#607

IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

CHERYL OLA,

Plaintiff,

-vs-

JUDGE McMONAGLE
CASE NO. 152815

MICHAEL MacFEE, M.D., ET AL.,

Defendants.

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Deposition of TANYA S. HEYMAN, M.D., taken as if upon cross-examination before Linda A. Astuto, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the offices of Don C. Iler, 1640 Standard Building, Cleveland, Ohio, at 9:30 a.m. on Monday, February 6, 1989, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

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Tanya Heyman, M.D.

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On behalf of the Defendants
MacDonald Associates, Inc.
and William MacFee, M.D.

TANYA S. HEYMAN, M.D., of lawful age, called by the Plaintiff for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF TANYA S. HEYMAN, M.D.

BY MR. ILER:

MR. ILER: Let the record reflect that we are taking the deposition of Dr. Tanya Heyman as on cross-examination in the above entitled case and all the lawyers involved in this piece of litigation have been advised of her deposition and given agreement and consent. We can talk to the doctor this morning.

Q. Doctor, may I please have your full name for the record, if you would?

A. Sure. Tanya, T A N Y A. S H E R E E. Heyman, H E Y M A N.

Q. And what is your home address?

A. 2520 Stratford, S T R A T F O R D, Cleveland Heights 44118.

Q. And you are married I understand?

A. Yes.

Q. Your husband's name?

A. My husband's name is Thomas Taxman.
Q. Is he a physician also?
A. Yes, he is.
Q. What kind?
A. Pediatric gastroenterologist.
Q. Where does he work out of?
MR. GOLDWASSER: Which hospitals?
A. Mount Sinai and Cleveland Metro General.
Q. You are a physician?
A. Yes.
Q. And you have been a physician for how many years now?
A. I graduated from Case Western Reserve in 1982.
Q. I didn't ask for a curriculum vitae. So I will just run through a few things to get a little bit of your background, if you will.
Your undergraduate school was done where?
A. Case Western Reserve.
Q. You finished that in what year?
A. '78.
Q. And then did you go right into medical school?
A. Yes.
Q. And that was at Case Western Reserve?
A. Yes.
Q. You started in '78 or '79?

A. '78.
Q. And then you continued -- when did you graduate?
A. 1982.
Q. And after you finished at Case did you take your one year rotating internship?
A. No. I took a year and I did research at University Hospital for six months and then we went to South Africa where I worked at Grute Schur Hospital which is in Capetown.
Q. Tell me a little bit about your research for six months. What did you involve yourself with?
A. It was in the immunology lab and we looked at stress and recurrent herpes. Well, depression and herpes.
Q. The connection?
A. Yes.
Q. After your work in taking care of patients in South Africa, what kind of work did you do there just generally?
A. OB/GYN.
Q. Then you returned to Cleveland?
A. Right.
Q. And decided -- did you take your internship then?
A. Right. I did my training as part of a combined

program, University Hospital and Cleveland Metro General in OB/GYN.

Q. Okay.

A. Four year program.

Q. That included your one year internship in that program?

A. Right. It's a four year program.

Q. When did you start your OB/GYN residency?

A. 1983.

Q. And you finished when?

A. 1987.

Q. And that completed your specialty in the field of OB/GYN?

A. Yes.

Q. Did you continue with your education after 1987?

A. Well --

Q. On a formal basis is what I mean.

A. Well, by a fellowship?

Q. Whatever.

A. Or by what?

Q. We know that you have indicated to us that you completed your OB/GYN residency in 1987.

Did you go right into the practice of medicine or did you take a fellowship or did you continue with research or what?

A. In two sentences I will tell you what I have done. I was hired by University Hospital after my chief residency as a consultant to work on a women's comprehensive health care project and I worked as an administrator in that project for one year's time.

Beginning in July of 1988 I did part-time clinical practice doing office gynecology only and then part-time administrative work.

Q. At the university?

A. Yes.

Q. Let's go back so I am just clear on a point.

After your residency you were hired by University Hospitals?

A. Yes.

Q. And that was to conduct a program or a model for women's health care?

A. Right.

Q. What did that in general terms, what did you do?

A. I did, I set up programs, designed what the center would be, developed a mission statement, developed a business plan.

Q. Was this for general women's care or specialty of their problems?

A. It was comprehensive care. So it would include

obstetrics, gynecology and some medicine.

Q. Did that for a year?

A. We did that for a year. And then by the same organization I was hired to do clinical care in one of the offices that they owned.

Q. Okay. Well, then, is it fair or accurate to state that since your residency was completed in '87, you worked for University Hospitals, one year in the setting up of a model program for women and their problems, and then, two, also doing some clinical GYN work for the hospital?

A. Right.

Q. Have you ever maintained an office of your own to this early point in your career?

A. No.

Q. Presently what are you doing?

A. As of two weeks I am not practicing. This job was discontinued. The program was not funded and so I'm looking for work.

Q. You will not have any problems.

Insofar as the funding, so I'm just clear for the record, this would be the funding for the women's model that you helped set up for women's care?

A. Right.

Q. And also the clinical GYN practice that you were doing, I guess that was together, right?
A. Let me state that the clinical setting was still available but the job as a whole, as it was described to me, was not available.
Q. Did they have a title to this project?
A. It is called Women's care.
Q. So just recently Women's Care was not able to be funded and so the program ended?
A. They have funded parts of Women's Care. My particular preventative medicine part of that was not funded.
Q. Are you sending out resumes or looking or just thinking about what you'd like to do?
A. I'm actively thinking about what I want to do.
Q. You think we have covered your formal education and your residency training and your formal medical education up to this point?
A. Yes.
Q. During the time -- you've had an opportunity, I assume, to take a look at the medical charts for Cheryl Ola?
A. Yes.
Q. If during the course of today's discussion, deposition if you find that you would like to

look at any of the records at all before you answer a question, take the time to do it. Everybody here has charts. Maybe you have too. And so that if you want to study it for a moment or whatever before you give me your answer, take all the time you want.

Some of the questions will be obvious but I need them for the record.

A. Okay.

Q. Can you tell me, either referring to the charts or your own memory, as to when Cheryl Ola first came to University Hospital and what were the reasons, what was her problem?

A. I will have to look at the chart.

Q. Sure.

A. The admission history indicates that she came first at 1/17/86 at 8:27 in the morning.

Q. That would be January or was it November?

MR. GOLDWASSER: I think it is 11.

A. I'm sorry, it is 11.

Q. Then she did come to the University on November the 17th, 1986?

A. Right.

Q. And I assume that a workup was done of her, some examination was done to find out what the

problem was.

What is your understanding was the reason for her coming to University?

A. She had a diagnosis of carcinoma in situ of the cervix and had been evaluated by Dr. MacFee and she was scheduled to have a total vaginal hysterectomy.

Q. All right. And I understand from the operative record that you assisted Dr. MacFee in that surgery?

A. That's correct.

Q. I understand that the surgery took place the following day -- pardon me, the surgery did take place on November the 17th, did it not, of '86?

MR. GOLDWASSER: Look at the operative report.

A. 11/17/86 was her date of surgery.

Q. And at the time of surgery what year were you in of your residency?

A. I was in my fourth year, which would be my last year.

Q. Final year. And your residency was to be a specialist, you are a specialist in obstetrics and gynecology?

A. Yes.

Q. Was it part of your training and requirements to fulfill your residency to assist in surgeries such as the one Dr. MacFee performed and you performed?
A. Yes.
Q. As a resident were you employed by University Hospitals at the time of Cheryl Ola's hysterectomy?
A. Yes.
Q. Paid by them?
A. Yes.
Q. You had no other outside practice except getting through your residency, being paid by University?
A. I had no other outside practice.
Q. Why is your attendance and your assistance at a vaginal hysterectomy such as Cheryl had required in your residency program, what is the purpose for your being there?

MR. GOLDWASSER: You're talking about just in the abstract generally speaking as far as her training program?

MR. ILER: Yes.

MR. GOLDWASSER: Go ahead.

A. Well, I think there are several reasons that a

senior resident has to be present. One is the technical part of the surgery, you need more than two hands to carry out a hysterectomy, a vaginal. Minimally you need four hands. That just from a technical perspective.

And why is my presence required --

Q. Experience thing for you?

A. And then additionally, you know, there is a requirement put out by the American Board of Obstetrics and Gynecology that you have assisted, observed so many surgeries throughout your training.

Q. All right. During the course of the hysterectomy that was performed on Cheryl Ola on November the 17th of '86, did you and Dr. MacFee in performing the hysterectomy work as a team?

A. Yes.

Q. Did you also work under his supervision? For an example, did he tell you to do certain things during certain portions of the procedure and then you followed his direction?

MS. REINKER: Objection.

A. Yes.

Q. You will find from time to time during your deposition there will be an objection.

Sometimes they get heated. It doesn't with these people. Just relax and do what your lawyer tells you to do. A lot of times the objections are just made to preserve that for the record.

A. Okay.

Q. I want to skip for a moment, and we will still use the charts unless you have a memory on it.

I see on the discharge summary that the principal diagnosis that Cheryl Ola came into the hospital with was carcinoma in situ of the cervix?

A. Yes.

Q. And then there is an additional diagnosis on the discharge summary which, discharge summary sheet I should say.

A. Okay.

Q. What?

A. Bilateral femoral neuropathy.

Q What is that?

A It is a problem with leg weakness bilaterally, probably secondary to some nerve involvement.

Q. When they say bilateral, you mean both legs?

A. Yes, right.

Q. So when Cheryl left the hospital the doctors

examined her, listened to what her problems were after the hysterectomy and then made a conclusion based upon their expertise, I assume, and their testing if it was done, and they said, well, she is leaving University with this bilateral femoral neuropathy?

MR. GOLDWASSER: Objection. I'm not so sure that is accurate. You can explain it, Doctor.

A. Yes. This sheet is made up by secretaries that go around the wards and they pull from the charts various diagnoses. So what may appear here may be a diagnosis like a urinary tract infection that was actually treated and resolved while the patient was in the hospital.

So what appears here doesn't necessarily mean that is what the patient goes home with.

Q. In your review of the charts of Cheryl, is it your judgment that is what she went home with?

A. That's not clear by the chart.

Q. Okay. Would you say that when she left University Hospitals after her hysterectomy she had some femoral nerve problem?

A. Yes.

Q. Okay. Just for a moment, can you tell us where

that femoral nerve comes from and where it runs its course through our bodies and eventually where it ends up?

