Samudio actually had more than one year of training prior to being a second-year resident in that she had been trained as a family practitioner. She, I believe, had completed a family practice residency and was now getting additional training in obstetrics and gynecology.

Q. Had you at any time while she was working as a resident under your watch, so to speak, or with you as the attending, had you ever experienced any type of an untoward outcome or a complication where she was either a first-year resident or

second-year resident in obstetrics?

MR. MOSCARINO: Objection.

MR. CRANDALL: Objection.

Q. Steve likes to object silently with just a hand rather than the vocal.

You can go ahead. The objections, unless Mr. Crandall instructs you otherwise, are just for the record.

A. I cannot recall having had any patients with whom I was supervising Dr. Samudio who had any adverse outcomes prior to this.

Q. Let me back up for a moment, Doctor, and ask you whether you have ever given a deposition before.

A. Yes.

Q. On how many occasions?

A. I can't tell you the precise number. I would say it is somewhere between 10 and 20.

Q. Have any of those cases where you have given deposition testimony been cases where you were named as a defendant in a medical malpractice case?

A. Yes.

Q. How many?

A. I think there were two.

Q. Two depositions?

A. Two depositions.
Q. Where you were a defendant?
A. Two depositions in which I was named as a defendant.
Q. This is now the third case where you have been deposed as a defendant?
A. To the best of my recollection, that's correct.
Q. Are either of those two cases, to the best of your knowledge, still pending?
A. No. I was dismissed from both of those cases.
Q. Were they both, the other two, both in Cuyahoga County?
A. Yes.
Q. What was the name of the plaintiff in the other two cases?
A. The first was Cheryl Hutchins.

MR. CRANDALL: So that I don't interrupt the rest, just a continuing line of objection to the questions regarding any prior lawsuits.

Q. I am sorry, Hutchins?
A. Hutchins, H U T C H I N S, first name Cheryl. The second was Diane Potts, P O T T S.
Q. Did either of those prior cases involve any type of complication at the time of a cesarean

section?

A. That's a rather broad question. One of them involved a bad outcome, a bad baby as a result of -- not as a result of -- the baby was delivered by cesarean section by one of my associates.

Q. Which of the two?

A. That was the Hutchins case.

Q. What was the subject matter of the Potts case?

A. That was an anesthesia complication.

Q. What type of surgery were you performing?

A. I was not performing. That was a delivery performed by my partner, and there was a complication of epidural anesthesia, but Ms. Potts had been my patient throughout the pregnancy, and I was named in the suit.

The same is true of Cheryl Hutchins. My involvement with her was early in the pregnancy, but I was named in the suit.

Q. I take it neither of those cases involved any type of a retained surgical sponge at the time of cesarean section?

A. That's correct.

Q. You would certainly agree, and I think you have already done so, that a laparotomy pad or, as is referred to by the hospital, I think M-tape may

be the reference in certain policies from the hospital, was left in Patty at the time that the cesarean section was concluded, correct?

A. Yes.

Q. And that is something that shouldn't be done, correct?

A. Correct.

Q. Have you ever been a participant in a surgery, whether it be C. section or any other type of obstetrical or gynecological procedure, where a retained laparotomy pad or other foreign body was left in that should not have been left in at the time that the surgery was completed?

MR. CRANDALL: Objection.

MR. MOSCARINO: Objection.

A. Not that I can recall, or, I should say, not that I know of. When you say "ever," it goes back to the days of my training, and I am not aware of any such case.

Q. Is it fair to say that this is the first one that, at the very least, has been brought to your attention, to the extent that one did occur? As you sit here now, you don't have any knowledge of same?

A. Yes.

Q. The other 8 to 18 cases where you have been deposed, in what capacity were you testifying?
A. I was an expert witness.
Q. In medical malpractice issues?
A. Yes, yes.
Q. So you are certainly familiar with the issues of standard of care in medical malpractice cases?
A. Yes.
Q. Certainly as it relates to the area of obstetrics and gynecology, you are familiar with what is considered to be acceptable care and what is considered to be unacceptable care?
A. That is generally correct.
Q. In those other cases, was there a predominance in your appearing as the expert for the physician as opposed to for the patient?
A. Yes. The breakdown is approximately 80 percent as expert for the physician, and approximately 20 percent I was expert for the patient.
Q. Do you regularly review cases where you aren't necessarily deposed, but that you write reports to an attorney for one side or the other in medical malpractice cases?

MR. CRANDALL: I need to object for the record. Go ahead.

A. I have done that in the past. I stopped doing it in the last few years because I simply don't have the time for it.

Q. Again, when you have done that, has it been about the same percentage, 80 percent reviewing and writing reports in connection with the doctor's case, and 20 percent in connection with the patient's case?

A. In cases that I have reviewed but for which I have not been deposed, I believe there is a larger percentage of reviews for the plaintiffs, but I can't give you a specific breakdown.

Q. Are you currently scheduled to testify as an expert witness in any cases?

A. I am involved as an expert witness in a case that is supposed to come to trial in February. I say supposed to because it has been postponed a number of times.

Q. That never happens.

You have been deposed in that case?

A. I don't recall. It has been so long that I honestly can't remember the current status of the case. It is something that has been on the shelf for a couple of years.

Q. Are you defendant's expert or plaintiff's expert

in the case?
A. I don't even remember that.
Q. That is the only case that you are currently scheduled to appear as an expert, that you know of?
A. That is the only one I know of. I think there may be one or two other cases that have been lying foul for two or three or four years, and could crop up at any time.
Q. What is the name of the attorney that you are working for in connection with the case that is scheduled for trial?
A. I honestly can't remember the details of any of these. They are so old, from my perspective, they are inactive right now.
Q. You have reviewed your office records which contain, presumably, parts of the records from University, and then records from St. Luke's?
A. Yes.
Q. Dr. Lerner has also I think from time to time carboned you on office notes when he has seen Patty, and that, I presume is also in your file?
A. Yes.
Q. Are you still being carboned by Dr. Lerner with regard to office visits?

A. I don't know what you mean by "still." I would have to -- I can check my records and tell you the date of the last communication I received by him.
Q. Please.
A. My last communication from Dr. Lerner is dated August 11, 1995.
Q. Have you had occasion to talk to Dr. Lerner personally about Patty's condition since Patty was discharged from St. Luke's Hospital?
A. Yes.
Q. When is the last time that you talked to Dr. Lerner?
A. I can't recall specifically, but I believe it was approximately six months ago.
Q. That would be obviously more current than your last correspondence from him?
A. I think that is correct.
Q. Tell me what you remember in terms of the substance of that conversation, perhaps starting by telling me where it took place and what doctor Lerner told you, and what, if anything, you indicated to him.
A. It took place as a casual exchange in the hallway of the hospital where I simply asked about her

current status, and he told me that she was doing well, and that is in very general terms, because I can't remember the specifics of the conversation.

Q. Do you remember anything more than just what you told me just a moment ago that he indicated to you? Again, the only reason I am asking you is because today is my opportunity to find out from you what you know and what conversations you might have had with some of the treating doctors.

So if there is anything else that Dr. Lerner said to you during that conversation, either specifically or in general, even though you can't remember verbatim, if you can remember the topic or synopsis of what he told you, I want you to tell me that.

A. At some point in one of our casual conversations, and I don't know if it was the last one or the one before that, we discussed the issue of what might have been responsible for Mrs. Doll's stroke, and were both of the opinion that we didn't know. That is, I mentioned to him that I still had no idea what caused her stroke, and he said he had no explanation for the stroke.

Q. And as you sit here right now, do you still not have an opinion to a reasonable degree of medical

probability as to what caused the stroke?
A. That's correct.
Q. And it is your understanding from an informal conversation with Dr. Lerner that he indicated, perhaps not in the same manner and to a reasonable degree of medical probability, because that usually is used by lawyers as opposed to doctors, but he indicated in general that he did not know specifically what caused her stroke?
A. That's correct.
Q. These casual conversations, how long did they last? Were they just a couple minutes?
A. A few minutes.
Q. Did you ever sit down and go over with Dr. Lerner the various possibilities that could explain why this woman did, in fact, suffer a stroke and try to determine what was the most likely explanation?
MR. MOSCARINO: Objection. I am just objecting to the term "possibilities."
MR. CRANDALL: Wait one second. Do you mean within these conversations, or are you asking him now a different question, which is did he ever sit down and have a conversation about her after the discharge?
MR. MISHKIND: Sit down with who?

MR. CRANDALL: Dr. Lerner.

Q. At any time with Dr. Lerner, have you ever sat down and reviewed, in terms of a differential, what are the various possibilities and tried to come up with an opinion as to what was the most likely cause?

MR. CRANDALL: Since her discharge, Howard?

MR. MISHKIND: That is a fair question. Yes, since her discharge.

MR. MOSCARINO: Same objection.

A. I can remember doing that while Mrs. Doll was in the hospital. At that time of course I was seeing Dr. Lerner and talking with Dr. Lerner very frequently.

I can't recall if we ever did such after Mrs. Doll's discharge from the hospital. I think at some point we may have talked about it, but there was no formal medical type consultation where I might have met him in his office or he may have come to my office, where we sat down and actually reviewed step by step the medical events and the differential. Again, we probably touched on some of that in our conversations as we passed in the hospital.

Q. And we will talk about discussions that you had with him in terms of a differential in the hospital in a moment.

Other than Dr. Lerner, in terms of informal discussions that you had after she was discharged, have you discussed with any other doctors that were involved in Patty's care the subject of what is the most likely explanation for why this woman suffered a stroke?

MR. MOSCARINO: Object to the form.

A. I can't recall having any conversations with any other doctors involved in her care as to what may have caused this stroke.

Q. Have you talked with anyone personally, yourself, that, while not being involved in Patty's care, was advised of information concerning her C. section, the retained laparotomy pad, the events that ensued up to the time of the stroke that provided you with an opinion as to what most likely was the cause of her stroke?

A. No.

Q. What is your relationship with Dr. Lerner?

A. Dr. Lerner and I are both members of the active medical staff at St. Luke's Medical Center. He

is the Director of the Division of Neurology, and our association is just as members of the staff.

Q. It is a professional relationship exclusively?

A. Exclusively.

Q. Do any of the articles, books, chapters that you have published, touch on the subject of postpartum cerebral artery infarcts?

