Scanned

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

Doc. 187

- - -

IN THE COURT OF COMMON PLEAS

- - -

DOROTHY SKEBE,)
)
Plaintiff,)
)
vs.) Case No. 127673
)
RICHMOND HEIGHTS GENERAL HOSPITAL, et al.,)
)
Defendants.)

- - -

ARBITRATION TESTIMONY OF CREIGHTON G. HEYL, D.O.
Wednesday, February 22, 1989

- - -

The arbitration testimony of CREIGHTON G. HEYL, D.O., a Defendant herein, called for examination by the Plaintiff under the Ohio Rules of Civil Procedure, taken before me, Diane M. Stevenson, a Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel, at the offices of Bentoff & Duber, 230 Leader Building, Cleveland, Ohio, commencing at 10:20 a.m., the day and date above set forth.

- - -

APPEARANCES:

On behalf of the Plaintiff:

Mitchell Weisman, Esq.
Weisman, Goldberg,
Weisman & Kaufman Co., LPA
540 Leader Building
Cleveland, Ohio 44114

On behalf of the Defendants:

John Irwin, M.D., Esq.
Reminger & Reminger Co., LPA
The 113 Building
Cleveland, Ohio 44114

ARBITRATION PANEL:

Robert Soltis, Esq.- Chairman
Jerome Bentoff, Esq.
Theodore Ward, Esq.

- - -

MR. IRWIN: Gentlemen, my first witness will be Dr. Heyl. In your defense arbitration brief you will see Dr. Heyl's curriculum vitae as well as Dr. Heyl's office records.

- - -

CREIGHTON G. HEYL, D.O.

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

DIRECT EXAMINATION

BY MR. IRWIN:

Q. Dr. Heyl, very briefly, if you would tell the members of the Panel about your educational background, and keep your voice up nice and loud.

A. I sure will. My undergraduate program was at the University of Michigan. I graduated in June of 1971 with a Bachelor of Arts degree.

Then I went to Michigan State University for my medicine degree, the College of Osteopathic Medicine, and graduated in August of 1974.

In the osteopathic profession, we are

required to undergo a year of rotating internship which is through all the fields of medicine, and I did that down at Detroit Osteopathic Hospital, which is an inner city hospital. Then we also had a rotation by county, which is a suburban hospital, and I finished that in September of 1975.

Following this, I went into general surgery to find out which field that I wanted to get into and did this at Art Center Hospital, which is downtown Detroit, graduating there in July of 1976.

I decided I wanted to go into orthopedic surgery and went to St. Louis, Missouri for this and finished there in December of '79.

I went into private practice immediately after my residency and went to Traverse City, Michigan and was up there until 1980.

My wife had the calling to go into law school, and there are no law schools up in Traverse City, Michigan, so I put out feelers for different areas to move to and we ended up coming to Cleveland, Ohio.

I have been at Richmond Heights Hospital since November of 1980 to the present. I'm on

staff at Richmond Heights General Hospital and also the Lake Hospital System.

I have licenses in Ohio, Michigan and Missouri. I'm Board certified. I passed my test in March of 1984.

Board certification is additional testing that you take after you complete your residency. It consists of three parts. The first is a written part, and then after that you take an oral, that is about a year later, and then a year after that you are allowed to take the practical, which is where they come and observe you do surgery and go through all of your chart records and x-rays and everything.

They determine that if you have passed all three of those parts that you are Board certified, and this is by the Board of Orthopedic Surgery and the American Osteopathic Academy.

I belong to several organizations, the American Osteopathic, the Cleveland Academy, Ohio Osteopathic, American Osteopathic Academy of Orthopedic Surgery, sports medicine section, and the American Academy of Orthopedics.

Q. Are you on any committees at your hospitals,

Doctor?

A. Yes. I'm on the Forms Committee, which determines the forms that we have for different consents and for charts, and also I'm on the Tumor Board Committee, which meets monthly, as does the Forms, and also the Executive Committee, which is an elected position.

Let's see. Also, I'm a Program Director for orthopedics training at Richmond Heights Hospital. I'm a clinical instructor.

Q. Doctor, as a percentage, how much of your time in the practice of medicine is engaged in the clinical practice of medicine?

A. 100 percent.

Q. Doctor, let's turn now to your care and treatment of the Plaintiff, and tell us when you first saw Ms. Skebe.

A. I saw her first in 1982 at the request of Dr. Emil Pogorelec, who was her family physician.

Q. What was the problem?

A. As everyone has talked about, Dorothy was having complaints regarding both of her hands and wrist and experiencing discomfort with numbness into the fingers and weakness in the hands.

She was being awakened from sound sleep due to the pain and the numbness in the fingers, and the pain would radiate up the arm and down into the fingers, which is classic for the diagnosis of carpal tunnel syndrome.

Q. What did your examination reveal? First of all, let's make sure we know when this was. What was the date of that?

A. Dr. Pogorelec, this is the consult that I carried out on 3/25/82.

Q. Yes. That is in the brochure.

What did your exam reveal?