MS. REINKER: Objection.

MR. GOLDWASSER: Only testify in your area of expertise. If you can explain it, by all means do it.

Q. It is a little anatomy.

A. Well, it innervates the muscles in your thigh and it comes from your spine and its course runs through your pelvis and down to your leg.

Q. Okay. I understand that it also has several branches. When the femoral comes out of our spinal columns, it goes down through the pelvis, runs down through our thigh, when it gets to our knee it branches off a little, I guess, into a popliteal nerve or so?

A. Right.

Q. But then it has a large branch which is called the saphenous nerve, am I correct?

A. I'd have to say that I don't know the leg anatomy.

Q. That's all right. From what you recall in your training, early training as a physician in some of your work, would you say that the femoral

nerve is the nerve that innervates or causes to be innervated some muscles of the thigh and of the leg and lower leg?

A. Yes.

Q. That's fine. Do you know who had made the conclusion in reading the hospital records for Cheryl -- strike that.

In reading the hospital records for Cheryl Ola at University Hospital do you know which physician had made the diagnosis of a femoral neuropathy?

A. The diagnosis was made by a neurologist.

Q. Do you know what his name is?

A. I saw it here. No is the answer to that question.

Q. It has a large diagram in here and so forth.

A. Do you know where that is?

Q. I will find it for you in just a moment.

MR. ILER: Why don't you mark this. I will help you. I think I have taken some sheets that might be helpful.

- - - -

(Whereupon, Plaintiffs' Exhibit No. 1A through 1F was marked for purposes of identification.)

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Q. I have taken some parts of the hospital record at University Hospital and had them marked as Plaintiff's Exhibit 1 which is the operative report. And page two continues with the operative report, the technique followed and so forth. Third sheet is a little more of the same, operative report. The fourth sheet is a consultation sheet that came out of neurology. It is dated 11/18/86.

That's the one that had a diagram of the foot and may have some information that you might want to review.

The last sheet in this little packet is patient's notes at 11/18/86. The final sheet in this packet, Exhibit 1, you know, has got, I think it is a progress note.

If you find that you need more than what I have given you in Exhibit 1, these six pages, fine. If you find it convenient, you might use that. I think -- no, six pages to it.

MR. ILER: You want to see it?

MS. REINKER: Yes. I would just like to take a look.

MR. ILER: Off the record.

- - - -

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

- - - -

Q. Doctor, now handing you what has been marked Plaintiff's Exhibit 1A through 1F, look at those records and see if they help you to determine who the neurologist was that made the conclusion of femoral neuropathy?

A. The neurology attending note is on page 1F and I can't read his signature.

MR. GOLDWASSER: It is not decipherable. I think the copies are of poor quality.

MR. ILER: Does anybody know? Susan, do you know?

MS. REINKER: No, I don't.

A. Maybe the original chart would be helpful.

MR. ILER: Gary, do you have the original?

MR. GOLDWASSER: I don't have the original. But we could find out for you, Don. I just wonder if we could find it anywhere else.

THE WITNESS: I have a feeling it

isn't anywhere else.

MR. GOLDWASSER: Okay. Very well. You read it recently.

THE WITNESS: I just read the whole chart and I didn't see it.

MR. GOLDWASSER: We have to look at the original and get the signature for you.

Q. Well, then, back to my initial question I think is who was the neurologist who made the diagnosis at University Hospital of femoral neuropathy on Cheryl Ola and I think your answer is you looked at page 1E or 1F?

A. 1F.

Q. And said it would be there, but you cannot, our copy is not good of that record and you can't tell who the physician was?

A. That's right.

Q. Do you recall ever having a discussion after the litigation was filed, after this suit was filed with that particular neurologist or neurology resident?

A. No.

Q. Aside from Mr. Goldwasser and your conferences with him concerning the litigation, have you ever made a written statement or tape recorded

statement concerning your participation in Cheryl Ola's vaginal hysterectomy?

A. No.

Q. Prior to this deposition today, have you ever had a discussion with Dr. MacFee concerning the suit? Have you ever said we both are involved in a piece of litigation here, did you ever have a discussion with him about it?

MS. REINKER: Objection.

A No.

Q. Can I ask, Doctor, when you received the suit papers, you did get those I assume?

A. Yes.

Q. You had an opportunity just to look at them, probably didn't mean a lot to you, except that there was suit brought against you.

What did you do with the papers then?

A. Put them in my file.

Q. Did somebody eventually come to you and say we are involved in a piece of litigation here that you are involved in also?

A. Yes.

Q. Did they ask you to discuss what your care and treatment was of her?

A. Well, specifically a paralegal at Reminger &

Reminger called me and set up an appointment for the deposition.

Q. And no discussions with Dr. MacFee about the suit?

A. No.

Q. And no discussions with any risk managers or anybody at University Hospital aside from the paralegal from Mr. Goldwasser's firm?

A. No.

Q. All right. Are you familiar with the term femoral neuropathy?

A. Yes.

Q. During the course of a hysterectomy, a vaginal hysterectomy such as Cheryl had, can an improper position of Cheryl's legs in the stirrups cause a femoral neuropathy?

MR. GOLDWASSER: Is it possible for such to happen, is that what you're asking?

MR. ILER: Yes.

A. Yes.

Q. How does that occur in such a situation?

A. Well, positioning on an operating table is a very important routine as part of surgery and because everybody's body is different in terms of size and weight, you have to take care with

placing any patient on a table for vaginal hysterectomy. And I would assume that is -- how would it happen?

Q. Yes.

A. Well, I'm not going to make an assumption. I don't know and I don't think it is known exactly how that happens.

Q. Well, insofar as your training was concerned before -- let me strike that.

Is this the first hysterectomy, vaginal hysterectomy you had done, the one you did with Cheryl Ola?

A. No.

Q. How many would you say that you participated in and assisted and helped on before Cheryl Ola's?

A. I can't even estimate.

Q. Five, 10, more?

A. More than probably 15.

Q. Okay. Then I would assume that you received some training on the placing of a patient, a woman, in the lithotomy position and in stirrups for a hysterectomy?

A. Yes.

Q. What do you recall of your training in that regard?

A. It is real important that you wait until the patient has been put to sleep, that you make sure that her hips are at the proper place on the table so that when you bring the legs up that she is at the end of the table so you actually can place the speculums and carry out the hysterectomy.

And then once the patient is under an anesthetic, you bring both knees up together and then it usually takes two people and one person maneuvers each thigh and you engage the foot in the stirrup and then the legs relax out to the side.

Q. And that is a technique that you have been trained to do?

A. Yes.

Q. In this case did you do that, do you remember?

A. I don't remember specifically.

Q. Generally would you do that, you and the doctor or somebody else?

A. It could be myself and the nurse in the room, myself and the medical student, myself and the attending physician.

Q. Those are the people who would be involved in putting a patient in position?

A. Right.
Q. And then of course you want to have the patient's buttocks in a position where the doctor and assistant such as yourself have easy access to the cervix?
A. Yes.
Q. Well, in the placing of the legs of the woman in that position as you have described to us, if the legs are placed in too high a position, that is placed, the thighs are placed too high and her legs are placed too high and as a result her foot is placed in the stirrup too high, can that result in some compression or pressure on the femoral nerve?
A. I don't know specifically.
Q. Okay. In your training as a physician, did you come to understand that there were dangers or some precautions rather than dangers, some precautions that should be taken in the placement of the legs?
A. Yes.
Q. And why is that so? To avoid injury?
A. Yes.
Q. During your experience as a resident and taking the required number of hysterectomies that you

had to do in order to complete your residency, have you ever had the experience of having a woman go through a vaginal hysterectomy and end up with a femoral neuropathy in addition to Mrs. Ola?

A. No.

Q. Is this the first time it occurred?

A. Yes.

Q. How many hysterectomies must you perform to complete your residency program?

A. There isn't a set number. They look at all the surgeries you have done and they want to make sure that you've had a wide experience so you can go out and practice carefully.

Q. Before coming to the deposition today, did you have an opportunity to consult with or look at any of the leading textbooks in your field of specialty to determine how femoral neuropathy occurs?

A. Not today.

Q. On prior occasion?

A. When this happened, when this patient was in the hospital we went to the library and we looked and pulled whatever literature we could find on femoral nerve neuropathies and I think there

were maybe two articles.
Q. Do you remember what they were or who wrote them?
A. No.
Q. Do you know where they are?
A. No. We would have to do a literature search to repull those.
Q. What caused you to do that?
A. Well, I work in a teaching institution and I work with, I worked with medical students and it is part of my job to, it was part of my job to make sure that what I couldn't answer, that we would go look up.
Q. And that's part of teaching --
A. Yes.
Q. -- and the knowledge you gain. What did you determine from the articles, do you remember?
A. That there was no good answer.
Q. Did the article go into, the articles, I guess there were two, did they go into the probable causes of a femoral neuropathy during the course of a woman being in the lithotomy position and going through a vaginal hysterectomy?
A. I don't remember. I'd have to pull those and read them again.

Q. Do you still have copies of those articles?
A. I don't know.
Q. If you would not mind, take a look through your materials, see if you do, turn them over to Mr. Goldwasser, your lawyer.
MR. GOLDWASSER: If we find them, I will favor you with a copy.
MR. ILER: You will favor me with a copy?
MR. GOLDWASSER: Is that all right? Send you a copy.
Q. Did you come to learn that during the course of the vaginal hysterectomy with the use of instrumentation that you have to use in order to do it, that some of the instruments can cause some pressure on the area of the femoral nerve?
A. Did you ask specifically vaginal hysterectomy?
Q. Yes.
A. Directly on the femoral nerve?
Q. Or in the area of the femoral nerve. I know you are not going to put a clamp on the femoral nerve because it is buried too deep in muscle structures or something.
But did you ever -- did you get my question?

A. If you won't mind.
Q. Sure.
MR. ILER: Read it back.
- - - -
(Thereupon, the requested portion of the record was read by the Notary.)
- - - -
A. Are you asking me in a vaginal hysterectomy can the instruments we use apply direct pressure to the femoral nerve?
Q. Direct or indirect pressure. Sure.
A. I think it depends on how the instruments are used. I think that's the bottom line.
Q. Can we conclude this, and then we will get a little more specific later on based on what you can recall, with the use of instrumentation, specifically in Cheryl Ola's case, were there instruments used that required some pressure to be applied in order to accomplish the hysterectomy, and that also applied some pressure on the femoral nerve?
MR. GOLDWASSER: Now there are two questions there. First instrument applying pressure, second question, pressure on the femoral nerve, is that what you want, those two

questions?