A. No.

Q. Have you ever written or lectured in any connection with the subject of a postpartum cerebral infarct?

A. No.

Q. In connection with this case, and in an effort to try to determine what was the likely cause of the stroke, did you do any medical research yourself?

A. No.

Q. So as you sit here now on September 5, am I correct in stating that you do not, after considering the information and going over it in this period of time, you do not have an opinion to a reasonable degree of medical probability as to what caused Patty to suffer the stroke?

A. That's correct.

Q. Is there anything that you believe Patty did or failed to do that caused or contributed to her

sustaining the stroke?

A. I don't think so.

Q. And I would include during her prenatal course, is there anything that she did that you feel was causative or contributed to the events that ensued leading up to her stroke?

A. There was nothing in the prenatal course. The only thing that might have been a contributory factor would be --

MR. CRANDALL: He is asking you if there is anything that she did, particularly that you can blame this on.

MR. MISHKIND: Yes, I think that is what he is about to respond to.

A. Just that following the cesarean she was at home having difficulty with nausea and vomiting, and I was not aware that that was an ongoing problem for almost a week before she came into the hospital. And the dehydration that resulted from that could have been a factor.

Q. She was discharged from the hospital following the C. section on November -- was it November 6? Yes, November 6, 1994.

MR. CRANDALL: That's correct.

A. Yes.

Q. And you had, according to your office records, a telephone conversation with her on November 7 where she indicated that she was nauseated, couldn't eat?

A. That is not quite correct. My conversation was with her husband.

Q. Okay, fair enough. In any event, the information that was provided to you by her husband the day after she got home, if you could just tell me what symptom complex was described by George to you.

A. She was having upper abdominal pain, cramping, nausea, and couldn't eat.

Q. And your diagnosis was what?

A. I thought she had gastritis from her ibuprofen.

Q. And what course of treatment did you recommend?

A. I recommended that she stop the ibuprofen and change to a different analgesic, Darvocet.

Q. Why didn't you have George bring Patty in to be examined?

A. This was one day after her leaving the hospital. I had seen her the previous day, and she seemed well.

She had had a relatively benign post-operative course, and the symptoms didn't sound

like something that were serious that required a visit to the office.

Q. If George's testimony is that he reported to you that Patty vomited, was weak, and was having cramping, as well as couldn't eat, would that be somewhat different than what you have noted?

MR. CRANDALL: This is during the first phone call?

MR. MISHKIND: Yes, on the 7th.

A. What would be different would be the comment that she had vomited and that she was weak. I did indicate in my note that she was having cramping and that she was nauseated.

Q. Based upon your note, would you have had any concern at all that the patient was becoming dehydrated?

A. At that point, no. This had not been going on long enough.

Q. If the nausea, the abdominal pain, the inability to eat persisted, would you then have a higher index of concern that the patient was becoming dehydrated?

A. Yes.

Q. Now, we can agree that you did not feel it necessary to have Patty in to your office or to

an emergency room on November 7, correct?
A. Correct.
Q. You didn't tell George, apparently, according to your note, that they should call you back in 24 hours or the same day or two days later if symptoms persisted, did you?
A. No, I did not.
Q. In any event, George or someone did call you back two days later concerning Patty's continued symptoms?
A. Right.
Q. And at that time, what were you told and by whom?
A. Again, it was a conversation with Mr. Doll telling me that she still had upper abdominal pain, but that the pain had improved from when he had spoken to me two days before, that she was passing flatus and had actually had a bowel movement. There is no comment in here about whether or not she was eating. And I can't recall whether or not he said anything about her eating.
Q. That would be an important issue that you would want to find out as to whether or not the patient is eating and, if so, whether they are holding down what they are eating, correct?

A. Right.
Q. Can we agree that certainly your records don't permit you to say one way or another what Patty's response was to the intake of food?
A. Yes.
Q. Can you explain why you don't have such a note on that date?
A. No.
Q. Is that something that you should have had a note for reflecting whether or not the patient was eating?
A. Since I don't recall what he told me, I don't know whether or not I should have had a note. In other words, if it was not an issue, I might not have felt it necessary to note it.
Q. You made a note that the pain had improved?
A. Yes.
Q. Which was an improvement over what you had noted on November 7?
A. Yes.
Q. On November 7 the patient couldn't eat, correct?
A. Yes.
Q. But you make no note as to whether or not that had changed two days later, correct?
A. That's correct.

Q. Would you agree with me that that is something that you, as a clinician that is treating this patient post-cesarean section, should be determining whether or not the patient is eating, and, if so, whether or not they are holding down the food?

A. Yes.

Q. Because that could also lead you to determining whether or not the patient is hydrated appropriately, correct?

A. Right.

Q. And whether or not appropriate nutrition is being provided?

A. Yes.

Q. Of what concern should you have, Doctor, if on November 9 the patient was not receiving appropriate nutrition because they couldn't eat, and they were still nauseated and weren't holding down food? What would that indicate to you?

A. Then I would be concerned that there is a serious problem responsible for her still being unable to eat. I would be concerned about a complication.

Q. And what kind of complication would you be concerned about?

A. I wouldn't know specifically until determining

what it could be. It could be any number of things.

Q. Would one thing that would be high in your index of suspicion be some type of an infectious process?

A. Would you be more specific?

Q. Being that the woman just had a cesarean section and is indicating that she is having abdominal pain, nauseated, would you be concerned that there might be some type of either a bacterial infection or a viral infection that might be causing her symptomatology?

A. That is something to consider. At this point I wasn't concerned about her having a bacterial infection because she didn't have a fever, she was on an antibiotic, had been treated for a bacterial infection prior to leaving the hospital. Viral gastroenteritis would be a consideration.

Q. I forget whether or not you told me that conversation was with George on the 9th.

A. It was.

Q. Do you specifically remember the conversation?

A. I specifically remember that the conversation was with Mr. Doll on both occasions. Do I

specifically remember the content? Not beyond what I wrote here.

Q. So you are relying on these notes as to what information you gathered and what recommendations and plan you implemented?

A. Right.

Q. You don't recall anything independent of your notes with regard to the 7th and the 9th of November, correct?

A. Correct.

Q. On the 9th, then, you don't recall specifically telling George to call back if A, B and C occurred, or to bring Patty in if certain symptoms persisted, do you?

A. No.

Q. Does Augmentin have the propensity to cause abdominal symptoms in certain patients?

A. I wouldn't say the propensity. But virtually any antibiotic might cause some abdominal symptoms.

Q. Is Augmentin one of those antibiotics that seemed to cause a higher incidence of abdominal symptoms over other antibiotics?

A. I don't think so.

Q. I was asking you before we got into your specific office notes whether or not there was anything

specific that you felt that Patty did or failed to do that may have caused or contributed to the ultimate development of the stroke, and I want to go back to that question now that we have talked about the office visits, and I want you to tell me again specifically what, if anything, should Patty have done, or George on behalf of Patty, differently during the period from the time she went home from UH until the time that she presented at St. Luke's Hospital that you believe caused or contributed to the stroke?

A. A call to me prior to November 15th or 16th would have precipitated a visit. On both of these occasions Mr. Doll and I discussed the association between Mrs. Doll's symptoms and medications that she was taking.

If these symptoms had persisted despite our manipulation of the medications, I would have seen her sooner. As it turned out, a call came on the 15th of November, and he was told at that time to bring her to the emergency room immediately because of the persistent problem.

So an earlier call would have precipitated earlier action, and the dehydration would not have progressed to the degree that it did.

You asked me if the dehydration may have been a factor. You are asking me to conjecture?

Q. In terms of possible cause or contribution to it.

A. Contributing factor.

Q. Would you agree that you had a duty and a responsibility to ad ise George, since he is the one that is making these calls, as to the need to call back to the office if certain symptoms occurred or persisted?

A. Yes, and I think I did that, although it is not specifically stated. Looking at my note, we are discussing the manipulation of medications. And he told me that she had stopped her Augmentin, the pain had gotten better. I told him to have her resume taking the Augmentin and, as a part of the instructions, my instruction would be if the pain gets worse again, then call me; that is, if stopping the Augmentin was responsible for making her get better, then she will get worse when she takes it again.

If her pain is improving for factors unrelated to the Augmentin, then it will continue to resume when we resume the Augmentin.

So although it is not written here, the reasoning involved in this is resume the

Augmentin and see what happens and call me.

Q. Certainly you would agree with me that you had a duty and a responsibility, as Patty's physician, to advise her or, in this instance, to advise her husband to call back if the symptoms persisted or got worse, correct?

A. Yes.

Q. And certainly if you failed to do that, that would not be in keeping with accepted standards of practice, correct?

A. Yes.

Q. And we can agree that your records do not reflect that you did, in fact, tell George on either of these visits, on either of those telephone calls, to call back if the pain persisted or got worse?

MR. CRANDALL: You mean specifically that phrase?

Q. Or call back --

MR. CRANDALL: He just indicated to you why he thinks his records do indicate that he told him to call back, and you are asking specifically does it say "I instructed the patient to call back in 24 or 48 hours."

MR. MISHKIND: Let me rephrase it, because I must have confused you, and I hate

doing that.

MR. CRANDALL: You didn't. I know exactly what you asked.

Q. Doctor, take a look at your November 7 and November 9 note. Is there anything in those notes that reflect that you communicated to George that if the symptoms continued or got worse that he should get back in touch with you?

MR. CRANDALL: Other than what he just explained to you?

MR. MISHKIND: Well, what he has just said, the record will speak for itself.

Q. (Continuing.) I am asking whether or not there is anything on November 7 or November 9 that indicates that you, Patty's doctor, indicated to her husband when these calls were made that if your symptoms persist or get worse to call back?

MR. CRANDALL: I am going to object. It has been asked and answered.

Go ahead.

A. My records reflect my process of reasoning in the management of this problem. And part of that process is in advice to the individual to call back if symptoms persist or get worse.

Q. But that process is not communicated in writing

as having been conveyed to the patient or the patient's husband, correct?

A. The specific statement to call back is not in the record.

Q. And that is something that clearly you had an obligation, whether you did it or not, you clearly had an obligation to tell George on the 7th and the 9th to call back if the patient's symptoms persisted, got worse, or anything along those lines?

MR. CRANDALL: Objection. Asked and answered. Go ahead.