A. The exam revealed the classic signs and symptoms of carpal tunnel syndrome. The two major studies, clinical findings, are the Tinel sign, which is where you tap the wrist where the medial nerve is and they get electric-type shock along the fingers along the distribution of the median nerve, and the phalanx sign is where they flex the wrist at 90 degrees and the fingers fall asleep. When that happens, that puts additional compression or pinching of the nerve in the carpal tunnel.

Also, she had decreased sensation along the median nerve distribution, which includes the

thumb, the index, the middle finger, and the radial or thumb side of the fingers. That is all controlled by the medial nerve.

The ulnar nerve controls the ring and little fingers. That was not affected in Dorothy's or other carpal tunnel cases.

Q. Did you have any laboratory studies done?

A. Yes. She had a nerve study test by Dr. Coppola to document that there was compression of the median nerve.

Q. So what was your diagnosis?

A. Bilateral, which means both wrists, carpal tunnel syndrome, which is compression of the median nerve and the carpal tunnel.

The carpal tunnel is formed by fibro-osseous canal. The bones are on the lower part of the canal, which is on the dorsal surface of the wrist, and then on this side is called the flexor retinaculum, which is fibrous tissue which runs cross-ways out the palm of the hand to about this point, and this way to the wrist and the hand. It does not extend out into the fingers.

In several cases, such as Dorothy's, the problem is where that ligament gets thickened or

what we call hypertrophied and decreases the space that the nerve has to pass in that canal or tunnel.

The treatment, when it has been going on for a prolonged period of time, which it had been in Dorothy's case, is to go ahead and release that carpal tunnel or cut that fibrous ligament that runs across the wrist.

That frees up the nerve and takes away the compression. It takes away the pain and allows them to sleep through a full night without being awakened.

There are several other medical reasons for carpal tunnel, but that was not Dorothy's case.

Q. What is the prognosis for this, Doctor?

A. The prognosis is very good. Very, very few people ever have recurrence of carpal tunnel. One you release that ligament, they don't seem to have recurrence.

They can go back to their regular work. They regain full strength in their wrist. They have full motion with some therapy because there is some initial--afterwards they have discomfort and they don't want to move the wrist, but after a proper time of a week, we take the stitches

out and start trying to get them to move.

If they don't start to move, then they can get scar tissue binding down that area and cause problems, so it is very important to have an aggressive therapy program.

So prognosis is very good for carpal tunnel.

Q. What is the prognosis without surgery?

A. It is a progressive compression of the nerve and, initially, it affects the sensory or the sensation, and then it can go on to affect the motor function of the nerve where they start to actually lose function of those fingers, and you don't want that.

Q. What do you mean by function of the fingers?

A. Well, the motor function, which is the flexion, the bending. The moving of the fingers can be affected by the median nerve, and they start to get atrophy, which is loss of muscle, in the muscles that are innervated or controlled by this nerve.

Once you get to that point, the prognosis is much poorer for full recovery because they have had longer, more severe compression of that nerve.

Q. Now, what was your recommendation to Ms. Skebe, then, in March of 1982?

A. My recommendation was for release of the carpal tunnel.

Q. Did you discuss this with her?

A. Yes.

Q. Tell us what you discussed with Ms. Skebe.

A. The standard discussion. I cannot--I have tried to recollect exactly talking to her, but dating back to '82 and '84, it is a little difficult.

My standard discussion with people that I'm taking to surgery for carpal tunnel release is, number one, to explain to them what the surgery is, why we were doing the surgery and where the scar is going to be so that they are aware of that, and what some of the potential complications are of any surgery, and especially of this surgery, and one of them is that, as after any surgery, you can get infection and you can have blood loss.

We do do the procedure under tourniquet control so that you have good visibility during the surgery of the anatomy as you are operating on it, but after you let down the tourniquet, there is some blood loss, and they may see blood

on their dressing. So I make sure they know that is nothing to be concerned about.

Any time you are dealing with the median nerve, there are several branches of the nerve that you have to be aware of, and that there is the potential for cutting these nerves.

Any textbook that talks about carpal tunnel surgery will tell you that these nerves are in this area and that that is a complication that is not uncommon. You try to avoid it.

One of the branches is called the palmar cutaneous nerve, and that's a nerve that leads from the median nerve into this area of the palm around the thenar eminence. That nerve runs off the radial or thumb side of the nerve. Also, the motor nerve runs off that side.

You try to keep the incision over more toward the little finger side to try to avoid that. Either go down the middle or a little bit to the side. Definitely, the dissection stays off to the side.

Q. Do you remember specifically talking to Ms. Skebe about this palmar cutaneous nerve and each of the branches?

A. Not specifically this nerve. I do tell the

patients there is potential for nerve damage, and if they ask what type of nerve damage, I'm willing to go in great detail as to the median nerve and what some of the potential complications can be of that nerve if there is damage done to it.

Q. Now, jumping ahead for just a minute, we know that there has been a nerve injured in her hand.

A. Correct.

Q. Is that one of the branches of the median nerve?

A. That is a branch more distal of the medial nerve, into the palm of the hand.

There are different anatomical variations of the nerve, and you try to make sure that you avoid--that you aren't coming across a patient who has a variation of the nerve. But that is a branch of the median nerve. It goes to the digit.