MR. ILER: Right.

MR. GOLDWASSER: Answer the first question first. The first question is pressure period. The second relates to femoral nerve. You may answer.

A. Okay. We use instruments called retractors during a hysterectomy. Those instruments pull the vaginal wall laterally. So in that sense there is pressure being distributed laterally. You also would retract anterior and posteriorly.

Q. Up and down?

A. Right. So those instruments are used during a vaginal hysterectomy.

Now the second question was did we use those?

Q. No. The second question is in the use of the retractors, let's stay with retractors, is there pressure applied necessarily on areas -- strike that.

Is there pressure applied in the areas of the femoral nerve by using those retractors as you have described, well, are those retractors in the area of the femoral nerve, just the area?

MR. GOLDWASSER: I'm going to allow her to answer. That is an awful general question. What is area. We are never talking about that much area talking about any surgical field.

A. The question is a yes/no answer and the answer is the degree. It depends how the retractor is placed, how high it is placed, how low it is placed, how hard someone may be pulling and the specifics of that, I can't answer.

Q. Okay. Is the potential then for pressure to be applied by a retractor during the course of a vaginal hysterectomy present?

A. Yes.

Q. Do you know as a physician that, taking a hypothetical situation, that in the event a retractor was so applied in a position with excessive pressure in the area of the femoral nerve, can that cause a neuropathy to the femoral nerve?

MR. GOLDWASSER: Objection. You may answer.

A. Yes.

Q. I am going to ask you just some basic questions about, there are two kinds of hysterectomies,

one is abdominal and one is a vaginal hysterectomy, is that correct?

A. Yes.

Q. And I think that what was decided here by Dr. MacFee, I don't think you decided on the course of treatment, is that correct?

A. That's correct.

Q. Dr. MacFee decided a vaginal hysterectomy was the one to perform, am I right?

A. Yes.

Q. Is there a medical reason for that as opposed to abdominal?

MS. REINKER: Objection.

Q. Vaginals are generally easier?

MR. GOLDWASSER: You may answer that generally speaking.

MS. REINKER: Objection to the form of the question.

A. There are certain criteria that you use to decide if you are going to need to do abdominal surgery or vaginal surgery and usually the size of the uterus, if there is cancer with -- if you need to do abdominal exploration, it would be obvious you need to do abdominal.

Vaginal is if the uterus is small, nice and

mobile, if it descends well, it is a much more benign procedure to do it vaginally.

Q. I guess you have less blood loss and less complications, I would assume, generally speaking?

A. The potential is there.

Q. In this case did you have anything to do insofar as your medical care and treatment in arriving at the diagnosis for Cheryl Ola for carcinoma in situ?

A. No.

Q. I assume whether she did or did not have carcinoma in situ is something that was beyond your treatment and care of this patient?

A. That's right.

Q. Have you treated patients before with carcinoma in situ?

A. Yes.

Q. Did -- I understand that Cheryl Ola had a colposcopy performed?

A. That's right. Not by us.

Q Different institution I think.

A Actually we would have to review outpatient records. We don't have those.

Q Well, what is carcinoma in situ, do you know?

MR. GOLDWASSER: Carcinoma in situ, just generally, you're not talking about the cervix?

MR. ILER: No.

A. When you talk about cancer of the cervix, there are several terms and we can start with the word dysplasia or abnormal cells and it is a long spectrum. And so the reason that we do Pap tests on women is to pick up abnormalities early on.

Q. She had that I think, didn't she?

A. Like I said, I wasn't part of this. So you start with like a mild dysplasia, a moderate dysplasia, severe dysplasia, carcinoma in situ and then you start to, and then you have invasive cancer and then you get into the staging of the cancer, depending on where the cancer has spread. So that is the whole spectrum.

In situ is a specific stage where you are talking about an invasion of, I don't want to get too technical --

Q. Epithelial cells, first lining?

A. Yes.

Q. Has it been your understanding based on your

training and experience that carcinoma in situ is noninvasive cancer?

A. Noninvasive. Yes, meaning that it has not gone beyond that certain depth.

Q. Yes. Have you in your experience as a physician and during the course of your expert training as a specialist, did you ever have experience in treating a lady with, a woman with carcinoma in situ and not perform a hysterectomy?

A. Oh, boy. I'd have to look over, in terms of my experience, I'd have to look back and see.

MR. GOLDWASSER: So you just don't remember.

A. I don't remember, thank you.

Q. That's fine. I am talking about academic training and what you recall to a point, because if a woman has carcinoma in situ doesn't necessarily mean you have to have a hysterectomy?

A. Right.

Q. We'll now probably go into the specific areas of the surgery, we will talk about the anesthesia that she received and then we will go into the surgical procedure itself. And we will just please refer to whatever you need to insofar as

the surgical notes are concerned and we will just follow a progression through it.

If you would, can you tell me, I think that Mrs. Ola, Cheryl received general anesthesia --

A. Yes.

Q. -- at the time of her vaginal hysterectomy on November the 17th of '87, am I correct in that?

A. I believe so. Yes.

Q. Is it generally true that before a patient comes to the operating room for such a hysterectomy, that she receive some premedication probably in her room?

A. Yes.

Q. Do you think that was done for her [illegible]o

A. I don't know.

Q. When she arrives in the surgical suite -- what does general anesthesia mean for purposes of the record, what is that?

A. The patient is given IV sedation and then an endotracheal tube is placed so that we can maintain respiratory, respirations for the patient. And she is essentially not awake for the procedure.

Q. And probably also not able to experience pain once the anesthesia has been established and the

anesthesiologist tells the physician you may proceed with your work, she probably could not feel anything, am I about correct?

A. Right.

Q. I understand from your testimony it is after she is in that position, that is not totally anesthetized, that is when her legs are placed in the stirrups in the lithotomy position?

A. Yes.

Q. For purposes of the record, when we say that Cheryl Ola was placed in the lithotomy position after she received, was anesthetized, what is the lithotomy position? I think you have explained it once. Would you help us again?

A. Sure. It is placing the woman's legs in stirrups with the legs flexed and abducted, meaning that the legs go out to the side.

Q. And the patient is flat on her back?

A. Right.

Q. And I think you mentioned earlier that Cheryl's butt would be close to the end of the table, surgical table so the doctor and you could have access to her?

A. That's correct.

Q. Then once Cheryl was anesthetized, she could not

move on her own, neither her legs or any parts of her body?

A. That's right.

Q. When Cheryl was placed in the lithotomy position, not only were her legs put up in stirrups, but also the knees were bent slightly, I believe, is that the correct position?

A. That's the usual position, yes.

Q. And do you recall whether or not Cheryl's feet were placed in stirrups themselves?

A. The usual procedure is that you put --

MR. GOLDWASSER: Wait a minute. You don't recall Cheryl but the usual procedure is, is that your answer, or do you recall Cheryl specifically?

A. I don't recall Cheryl specifically.

Q. Take Mr. Goldwasser's suggestion, what usually happens.

A. Usually the patient before she is put to sleep has stockings put on and then her legs are inserted into the stirrups.

Q. During the course of the vaginal hysterectomy on Cheryl, with Cheryl's legs then raised, knees bent and spread apart, was Dr. MacFee's position and yours between her legs?

A. Oh, yes. We were between her legs.
Q. And were there occasions when you were both between her legs during the course of the hysterectomy?
MR. GOLDWASSER: At the same time?
Q. At the same time assisting each other.
A. Yes.
Q. From the look of either the anesthesia record or the nurses' notes or the recovery notes, can you tell me how long Cheryl Ola was in the lithotomy position from beginning to the end of the surgery?
A. I will look.
Q. Take your time.
MR. GOLDWASSER: For the record, we are going to try to answer that for you. All we are doing is we are looking at the same record Mr. Iler has and trying to interpret it.
So if we turn out later to be incorrect, so be it. But we will give it our best shot.
MR. ILER: I think that is fair enough. That is all we are asking for this purpose is to do the best we can among us.
MR. GOLDWASSER: Sure, because we didn't prepare this.

MR. ILER: If it proves later not to be so, we will consider that.

A. I think the best estimate is what you've given in terms of the cautery plate on and off.

MS. REINKER: That is on the operating nurse page.

MR. GOLDWASSER: Well, they usually have it under the operating. But maybe she didn't do it this time. Right under that same tab is operating pathology, do you have it there?

A. Okay. In the nursing notes --

Q. This would be the nursing notes at University, go ahead.

A. It says that the electrocautery plate was placed at 1235 and it was off at 1315.

Q. What is that cautery plate?

A. It grounds the patient and we use it to help control bleeding.

Q. Okay. Does that, did you, do you think that jibes with the anesthesia record? Have you had a chance to look at it? If we look at the anesthesia record we find a symbol that she was in lithotomy position, do you see that?

A. Yes.

Q. Anesthesia time up in the right-hand part of the record, the anesthesia time they have got there is 1120 to 1340. Do you see that okay?
A. Yes.
Q. Right in this part.
A. Yes.
Q. And then it has underneath that, the upper right-hand portion of the anesthesia record shows operation time 1145 and it goes to 1320, okay?

So we have two ways to help us to determine how long she was in the lithotomy position, do you agree that is about as good as we can get?
A. Yes.

MR. GOLDWASSER: The record contradicts itself in another place. We don't know which is correct.

MR. ILER: Okay.

Q. Well, we have an estimate of approximately two hours for the surgery, an hour 45 minutes to two hours for the vaginal hysterectomy, does that sound about right to you?

MS. REINKER: Objection.

A. We have anesthesia time and we have surgical time. And I'm not sure what you are asking

about.

Q. Let's do this. Let's go to the anesthesia record. Hang on just for a moment.

MR. ILER: Mark this.

- - - -

(Whereupon, Plaintiff's Exhibit No. 2 was marked for purposes of identification.)

- - - -

MR. ILER: What I have done, I have just photographed the anesthesia record and marked it 2.

Q. Handing you Plaintiff's Exhibit 2, it is a copy of the anesthesia record for Cheryl made up by the anesthesiologist, am I correct?