Q. Correct?

A. Correct.

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

(Thereupon, a short recess was taken.)

BY MR. MISHKIND:

Q. When did you first learn that Patty was being taken back to St. Luke's Hospital -- or being taken to St. Luke's Hospital?

A. November 15.

Q. You had a telephone call?

A. Yes.

Q. Was that call from George?

A. Yes.
Q. Is the November 15 telephone call reflected in your office notes?
A. No. The reason for that is I can't even recall if I was in the office at the time I told him to bring her to the emergency room and I would meet her at the emergency room. So the issue is reflected in the emergency room contact.
Q. Do you recall your conversation with George on the 15th?
A. Yes.
Q. Based upon what is reflected in the emergency room record or independently?
A. It is both independently and based on what is in the emergency room record.

What I remember independently is that he said she was still vomiting and she couldn't keep anything down. And I simply said, "Take her to the emergency room."

Q. Do you remember him saying that she was still vomiting?
A. When you say do I remember, he said she was still vomiting. Maybe "still" is not the appropriate term. I remember he said she was vomiting and couldn't keep anything down. Now, whether she

had been able to eat for sometime and then developed vomiting subsequently, I don't know. But what I remember is that she was unable to retain anything. And I said that she had to go to the emergency room.

Q. Specifically as to whether he indicated "still," and, more importantly, whether he indicated how long she had been vomiting, is it fair to say that you don't have any specific recollection of whether he said she was still, and, if so, how long she had been vomiting?

A. I don't remember if he said "still." I do remember he said she just couldn't keep anything down, she couldn't eat. Maybe he didn't even say she was vomiting. He said she couldn't eat, couldn't keep any food down. And because she couldn't eat, I said she had to come in to be seen.

Q. Now, why on the 16th, if she couldn't eat, did you feel at that point that intervention by way of being seen, either by you or specifically in the emergency room, was indicated, and it apparently wasn't on the 7th or the 9th?

A. I am not sure if I understand the question completely. Are you asking me why at this time I

felt she had to be seen?

Q. That is basically it. In other words, we know that on one or more occasions, the 7th certainly, maybe not the 9th, whatever was told to you on those dates, at least one of the dates, she couldn't eat. And, basically, I am asking you why on the 16th did you tell George to take her to the emergency room, and why didn't you tell George to take Patty on the 7th or the 9th?

MR. CRANDALL: That is two different questions. I know you don't mean it to be that way.

MR. MISHKIND: I just can't word things properly.

MR. CRANDALL: If you want to ask him why he didn't come in on the 7th and 9th, that is one question.

The second one is why on the 16th, when you didn't on the 7th and 9th. So which one do you want him to answer?

MR. MISHKIND: He can answer both of them in whatever order he wants to. But, as usual, you are correct.

MR. CRANDALL: The first thing you want him to answer is why he didn't tell her to

come in on the 7th or 9th?

MR. MISHKIND: Well, pretty much he has answered that before.

Q. (Continuing.) You felt you didn't think she needed to be seen?

A. I answered that before. I said on the 7th she had just left the hospital, I had seen her the day before, and it was my impression that she was stable, that she had had a fairly benign course except for the endometritis and anemia, which were not unusual, and thought that her complaints were due to medication.

When we spoke on the 9th, her pain was actually getting better, so there was no need to see her at that time, she appeared to be improving.

MR. CRANDALL: Now George -- Howard wants to know --

MR. MISHKIND: George probably wants to know it, too.

MR. MISHKIND: Don't insult him.

A. Oh the 15th, let's get the date correct, I got another call. And, first of all, this was presented as a continuing problem. And even if it wasn't presented as a continuing problem, we

have a situation in which she had complaints of pain and nausea previously for which we tried some medical management. And when the problem is presented to me again, I have to assume the medical management is not working, and so I have to determine whether or not it is a more severe problem and must see her.

The other is that on the third occasion Mr. Doll indicated more concern, and a greater sense of urgency about this.

On the previous conversations he didn't convey to me the same concern and the same sense of urgency. At this particular time he felt something was wrong, and I felt it was essential to see her.

I didn't just tell him to take her to the emergency room. I told him to take her to the emergency room so I could see her in the emergency room.

Q. Certainly while you want to hear the degree of urgency that the patient or the spouse communicate, that is no excuse for the physician not to inquire to obtain appropriate details on the patient's condition so as to make appropriate recommendations, correct?

A. Is that a suggestion that I did not?
Q. Well, I am not suggesting one way or another. But you did indicate that George expressed more urgency on the 15th as opposed to the other dates.

If, in fact, there was an indication for George to bring Patty in on the other two dates, you wouldn't excuse that on the basis that he didn't express any urgency if you, as the clinician, had reason to say to George, "Bring Patty in," or "Take Patty to the emergency room," correct?

MR. CRANDALL: I am going to object.

A. This question, 1 am sorry, it is too complex, convoluted. Could we redo it?
Q. It is probably poorly-worded. I appreciate you saying it nicely.

Simply because a patient presents urgency about symptoms doesn't necessarily indicate that you are going to see the patient.

MR. CRANDALL: We are talking in general, here?

MR. MISHKIND: Generally, yes.

Q. (Continuing.) Correct?

A. Correct.

MR. CRANDALL: Do you understand?

A. Simply because a patient expresses urgency does not mean that we are going to see the patient. There are other factors to take into account.

Q. And those factors include what, Doctor?

A. In this case?

Q. No, generally.

A. Those factors include the nature of the complaint. They include some objective information that may go along with the complaint, such as whether or not there is a fever. That is an objective finding.

And they include some understanding of the patient and how the patient tends to react to certain symptoms, certain problems, and how the patient conveys those concerns to you.

Q. So it is important for you to apply your medical knowledge, training and experience, in conjunction with listening to the patient or the spouse, decide whether or not the patient needs to be seen or not?

A. Right.

Q. Now, on the other side, if a patient doesn't express any urgency with regard to symptoms, that

still doesn't excuse your responsibility to apply your training and experience and to listen to what is said and to decide whether or not the patient should or should not be seen?

A. Correct.

Q. The urgency is just one factor amongst a number of factors in terms of whether it is okay to get off the phone with the person and not have them come in or direct them to an emergency room?

A. Urgency is a factor to be taken into consideration, and urgency or a sense of urgency is particularly helpful when you can relate one episode to another episode in the same individual and compare sense of urgency that is relayed in the various situations.

Q. Can we agree that from the time that Patty went home until the time that she was brought to the emergency room on the 15th that there was some clinical evidence on presentation to the emergency room that she was dehydrated?

A. I am sorry, you asked from the time she went home until the time that she came in, and then you said to the emergency room.

When she presented to the emergency room there was clinical evidence of dehydration. I

cannot tell you there was clinical evidence of dehydration from the time she left the hospital.

Q. You don't know from the emergency room record how long, at least to a probability, she had been in a dehydrated state?

A. No.

Q. Certainly she was dehydrated upon presentation to the emergency room, correct?

A. I think so.

Q. And of what significance, if any, is a state of dehydration in a postpartum patient, as it relates to the subsequent development of the middle cerebral artery stroke?

MR. MOSCARINO: Can I have that question again?

(Record read.)

A. Dehydration will decrease intravascular volume, and may decrease blood flow. That is in general. I don't believe that it is of any greater significance in a postpartum individual than it is in somebody at any other point in life.

Q. If the intravascular volume is decreased, what does that precipitate in terms of the patient's coagulopathy?

A. That has no bearing on coagulopathy.
Q. What bearing does reduction in intravascular volume have on the hemodynamic status of the patient?
A. As I said before, it may decrease blood flow.
Q. Decreased blood flow, does that increase the potential for stroke or an infarct?
A. I am getting outside of my area of expertise to answer that.
Q. I will accept that. That is fine. You would certainly agree if Patty was in a state of dehydration prior to November 15th that it would have been preferable to have had her seen in the emergency room or seen in your office so as to evaluate her hemodynamic status and her intravascular volume and things of that nature?

MR. CRANDALL: I am going to object. How early are you talking? At any time?

MR. MISHKIND: At any time prior to November 15.

MR. CRANDALL: So from the 14th to the day she was discharged, if she was dehydrated at any point?

MR. MISHKIND: Sure.

A. You are saying if she would have been dehydrated, it would have been preferable to see her? Was that the question?

Q. If her dehydration existed more than just on an acute basis that day on the 15th, we can certainly agree that it would have been preferable, from the standpoint of Patty's condition and the events that ensued on presentation in the emergency room, for her to have been seen either earlier on the 15th or the 14th or the 13th, or whenever her state of dehydration first was clinically apparent?

MR. CRANDALL: Objection. Go ahead.

A. Yes.

Q. Did you know that a laparotomy pad was left inside Patty?

MR. CRANDALL: At what point?

MR. MISHKIND: At the conclusion of the case.

A. At the conclusion of which case?

Q. I am sorry, at the conclusion of the C. section.

A. No, I did not.

Q. Why not?

A. Why not?

Q. Yes.
A. Because I had removed all of the laparotomy tapes that I generally place at the time of the cesarean, and because we had a correct count.
Q. Who did the count?
A. The nurses did the count.
Q. Did you have a responsibility to make sure that the count was accurate?
MR. CRANDALL: I am going to object. Go ahead.
A. No.
Q. Why not?
A. Because the surgeon doesn't do the count. The surgeon is not involved in the count. The surgeon's responsibility is not to make sure that the count is accurate.
The surgeon's responsibility is to respond to an incorrect count if he is told by the nurses the count is not correct, then it is the surgeon's responsibility to find or help find the missing sponge or tape.
Q. In your opinion, did the nurses meet their responsibility in this case?
MR. MOSCARINO: Object to the form.

MR. CRANDALL: Objection.

A. I don't -- the nurses' met their responsibility in terms of doing a count. And it was their impression that there was a correct count. I have no concern with their responsibility.

Q. Well, you would agree that they have a responsibility to do an accurate count of the laparotomy sponges or laparotomy pads, correct?

A. Yes.

Q. And you would certainly agree in this case that they did not do an accurate count of the laparotomy pads or sponges?

MR. MOSCARINO: Objection.

A. I really don't know. They counted several times. They came up with the correct number. I don't have an explanation as to why they had a correct count as they counted and we ended up with a retained tape.