Q. Doctor, I just want to hand you a copy of the Richmond Heights medical record. Can you tell us what that is?

A. Yes. This is a standard consent form that as long as I have been at Richmond Heights the hospital has used.

Q. Is that your signature on the bottom of that?

A. Yes, it is.
Q. What does that indicate to you?
A. That indicates that we have discussed with the patient the potential complications of the surgery, and the patient has read the print in there and they have signed it and are aware that, number one, there are potential for complications and, number two, if something comes up at surgery that you feel has to be done and it is important for this case, that the patient has given you the permission to go ahead an do that rather than wake them up and ask them.
Q. Now, the date of that form is 1982?
A. That is the '82 one.
Q. I'm going to hand you a second consent form from the records and ask you to identify the second one for us.
A. That is from the '84 surgery.
Q. That is the same sort of thing before the second carpal tunnel operation?
A. That's correct.
Q. Is that Ms. Skebe's signature on the bottom of that form, to your recollection?
A. To my recollection.

Q. Now, Doctor, before you operated on Ms. Skebe in 1982, give us an approximation of how many carpal tunnel operations you had done in your career.

A. Well, during my residency, which was three years in St. Louis, we had a very active carpal tunnel surgery program during the residency. Of course, this is a common surgery that we do in orthopedics, and it is a very good learning procedure for residents, and that is because the head surgeon allows the residents, under his supervision, being there, to do the procedure.

So I would say I would average at least 50 a year during my residency, and that's a total of 150 during three years there. As you get into your senior program, you do more of the procedures.

Then, as I got out into practice, it would probably not average that many per year because of being solo, and we had four orthopedic surgeons that we worked with during our residency. So probably an average of about, I will say in '82, which I had been out since November of '79, that is two years, probably about close to 75 or 100 by this time, by '82

and, of course, more by '84.

Q. So this was an operation that you had done more than 150 times, I take it?

A. Oh, yes.

Q. And did you feel in your medical opinion that you were competent and experienced enough to do this kind of an operation for Dorothy Skebe?

A. Yes. I felt that I had had good results in the past and felt comfortable doing the procedure.

Q. In this particular case in 1982 and again in 1984 for Ms. Skebe, did you do the operation or did you have a resident?

A. No, I do not have a resident that I'm training. I do all my own surgeries.

Q. Now, during the operation on Dorothy Skebe in 1982, did you have any complications during the surgery? Did you encounter any problems?

A. No.

Q. Tell us what her postoperative course was like after that operation in 1982.

A. In 1982--I can refer to my chart? I first saw Dorothy 10 days after the surgery, and she had aching in both of the hands.

I had protected her with wrist splints after the surgery.

Q. Did she have pretty much a generally normal recuperation after her operation in '82?
A. I would say so.
Q. She had no problems with infection or anything like that?
A. No.
Q. According to your memory and your notes, did she have a good result from your operation in 1982?
A. Yes.
Q. So then what happened later on? You have heard her testify today that symptoms returned at some point later. Tell us what your recollection is with respect to that.
A. Prior to the '84 surgery, my chart notes jump from '82 to '84 and, like Dorothy had mentioned, she works at the hospital. Frequently, rather than make her come into the office, I would examine her or discuss her case in the hospital itself.

I'm trying to find my notes from '84. Yes, there is a consult that I again did for Dr. Pogorelec on 4/22/84, which explained how Dorothy was having persistant left wrist pain and weakness on grip, and she did well but progressed slowly after that surgery.

Q. And did she then develop, after the March, 1982 surgery, a problem with her left shoulder?
A. Right, she had been diagnosed as having a left thoracic outlet syndrome.
Q. Do you have records in your office chart that relate to that problem?
A. Just in the consult that I have here on 4/22/84 making mention of that, but I'm--
Q. Why don't you tell us about thoracic outlet syndrome.
A. Sure.
Q. Is that something which you, as an orthopedic surgeon, are familiar?
A. Oh, yes.
Q. Tell us about it.
A. I see a lot of thoracic outlet syndrome and refer that to Dr. Medina for the care of it. But because I'm in orthopedics, where patients have shoulder and arm pain, it is very, very common. I probably see it more than any other orthopedic surgeon in the city, I think, and the symptoms that they complain of is pain in the shoulder extending down the arm with weakness into the hand and the arm. They fatigue very easily with that.

Q. Why is that? Explain the reason for the weakness and the easy fatigability.

A. Well, the muscles are innervated by the neurovascular structures that are being compressed in the thoracic outlet, which is another tunnel type of an area where these vessels and nerves pass between the first rib and the pectoralis minor muscle.

Q. What muscles are those that you are talking about?

A. In the front of the shoulder. The pectorals is the first muscle, and deep in the armpit area. All the nerves come from the neck, and the vessels come from the neck through the axilla and down to the hand.

Q. What muscles in the arm and hand are affected by this condition?

A. The ulnar muscles and nerves. There can be variations where one part of the brachial plexus, which is the collection of the nerves, is affected more than the other.

There are three different trunks of this plexus, and the lower trunk is the more common portion of the brachial plexus to be affected, and that affects more of this half of the arm,

but it can affect all of it and be aggravated especially when they do work overhead or above their waist, at least. That seems to aggravate it the most.