A. Yes.

Q. Up in the right-hand corner, these two numbers that we spoke about, there is a category and it is called anesthesia time, and in that we have marked in here --

A. 1120 to 1340.

Q. Underneath that is the operative time, and what times are reflected there?

A. That is usually the time from the first incision to when you've completed.

Q. And what time is given there?

A. 1145 to 1320.
Q. And what would that mean in real time insofar as layman's time?
MR. GOLDWASSER: You mean rather than military time?
MR. ILER: Yes.
MR. GOLDWASSER: It is 1:30.
A. To 1:20.
Q. That would be about how long?
A. That is about an hour and 20 minutes.
Q. Okay. Thank you.
A. Is that right? No. A little bit more than that. 20 minutes and 15 minutes is 35 minutes. So an hour and 35 minutes.
Q. So approximately from the anesthesia record, the surgical time was an hour and 35 minutes?
A. Yes.
Q. Okay. Would you say, Doctor, that in Cheryl Ola's case, that great care must be used in placing her legs in the lithotomy position and in the stirrups in the proper position?
A. Yes.
Q. Now after that was done, we will go to the surgery. Insofar as the surgery is concerned, I'm going to the surgical record itself.

MR. GOLDWASSER: The typed surgical note?

MR. ILER: Yes. The typed surgical note.

Q. And I think it is approximately, you're looking at Plaintiff's Exhibit 1 --

MR. GOLDWASSER: We have a copy of it.

Q. I think it is a little more than two and a half pages.

MR. GOLDWASSER: That is the discharge summary, isn't that what you are looking at there? 1B and C.

Q. So now we have Cheryl asleep, have her already in stirrups. We are about to begin the surgery.

What it talks about is a total vaginal hysterectomy, that means I think removing the entire cervix?

A. Uterus.

Q. Doctor MacFee is marked as the surgeon and the assistant as yourself?

A. Yes.

Q. And general endotracheal was given. Let's go into the surgery itself.

It says operative note, and I'm talking about page 1B, and here is, it says "the patient was taken to the operating room and after an adequate level of general anesthesia was obtained, the patient was placed in dorsolithotomy position," that is the position you already told us about. "The patient was examined and a normal sized, shaped and consistency of the uterus was found."

I am skipping to the line that says "the patient was prepared and draped in the usual sterile fashion and hysterectomy was begun."

A. I see it.

Q. Usually when the hysterectomy is begun, in this case was it you and Dr. MacFee that were between her legs or was either alone procedurally speaking?

A. Dr. MacFee and I were there.

Q. It says "a heavy weighted speculum was placed in the posterior vault of the vagina and the cervix was grasped with a single tooth tenaculum."

What is a weighted speculum?

A. It is an instrument that has a blade and an angled handle with a weight at the bottom which helps retract the posterior wall of the vagina.

Q. It is an L-shaped instrument with a weight on one end and when you put the unweighted end in to hold the position, the weight sort of holds it in the position?

A. That's correct.

Q. And that was placed, according to the operative note, was placed in the posterior vault of the vagina.

Where are we speaking about on that?

A. Where are we talking?

Q. Yes.

A. A woman is lying on her back and the posterior wall would be the area between her vagina and her rectum.

Q. And the back --

A. It is the back wall.

Q. Back wall of her. And then it goes on "and the cervix was grasped with a single tooth tenaculum."

What is that?

A. It is an instrument that has, comes in two varieties, either single tooth or double tooth and it has, it is like a pincher that enables you to grasp the tissue, in this case the anterior cervix, anterior lip of the cervix and

to pull it down within view.

Q. So this grasping, I will just call it like a grasping forcep, what did you call it, pincher?

A. For lack of a better word.

Q. It is used to grasp the tip of the cervix and then pull it out so it pulls the cervix out?

A. Pull it down.

Q. That is to bring Cheryl's cervix into view so you could see the whole thing I assume?

A. Yes.

Q. At the time that, I'm going back for just a moment, Doctor, to the time when the heavy weighted speculum was placed in the posterior vault of the vagina, if the heavy weighted speculum is not placed properly, can it cause pressure on the femoral nerve?

A. No.

Q. Then we are moving to the single tooth tenaculum.

Is there a procedure that is followed on how that is done so as not to cause any injury or problems with the femoral nerve or is not the femoral nerve involved?

A. The femoral nerve is nowhere near the cervix.

Q. All right. And the heavy weighted speculum that

we talked about earlier, you indicated to us that the unweighted end of it is on the back of Cheryl's rectum, is that where it rests?

A. It rests on her vagina and the rectum and the vagina share a brain of tissue.

Q. And that is where it was resting?

A. Yes.

Q. What is below that or on the posterior side, what structures are there?

A. Below the vagina?

Q. Yes.

A. You've got muscles that help keep the vaginal orifice intact.

Q. And are those --

A. You are asking me what is between the vagina and rectum?

Q. Yes.

A. Muscle and connective tissue.

Q. Are there nerves running through that area?

A. Well, you have innervation.

Q. Where would that be, what nerves?

A. To the perineum, pudendal innervation.

Q. Does that come out of L-3 or L-4, do you know?

A. Let's see. I think it is L-3 and 4 but I don't know specifically.

Q. All right. Let's continue on with the operative report.

A. That's pretty good.

Q. Let's continue on with the operative report, Doctor.

"Epinephrine solution was used," do we have that part right, Doctor?

A. Yes.

Q. I am continuing.

A. I am still thinking about the innervation because I think what I said is not exactly right. I think pudendal is separate from L-3 and L-4.

Q. How about L-5 and S-1?

A. Well, you have different innervation from the upper birth canal, upper birth canal and the pudendum. And none of those are related to the femoral nerve and they are sensory.

Q. When it comes to sensory then, to what areas of the body do they sensitize or innervate? The thigh, leg?

A. Sensory meaning they send back nerve stimuli from the pudendum or from the lower birth canal to the spinal cord to your brain saying I have pain.

Q. It goes no further than that?
A. Right.
Q. Then we are coming down to the next section, Doctor, where it says, I am going through the epinephrine?
A. Yes.
Q. And then a little further it says, "next", do you see that part, "a knife was used to circumscribe the cervix".
A. Yes.
Q. Insofar as we have gone now, up to the position using the knife, were you assisting in this regard? Did you use or help with the weighted speculum, do you recall, is that your usual duties in such a hysterectomy?
A. Yes.
Q. And do you usually assist in the epinephrine solution being used?
A. Yes.
Q. And do you also assist in grasping the cervix with the single tooth tenaculum as we did here?
A. Yes.
Q. I am trying to place you in the story line and see just what you did do. That's why those questions are asked.

Next the knife is used, what does that mean for us lay people, what does circumscribe mean?

A. You make a circle all around the cervix.

Q. You actually cut with the knife?

A. Right. It is a very superficial, you delineate around the cervix very superficial and the purpose of it is to be able to push back the tissues so that you push the bladder out of the way and you push the rectum out of the way posteriorly.

Q. Sort of isolate the cervix then?

A. Yes.

Q. As that is performed, are you in the area of any nerves which innervate the thigh, the leg?

A. No.

Q. Then the next portion I am moving to along the operative report is that it says "next, a four by four was used to push the bladder off the cervix anteriorly and the rectum posteriorly."

What does that mean, what is a four by four?

A. It is a piece of gauze and you use it because it is thought to be a blunt, less traumatic way to dissect tissue planes.

Q. Okay. Once again, is that technique used in

Cheryl's case just to get that cervix isolated and away from the other organs?

A. Yes.

Q. Okay. And is the four by four left in there or is that removed, do you know?

A. It is removed.

Q. Next we are going down to the sentence which says "following this, the peritoneal cavity was entered posteriorly by securing the peritoneum using an Allis clamp and entering sharply," do you see that?

A. Yes.

Q. What is an Allis clamp?

A.

a clamp used to grasp tissue and it is less traumatic. It doesn't actually penetrate tissue.

Q. Do the best you can with the art work. It will help us all.

A. It is slightly serrated. And then it has another handle on the other side identical to this and the tissue comes between these two pieces. It doesn't have teeth.

Q. And how long would the instrument be size wise? Two inches, three inches?

A. Oh, no. Whatever this is.
Q. Six or seven inches?
A. Yes.
Q. Then how is it used, how is the Allis clamp used and what is grasped by it?
A. Okay. It is grasping the peritoneum.
Q. Which is what?
A. Which is a layer, a lining, a layer and what it does is it helps identify the anatomy. Once you identify it you want to mark it. So you use an Allis clamp.

And then it helps you position the tissues so that you can then do what the next step was, which was to enter through the peritoneum.

Q. Once the Allis clamp is used in the way you have described, it says "and entering sharply"?
A. That just means that you use a knife or scissors or you go through the tissue.
Q. And then the next part of it indicates "a retractor was used and placed, it was then placed posteriorly."

Now what is a retractor for our purpose?

A. Routinely what is done is once you have entered the peritoneum, you take that heavy weighted speculum and you place it through the small

little incision you just made. And now the rectum is out of the way. It is below and underneath this retractor.

Q. And then a retractor was placed posteriorly.

What is a retractor?

A. Retractor is an instrument used to hold tissue out of the way.

Q. Okay. And is it like an object that has some teeth but not blunted or sharp ends that hold things back?

A. Most retractors don't have teeth because you want to use it very atraumatically.

Q. It is an L-shaped elongated instrument used to hold something back?

A. Yes.

Q. How is it held back? Where does the pressure come from to hold back the area that the retractor is holding back?

A. Well, in this case the posterior retractor usually is a heavy weighted retractor. In other words it holds on its own with the help of gravity.

Q. Where does it rest upon?

A. It is resting on the rectum.

Q. And are there any nerves in that area, do you

know?

A. Well, yes, you have nerves in your rectum.

Q. And are any of those coming off of L-3, 4 or 5, do you know?

A. I don't know.

Q. And is then this particular retractor, is that left there until the completion of the surgery?

A. Yes.

Q. Okay.

A. Yes.

Q. When you say it is weighted, do you have any idea what the weight is of the retractor? For an example, quarter pound, half pound?

A. I have to guess.

Q. Are there different retractors for different weights?

MR. GOLDWASSER: Are there different weights for different retractors.

MR. ILER: That is a better question.

A. Yes. And different angles. There are different retractors, sure.

Q. Okay. And if this retractor that we are talking about at this particular point in this surgery was inappropriately applied, just assume that,

inappropriately applied of the incorrect weight and heavy, could it cause pressure on part of the femoral nerve or its distributions?