Q. Well, let's talk about it. Is there any evidence in this case that the retained tape, the laparotomy pad, whatever you want to call it, existed inside Patty's abdomen before she had her C. section?

A. No.

Q. Can we agree that the tape that was retained,

that was ultimately removed at the time of the laparotomy, was inserted at University Hospitals at the time of the C. section?

A. We can agree on that.

Q. And can we further agree that someone had a responsibility to make sure that all laparotomy pads were removed at the conclusion of the C. section before sending Patty to recovery?

MR. CRANDALL: What do you mean, "someone"? Who is "someone"?

Q. I am not defining. The people in the operative field, that there was someone, one or more people, we will talk about that in a moment, but that someone had the responsibility to make sure that all the pads that had been put in were removed at the conclusion of the case, correct?

A. Yes, yes.

Q. It is not the design or the practice or the standard to leave a laparotomy pad in at the conclusion of a C. section, is it?

A. That's correct.

Q. Is it your testimony that you, as the attending surgeon, did not have a responsibility to make sure that all of the laparotomy pads were removed at the time that the C. section was concluded?

A. It is my responsibility to take all appropriate precautions to remove all of the tapes that are inserted. And it is my responsibility to make sure that I am given a correct count before closing the abdomen.

Q. So, in part, you are relying on the accuracy of the nurses that are in the surgical suite with you as to the count?

A. Yes.

Q. And we know, so that we can just move on from this interesting discussion, that the count was inaccurate, as evidenced by what ensued at St. Luke's Hospital?

A. Yes.

Q. And that is not, in your opinion, in keeping with accepted standards of practice for the performance of a C. section, correct?

MR. MOSCARINO: Objection to the form.

MR. CRANDALL: The fact that a sponge was left in?

MR. MISHKIND: Yes.

MR. CRANDALL: That is all he is asking.

A. The fact that a sponge was left in is not

consistent with accepted standards of practice.
Q. And do you believe that you failed to comply with your responsibility as the attending surgeon by permitting the case to conclude with a surgical sponge retained in Patty Doll's abdomen?
A. No.
Q. Why?
A. Because I removed all of those tapes that I routinely place as I am doing a cesarean. And I was told that the sponge count was correct prior to closing the abdomen.
Q. Any other reason why you state that you don't feel that you were negligent other than what you have just said?

MR. CRANDALL: You mean about the sponge count?

MR. MISHKIND: The sponge count, exactly. There are other issues, but we are just talking about the sponge count right now.

A. Would you repeat that question?
Q. Sure. In other words, you told me that you relied on the nurses to give you an accurate count, and presumed that they had given you an accurate count. And, therefore, you do not believe that you provided substandard care,

because you removed the ones that you typically removed, and relied on the nurses to remove the ones that they typically remove?

A. I removed the ones that I typically place, and I relied on them to give me an accurate count, not to remove. They don't remove, they give me a count.

Q. As you remove the sponges, you don't count them yourself?

A. I count the ones that I typically place. I know that I put in two sponges, routinely, and I take two out.

Q. Are there any other sponges that are put in for a C. section?

A. Not as a routine.

Q. Okay.

A. There are situations that arise in doing any emergency surgery or in doing any surgery where a sponge may be rapidly put somewhere to help with exposure or to clear up blood in the field, and it is these nonroutine issues, nonroutine situations, that are to be covered by the sponge count.

Q. Ultimately, though, you are the one that puts the sponges in?

A. Yes.
Q. And you are ultimately the one that removes the sponges?
A. Yes.
MR. CRANDALL: Which ones are you talking about, the two he routinely does, or all of them?
Q. Well, in Patty Doll's case, were you the one that was responsible for putting the sponges at the time of her C. section?
A. I am the one who is responsible for putting in those two sponges that I routinely place. During the course of the procedure, we may at some time use a laparotomy tape to push something out of the way, to keep something out of the way, to absorb blood that may be collecting in the field, and that may be done by the surgeon or by the first assistant.
Q. And let's assume that it is done by the first assistant. Is it the first assistant's responsibility to remove that sponge at the end of the case, or is it your responsibility, or someone else's?
A. It is the responsibility of both the surgeon and the first assistant to remove the sponges.

Q. So it is a shared or a joint responsibility?
A. Yes. I would say that the greater responsibility rests on the primary physician.
Q. Which would be you?
A. Yes.
Q. In this case, were there more than two sponges inserted?
MR. CRANDALL: More than the two he usually uses, routinely uses?
MR. MISHKIND: Yes.
A. I would have to say, because of the turn of events that there were. I can't recall putting in any other sponges, and that is why I say the sponge count is used to compensate for those situations. I know I put in two sponges, I take out two sponges.

During the heat of the procedure, if another sponge is quickly tucked in somewhere and it escapes your recollection while you are finishing the case, that is brought to your attention by an incorrect sponge count. So that is --
Q. I am sorry, I didn't mean to interrupt you. Go ahead.
A. That is why I say things like that happen as you are working, and you have to understand that,

particularly in an operation like a cesarean, things happen quickly. There can be a great deal of amniotic fluid and blood in the field. There can be loops of bowel that come down into where you are working. So you might take and put a sponge somewhere quickly while you are trying to control bleeding or trying to deliver the baby. Because it is not a routine step in the procedure, that may escape your recollection in the end.

So the sponge count protects you because you take out the sponges you routinely put in, and then you are reminded that there is an incorrect count and you have to go find what you left behind.

Q. So the nurses, in the final analysis, are there to make sure that not only the routine sponges that are put in, but also any nonroutine sponges that are put in, are accounted for?

A. Correct.

Q. And then ultimately removed?

A. Yes.

Q. Is there anything that you can tell me from Patty's C. section that specifically would have caused you to use more than the two routine sponges that you used?

A. I can tell you there is a probable explanation, and that is that this cesarean was being done for a placenta previa. Placenta previa is typically a more bloody section than a cesarean section that might be done for a woman who is in labor where the baby simply can't deliver.

Q. From the operative report or any of the records, are you able to tell me that because of the placenta previa that there was more than the two typical sponges used?

A. I can't tell you for sure that there were -- that is, I can't tell you from a recollection or from the operative report that there were more than two typical sponges that were used.

I can tell you that cesarean section for placenta previa is a more bloody operation than most cesarean sections.

Q. So it certainly is conceivable -- I am sorry, Doctor, go ahead, I interrupted you again.

A. If I could tell you what happened and why it happened, we wouldn't have a retained sponge.

Q Okay. It is conceivable because of the placenta previa that more than the two routine sponges were used in this case. It is conceivable that there were other explanations for why more than

two sponges, the routine sponges, were used. But the fact is all of the sponges that were used were not ultimately removed as they should have been, correct?

A. Yes.

Q. And it is inexcusable to have one or more sponges left in at the conclusion of Patty Doll's cesarean section?

MR. CRANDALL: We have beat this issue to death. Let's get beyond this.

MR. MOSCARINO: Objection to the form. He answered that in the last question.

Q. Your answer to the question?

A. Yes.

Q. Did Patty have an infection when she was admitted through the emergency room at St. Luke's Hospital?

A. I don't think so.

Q. And did she at any time develop an infection while in the hospital?

A. It was our clinical impression that she had an endometritis, that is, an infection of the uterus, when she was hospitalized with the cesarean section, that is, during that post-operative recovery period from the cesarean

section.

Q. And that was treated with, was it, oral antibiotics or IV?

MR. CRANDALL: In the hospital?

A. It was treated initially with intravenous antibiotics, and discharged on oral antibiotics.

Q. And upon presentation back to St. Luke's Hospital, and at any time prior to doing the laparoscopy, and then ultimately the laparotomy, was there any indication that Patty had infection?

A. I found no indication that she had infection beyond that endometritis that was treated in the post-cesarean section recovery period.

Q. Did she still have signs of infection, whether it be endometritis or otherwise, upon admission to St. Luke's Hospital from the emergency room on the 15th?

A. I can't tell you specifically. I don't have the vital signs that were done in the emergency room. I don't know if she had a fever.

And the question is a difficult one to answer in that signs of infection and signs of other problems may overlap. It was not my impression that she had an infection at the time

that she was seen in the emergency room.
Q. Was it your impression that at any time immediately prior to or at the time that you went in to do the laparoscopic surgery that she had an infection?
A. Immediately prior to?
MR. CRANDALL: So from the ER to the time you did the surgery, anything new that showed you she had an infection.
A. No, I did not think that she had an infection.
Q. The presence of the retained surgical sponge or the laparotomy tape was based upon a CT scan?
A. No.
Q. What was it based upon?
A. An x-ray on flat film of the abdomen.
Q. The two sponges that you routinely use, are they universal in size to the ones that would be used other than routine?
A. Yes, they are all the same size laparotomy tapes.
Q. So even though upon removal -- were you able, by looking at the tape, to determine whether this was one of the two that you had routinely used during your procedure, or whether this was one that may have been used because of the bleeding caused by the placenta previa?

A. I couldn't tell by the appearance of the tape, no.
Q. Why weren't you able to extract the tape at the time of the laparoscopy?
A. Because loops of bowel had become adherent to the tape, they had collected around it and had become adherent to the tape and to one another to -- you might say this is the body's reaction to isolate a foreign body.
Q. And this obviously was going on from the time that she was closed up from the C. section until you went in and did the laparoscopic procedure?
A. Yes. It was a process that would have begun at the time that the tape was left there.
Q. Because the body's mechanism of dealing with this foreign object had been going on for that period of time, and the sponge was adhering to the bowel, you were unable to do the removal or extraction of it through a laparoscopic procedure?
A. That's right.
Q. And had to go to an open laparotomy?
A. Yes.
Q. And it is my understanding that at the time that the open laparotomy was done to remove the tape,

that there was some inadvertent injury to the serosa of the small bowel, some tears that occurred to the serosa or to the lining of the small bowel?

A. Yes, that is a reasonable assumption, yes.

Q. Is there any other reasonable explanation for why there were tears to the small bowel other than inadvertent occurrences in an attempt to extract that foreign object?

A. It is not something that is entirely inadvertent. You have to understand, the serosa is just the very thin surface, outer surface, of the bowel. It was adherent to the tape. And when something is densely adherent, in order to remove it, in the process of dissection, you have to leave -- you may have to leave a little bit of the surface tissue behind on the structure to which it is adherent.