Q. Doctor, when I close my hand and make a fist, what muscles are involved in that action?

A. Those are all the muscles.

Q. Where are those muscles located?

A. Those muscles are in the forearm, and they lead to tendons which move the fingers.

Q. When I make a fist like this or close my hand around the pen, are there muscles in the hand that are involved?

A. Not with--sometimes with spreading would be muscles called lumbricales, which affect this motion, muscles between the fingers. A little bit of that may be a part of holding onto something, but these are tendons which are affected by the muscles in the arm.

Q. Are these muscles in the arm the ones that are connected in this thoracic outlet condition?

A. That's correct.

Q. We know, jumping ahead a bit, that the nerve that is involved in the numbness that Ms. Skebe has in her fingers is located where?

A. The nerve is in the palm of the hand.
Q. Does that have anything to do with the muscles that close the hand?
A. No.
Q. Is that nerve involved in her numbness? Does that have anything to do with the motion, the motor function?
A. No, it doesn't.
Q. So what happened then with respect to Ms. Skebe's thoracic outlet problem in 1984?
A. Well, Dr. Medina did release the thoracic outlet. However, I understand from today that she is having still some persistent weakness in the arm, and that is not unusual for thoracic outlet to recur, more so than it is for carpal tunnel to recur.
Q. Doctor, you have heard Ms. Skebe testify today about her problems with numbness in her finger, and also you have heard her testify about problems that she has with weakness or easily tiring out.

Can you tell us, as a physician, what the cause, first, of that easy fatigue and that weakness is in this situation?

A. That's a motor function which I would say would

be due more to a problem with the higher up nerve and maybe vascular problem and would be, in her case, more likely due to maybe some scar tissue in the brachial plexus.

Q. Does that have anything to do, Doctor, in your opinion, with a problem with the cut nerve down in her hand?

A. No.

Q. What about the numbness, can we agree that the numbness in her web space is due to the cut that we talked about earlier?

A. Yes.

Q. But the other symptoms--

A. No, just the numbness.

Q. Now, Doctor, you performed a second carpal tunnel release in April of 1984, correct?

A. Yes.

Q. I want you to tell us about that operation.

A. When Dorothy again was having her recurrent symptoms with the dropping of items from her hand and the tingling or the paresthesias and dysesthesias into the fingers, which is associated with carpal tunnel, and they are in my opinion, I felt that she had formed scar tissue in the surgical area.

So I discussed with her the options that we had. One was of doing nothing and trying to live with her condition, and if this was not a valid option, that then the next would be to go back in and explore the surgical area and release the adhesions that had formed around the nerve area.

Q. Is that what you did, then?

A. That is what I did.

Q. During that operation, did you encounter any complications or difficulties during the operation?

A. There was a lot of scar tissue in that area, which makes it a more difficult case, and you have to be more cautious. You have to be cautious with any surgery but, in this case, more cautious.

To the best of my ability I felt that I had released the scar tissue at the surgical area where I had operated before and did not feel that I had any complications, to my knowledge.

Q. Now, as we subsequently know, it turned out that there was a nerve injury during that operation.

A. Correct. That's correct.

Q. First of all, when you were doing that

operation, did you know that? Were you aware of that nerve being injured?

A. No, I wasn't.

Q. I want you to explain to the panel why that is.

A. The surgical area--you know, I was taken completely by surprise to find out that Dorothy had had that nerve lacerated. At the time of surgery she did have scar tissue, and I dissected that scar tissue very carefully.

Now, the surgical area that I was concerned with was out into the palm area, which was where I had operated before. We do dissection carefully with scissors and try to gently ease the scar tissue off of the nerve.

The only thing I could believe, and I know that the nerve was cut, would be that the tips of the scissors extended out further than what I was aware of and lacerated the nerve.

Q. Now, Doctor, you have seen Dr. Fleegler's report, haven't you?

A. Yes.

Q. Dr. Fleegler is critical of you for not having made an incision, apparently, where the first incision was. What is your explanation for that?

A. My explanation is that I was looking for scar tissue in the area where I had operated before, and that was within the confines of the extent of that ligament. That ligament extends out to here.

I have no problem in my surgical exposure with the incision carried out into the palm this far of seeing the full extent of the flexor retinaculum, which is the ligament that was cut, and evaluating the scar tissue in that area.

I had no intention and have not even a thought of extending out and exploring the digital nerves, which are further out into the palm of the hand. That was not Dorothy's problem at the time. The problem was at the carpal tunnel, which is much more proximal or more toward the elbow.

Q. Now, Doctor, do you have an opinion, as an orthopedic surgeon, based upon reasonable medical certainty, as to whether you failed to comply with accepted standards of practice for an orthopedic surgeon in your performance of the operation on Dorothy Skebe in April of 1984?

A. No, I felt that I had good results with relieving her symptoms of the carpal tunnel.

Q. That wasn't my question,?

A. Okay.

Q. My question was: In performing that operation on Dorothy Skebe, do you have an opinion as to whether you, as an orthopedic surgeon, complied with and met accepted standards of practice for an orthopedic surgeon?