A. No.

Q. The next item, "Allis clamp and entering sharply." We talked about that. Then you have a retractor that was placed posteriorly and the report goes on.

The next thing I will talk to you about the report says "next, the uterosacrals were identified bilaterally and a Heaney clamp was used."

What are uterosacrals?

A. They are ligaments that help support the uterus.

Q. And are they in the front of the uterus or in the back?

A. In the back.

Q. And what was the purpose in the procedure of using an Allis clamp, pardon me, the Heaney clamp, what is it and how is it used?

A. Heaney clamp is another clamp that we use in surgery that helps to, once you have identified the tissue you want, it will clamp it so you can incise it and suture it without bleeding or involving tissues that you should not have.

Q. Do you know if you were the person or the physician who used the Heaney clamp on Mrs. Ola at this time? Would that be part of your general duties?
A. Do I know if I did this stuff or not?
Q. Yes.
A. No.
Q. Is it something that usually you would do as an assistant in the vaginal hysterectomy?
A. Sure I could.
Q. All right. Now then is the Heaney clamp, did it remain in that position during the entire course of the hysterectomy?
A. No.
Q. Okay. And it was used, I understand, to move these uterosacral ligaments which support the uterus and move those aside, is that correct?
A. The next sentence helps describe kind of specifically what we do.
Q. Sure.
A. Isolate the tissue, you clamp it and a pedicle is then made, we call it a pedicle.
Q. What is that?
A. I wish I knew more Latin or Greek. But it is a little stump, a stump of tissue.

Q. Where is it made from?
A. From what used to be like a band of tissue, you clamp it and then you cut above it and then what's left is the pedicle. Sometimes there will be vessels in there. In this case it was a ligament. So it is the remnant of that ligament that once attached the uterus to the wall.
Q. Was it one of the uterosacrals?
A. Yes.
Q. And then you stated you clamped it and it was sutured?
A. Right.
Q. Let me stop for just a moment and then we will come back to the point that we left off.

What did you understand that -- strike that.

What did you come to understand was Cheryl's complaints after the hysterectomy?
A. I believe she stated that she had some weakness in her leg.
Q. There was a point, am I correct, where she complained after the hysterectomy and before she left University Hospitals that she was having weakness in both legs bilaterally, left and right, am I correct?

A. Yes.
Q. I understand that the left eventually improved, am I correct in that?
A. I have not had follow-up. So I don't know if and to what degree. But you mean in the hospital? Yes.
Q. And then I understand she had some loss of feeling, paresthesia, and it went down from her right thigh and went down to her calf, did you understand that to be so?
A. Her complaint as it was stated in the notes when I looked at it was that she had numbness and weakness and I didn't read specifically the radiation. I would have to review the neurology note.
Q. Why don't you take a look at it. I have it in here.
A. What was your question?
Q. What were her complaints while she was at University Hospital and after the hysterectomy was performed?
A. Okay. The complaints stated to the neurologist, or as he documented, was that "she had difficulty with right hip flexion with straight leg," and I can't read the rest of that

A. Yes.
Q. What does he say here? I will read it and see if it makes sense to you, see if it coincides with you.
MR. GOLDWASSER: You are not reading from the chart? You have some notes there, Don?
MR. ILER: That's right.
MR. GOLDWASSER: That's fine. Obviously we are just guessing along with you. We will do the best we can.
MR. ILER: Okay.
MR. GOLDWASSER: It is very tough to read. That is where we need your magnifying glass, Don.
MR. ILER: I can get it for you.
Q. "Impression", here is what I have, "patient with post-op weakness of iliopsoas, quad and adduction of right leg and sensory loss over the distribution of saphenous N." Okay?
A. Yes.
Q. In parentheses, "(L3-4)", close parens. "Probably secondary to injury at nerve level of inguinal ligament. However, involvement of iliopsoas suggests a higher involvement through

sentence, "and patient noted going to bathroom that her right leg gave out in area of knee. Denies changes in sensation," and I'm not sure what the next word is. "Questionable numbness over knee."

Q. And that would be in which leg? The right leg?

A. He didn't document it.

Q. Okay. And did you notice from the neurologist's report that he gave her a pinprick test? It is down near the bottom where the drawing of the foot is.

A. Yes.

Q. Are you familiar with that test?

A. Yes.

Q. What is it supposed to test for?

A. It helps determine sensation and to localize if there is a decrease in sensation.

Q. What did the neurologist find with the pinprick test?

A. He has "medial aspect of right leg in saphenous nerve distribution, that there is a slight decrease" in something, I can't read, "distribution".

Q. Okay. And when the neurologist finished his examination, he made an impression, did he not?

higher mass. Could be secondary to mass or vascular event, both of which are unlikely in this woman." Then he writes, "diagnosis", I have --

MR. GOLDWASSER: I think I lost you. "Suggests a higher involvement of iliopsoas. Suggests a higher involvement"?

MR. ILER: Yes.

MR. GOLDWASSER: Go ahead. What do you have there after that?

Q. "Through higher mass," M A S S, "could be secondary."

A. "Higher involvement would be secondary."

Q. Okay. "Through higher mass could be secondary."

MR. GOLDWASSER: No. That is not what we see here.

MR. ILER: Then correct it.

A. "Higher involvement could be secondary to a mass compressing on --"

MS. REINKER: Or.

A. "Or vascular event which --"

MR. GOLDWASSER: It is "are both --"

A. "Can both, are both unlikely in this woman."

Q. Then the --
A. Can we go on with that next sentence?
Q. Sure.
A. Something "patient, person," something "has report she has improved in the last 24 hours." And then I see "bilateral femoral neuropathy secondary to" blank, not blank but I can't read that.
Q. Okay.
A. Sorry.
Q. If there is anything else you want to comment, just say it.

MR. GOLDWASSER: We are not going to comment unless there is a question. We are trying to go over this with you.

Q. Now, the notes also, on the patient's notes of this lady there is a progress note of 11/18. I think I have that in that little package for you.

So the progress notes, the next day after her hysterectomy she has got some kind of hip problem, am I right?
A. Not -- oh, here. It states in the notes that "right hip flexion difficulty with straight leg."

Q. Okay. That means raising her leg up?

MR. GOLDWASSER: Straight leg raises.

Q. Okay. That's fine. Now insofar, would you also take a look at the sheet which I have attached to your little Exhibit A there, it says the neurology attending notes, do you see that, on November the 19th?

A. Yes.

Q. So once again the neurologist, specialist, he is looking at her and he finds that she's -- can you describe what he finds there?

A. This is again, I am going to need some help to read it.

MR. GOLDWASSER: Do you want us to read this, Don?

MR. ILER: Yes. Because my questions will be predicated on that.

MR. GOLDWASSER: We are certainly not going to assure you we will read it correctly. But the Doctor will do it if you want.

Q. Here is what I come up with, may I just address your attention, look at the note of 11/19/86, it is made at 11:00 a.m. and it is under the

neurologist attending note.

MR. GOLDWASSER: We have 10:00.

Q. Down at the bottom it says "this could be related to surgical procedure. At present she is improving," do you see that?

A. Yes.

Q. Now is the surgical procedure that this neurologist is referring to the vaginal hysterectomy that you and Dr. MacFee performed?

MR. GOLDWASSER: Technically speaking we don't know what the neurologist is referring to. But I think we would acknowledge it as probable.

Q. Does it seem likely or not that her surgery of, femoral neuropathy occurred sometime during the vaginal hysterectomy?

MS. REINKER: No. Objection.

MR. GOLDWASSER: Let's restate the question. You are talking about what the neurologist is interpreting. Now you are asking the Doctor for her independent opinion?

MR. ILER: Yes. Read it back.

- - - -

(Thereupon, t e requested portion of the record wa read by the Notary.)

- - - -

MS. REINKER: Objection.

MR. GOLDWASSER: If you have an opinion, you can answer that.

A. If we look at the fact that prior to her procedure she had no complaints and then post-op she had a complaint of leg weakness and lack of strength, it needs to be evaluated in terms of did it happen, did something happen during surgery to cause that.

Q. And do you agree that something did happen during surgery to cause that?

MS. REINKER: Objection.

A. I can't be certain of that.

Q. Why not?

A. I could think of -- there are other things that happen to the patient between like her room and the operating table or the operating table to her bed in terms of transferring the patient.

So I can't be certain that it was actually during the procedure that something, that an injury occurred.

Q. Let us eliminate hypothetically anything happening to her from the time she left her surgical, her room, you know, until the

surgery. Let's just hypothetically eliminate that.

Then would you agree her femoral neuropathy occurred during the vaginal hysterectomy?

MS. REINKER: Objection.

MR. GOLDWASSER: Is that before or after?

MR. ILER: Before the surgery.

MR. GOLDWASSER: The Doctor is talking about after the surgery.

A. So if between the hours that we stated that the surgical procedure took place, if during those hours, and if we eliminate all other time?

Q. Yes.

A. Did then something happen during that time?

Q. Yes. Which would be the time of the hysterectomy.

A. It could, sure, yes.

Q. Would the answer be yes?

MS. REINKER: Objection. She answered it, Don. Her answer is it could.

MR. GOLDWASSER: I will stipulate if you remove everything else hypothetically, I am going to state, on behalf of my client, it probably happened at the time you are alluding

to.

But we don't know if everything else can be eliminated. I will agree to that on the record on behalf of my client.

Q. Let's take some of the considerations that you have that may have caused her a problem before the surgery of November the 17th, 1986, which may have caused the femoral neuropathy, what things are you thinking about?

A. I mostly would be concerned, you know, what happened between the time that she was, most recently had a physical examination, complete exam. The time from her pre-op evaluation to the time she was put to sleep on the table.

Q. And what times would that be? When did the pre-op evaluation take place? You can refer to the record.

A. I don't think it was timed.

Q. Can you just give me a date of when the pre-op was, evaluation was done on this lady?

A. Actually there is a date and a time. This is under the patient history 11/16/86 at 4:30 p.m.

Q. And who conducted it?

A. It is signed Paul Kunart and co-signed by Dr. MacFee.

Q. Is there anything in those notes of the examination preoperatively of Cheryl Ola which indicates to you that she had a femoral neuropathy?

A. Nothing.

Q. So we can eliminate from your judgment in this case anything in the preoperative history that was taken by the physician and his notes countersigned by Dr. MacFee which would lead us to even assume or believe that there was any kind of an injury, can we eliminate that?