In this case it was the laparotomy tape. It could be another piece of small bowel. If you have two pieces of small bowel stuck together, when you separate them, one of them may lose a little bit of the surface layer.

So it is not something that is inadvertent in that it was an accident. It is an inevitable

process in dissecting the bowel off another structure if it is densely adherent.

Q. It is obvious that there wouldn't have been serosal tear, inadvertent or otherwise, had the laparotomy tape not been left in --

MR. MOSCARINO: Objection.

Q. -- correct?

A. That is probably correct.

Q. Well, can you tell me --

A. What I am saying is I can't say with 100 percent certainty that there wouldn't have been a small bowel obstruction and need for surgery for other reasons.

I will say that in this particular case the laparotomy tape was responsible for what occurred.

Q. And that is to a reasonable degree of medical probability, correct?

A. Yes.

MR. CRANDALL: Objection.

Q. As a consequence of the serosal tear, you had to call in the surgical team to address the colon injury?

A. The small bowel injury.

Q. I am sorry, small bowel injury.

A. Yes.

Q. And then to repair the small bowel at the time that you had removed the sponge?
A. Yes. Let me explain what that involves. That simply involves putting a few sutures in to bring the edge of the serosa together. This was not an injury to small bowel that caused small bowel contents to leak into the abdomen. It wasn't a serious complication. It is akin to putting a Band-Aid on a superficial scrape on your hand.
Q. But it is something that you weren't qualified to do and felt that you needed to call in a different surgical team to do?
A. I am actually qualified to do it. In this particular situation, I thought it would be best to make sure that we had somebody that was more qualified than I to do it.
Q. And this was done at the same time while she is open; you didn't have to close her up and then reopen her another time for the small bowel repair to take place?
A. That's right.
Q. Certainly the need for another surgical team coming in and repairing the bowel, to a probability, more likely than not, would have been avoided had the laparotomy pad not been left

in at the time that the C. section was concluded?
A. Yes.
Q. When did you first become aware that Patty's clinical condition was at least suggestive of some neurological problem after the conclusion of the laparotomy, about what time?
A. It was the evening of November 16th, and it was, I guess, sometime shortly after 6:00 p.m.
Q. How, specifically, did you become aware of it, and what were the mechanisms or the mechanics of what went on at that point?
A. I had been called by a house officer to tell me that Patty was very lethargic and she had not voided and the nurses wanted to put in a catheter. I did not want a catheter inserted. I asked her to make every effort to avoid that, and please have the nurses get her up to the bathroom or get her up to a bedside commode to void.

I at that time was out of the hospital at a meeting of the OB/GYN societies. I wasn't on the premises.

Shortly after that, and I can't recall whether I called back to find out what was happening because I was concerned or if the resident then paged me again, but I was told that

when the nurses tried to get her up she couldn't stand, and they noticed that she wasn't moving, I believe, the right side of her body.

Q. Did you call for the neurological consult?

A. I asked the resident to call the neurologist, and I left the meeting and went right to the hospital. I asked the resident to call the neurologist, because the resident was based at the hospital and could do it more efficiently than I. And I went to meet everybody at the hospital.

Q. Was this a hemorrhagic stroke?

A. I am not certain. Again, you are outside of my realm of expertise. I see references in the record to an infarct and hemorrhagic stroke. I think it would be best to get the opinion of a neurologist on that.

Q. You are not intending at the time of the trial to render any opinions as to whether or not this was hemorrhagic embolism, or any specific opinions as to the etiology of the stroke, are you?

A. I am not at this time.

Q. And you are not at this time in large part because you don't feel that you are qualified from your training and experience to render such

opinions?

A. Correct.

MR. MISHKIND: Obviously to the extent that he does become qualified between now and trial --

MR. CRANDALL: Well, that goes to the credibility. I mean, he can give an opinion at trial, if he wants to. You certainly can feel free to attack it based on his qualifications. But he can give an opinion, just like any other doctor.

Q. But you don't have an opinion as you are sitting here now, correct?

A. Correct.

Q. And you have obviously had almost two years to think about this matter in terms of what happened to Patty, and go over it in your mind and talk to other people, correct?

A. Correct.

Q. And based upon all of that, you are still where you are right now?

A. Based upon all the available data and my font of knowledge, I don't have an opinion.

Q. Do you have an opinion as to whether she would have suffered the stroke had she not had the

laparotomy pad left in her, subsequently admitted to the hospital and undergone laparoscopy and then laparotomy to remove the sponge with the associated serosal tear, do you have an opinion as to whether had all of that not occurred whether more likely than not she would have suffered the stroke anyway?

MR. MOSCARINO: Objection.

MR. CRANDALL: Objection.

A. As much as I don't know what caused the stroke, I have to say no.

Q. You don't know whether it would have been avoided?

A. No.

Q. Had all those things not occurred?

A. No.

Q. You talked with Dr. Lerner in the hospital in terms of differentials as to causes for the stroke, correct?

A. Yes.

Q. And based upon those discussions in the hospital, tell me what factors were being considered as being causative of the stroke, and if those factors were ruled out, and, if so, how they were ruled out.

MR. CRANDALL: I will object to the form.

MR. MISHKIND: Well, I am making it as broad as I possibly can to try to save some time.

MR. CRANDALL: I understand.

Q. Go ahead.

A. I can't remember all the details.

Q. Do the best you can.

A. Some of the things we talked about were: Was there a thrombosis? We didn't have any specific reason to presume that someone of this age would have a thrombosis.

I believe we considered the infectious etiology, and there was no reason to believe there was an infection, this was not an abscess. We considered an embolus, and we couldn't come up with any explanation for an embolus.

She was not -- she didn't have high blood pressure, so this wouldn't -- we didn't feel that this was a hemorrhagic stroke due to high blood pressure.

We considered the possibility of a vascular anomaly, and I don't believe that could be demonstrated. Whether or not it could be

demonstrated and whether or not it was possible to demonstrate it after the fact, I don't know. Again, that is something beyond my area of expertise. Obviously there weren't any associated vascular abnormalities or malformations to give us a high index of suspicion that that was the reason.

So we came up with dead-ends for everything that we discussed.

Q. Any other discussions about differential, other than what you have just indicated?

MR. CRANDALL: That he can remember?

MR. MISHKIND: Sure.

MR. CRANDALL: There could be some things in the medical records.

MR. MISHKIND: Sure.

A. I mentioned thrombosis. We considered phospholipid antibody. And I don't know whether or not that was ever adequately assessed.

Q. What caused the thrombosis of the right iliac vein and the partial thrombosis of the left ovarian vein that was diagnosed by CT scan on November 22?

A. I am not sure there was such a thrombosis. My

interpretation of the record is that there was no such thrombosis.

Q. Did you look at the CT of the abdomen and the pelvis yourself?

A. Did I look at the scan?

Q. Yes.

A. No.

Q. The interpretation on November 22 indicates, "Impression: Suggestion of right iliac vein partial thrombosis. Also suggestion of left ovarian vein partial thrombosis." At least that is what the record says.

Was the existence of some pelvic thrombosis ever ruled out?

A. I would have to say it wasn't absolutely ruled out, and it wasn't absolutely documented. There are differing interpretations in the record here.

What I read in the CT record is a suggestion of a right iliac vein partial thrombosis, and a suggestion of a left ovarian vein partial thrombosis, so it is not a definite diagnosis.

And then there is a further interpretation of that CT scan and of other studies which failed to document any thrombosis. As I read the

record, most of the data, most of the interpretations tell me that there was not a thrombosis.

Dr. Savrin, who is a vascular surgeon, indicated that he could not find any thrombosis. He had the CT scan reviewed with a radiologist. Now, that was Dr. Davis. Let me see if it was the same radiologist who --

MR. CRANDALL: You answered his question already anyway.

THE WITNESS: Okay.

Q. Is that the same radiologist that did the CT scan?

A. I am going to check that. The CT scan was read by Dr. Friedman, and it was then reviewed by Dr. Davis, who looked at some additional studies, performed an additional study duplex, and you will have to get a radiologist to explain to you what a duplex is.

Q. You never looked at the CT scan to make a determination whether she did or did not have evidence of pelvic thrombophlebitis, correct?

A. That's correct. I am not qualified to read a CT scan to that level of expertise.

Q. Have you ever seen in a post-cesarean section

patient the development of a pelvic thrombophlebitis?
A. Yes.
Q. Is that usually infectious in origin?
A. There is usually some infectious component to it in that the infection sets up the inflammatory reaction in the pelvis that precipitates the development of the thrombosis.
Q. And you typically have what is known as a septic pelvic thrombophlebitis?
A. Correct. You may have a septic pelvic thrombophlebitis or aseptic pelvic thrombophlebitis. Either one may occur.
Q. Can you state to any degree of probability in this case whether or not Patty did or did not have septic pelvic thrombophlebitis?
A. I am reasonably certain that she did not have septic pelvic thrombophlebitis.
Q. And the basis for that opinion is what?
A. The basis for that opinion is that she did not have the fever associated with that condition.
Q. Any other basis for that opinion other than what you believe to be a lack of fever associated with that condition?
A. The CT scan interpretation, the duplex interpreta-

tions, the vascular studies done by Dr. Savrin.
Q. Are you familiar, at all, with the significance of D-dimer?
A. Yes.
Q. Was there any abnormality in her D-dimer?
A. I don't know.
Q. Of what significance is D-dimer?
A. I believe a D-dimer would be in thrombotic conditions.
Q. If there is a thrombotic condition, do you expect to see some alteration in fibrinogen levels?
A. No, not necessarily.
Q. What would cause an alteration in the fibrinogen level?
A. Well, it takes a rather catastrophic event to cause an alteration in fibrinogen level. Fibrinogen levels may be low if you have something like a placental abruption, or may be low if you have disseminated intravascular coagulation. But fibrinogen levels are not going to be altered by a localized thrombophlebitis.
Q. We don't have any evidence of DIC in this case, do we?
A. No, we don't.
Q. Do you have any explanation, assuming there was

some alteration in the D-dimer or the fibrinogen level, what caused those alterations in this case?

A. I don't know what the alterations were, so I can't conjecture. Do you --

MR. CRANDALL: No, you are done.