A. Yes, I felt I did.

Q. I would like you to tell us what her postoperative course was, in general, after that April, 1984 operation.

A. Well, after the operation, Dorothy progressed as far as the wrist goes similar as she had after the first surgery, with the additional complaint immediately--well, within I guess hours, according to Dorothy--of having the numbness in the fingers.

In my mind, and I can recall this, I can recall that she had not only the problem with the thoracic outlet, but also had a great deal of swelling.

My thought process at the time was that this numbness would resolve with a decrease of the swelling and the resolution of the thoracic outlet surgery, because that causes a great deal

of swelling around those nerves that go down to the hand. Thoracic outlet also causes numbness into the fingers, and that was my thinking process.

As far as the remainder of her progress, she was to go to physical therapy. Her sutures were removed at the normal time. She did not develop any infection. She did dutifully come in to see me in my office and follow-up and--

Q. Doctor, did you ever cut her off and tell her you didn't want her to come back anymore?

A. Absolutely not. I know that Dorothy stated to me that she felt that I was shutting her off. I recall one time that she said that I ignored her in the hallway.

To be honest, I never saw her in the hallway, but she was a very emotional person, and she felt that I was ignoring her.

Q. Doctor, what is your last note in your office chart about Ms. Skebe?

A. This goes to 3/20/85.

Q. What was your last recommendation to her at the end of that note?

A. The last recommendation--

Q. What were your instructions to her?

A. Let me see. She had full range of motion, carrying out her job well. Let me see which note--

Q. Just the last sentence of that last note. What were your instructions to her?

A. She is to see me in the office.

Q. And that was after she was to have an EMG?

A. By Dr. Coppola.

Q. Ms. Skebe had testified to us today that she thought she wasn't supposed to come back to you, and you would disagree with that?

A. I would. I never turn patients away.

Q. She then did have, shortly thereafter, another EMG by Dr. Coppola; did she not?

A. Yes.

Q. That was April 1st, 1985?

A. That's correct.

Q. She did not return to you thereafter?

A. No.

Q. Now, Doctor, have you had a chance to take a look through some of the Cleveland records, Dr. Fleegler's surgery, things like that?

A. Yes, I have.

Q. Before I get into that, what did you charge Dorothy for your surgery?

A. My carpal tunnel release is $600 per wrist, so the first surgery was a total of $1,200, and for the second surgery we charge $900. It was a more extensive surgery.

Q. Tell us briefly about what Dr. Fleegler did, based upon your review of his records.

A. Dr. Fleegler was aware, based on the neurologist's report, that there was a digital nerve cut, and he was looking for this nerve. He extended the incision way out past where normal carpal tunnel is.

Q. Now, when you say "extended the incision," what do you mean by that?

A. He extended or made his incision longer out toward the fingers looking for the nerve, and I guess he had in his mind that if he found the nerve cut, he was going to do a procedure where they take a nerve graft, very, very tiny nerve and try to connect the nerves together with multiple very, very tiny sutures.

Q. Is this a common type of an operation performed by Dr. Fleegler?

A. No, this is not common.

Q. Is this the type of operation that you, as a general orthopedic surgeon, would be doing?

A. No.
Q. What kind of a doctor does this kind of an operation?
A. These are hand surgeons, hand surgeons that specialize in peripheral nerve injuries.
Q. Now, in your own words, Doctor, tell us what you think is the cause of Ms. Skebe's complaints that you have heard today. What is the cause of her problems today?
A. I feel that that third common volar digital nerve was cut inadvertently during her second surgery in 1984.
Q. And her other complaints, the weakness and the fatigue?
A. I feel that that would be due to a motor problem and much higher upper proximal level of nerve and vascular location.
Q. Now, based upon your knowledge and your training and your experience with orthopedics, how would you anticipate that Ms. Skebe's problems of numbness will, if in any way, interfere with her ability to function?
A. I don't feel that it would inhibit her ability to function.
Q. Tell us why.

A. Well, it is in a location, as Dorothy has shown us, that it does not interfere with writing or knitting. It is involving a portion of the finger which is not really a sensory location or a location we feel things with.

As she mentioned, and I still feel that, we are lucky that it did not involve the thumb and index and the thumb side of her middle finger, which is, as you can see yourself, just where we do all of our work with.

Q. It has been pointed out that Dr. Wilbourn has testified in his deposition on page 16 of Dr. Wilbourn's testimony, that Dr. Wilbourn, himself, had some problems.

Mr. Weisman had read to you a section of Dr. Wilbourn's testimony commencing--excuse me--on page 27, which I want to ask you a question about.

Dr. Wilbourn testified, beginning at Line 23, "But I can tell you from my own personal experience that that is extremely annoying. I had one digital nerve cut in one finger several years ago in my dominant hand and, actually, I cut it myself when I was trying to lay tile. Never do things like that.

"It was inadvertently sutured when I let an inexperienced resident sew it up rather than bothering the hand surgeon. That is another thing I will never do.

"The end result was I had electrical shock every time I touched a patient to put down a needle. When I tried to convince a hand surgeon, he just couldn't believe that it was that annoying until I finally told him I wanted him to amputate the finger because I would rather not have the finger than to be bothered with it the way that it was."