A. Yes. Prior to at this time and this date, there is nothing.

Q. Okay. Then are you satisfied yourself, Doctor, that from the pre-op examination to the time the lady, Cheryl got into her room at the hospital, there was no indication she had a femoral neuropathy?

A. Well, there is a big time gap because this is 4:30 in the afternoon the day before surgery and the patient goes home and then comes in the morning of surgery. So I can't account for that time.

Q. Is there anything -- and that would be from the 16th until the following day when she came in,

right?
A. Right.
Q. Is there anything that has ever come to your attention as a physician that anything occurred to Cheryl Ola from the time she left the hospital after her preoperative physical examination until the time she came in that indicated she had a femoral neuropathy?
A. I didn't specifically question for that. She didn't volunteer any information.
Q. Then can we assume insofar as your observations of her and your observations of the medical record, there is no such event from the time she left University Hospital after pre-op exam until the time of surgery which would cause you to believe as a doctor that she had any femoral neuropathy?
MS. REINKER: Objection.
A. It would be an assumption.
Q. What would be the assumption?
A. The assumption would be as you stated that nothing happened between that time.
Q. How about evidence, do you have any of that?
A. Again, I didn't look for evidence.
Q. Okay. Did you see her before the hysterectomy?

A. I don't remember. I usually met the patient prior to her going to sleep or her having anesthesia.
Q. Okay. Did she ever report to you that there was any accident or injury she sustained in the previous day?
A. Not that I remember.
Q. And was there any indication physically from her that any such thing occurred?
A. There is nothing documented and I don't remember.
Q. Now we bring her to the surgical table. And can I say this, Doctor, as Cheryl Ola is entering the surgical suite and being anesthetized, given anesthesia, that you have no evidence or facts whatsoever to support an idea that she suffered any injury prior to the time she came to the surgical room that she had an accident or any other problem that caused a femoral neuropathy?
A. The beginning of that question was prior to her anesthesia, we had no indication of a femoral neuropathy.
Q. Is this true, that a neurologist is a specialist in the field of nerves and the conduction of nerves, people's illnesses?

A. Yes.
Q. His speciality is a little different than yours of OB/GYN I presume?
A. Yes.
Q. Do you know why Cheryl was asked to have a consultation with a neurologist at University Hospital the day after her surgery?
A. I believe she complained of the first time she got out of bed that she felt weak and the weakness and -- did she complain of numbness? The first note in the chart that indicates that is 11/18/86 where the house officer, Mary Fiske, F I S K E, she wrote in her note addendum, "patient fell this morning."

We went over this note before. "Right leg flexion, difficulty with straight leg. Raise, must abduct leg to raise leg. Rule out femoral nerve palsy, neurology called."

Q. Then a neurologist looked at her to determine what the cause of that was?
A. Right. And that's the note that is part of this collection.
Q. Which would be Exhibit 1D. Then shall we leave it to the neurologist, this specialist, to tell us what probably caused this lady's femoral

neuropathy because he is a specialist in the field?

A. Shall we leave it to him to tell us?

MR. GOLDWASSER: I am not, as your counsel, necessarily leaving it up to him to tell us.

MR. ILER: I just want her opinion.

MR. GOLDWASSER: You want her opinion as to who is in a position to evaluate?

A. He is, as a neurologist, much more familiar with diagnosing a nerve problem and it is for that reason that when she made her complaint that he was consulted and, therefore, you know, we ourselves valued his opinion to help us figure out why she was having weakness and numbness.

Q. Do you believe his opinion is correct, that it probably occurred or possibly occurred -- strike that -- that possibly her femoral neuropathy occurred during the procedure which was a vaginal hysterectomy?

A. Yes.

Q. Can we go back to the surgical record again, please.

MR. ILER: Off the record.

laterally. They are not in the cardinal ligament.

Q. In order to get to the cardinal ligament, must you pass areas innervated with nerves L-3, 4 and 5?

A. It is not like you have to get to them. They are directly lateral to the cervix. So they are right in front of you.

Q. And are any of the branches of L-3, 4 and 5 nerves in that particular area?

A. In the cardinal ligament, no. Not that I know of.

Q. And then this ligament was just grasped using the Heaney clamp, you told us about that?

A. Yes.

Q. And can enough pressure be put on the cardinal ligament as to cause some pressure on any of the nerves that innervate the thigh or her ankle?

A. No.

Q. And then you sutured the cardinal ligament, is that what happened next?

A. Yes.

Q. The next point in your procedure was "care was taken to clamp the peritoneum to the peritoneum," is that what it says?

- - - -

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

- - - -

Q. Doctor, we are now going to return to the surgical record which is a description of what you and Dr. MacFee did. Let me start now with the sentence in the surgical record that says "next, the cardinal ligament was grasped using a Heaney clamp."

What is the cardinal ligament?

A. It is the ligament which, there are two cardinal ligaments, one on each side of the cervix, and they are lateral ligaments. And again they attach the cervix to the pelvic wall.

Q. And are there any nerves running in that area of the cardinal ligaments?

A. The nerves are out laterally. The cardinal ligaments, we are more concerned with the ureter and the vasculature that is there.

Q. Are there any nerves that run in the area of the cardinal ligament which are innervated out of L-3, 4, 5, do you know?

A. In the cardinal ligament there are nerves. In order to get to those nerves, they are out

A. Yes.
Q. Is that correct?
A. Yes.
Q. Why did you have to take care? What can happen if you are not careful there?
A. Well, you want to make sure that you keep the ureter out of the way there because that, and that you reconnect those tissues and expose the pedicle properly.
Q. So what is the danger there?
A. Well, you want to make sure you have hemostasis at all times and that you are identifying your anatomy appropriately.
Q. Okay. Otherwise what happens?
A. Well, you could have post-op complications like, you know, hidden bleeding, hematomas or problems with the urology --
Q. Okay.
A. -- system.
Q. Next you were going through your report, surgery report, it says "care was taken to clamp the peritoneum to peritoneum. Next, the uterines were clamped," what is that?
A. The uterine arteries.
Q. And where are those located?

A. Those are laterally.
Q. Okay. From the uterus?
A. Right.
Q. And are they around any nerves?
A. The nerves are way out laterally.
Q. When you say way out laterally --
A. Meaning if you look at your cervix and the uterus is right above that, you're talking the nerves are running in the side walls of the pelvis.
Q. And was any of that area clamped?
A. No.
Q. And finally this says here, "and then finally the uterus was flipped and a clamp was placed across the utero-ovarian ligament."

Where is that?

A. This is what would separate, this is so we can leave the woman's ovaries intact. So it separated the ovaries from the uterus.
Q. And where is that ligament located, the utero-ovarian ligament? It is attached ovary to what?
A. It is a ligament attaching the ovary to the uterus.
Q. And --

A. This is so we can remove the uterus and leave the ovaries.
Q. When you say the clamp was placed, where, on what, what structure?
A. On the ligament. As it reads a clamp was placed across the utero-ovarian ligament.
Q. Could pressure by that clamp have affected the femoral nerve or any one of its tributaries?
A. No.
Q. "And the tube bilaterally," I think I read that. Then indicating "a free tie was placed around the lower clamp and tied and then a Heany suture was placed. This was carried out bilaterally and the specimen was removed," that is the uterus, right?
A. Right.
Q. "All pedicles were examined for bleeding" and then the suturing was done and the hysterectomy was completed, right?
A. Yes.
Q. From the beginning of the surgery, which we talked about in the operative note where it starts with, "the patient was taken to the operating room," that typed portion --
A. Yes.

Q. -- to the completion of the report of th operation which ends with saying "and her specimen which included the uterus was taken to pathology," from those points in time, from the beginning of the surgery what clamps remained in Mrs. Ola for the entire procedure?

A. No clamps remained inside for the whole procedure.

Q. What retractors remained for the whole procedure?

A. The retractors used during the procedure are the posterior retractor, the weighted retractor which we talked about. And then we have --

Q. Is that the weighted tenaculum?

A. No. It was the weighted retractor. And then we use lateral retractors, which are flat blade retractors that are very malleable and you can bend them and place them as needed so that you can see.

Q. Okay. So what remained for the entire operative procedure would be the weighted retractor, retractors, is that right?

A. Just one.

Q. Just one.

A. And I'm sorry.

Q. That is okay. I didn't want to make a mistake. You have one weighted retractor which was left in Mrs. Ola for the entire period of time?

A. You define entire period of time from the time she entered until --

Q. No.

A. -- until the uterus was delivered.

Q. No. From the time it was first used, in other words, from the time the retractor was first used until the time it was removed, during that course of time was that course of time the entire operative procedure?

A. Yes. That is a different question. Was it in the entire procedure? Actually that retractor is placed and removed and placed, you know, because visibility is the most important thing and I can't tell you for the entire, for how long it was actually in and how long it was out.

Q. Okay. And in your judgment were there any retractors that were left in Mrs. Ola during the period of time of one hour, one hour 15 minutes?

MR. GOLDWASSER: Any present that long?

MR. ILER: Yes.

MR. GOLDWASSER: As long as an hour or hour and 15 minutes without being removed?

MR. ILER: Yes.

A. I would say it is highly unlikely that any retractors were left in for an hour and 20 minutes.

Q. And what would be the longest time that a retractor would be placed and left in her?

A. That is too variable.

Q. We don't know. It could be 10 minutes, it could be five minutes?

A. Well, yes, or it could be 35 minutes.

Q. How about any other clamps, the Allis clamp or the Heany clamps, were any of those left in for an hour?

A. No.

Q. All right. And then what kept the area of the uterus open so you could work on it? Were they retractors?

A. The area of the uterus. You are asking what kept the vagina open?

Q. Yes.

A. Retractors.

Q. And how many were used usually?

A. During the whole procedure?

Q. Yes.
A. Possibly four.
Q. Okay. And are those kept holding the vagina open during the time from the beginning of the hysterectomy until its end?
A. No. You rotate them around depending on what you need to see and what you need access to.
Q. But it is obvious that during the course of the hysterectomy some retractors have to be left in place during the entire procedure, don't they?
MS. REINKER: Objection.
A. They are constantly being moved is the problem.
Q. But they are being moved in different areas as needed?
A. During most of the procedure we are using retractors in order to see. The question you are asking is do they stay in one place for the whole hour and a half. The answer to that is that is very unlikely.
Q. But for a whole hour and a half they may be moved from one position to the other depending on what has to be visualized by the surgeon?
A. Yes.
Q. Are those retractors kept, is the vagina kept open by retractors through pressure?