Q. You have looked over the record, and that has never been anything that has been brought to your attention as being anything of significance?

A. That is an extensive -- no, I don't think it has been brought to my attention as being significant. And I can't remember very bit of data that is in the record.

Q. I would be surprised if you did.

The nurses that were involved at the time of Patty's C. section, the scrub nurse and the circulating nurse and, apparently, an operating room technician -- does that sound right to you?

MR. CRANDALL: That there were those people?

MR. MISHKIND: I am sorry.

MR. CRANDALL: You are asking if that is the number of nurses that were there?

MR. MISHKIND: Yes.

MR. CRANDALL: Why don't you look

at the operative notes.

THE WITNESS: It won't be in the operative notes.

MR. CRANDALL: It should be in the nurses' notes of the operation.

A. I know there was a scrub tech. The OR technician is the scrub tech., and she is listed as the scrub nurse, ORT.

Q. And, I am sorry, you referred to her as a scrub tech.?

A. Scrub tech. or operating room technician you called her. She is the person who functions as what you call the scrub nurse. She is listed here as the scrub nurse.

Q. Who is the person that is supposed to do the accurate laparotomy pad count, the sponge count?

A. It is done by both the circulating nurse and the scrub tech.

Q. Who is the circulating nurse in Patty's C. section?

A. There were two.

Q. Their names?

A. I believe this is Lois Edgecomb and Susan Ford.

Q. And the tech. was whom?

A. Ms. Chaney.

Q. Had these individuals been participants in any prior surgeries that you had performed?
A. Certainly Ms. Chaney had. Whether or not the others had participated as circulators in other cases, I don't know. They are labor and delivery nurses, and I have worked with them on other occasions, but I don't know if it was specifically in surgery.
Q. Did you ever talk with them after you learned that a pad had been left in at the time of the C. section conclusion?

MR. MOSCARINO: I am just going to object to the extent that any of that was peer review of any form or fashion.

Q. Did you ever talk with them at the hospital outside of any formal meeting, approach them in the hallway, or talked to them after you learned that the pad count was inaccurate? Did you have any discussion with them about it?
A. We had a formal meeting. I don't know if we had any discussion informally in the hallway.
Q. Where was the formal meeting held?

MR. MOSCARINO: Same objection.

A. At University Hospitals.
Q. Who was present for that formal meeting?

MR. MOSCARINO: I am going to object regarding anything at the formal meeting as being something for discovery.

MR. MISHKIND: I am not sure at this point. If we get into that, I will stop. I don't think we have gotten to that point.

MR. MOSCARINO: I can still place the objection. He is not my witness, I can't instruct him not to answer. I am entitled to put forth my objection.

MR. CRANDALL: Even if it was a peer review, he can still find out who was there.

MR. MISHKIND: That's right.

A. We had the two circulating nurses, Lois Edgecomb and Susan Ford, the OR technician -- excuse me, Georgia Chaney, and I was there. And we had someone provided by the hospital as a facilitator. I don't remember who it was. I don't know her title. I don't know her title, but it was someone to help us in our discussion.

MR. CRANDALL: Before we get any further, do you mind if I take a break? I want to talk to George for a second.

(Thereupon, a short recess was taken.)

(Record read.)

BY MR. MISHKIND:

Q. You had mentioned that there was a facilitator, and I think you said you don't remember who the facilitator was; is that correct?

A. That's correct.

Q. Was there anyone else that you can recall being present at the meeting other than the people that you have identified?

A. I can't recall.

Q. Did this meeting have a name to it in terms of was it a committee meeting? What exactly was it called?

A. Well, I don't know if there is any name for it. It was an informal -- it was not a committee meeting.

Q. Were there any minutes or notes taken by anyone?

A. No.

Q. Was there anything that resulted as a consequence of that meeting in terms of any of the participants?

MR. CRANDALL: Objection.

MR. MOSCARINO: Objection.

A. Can you be more specific?

Q. Did anyone receive any discipline or sanctions or --

A. No.
Q. Did you leave that meeting, that informal meeting, with any better understanding as to why the laparotomy sponge was left in than what you had prior to going into the meeting?
A. No.
Q. Other than that meeting, did you have any other formal or informal meetings with anyone, any of the nurses that were present at the time of the C. section?
A. No.
Q. Did you see Patty at any time after she was discharged from St. Luke's Hospital?
A. No.
Q. She was discharged, was it, on December 2?
MR. CRANDALL: Yes, December 2.
A. Yes.
Q. After December 2, 1994, then, did you consider your physician-patient relationship to have terminated?
A. I did not. I tried to get her back for a visit.
Q. How did you try to do that?
A. I called and left a message on the answering machine for her to return for a postpartum visit.
Q. Did you receive a return telephone call?

A. No.
Q. Did you have any communication with Patty, George, or anyone on their behalf subsequent to that telephone call as to why either the call wasn't returned or why they weren't coming in for postpartum visit?
A. No.
Q. Did you subsequently learn who was taking care of her postpartum follow-up?
A. I did.
Q. And how did you learn that?
A. Dr. Rob Collins sent me a letter after he saw her.
Q. How were you referred, or how did Patty get introduced to you to begin with?
A. Dr. Collins sent her to me.
Q. Was that when Dr. Collins was at The Clinic, The Cleveland Clinic?
A. I have to refer back to his note to know that, and I think he was.
MR. CRANDALL: You want to know if Collins was at The Clinic when he made the referral?
A. Yes, he was at The Clinic when he made the referral.

Q. When Patty continued her care after December 2, '94 with Dr. Collins, was that at a point in time when he had moved to Youngstown?
A. Yes.
Q. Other than your office notes that are contained in the office file in front of you, do you have any personal notes or records that you maintained concerning the events that occurred at the time of the C. section or the events that occurred at the time of Patty's admission to St. Luke's Hospital?
A. No.
Q. So everything that you created or wrote down concerning this case either is in your office chart, which is in front of you, or entries that you would have made in the hospital records?
A. Other than my communications with attorneys.
Q. Obviously, right. Could I see your file for a moment, please.

Doctor, in a letter that you wrote to Dr. Collins, which is in your file dated January 26, 1995, you indicate, among other things, she has done a wonderful job at rehabilitation. What were you basing that statement on?

A. I was basing that on her course in the hospital and the report that we got from the rehab. center. And I may have had -- when did I get my last note from Dr. Lerner?

Q. That was August of '95.

A. Probably also from my communication with Dr. Lerner.

Q. Have you received any information from any source since August of 1995 concerning the residual disabilities, if any, that Patty has?

A. Mr. Crandall told me that she has returned to work.

MR. CRANDALL: Other than anything I told you.

Q. Other than discussions with Mr. Crandall, in other words, do you know what degree of disability she has, and, if so, what areas of her cognitive function or her functional capacities have been limited in any respect?

A. I don't know her current status. As I indicated, I did have a conversation with Dr. Lerner probably sometime around February or March of 1996, and I don't remember the details of it.

MR. MISHKIND: Steve, what I would like to do, if it would be okay with you, I have

what you produced in response to request for production, I have part of the doctor's office chart.

MR. CRANDALL: Yes.

MR. MISHKIND: It is clearly not the entire chart.

MR. CRANDALL: Okay.

MR. MISHKIND: It also does not include the letter from Dr. Collins dated January 5, '95, and the doctor's letter back to Dr. Collins, and various --

MR. CRANDALL: I must have gotten the chart after the request for production, because I think I gave George the whole one. I will have a copy of it made for you.

MR. MISHKIND: Just from cover to cover and just photocopy it.

THE WITNESS: He --

MR. CRANDALL: There is no question before you, sir.

BY MR. MISHKIND:

Q. Have you talked to Dr. Samudio since discovering the laparotomy tape as to what happened?

A. I told her what happened.

Q. She wasn't at this informal meeting that you

talked about?
A. She was not.
Q. What did Dr. Samudio say to you, if anything, when you told her what happened?
A. I can only tell you her general reaction.
Q. Which was?
A. That she was surprised and she was shocked.
Q. In this C. section, did you physically put the sponges in, or is it possible that Dr. Samudio put the sponges in?

MR. CRANDALL: If you know. I don't want you to guess.

MR. MISHKIND: I mean, if he knows to a certainty that it was him or her or if it is conceivable that --

MR. CRANDALL: Any responses you are asking, or all responses?

MR. MISHKIND: We are just going to talk about the two that are routinely put in.

Q. (Continuing.) Can you state that you would have put in the two routine ones, or is it just as likely that Dr. Samudio put in the laparotomy pads?
A. It is probable that we each put in one.
Q. And if there was an additional one or more that

were used because of the placenta previa, or for other reasons, would you have any way of telling me whether it was you or her or any of the nurses that would have put that in?

A. No.

Q. After you told her --

A. Excuse me, it was not one of the nurses. They are just simply not put in by nurses. I can't tell you if it was Dr. Samudio or me.

Q. There are two operative notes that are dictated for the C. section, one by you and one by Dr. Samudio. Can you explain to me why that is.

A. Yes. When a resident plays a major role in a surgical procedure, we usually ask the resident to dictate the case, it is a part of the learning process.

I assumed that the operative note had been dictated. And after we did the laparotomy on November 15 and found the retained sponge, I saw Dr. Samudio a day or two later and I told her what happened. And I said, "I sure hope you dictated that operative note." And the response was affirmative.

Shortly after that when I was signing out the chart in medical records, I did not find a

dictated operative note. So to complete the chart I dictated an operative note at that time.

And it appears that between the time I spoke with Dr. Samudio and the time that I dictated a note, she dictated a note. That is what the dates on the dictations would indicate.

Q. Have you reviewed her operative note?

A. I have.

Q. Do you take issue at all with anything that is said by her in that operative note?

A. Yes.

Q. What do you take issue with?

A. She doesn't clearly describe the delivery of this baby as a breach. There is a statement in there that is faulty when she describes making the incision in the uterus and reaching in and grasping the baby's head. She was not thinking what she was saying at the time, because she subsequently stated in the note, I believe, that the baby was delivered as a breach. But the head would have been the last thing to come.

And she didn't describe the adhesions in the left side of the pelvis that we noted at the time of cesarean.

Q. Anything else?

A. Without going over it line by line right now, I can't tell you anything else. But those are the things that immediately come to mind.