Now, Doctor, that story that Dr. Wilbourn testified to, is that comparable to what Ms. Skebe's condition is?

A. No, it is not.

Q. Why is that?

A. Well, the resident sutured the nerve, and this created what we call a neuroma, and this is very sensitive. When you do touch that, it does send electric shocks, but this is not the same as what we are talking about with Dorothy.

Q. So I take it the numbness is different than electrical shocks?

A. Absolutely.

MR. IRWIN: That is all. Thank you very much.

- - -

CROSS-EXAMINATION

BY MR. WEISMAN:

Q. Your deposition was taken previously in this case in September of 1988. At that time you were under oath, correct, like you are now, sworn to tell the truth?

A. That's correct.

Q. On page 24, I put a question to you. Do you recall that the question was--this is page 24, line eight: "Do you feel it happened at surgery--"

In fact, let me read this line before. "But this question just goes to the cause of numbness. Do you feel it happened at surgery or do you know of any other cause?" and your answer--do you recall your answer was: "I don't know what caused the numbness." Correct?

A. Yes. Do you want a response to that?

Q. No, I just wanted to ask you if that is what you said just five months ago.

A. Yes. But you didn't follow that through.

MR. IRWIN: Do you want to let him

explain?

A. Well, as I have already told the Panel, I still am bewildered as to how that happened. When I saw what was caused, I'm still bewildered as to how that could have happened, and that is what I meant by that statement.

Q. Okay. You are bewildered, but you just testified when Dr. Irwin asked you with reasonable medical certainty, you testified that the cause, to your knowledge, was that it was lacerated during surgery.

A. Right.

Q. And you have no dispute with Dr. Fleegler's findings that--

A. That's correct. We have a terminology difference here.

Q. Let me ask you this: Is there anywhere in this deposition, as I asked you questions about the cause in September, in September of '88, did you admit anywhere that that was the cause?

A. I think at the end, yes, where I talked about the findings of Dr. Fleegler.

Q. Specifically, I'm asking you: Did you ever admit in your deposition five months ago that the cause of the loss of sensation in the two

fingers was the surgery of April 24 of '84? I asked you a number of times.

A. I know what you are saying, yes, and I'm trying to find it.

Q. What page?

A. On page 39, Dr. Fleegler, line six and seven--wait a minute.

Q. I can keep going and your attorney can look for you.

A. Okay, sure. In there I did talk about it.

Q. This surgery, you said, was a fairly common surgery, correct?

A. Yes.

Q. And that was a carpal tunnel release, and you had done several hundred in your career?

A. Yes.

Q. This particular complication, loss of sensation of these two fingers, you have never seen that problem as a result of the surgery in your experience, correct?

A. As I mentioned in my deposition, if that did happen during my residency, I was not aware because we rarely followed patients in the office.

Q. And the approximately 300 that you did, you have

never had that?

A. No, I haven't.

Q. You have not retained an expert besides yourself to testify on your behalf, correct?

A. No, I haven't.

Q. Now, if I understand your testimony, you felt the surgical site where the incision was made by yourself, that was, I guess you could say, proximal to where the nerve was injured, correct? In other words, closer to the elbow than where the nerve was actually damaged, correct?

A. Correct.

Q. And I think your word was inadvertent. In other words, this cut was made of the nerve, but you were not intending to do that, correct?

A. Right.

Q. Now, you are not a neurologist, correct?

A. No, I'm not.

Q. And the neurologist, if I understand correctly, deals with the nervous system, right?

A. Correct.

Q. Nerves, the brain, the spinal cord; is that fair?

A. That is fair.

Q. Dr. Wilbourn is a neurologist, correct?
A. Correct.
Q. I take it you would defer to Dr. Wilbourn on any discussion on nerves and the nervous system, generally. I mean, he has more expertise in that area. Is that fair?
A. Yes.
Q. When Dr. Wilbourn feels that it is an appropriate analogy, not that it is exactly the same injury, but when he compares the injury that he had on a digital nerve to Dorothy's injury, you may differ with the analogy, might not agree that it is a good one, but he certainly has the expertise to make that analogy; can we agree with that?
A. The analogy is nowhere even close. I don't understand how he can even compare the two.

MR. WEISMAN: That is all that I have.

MR. IRWIN: Just one or two.

- - -

REDIRECT EXAMINATION

BY MR. IRWIN:

Q. Dr. Wilbourn's analogy was somebody with electrical shooting pain.

A. That's correct.
Q. That is not what we have here?
A. That is with a neuroma.
Q. Do you remember telling Mr. Weisman that you thought this had to happen during the second surgery on the severing of the nerve on page 28?
A. Yes. I couldn't find it.

MR. IRWIN: That is all I have.

MR. WEISMAN: One more question.

- - -

RECROSS-EXAMINATION

BY MR. WEISMAN:

Q. Let's go to page 28 because I--just for clarification, you are referring to lines three through six?

MR. IRWIN: Correct.

Q. Your statement was that I presume it would have to happen during the second surgery, right?
A. Yes.
Q. And that is after you were asked about the findings of Dr. Fleegler, correct?
A. Correct.
Q. But just for clarification, when you were asked directly what you thought the cause of the problem was, your answer was five months ago

that you didn't know.