A. Or gravity.
Q. Okay. In other words if they have weighted ends, then gravity would keep them open?
A. Yes.
Q. During the procedure, the total hysterectomy procedure that you and Dr. MacFee did, were you both during the course of the entire procedure in between Cheryl Ola's legs working there?
A. Yes.
Q. Where is the bilateral lumbar plexus?
A. Bilateral -- I don't know.
Q. Okay. Do you know where the lumbar plexus is?
A. No.
Q. Did you know where the lumbar plexus was at the time you were helping perform the vaginal hysterectomy?
A. I'm sure I probably did.
Q. You have forgotten it since that time?
A. Right.
Q. Doctor, on the last, would you please take a look at Plaintiff's Exhibit 1A and the second paragraph under PE?
A. Yes.
Q. In the middle of that paragraph that is PE, it says "post-operative course was remarkable."

What does remarkable mean?

A. That means that it is either, it is usually stated either unremarkable means that things went very smoothly, there were no complications of note. Remarkable means that it went well except for the following.

Q. And the following that is written out in this report, Exhibit No. 1, "for some complaints of a weakness in her right leg with difficulty straightening that leg," correct?

A. That's right.

Q. And then it goes on to say "neurology was consulted and the feeling was --" whose feeling?

A. The way that is stated is the neurologist who evaluated her, the consultation.

Q. "Feeling was that she probably had a bilateral femoral neuropathy with the right being greater than the left."

Do you mean right leg as opposed to left leg?

A. Yes.

Q. "That this could have been related to the surgical procedure," do you see that part?

A. Yes.

Q. "And was improving rapidly," okay?

A. Yes.
Q. Now if the surgery on her bilateral -- correction. Strike that.
If her surgery for her vaginal hysterectomy was done properly and in accordance with all the correct procedures, then she should normally not end up with a bilateral femoral neuropathy, correct?
MS. REINKER: Objection.
A. To any surgical procedure there are complications and risks that are inherent in the procedure. And I think this is one.
Q. And you're saying that, what leads you to believe that this was a complication of the procedure that you performed with Dr. MacFee?
A. The we -- restate.
MR. ILER: Read it back.
- - - -
(Thereupon, the requested portion of the record was read by the Notary.)
- - - -
A. I believe that was the advice of the neurologist who evaluated the patient and who felt that it could have been a complication from the surgery that I was basing my feeling on.

Q. You used the word complication?
A. Yes.
Q. What does that mean?
A. Well, prior to having surgery we always go through a risk benefit discussion with the patient and part of the risks of a procedure are complications that can occur unexpectedly and it is our duty as physicians to make sure that our patients know about those.
Q. Do you know -- the neurologist though, he never used the word complication, did he?
A. I don't remember reading that.
Q. Take a look at it and see if the neurologist ever used the word complication.
MR. GOLDWASSER: Well, the record speaks for itself.
MR. ILER: I don't think it has. But I want the doctor to be satisfied on that point.
A. No. I see his note here and I believe we read through it before.
Q. And he did not use the word, the neurologist did not use the word complication?
A. No.
Q. That was your word?

A. Yes.

Q. The neurologist is implying to us, is he not, that something was done during the course of the vaginal hysterectomy which should not have been done?

MS. REINKER: Objection.

MR. GOLDWASSER: Excuse me. You are not to answer that. She can't answer for the neurologist. All we know is what the neurologist states in his record. If you want to find out, take his deposition. She is not answering your question. If you want to pose another one, you may.

MR. ILER: You are instructing her not to answer?

MR. GOLDWASSER: Of course. She can't answer for the neurologist.

MR. ILER: Read it back.

- - - -

(Thereupon, the requested portion of the record was read by the Notary.)

- - - -

MR. GOLDWASSER: She is instructed not to answer that question.

Q. Do you as a physician in OB/GYN believe that it

is reasonable to interpret as an OB/GYN that what the neurologist has written out here is something occurred during Cheryl Ola's vaginal hysterectomy?

MR. GOLDWASSER: Objection.

MS. REINKER: Objection.

A. To answer the question the neurology attending note, and I quote from his note, "this could be related to the surgical procedure." And --

MR. GOLDWASSER: Why don't you ask her if she has any reason to disagree with that.

Q. Do you?

A. No, I don't.

Q. The neurologist gave no other cause for Cheryl's femoral neuropathy except that it could have been related to the surgical procedure, am I correct?

A. In his note he didn't document a differential diagnosis.

Q. Well, the point is it seems to be the only reason he gives, the neurologist gives in this report for the femoral neuropathy, true?

A. Let me just, again, I'm going to say he didn't give a differential. He just gave one

possibility and that is what is listed on the chart.

Q. And he gave no other possibilities?

A. No.

Q. Okay. Now you indicated to us that you generally advise the patient of some risks that are involved?

A. Yes.

Q. Do you have the consent form here for Cheryl Ola and her hysterectomy?

A. Yes.

Q. Would you take a look at it, please? Let me see if I can get mine.

A. Here. It is on page 83.

Q. These are not numbered, Doctor.

MR. ILER: Mark that.

- - - -

(Whereupon, Plaintiff's Exhibit No. 3 was marked for purposes of identification.)

- - - -

Q. Take a look at the consent form which I have marked as Plaintiff's Exhibit 3 and did you read this consent form to Cheryl Ola?

A. No.

Q. Okay. Have you read the consent form?

A. This is our standard hospital consent form.
Q. Okay. And do you think as a physician that a woman looking at this form would come to know she could end up with a femoral neuropathy by going in for a vaginal hysterectomy?

MS. REINKER: Objection.

MR. GOLDWASSER: You are instructed not to answer that question. She can't know the mind of the patient. All she can know is what is communicated to the patient.

She doesn't remember this patient. She didn't tell her as to the consent and she didn't give it.

Q. Look at this consent form, Doctor, and was it designed to advise Cheryl Ola and other women that if they go and have a vaginal hysterectomy, she could end up with a femoral neuropathy?
A. This is for the record, this authorization for medical procedure form is written with several blanks in it to be filled in by the physician obtaining the permission.

And so in answer to your question, would someone know by reading this form that there is a risk such as a femoral nerve palsy secondary to a vaginal hysterectomy, the answer is no.

Q. Doctor, insofar as the procedure which we have discussed here, the surgical procedure on Cheryl Ola, at any of the steps in the procedure which we have discussed, if improper technique was used in any one of them, from the beginning to the end of the vaginal hysterectomy, could a femoral neurological problem such as she had result?

MR. GOLDWASSER: Objection. You may answer.

MS. REINKER: Objection.

MR. GOLDWASSER: He is asking you a possibility.

A. I hear the question. Yes, if improper technique is used, sure you can get palsy.

Q. The kind that Cheryl had is what I'm interested in.

A. Yes. It is very unlikely in a vaginal hysterectomy. They are more common in other procedures. Yes, it is a possibility.

Q. How could that occur?

MS. REINKER: Objection.

A. I don't know. Specifically I think positioning on the table is the most likely cause.

Q. The other causes, that is the use of clamps,

retractors, moving the retractors as needed during the surgical procedure, can they also, if improperly done, that is use of retractors and clamps, can that also result in a femoral neurological problem?

MR. GOLDWASSER: Objection. You may answer that question.

A. They could.

Q. Okay. In the preparation -- strike that.

After it came to your attention that Cheryl had a problem with femoral neuropathy that we talked about up until the present time, have you done any research into the area that eliminates the improper, an improper position of Cheryl in the lithotomy position as being a cause of her femoral neuropathy?

MR. GOLDWASSER: Any research beyond what she already told you about that was done?

MR. ILER: Yes.

MR. GOLDWASSER: You may answer.

A. No.

Q. Have you been able to eliminate, Doctor, from your thinking the improper position of Cheryl Ola on the table in the lithotomy position as

being the cause of Cheryl's femoral neuropathy?
A. No.
Q. Have you been able to eliminate from your medical thinking, Doctor, the improper use of any clamps or retractors or other instrumentation during the course of her vaginal hysterectomy as being the cause of her femoral neuropathy?
A. I can't totally eliminate that. I can only say it is highly improbable. We used the standard, the standard equipment, the standard instruments.
Q. Okay. Highly improbable in your judgment but possible?

MR. GOLDWASSER: Anything is possible. I will object to that. You may answer as to possibility.

A. Sure.

MR. ILER: May I have just a moment. Off the record.

- - - -

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

- - - -

MR. ILER: I can go back for a

minute here.

Q. I think, Doctor, for the matter of the record, when Cheryl came to the hospital for her vaginal hysterectomy, she had no difficulty with either her right or left leg, am I correct?

MS. REINKER: Objection.

A. According to her history and physical on admission on the 16th, she didn't.

Q And do you think that in doing the vaginal hysterectomy that -- strike that.

Remember you mentioned earlier that there were some risks involved with this abdominal hysterectomy. We talked about it.

Is it your belief that sometimes you can end up with a femoral neuropathy during a vaginal hysterectomy?

A. You mean how many documented cases there are in the literature?

Q. No. Do you believe that it can happen?

A. Yes.

Q. And why?

A. I said this before, I don't think we know why and I think that positioning on the table would be the most likely, in my mind.

Q. And in the positioning on the table, how would

that affect the femoral nerve?

A. Well, positioning on the table involves several things. It involves how low the patient is on the table, her weight and her weight distribution, if she, you know, has a big pancreas, if the weight is more in her thighs and how gravity would affect her thighs abducting, how high, you know, her legs are.

Q. Would those things put --

A. Pressure on the nerve.

Q. On the femoral nerve, is that right?

A. *Some, yes.*

MR. ILER: I don't have to do this on the record, some of the copies are really poor, that one record, would you get me -- off the record.

- - - -

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

- - - -

MS. REINKER: I have a few questions.

MR. ILER: Let me make an objection here. I assume, Susan, you're going to ask some questions of the doctor concerning this case

obviously but I just want to make a note of an objection for the record that a co-defendant cannot cross-examine another defendant in the case. I will just make my note for the record on that. You can go ahead so I don't have to interrupt you.

MS. REINKER: Are you objecting to my right to ask any questions whatsoever?

MR. GOLDWASSER: Let's go to it. I have to go. He has made his objection.