Q. What caused the adhesions?

A. These are adhesions that were present at the time of cesarean section, so they were old, they were chronic. What caused them? Dr. Collins would probably know better than I since he did her previous laparoscopies for infertility.

She had a history of endometriosis, that is what I was told. So it is very probable that they were caused by endometriosis.

Q. Do you have an opinion as to whether or not the endometriosis or the adhesions that were found at the time of the C. section played a part at all in the subsequent events that led to the stroke?

A. No.

Q. No, you don't have an opinion, or no, they didn't play a part?

A. All right. I have an opinion.

Q. And what is your opinion?

A. I don't think they played a part.

Q. Fair enough. Thank you.

Both your operative note and Dr. Samudio's operative note were dictated after you both knew

that there had been a retained foreign body or surgical sponge left in Patty, correct?

A. Correct.

Q. Did you or Dr. Samudio acknowledge that there was a sponge left in either your operative note or in her operative note?

A. I don't believe *so.*

Q. Has Dr. Samudio ever given you an explanation to this date as to why there was a sponge left in, or has she indicated to you that she had an explanation for why the sponge was left in?

A. No.

Q. Has anyone from the hospital ever come forward and told you personally that they or she was the one that missed the count?

MR. MOSCARINO: Objection.

A. No.

Q. So no one, to your knowledge, has fessed up and assumed responsibility for having not accurately done the count?

MR. CRANDALL: Isn't that the same question you just asked him?

MR. MISHKIND: In different words, I suppose it is.

MR. MOSCARINO: Same objection.

A. No.
Q. Is a laparotomy pad radiolucent?
A. A laparotomy pad is radiolucent. There is a radiopaque marker in a laparotomy pad.
Q. Why is that?
A. So that it can be picked up on x-ray.
Q. Is there a routine post-op x-ray that is done at the conclusion of the cesarean?
A. No.
Q. Were there any x-rays that were done between the time that the cesarean was concluded and the time that Patty was sent home?
A. No.
Q. If there had been one, would that more likely than not have picked up the pad?
A. Yes.
Q. Had it been picked up, would a laparoscopy have been the treatment of choice at that point in an effort to remove the pad?
MR. CRANDALL: I am going to object. Go ahead.
A. The treatment of choice would have been removal of the pad.
Q. Initially through an attempted laparoscopy?
A. I can't tell you that there is a treatment of

choice as to how it is done.
Q. The less invasive, obviously, is through a laparoscopic means, correct?
A. Yes. I doubt that it would have been possible.
Q. Why is that?
A. Because of the findings at the time that we did our surgery.
Q. But can you say that those findings that you saw when you did your surgery down the road on the 15th or the 16th would have been the same as if they had been discovered while Patty was still in the hospital following the C. section?
A. I can't say that with certainty.
Q. Isn't it more likely that the adherence to the small bowel and the body's reaction to that foreign body would have been less had it been discovered shortly after the C. section before she was sent home as opposed to when she came into St. Luke's Hospital?
MR. CRANDALL: Objection.
A. Yes.
Q. And isn't it more likely than not that the removal of the sponge or the retained laparotomy pad would have been easier with less potential for adherence to the bowel and injury to the

small bowel had it been removed at the time shortly after the C. section, as opposed to when it was removed?

MR. CRANDALL: Within the hospitalization, that is what you mean by shortly afterwards?

MR. MISHKIND: Yes, right.

A. Yes.

MR. CRANDALL: Do you want to give George a crack and come back at it?

MR. MISHKIND: I am going over my notes. I may not have, in fact, any questions. But if I do, I will check them off and come back in.

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CROSS-EXAMINATION

BY MR. MOSCARINO:

Q. My name is George Moscarino. I am one of the attorneys for University Hospitals in this case. I have a few questions for you. Okay?

A. Yes.

Q. Just so we are on the same wavelength, during the course of this deposition we have talked about tapes, M-tapes, and sponges; are they universal in terminology?

A. Yes.
Q. Just *so* I understand, the tape that was found in this case was located where?
A. It was located in the left side of the pelvis. Perhaps, actually, it was more in the left lower quadrant of the abdomen. It was fairly high up, it was not deep in the pelvis. So it was, as I recall, proximately midway between the umbilicus and the anterior superior spine of the iliac crest on the left side.
Q. And *so* that I understand, you told Mr. Mishkind that you routinely place two tapes or pads in a cesarean section?
A. Yes.
Q. And those are placed where?
A. They are placed down low. They are placed between the broad ligament of the uterus and the abdominal wall. And they extend up *so* that they are situated between the body of the uterus and the abdominal wall.
Q. I see in the operative report, or both reports, that tapes are placed in, quote, unquote, "the gutters." That what you have described to me, the gutters?
A. Actually, no. That dictation is not really

precise, because they are not out in the gutters. The gutters are farther lateral and farther posterior. So that is an imprecise statement in the operative note.

Q. So the tapes that you told us that you routinely place -- bear with me for my lack of medical terminology -- are they in the gutters, or are they what you told me about?

A. They are not truly in the gutters. They are up against the abdominal wall, situated between the abdominal wall and the uterus and the broad ligaments, which are the extensions out to the sides from the sides of the uterus.

Q. And what is the purpose of placing these tapes or these pads?

A. They are placed there to prevent the amniotic fluid and the blood that come from the uterus from spilling out into the gutters and into the peritoneal cavity. So they form a sort of barrier or dam to keep all this material from contaminating the peritoneal cavity.

Q. When you say you place these tapes on each side of the location you described, is that one tape, or is that a package of tapes that is put together, or how do you work that out?

A. It is one laparotomy tape on the left side and one laparotomy tape on the right side. And they are placed so that they actually extend from down at the lowermost part of the broad ligament up and to meet in the midline across the uterus and form a dam.

Q. Can you give me a dimension on each one of these tapes?

A. Laparotomy tapes vary in size and shape. I think the ones we are talking about are probably about 12 inches square, 12 inches on a side.

Q. And then during the course of this surgery, would you be on one side of Mrs. Doll and Dr. Samudio on the other?

A. That's right.

Q. Do you know which side you were on during the surgery?

A. I was on her left side.

Q. Is that by usual protocol and procedure, or you just remember the specific procedure?

A. That is usual procedure.

Q. And then I take it, obviously, then, Dr. Samudio would have been on the right?

A. Yes.

Q. And then do you personally place each of these

pads or tapes, or do you direct the resident to do the other one?

A. I usually place one and direct the resident to do the other one.

Q. And then when they are removed, do you take them both out, or do you direct the resident to do one, or do you direct the resident to take the other one out?

A. That varies. Sometimes the resident will remove one and I will remove one. Sometimes I will remove them both.

Q. Now, you told us that during the course of the surgery, such as somebody who has this placenta previa condition, additional pads or tapes might be used because of the bleeding that is associated with this condition?

A. Yes.

Q. Would that be your decision to use the additional tapes, or the resident's, or the nurse's, or whose?

A. Could be either me or the resident, whoever is at that time trying to get exposure.

Q. And would these additional tapes be placed in an area different than the original wall or dam that you had described?

A. Usually, yes.
Q. So that I am clear, you have no specific recall as to where additional tapes, if any, were placed?
A. No.
Q. Do you know if additional tapes were placed?
A. I have no recall of where or when additional tapes were placed.
Q. Would those be of the same size or dimensions than those that you have previously described that form this dam?
A. All of the tapes used in the case are of the same size and dimensions.
Q. Now, what side of Mrs. Doll's body was the tape that was found?
A. It was on the left side.
Q. And where was it in proximity to the wall or dam that you told me about?
A. It was higher. It was located higher in the abdomen than the tapes that I typically place at the time of cesarean.
Q. How much higher, dimension-wise, in centimeters?
A. Oh, as I recall, it was about eight or ten centimeters higher.
Q. These tapes, do they look like gauze pads of some

sort when they are first put in or prior to being put in someone's body?

A. They are a fluffy cotton material, I believe, thick. I guess the closest thing to which I can compare them in lay terms would be something like soft face cloths.

Q. Once they are placed, is there something that the surgeon or that the residents or the nurses do to flag to themselves as to where these things have been placed?

A. Some do and some don't.

Q. Do you do anything in particular yourself with respect to placement of these tapes or pads? In other words, I understand some people put like a scissors on them or they do certain things just to make a mental marker, kind of like a string around the finger, to remind themselves that they have these things in place. Am I right in that or am I wrong?

A. You are right. At that time I did not.

Q. Are you able to tell me -- I am sorry if this is repetitive -- as to who exactly placed the pad that you retrieved in the surgery at St. Luke's in Mrs. Doll's abdomen during the course of the cesarean section?

A. I can't tell you that.
Q. Based on your answers to the questions posed by Mr. Mishkind, am I correct to conclude that it would have been either you or Dr. Samudio?
A. Yes.
Q. Is there any more likely that it was you since it was on the left side than Dr. Samudio?
A. No.
Q. I take it people are reaching in and across her body?
A. Yes.
Q. What happens to these pads once they are in the body and they soak up blood, do they change their appearance?
A. They simply become wet and bloody.
Q. Based on the location of this tape that you removed, are you able to tell me what purpose it was placed there for other than to soak up blood or fluid?
A. I can't tell you specifically. It was more likely placed to wall off some bowel or omentum that may have been coming down into the field.
Q. Then what happens at the point in time when the baby is delivered and you are getting ready to close? Who makes the directions as to taking out

these tapes or pads, if any?

A. I direct the removal of the tapes that I routinely put in after the uterus is closed and we are ready to close the abdomen. I direct the removal of those tapes.

Q. And that is with respect to solely this initial wall or dam that you told me about?

A. Yes.

Q. And who makes the directions regarding any additional tapes or pads that would have been inserted during the course of the operative procedure?

A. If I recall placing any additional pads, then I direct the removal of those pads. The resident may do the same if the resident recalls having placed a pad. If neither one of us recalls having placed a pad, then the nurse directs it because of an incorrect count.

Q. Is there some type of visual or hand type of checking by you and/or the resident, feeling around for tapes prior to closure?

A. We look. We routinely look. When the tapes are removed, the ones that I standardly put in as a matter of routine, when those are removed, then we look over into the gutters that we referred to

earlier to see if there is any blood there to be able to remove that.