A. No. Again, you are misinterpreting what I said there.

MR. WEISMAN: Well, that is all I have.

THE WITNESS: That is not the interpretation.

MR. WEISMAN: No further questions.

MR. IRWIN: No, sir, I do not.

MR. BENTOFF: You were operating in this area?

THE WITNESS: That's correct.

MR. BENTOFF: The laceration occurred up here?

THE WITNESS: I'm not exactly--I don't think that I have ever--

MR. BENTOFF: You made a comment, although I'm not sure, you said you thought the tip of the scissors extended out further--

THE WITNESS: That is the only way that I can explain it.

MR. BENTOFF: --than you intended. I mean, the laceration would be somewhere in this area away from that area?

THE WITNESS: Unless she had anatomical variation that made it closer.

MR. BENTOFF: You said there was no anatomical variation. Assuming there wasn't any, that, in all likelihood, would be what occurred. Am I correct in what you had said before, that you think the tip of the scissors extended out further than it should have done?

THE WITNESS: If I have to explain, the nerve was cut.

MR. BENTOFF: And it was further away from the adhesions. It wasn't in the area of the adhesions?

THE WITNESS: That is the only way I can explain it.

- - -

FURTHER REDIRECT EXAMINATION

BY MR. IRWIN:

Q. Let me clarify one point. Doctor, the variance in the anatomy, do you know with reasonable probability that Dorothy does not have a variant of the anatomy?

A. No, I don't.

Q. What is the anatomy of that area? That's a good question.

A. Sure. The digital nerve can branch off of the medial nerve, which goes into the palm of the hand at different locations, depending upon each person, just the same as the palmar cutaneous nerve can come off a different location and the motor branch can come off a different location.

It is normal for us to have anatomical variations. The area where the scar tissue was located would be in this location where I had done the surgery.

Now, you also get bleeding. Let me add this to it: You get bleeding after surgery, and blood causes fibrous tissue, which is scar tissue, so you can actually get extension of the scar tissue further out than where you cut the ligament.

I must have seen some additional scar tissue. I wanted to be very meticulous in trying to make sure that Dorothy did not have any symptoms after she woke up. I wanted her to be painfree and have very good results with the surgery, as I do with every surgery.

I must have seen some additional scar tissue and felt that with my exposure I would be able to easily dissect that area.

MR. SOLTIS: Knowing of anatomical variations, doesn't that impose kind of a duty to look out for that, to take precautions against it?

THE WITNESS: Sure. I did not see the nerve. I did not see the nerve. I saw scar tissue, and I felt that I had meticulously dissected that scar tissue.

MR. SOLTIS: The nerve, does it merge with the scar tissue?

MR. IRWIN: Maybe you better explain to these gentlemen who are not surgeons what it looks like as far as scar tissue and nerve tissue and try to get them to understand what you are looking at.

THE WITNESS: If you look at an anatomy book, everything is colored and pretty, but when you get down to actually looking at it, the nerve is pale, it is white. It blends in with all the other tissues around it.

Sometimes you try to stay away from that. If you are looking at what you are doing, and you are just working on what you see, then you avoid injuring the nerve.

MR. BENTOFF: Have you ever used a

pulsator?

THE WITNESS: The pulsator is for irrigation, correct. Is that what you are talking about where you irrigate things?

MR. BENTOFF: Where you know where the nerves are, where you can see them jumping around?

THE WITNESS: I can see a hand surgeon, if they are doing the type of surgery that Dr. Fleegler did, but for carpal tunnel and for what I had intended, what I felt was her diagnosis and what I wanted to do, I did not feel that any kind of pulsator or nerve stimulation was important or was necessary.

MR. IRWIN: Would a nerve stimulator work for a sensory nerve like this branch?

THE WITNESS: That's a good point, too. Pulsators stimulate for muscle, for making things jump.

MR. BENTOFF: Nerves?

THE WITNESS: Making nerves jump, but not for sensory nerves. A sensory nerve does not control motor. It does not make a finger flex or move, and the patient is under

anesthetic, so they can't tell you if they are feeling that electric shock like you can with, say, a nerve conduction.

So for a sensory nerve, in this case it would not have been of any benefit.

MR. BENTOFF: Nothing else.

MR. WARD: Just a clarification. Dr. Fleegler went in, apparently, to cure this problem. He was unsuccessful in that. Could that be done again? Is there a cure?

THE WITNESS: To be honest, I think the percentage--I don't even understand why he tried to do it in the first place, because the percentage of success with that has to be very, very poor when you are dealing with such a tiny nerve.

You are connecting a real little thing, and he is putting ten sutures--you have to have a magnifying glass or something. He is putting eight sutures in each end of that, and I don't think he would try it again, no.

MR. BENTOFF: That nerve will never regenerate?

THE WITNESS: I think she is actually getting sweating in the finger.

MR. BENTOFF: But will the nerve regenerate four years later?

THE WITNESS: No, I don't think that nerve will regenerate. But whether or not she still has a chance of having some form of improvement, I think that the neurologist himself still was not absolutely positive to say that that nerve will never improve.

He did not say 100 percent undeniably that it was at its end point of improvement, and Dr. Irwin himself told me that she was having some sort of sweating on the fingers, which is a sign of some innervation to the fingers.

MR. IRWIN: That is in the Cleveland Clinic records.

MR. SOLTIS: How would that occur if the nerve didn't regenerate? It is not like capillaries that form when a blood vessel is damaged.

THE WITNESS: Apparently there is some connection between the proximal part of the nerve and the distal part of the nerve to allow this function to go on, and that was apparently a good sign.

MR. WARD: One last question.

Fleegler once again stated that, if I'm understanding this correctly in his report on page 26 of Mr. Weisman's handout, it says that there wasn't--he seems to be critical about precautions to prevent such an injury, and it was stated that usual precautions to attempt to prevent such an injury were not followed.

What precautions were followed and what is your comment on this statement?

THE WITNESS: My comment is that the precaution that I take for damaging any nerve is to have good exposure and to be able to see the surgical area and, with my technique, I'm able to see the nerve to the extent that I need to see it.

Again, I'm not going out or I have no intention in my surgery of going out into that palmar area, because I did not feel that that was where her problem was.

I felt that her problem was in the carpal tunnel. We have a tourniquet on so there is no blood in the field, and I felt that I had good visibility of the surgical area where I was working.

MR. WARD: These are the

precautions that you always do and you have done for the 300 surgeries, and they are the ones that are accepted?

THE WITNESS: Yes. I followed the same--

MR. WARD: When he says the usual precautions were not followed, what could he be referring to then?

THE WITNESS: You would have to ask him. I felt in my standard and my practice, and I have had good results, that I had stuck with the program, the protocol that my trainers had given me.

When you do something and you do it well and you have good results, you have no--I had no thought that I was going to have any bad results with the surgery, and she did turn out to have good results to the carpal tunnel.

MR. BENTOFF: "The surgical site was not exposed." He must be talking about making the incision bigger.

MR. WARD: So he is saying in here and I, of course, have not had a chance--if you can help me out here one second, is he saying that the incision was not large enough?

MR. WEISMAN: Exactly.

MR. WARD: In layman's terms, area free from scarring. It says required for safe exposure of the nerve. Adequate surgical exposure of the nerve in question from an area free of scarring approximately to an unscarred area distally, if attainable, if it can be done, is required for safe exposure of the nerve.

It is not a large enough incision to expose it, so you can see what you are doing, I think he is saying.

And your comment on that?

THE WITNESS: My comment is I felt I had adequate exposure to see what my diagnosis was, the reason for her problems, and I felt that the exposure was very adequate, and I have used that same exposure and used it again.

MR. WARD: And that is the standard of medical care?

THE WITNESS: I believe so. Again, their exposure was much more extensive because they were looking for a digital nerve problem. My exposure was to release scar tissue at the surgical area where I had been before.

MR. SOLTIS: I'm sorry, I didn't

hear it.

THE WITNESS: His exposure was extended because he was looking for the digital nerve injury, whereas when I was doing the surgery, I was looking for exposure of the area where the scar tissue was that had formed from the first surgery.

MR. BENTOFF: Had you ever done one of these where you operated on the same wrist a second time?

THE WITNESS: I never had to.

MR. BENTOFF: This is the first one you had ever done?

THE WITNESS: As far as a recurring carpal tunnel.

MR. BENTOFF: This the first time you had to go in scarring from a previous surgery?

THE WITNESS: That's correct.

MR. BENTOFF: Why was there so much scarring if, in fact, she had physiotherapy after the first surgery?

THE WITNESS: Again, some people are scar formers, and she is having scar apparently form on her right wrist now. She

probably is getting scar tissue in her thoracic outlet area, too.

Dr. Medina, who has done multiple thoracic outlet, has had a number of re-dos because of people that form scars underneath the skin. They heal the incisions very well but, for some reason, usually a collection of blood, or whatever, that causes scars to form.

MR. SOLTIS: On Dr. Fleegler's report just beyond the middle of the first paragraph, it says, "My opinion, then, in such situations adequate surgical exposure of the nerve in question from an area free of scarring proximally to an unscarred area distally, if attainable, is required for safe exposure of the nerve," it seems to indicate that you should have tried to expose the nerve beyond the area of the scarring.

Is that what he is saying?

THE WITNESS: Yes, that is what he is saying in retrospect.

MR. SOLTIS: How do you explain that?

THE WITNESS: At that time I felt that I had adequate exposure. I was seeing what

I felt was her problem and took care of the problem through my exposure.

Again, I had no idea that that nerve was lacerated or involved with it, with the surgical site, and it definitely wasn't done intentionally.

If I had seen it being done, I definitely would have taken measures to correct it at that time.

MR. BENTOFF: We are all sure it wasn't done intentionally. Rest assured.

THE WITNESS: Thank you.

- - -

(EXAMINATION CONCLUDED.)

- - -

CERTIFICATE

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

I, Diane M. Stevenson, a Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, CREIGHTON G. HEYL, D.O., 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 AUGUST, 1989.

Diane M. Stevenson

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

My Commission expires October 26, 1990.