At the same time we look around the tube and the ovary on each side to see how it looks, to see if we can see it. We cannot see the tube and the ovary without having first removed the tape. We took out the tape, looked at the gutters, and so we do look inside to see if we have left anything there.

Q. Do you have an understanding as to how many sponge counts are conducted prior to closure?

A. I don't know how many sponge counts are routinely done prior to closure. I think there is one done before you close the peritoneum and one done after you close the peritoneum as a check, but that is nursing protocol, and I can't tell you for sure.

Q. Do you actually receive word in some form or fashion from one of the nurses that the sponge count has been done and is, indeed, correct?

A. Yes.

Q. That is prior to closure?

A. Usually we receive that as we are closing. As we are in the process of closing the abdominal wall, we will usually be told sponge counts, correct.

Q. And I take it by your testimony you don't personally participate in the counting of these pieces of gauzes or sponge?
A. I don't participate in counting them unless the sponge count is incorrect.
Q. And you would not then have participated in this case, based on what you told Mr. Mishkind?
A. Correct, because we were given a correct count.
Q. Do you know if this specific tape or sponge is still being housed at St. Luke's Medical Center?
A. According to the pathology report, it is. I am sorry, let me correct that. At the time of the pathology report, it was. I don't know if they retain it this long.

MR. MOSCARINO: Off the record.

(Thereupon, a discussion was had off the record.)

Q. Do you, in your memory, or mind's eye, do you remember removing this initial pad or tape that you placed to form this dam on the left side of Mrs. Doll during that specific surgery?
A I don't remember the act of removing it, but I know I did.
Q And do you know or remember whether Dr. Samudio removed one from the other side or whether you

did both of those?

A. I don't remember. I probably did both of them.

Q. Is that your usual procedure that you remove both of the initial pads that are placed to form this dam?

A. More often I will remove them both, but a fair number of times the resident will remove one.

Q. Would they do that on their own, or would they wait for you to tell them to do that?

A. Wait for me to tell them.

Q. With respect to the removal of the other pads, would they wait for you to tell them, also, if additional sponges or pads were placed in the operative field?

A. No. This is a process. We are removing tapes, inspecting, and preparing to close, and it is just a process you go through. Once the process is initiated, the resident will continue the steps along with me.

Q. Are the tapes or sponges taken out during the course of the procedure, or are they all taken out at closure?

A. They are generally taken out at closure. There may be others that are put in and taken out during the course of the procedure, but most of

them are taken out at closure.

Q. Just so that I understand, you told Mr. Mishkind that you removed all the tapes that you routinely place, and then you were told that the sponge count was correct, right?

A. Yes.

Q. And when you say you removed all the tapes that you routinely placed, we are talking about these two that form the dam, correct?

A. Yes.

Q. And with respect to the other ones, you are not really able to tell me who took out any of the other tapes; am I correct in my summarization?

A. That's correct.

Q. But whoever would have taken them out, it would have been either you or Dr. Samudio?

A. Yes.

Q. Are you able to tell me whether the sponge that was removed in your subsequent operative procedure was one of these sponges that was initially put in, or was it something else that was put in afterwards?

A. It was not one of the ones that were initially put in.

Q. And you are able to tell that because of size,

location, or what?

A. Because of location.

Q. In the specific one that we are talking about, the one that was left inside Mrs. Doll, is that something that as you and Dr. Samudio are closing you could see, or is it something that you would have to stick your hands in and dig for?

A. Something you would have to dig for or look for by lifting the abdominal wall and inspecting.

Q. During the course of the surgery, you supervise the activities of Dr. Samudio; am I correct?

A. Yes.

Q. She is a physician in training that, just by rights of hierarchy, you can direct and control?

A. Yes.

Q. How about the nurses, do you have supervisory responsibility for the nurses?

A. To some degree I direct nurses in terms of what is to be done with the patient. I do not supervise them with respect to how they perform their tasks.

Q. You have the authority, just by your position as the attending physician, if you tell them to do something, it is their job to go ahead and do that, correct?

A. Within reason, yes.
Q. And the attending physician or the OB/GYN/surgeon in the case obviously was you?
A. Yes.
Q. You would be, then, the highest ranking medical professional in the operative suite?
A. I haven't thought of it that way. I don't honestly know. That may be so.
Q. Are you ultimately responsible for what goes on during the course of the surgery?
MR. CRANDALL: Objection. For every single thing that goes on in the operating room, you are asking if he is responsible for that?
MR. MOSCARINO: Yes.
A. Not for everything, no.
Q. Well, I don't want to include the absurd, crazy thing that might happen with you.
A. I am responsible for those things that --
MR. CRANDALL: You answered his question already.
Q. You are responsible for the performance of the surgery?
A. Yes.
Q. And in a teaching institution, that would also

include for the activities of Dr. Samudio during the course of the surgery?

A. Within reason, yes.

Q. With respect to the actual counting of the sponges or the tapes, you rely on the nursing staff to give you that information, correct?

A. Yes.

Q. Do you have a duty with respect to the sponge count to perform it in any form or fashion?

MR. CRANDALL: To perform the sponge count itself you are asking?

MR. MOSCARINO: Yes.

A. No.

Q. If I understand your testimony, you only become involved if you understand the sponge count is incorrect, then you would become more involved. Am I right in summarizing your testimony?

A. Well, not only. I become involved if there are sponges that can't be located.

MR. MOSCARINO: That is all I have, thank you.

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CONTINUED CROSS-EXAMINATION

BY MR. MISHKIND:

Q. A couple quick questions, Doctor, and then I will

let you get to your patients.

Ultimately, are you responsible for insuring that foreign objects, such as a laparotomy pad, are not left inside a patient at the end of a C. section?

MR. CRANDALL: I am going to object.

A. Ultimately, no.

Q. Who has the ultimate responsibility at the conclusion of the case to make sure that retained laparotomy pads are not left or a laparotomy pad is not left inside a patient?

A. I am not sure I can tell you who is ultimately responsible. I have told you what I think are the various responsibilities.

MR. CRANDALL: Ad nauseum I think we have gone through this.

Q. Would you agree that there is a shared responsibility between you, as the surgeon, and the nurses of the hospital?

MR. CRANDALL: I am going to object. We have been through this before.

MR. MISHKIND: Okay.

MR. CRANDALL: And he has told you that his responsibility --

MR. MISHKIND: Well, Steve--

MR. CRANDALL: We are going to --

MR. MISHKIND: Are you going to testify for him?

MR. CRANDALL: Exactly, because this is ridiculous. We are asking the same questions again and again looking for different answers.

MR. MISHKIND: No, I am not. I am going to make sure now you can go ahead and testify.

MR. CRANDALL: I am not testifying, I am telling you what he said.

MR. MISHKIND: You are testifying. Go ahead.

MR. CRANDALL: Fine. He has told you he has the responsibility to look for the sponges, and that the responsibility of the nurses is to count for the sponge count.

MR. MISHKIND: Are you done?

MR. CRANDALL: Apparently, yes, for right now I am,

MR. MISHKIND: I just wanted to know whether you wanted to add anything further.

Q. (Continuing.) That isn't my question.

I am asking in terms of the ultimate responsibility for insuring that a foreign object, such as a sponge, is not left in a patient, the ultimate responsibility, is that yours or is that shared between you and the nursing staff?

A. The overall responsibility is shared.

Q. Now, you indicated that a correct count was done in this case. Bear with me, I don't mean to go over something that has already been gone over, but how are you able to say that a correct count was done at the conclusion of the C. section?

A. Are you sure that is what I said?

Q. Well, when Mr. Moscarino was questioning you, you indicated a correct count was done.

A. Did I say that or did I say that I was given a correct count?

Q. Okay. Well perhaps --

MR. CRANDALL: I think you are saying the same thing.

Q. When you say you are given a correct count, how do you know that you are given a correct count?

A. By saying I was given a correct count, I mean the nurses reported to me a correct count.

Q. In other words, they accounted for X number going

in and X number going out?

A. That's right.

Q. I am sorry, go ahead. You know that that count, in actuality, was not correct, correct?

A. At this point in time I know that, yes.

Q. There was some question about placing a marker on the pads, and you indicated that at that time you weren't doing any type of flagging or marking. Do you do something differently now with regard to lap pads?

MR. CRANDALL: Objection. Go ahead.

Q. Or laparotomy sponges?

A. I tag the sponges that I routinely place on the sides with instruments. When sponges are used in an emergency situation, they are generally not tagged, because we don't have time to put tags on them.

Q In nonemergency situations, you are now, did you say -- what are you putting on them?

A. Tag, is that we attach a surgical instrument, such as a clamp, to each tag.

Q. Is this a new concept, or is this something that has been used in the medical world for some time?

A. It is something that has been used.

Q. Did you start using surgical instruments on pads as a consequence of the Patty Doll situation?

MR. CRANDALL: Objection. Go ahead.

A. Yes.

Q. Is there any particular reason you weren't using surgical instruments prior to Patty's case?

MR. CRANDALL: Objection. Go ahead.

A. Yes. It wasn't necessary because I routinely place the same number of tapes in the same place and remove those same tapes at the end of the procedure.

Q. It was as feasible before Patty Doll and in Patty Doll's case to use surgical instruments to tag the sponges as it is now, correct?

A. Yes.

Q. Was Patty at increased risk of experiencing a stroke by virtue of being in a postpartum state?

A. I don't think so.

Q. Was she at increased risk of sustaining a stroke by virtue of having to undergo a laparoscopy and then a laparotomy to then remove a surgical retained sponge?

A. No.

MR. CRANDALL: Is that it?

MR. MISHKIND: It is. Doctor, thanks for your time.

MR. CRANDALL: We will read this.

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(DEPOSITION CONCLUDED.)

MICHAEL THOMAS GYVES, M.D.

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CERTIFICATE

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

I, Diane M. Stevenson, a Registered Merit Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, MICHAEL THOMAS GYVES, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to stenotypy in the presence of said witness, afterwards transcribed by means of computer-aided transcription, and that the foregoing is a true and correct transcript of the testimony as given by him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified, and was completed without adjournment.

I do further certify that I am not a relative, employee, or attorney of any party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 9th day of DECEMBER, 1996.

Diane M. Stevenson

Diane M. Stevenson, RMR
Notary Public in and for
The State of Ohio.

My Commission expires October 31, 2000.