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CROSS-EXAMINATION OF TANYA S. HEYMAN, M.D.

BY MS. REINKER:

Q. We met earlier and I represent Dr. MacFee in this lawsuit.

You indicated earlier that you read a couple of articles while Mrs. Ola was in the hospital concerning femoral neuropathy, correct?

A. Yes.

Q. And that those, from those articles you learned that really nobody has an explanation as to why femoral neuropathies occur, correct?

MR. ILER: Note my objection.

A. I think I stated that what I remember was that there was not a really good reason and that I

needed to review those for specifics.

Q. So your opinions that femoral neuropathies can occur from positioning, that is really speculation?

MR. ILER: Objection.

A. Yes.

Q. Your opinion that femoral neuropathies can possibly occur from instrumentation, that is another speculation?

MR. ILER: Objection.

A. Yes.

Q. You are aware or learned that a femoral neuropathy can occur when even nobody did anything wrong, correct?

MR. ILER: Note my objection. Go ahead. When nobody do anything wrong?

MS. REINKER: Correct.

A. In other words, no problem with the surgery?

Q. Correct.

A. Yes.

Q. And that just because a femoral neuropathy occurred does not mean that somebody either positioned the patient wrong or used improper instrumentation?

A. Yes.

MR. ILER: Note my objection.

Q. That's correct?

A. Yes.

Q. There can be other causes of femoral neuropathies which have nothing to do with what the surgeons or other physicians in the room did?

A. Yes.

Q. Did you happen to talk to Mrs. Ola before her surgery?

A. I don't remember that.

Q. Do you know the name of the physician who witnessed her signature on the consent form?

A. Yes. That is Steven Weight, W E I G H T.

Q. Do you happen to know where he is at the present time?

A. He is in Cleveland.

Q. Is he still doing a residency?

A. No. He is at Metro General, I believe. I think he is there at Booth Hospital.

Q. Has he completed his training?

A. Yes.

Q. The decision to do a hysterectomy for a patient with carcinoma in situ, that depends to a great extent on the patient's choice, correct?

MR. ILER: Objection to that.

A. The patient's choice? I think to answer that, it depends on the alternatives given to the patient.

Q. If the patient were given alternatives, they would play a role in deciding which approach would be used, correct?

A. Again that depends on the physician.

Q. Well, is it fair to say that the patient has some input into how her carcinoma in situ is going to be managed?

A. In all cases or -- I would want to believe that physicians give their patients the opportunity to interact and help make decisions. And in this case being carcinoma in situ, that's usually what happens.

Q. Did Mrs. Ola ever talk to you about the decision to have a hysterectomy as opposed --

A. No.

Q. Do you recall any specific conversations with Mrs. Ola at any point in time in her hospitalization?

A. No.

Q. Do you remember the patient at all?

A. No.

Q. Do you have any direct recollection of this particular surgery?

MR. GOLDWASSER: Independent recollection?

A. Independent what?

MR. GOLDWASSER: Independent of the chart, do you recollect this surgery?

A. No.

Q. Going through your chart does it refresh your memory and allow you to recall this particular case?

A. Pieces of it.

Q. Do you have any recollection of at what point in time you first met Mrs. Ola in the operating room?

A. No.

Q. Were you there when she was brought into the room?

A. I don't remember.

Q. Do you recall at what point you did enter the room?

A. No.

Q. Do you recall specifically at what point Dr. MacFee entered the room?

A. No.

Q. Do you have a recollection of whether he came in the room after you were there?
A. No.
Q. At what point in time is it customary as far as Dr. MacFee's practice goes for him to enter the room at the beginning of the case?
MR. ILER: You mean enter --
Q. Enter the actual operating room.
MR. ILER: Okay. Go ahead.
A. Standard is that the patient is called for, the residents are usually notified, the patient is brought to the room and then Dr. MacFee and I or the resident meet at the room and we would either talk, you know, about this particular patient or whatever work had to be done.
If I had not met the patient before, I tried to introduce myself before she went to sleep.
Q. This is while the patient is still awake?
A. Yes.
Q. And then would you leave the room or Dr. MacFee would leave the room to scrub?
A. Yes.
Q. And then are certain things usually accomplished before you re-enter the room?

A. Well, anesthesia continues, nursing staff continues. So yes, things are done while we are scrubbing.

Q. At what point in time would the patient be posed in the lithotomy position?

MR. ILER: In this case?

MS. REINKER: In general.

A. Usually after the patient is asleep anesthesia gives the sign you may now put the patient up.

Q. Now I noticed in the operative note that this patient had an examination after she was under general.

A. Yes.

Q. And that was done before she was put in lithotomy?

A. No.

Q. That was after she was in?

A. Yes.

Q. Was that examination done by you or Dr. MacFee, do you remember?

A. It was probably both of us.

Q. Would that have been done after you were scrubbed or before?

A. Before.

Q. Do you have any recollection in this case of

specifically who positioned this patient on the table?

A. No.

Q. At what point in time would the patient be catheterized if it is going to be done in the operating room?

A. Usually it is part of prepping the patient.

Q. At what point in time would she be catheterized?

A. After she is put in dorsi lithotomy position.

Q. Now if you would look at a document that we were looking at earlier, Mr. Iler asked you to look at the anesthesia record to determine the length of time she was in the anesthesia?

A. Yes.

Q. If you would look at the operative nurses' notes.

A. I borrowed yours last time.

Q. Okay. Now from that --

MR. ILER: Hang on just a second. I am trying to locate it. I can read over her shoulder.

Q. According to that document, what time did the patient arrive in the operating room?

A. The patient entered room at 11:40 a.m.

Q. And according to that document, what time was

the electrocautery plate applied?
A. Electrocautery time on 12:05.
Q. Now how does the application of the cautery plate relate to placing the patient in a lithotomy position?
A. It is part of prepping the patient and it is done before draping. So we are really talking about matters of like minutes.
Q. Generally is the plate applied before the patient is put in lithotomy?
A. It is usually right before and then, you know, the legs are put up. I mean it is literally put on there, the legs are put up.
Q. If the time of 12:05 is correct on that document, would that indicate to you that the patient was first put into lithotomy at roughly 12:05?
A. Yes.
Q. According to that document, when was the plate taken off?
A. 1315.
Q. Which is 1:15, correct?
A. Yes.
Q. How does the removal of the plate relate to taking the patient out of lithotomy position?

A. It is fairly well in terms of correlation.
Q. So again it is roughly at the same time?
A. Yes.
Q. So if that document is correct, when would the patient have been taken out of lithotomy position?
A. Approximately 1:15 or 1315.
Q. If that document is correct then, for what period of time was Mrs. Ola in lithotomy position?
A. It looks like an hour and 10 minutes.
Q. As between that document and the anesthesia record, do you have an opinion which is more accurate or most likely accurate?
A. I can't give an opinion, no.
Q. Knowing the time usually spent in a vaginal hysterectomy, do you have any opinion as to whether it would be closer to one hour and 10 minutes or one hour and 35 minutes?
MR. ILER: Note an objection. That is speculation.
MS. REINKER: I am just asking if she has any opinion.
A. It widely varies.
Q. This document shows the patient leaving the

operating room at what time? I think it is on the next page.

A. 1325.

Q. Which is 1:25?

A. Yes.

Q. And do we know from the recovery room record when the patient arrived in the recovery room?

A. The first note is 1325 or 1:25, received from OR.

Q. So that note would roughly jibe with the nurses' notes as far as when the patient left the room, correct?

A. Yes. She had to fly there.

Q. Doctor, when you are doing a surgery with an attending, specifically vaginal hysterectomy, are both of you seated between the patient's legs or --

A. I have done it both ways, with one person sitting, one person standing. It is hard to do with both sitting but I have done it with both sitting.

Q. In some, when you are in your fourth year of residency, are there some of the cases that you do with the attending essentially observing and then somewhere you assist the attending?

A. Restate that.
Q. You were a fourth year resident at the time of this case, correct?
A. Right.
Q. By the time you get to your fourth year of residency are there some cases where you primary operating surgeon with the attend assisting and some the other way around, attending being the primary surgeon and y the assistant?
A. Yes.
Q Do you recall in this case who was the primary operating surgeon and who was the assistant?
A. I don't recall in this case.
Q It could have been either way?
A Yes.
Q Doctor, I would like you to look -- going back just a moment. You identified certain people who might help you with positioning the patient, do you remember that earlier?
A. Yes.
Q. Anyone else you can think of who could position the patient in the operating suite into the lithotomy position?
MR. ILER: In this case or

generally?

MS. REINKER: In general.

A. No.

Q. Nurses, med students or the attending.

A. I even have had the anesthesiologist help me on occasion, especially, I was just going to say, you know, it depends a lot on the weight of the patient, et cetera.

Q. In general though are you one of the two people doing the positioning?

A. I have had in general, I would say, I would say often I am the person involved.

Q. Now I would like to direct your attention to the discharge summary.

A. Yes.

Q. You dictated the discharge summary, correct?

A. Yes.

Q. And when you dictated this discharge summary it was based on some sort of review of the chart?

A. Yes.

Q. Your last sentence, "the recommendation was for physical therapy and to follow-up with EMG if she did not have rapid improvement. However, the patient regained full strength and was discharged on post-op day four in good

condition."

A. Yes.

Q. I gather from that the plan was to do an EMG if this patient did not show significant improvement?

A. Yes.

Q. But she did in fact show significant improvement, so the EMG was not deemed necessary?

A. That is hard to interpret what I dictated.

Q. And in fact based on your statement here, by the time Mrs. Ola was discharged, she had regained full strength?

A. That's what I have dictated here.

Q. Do you recall any post-operative conversations with Mrs. Ola?

A. I'm sorry, no.

Q. Do you remember ever discussing with her the problem she was having with her leg or legs?

A. No.

MS. REINKER: Okay. I have no other questions.

MR. ILER: I have just a few.

- - - -

RECROSS-EXAMINATION OF TANYA S. HEYMAN, M.D.

BY MR. ILER:

Q. Miss Ola was sent to physical therapy, correct?

A. Yes.

Q. Could you get those notes in front of you?

A. Yes. I am just trying to remember where they were. Consultations maybe? What do they look like?

Q. Here is a request for physical therapy, it looks like that near the end of the chart. And then you have got the attendance record, hang on a minute. I have to find it for you.

MR. GOLDWASSER: It is this page and the next page.

Q. Those are the only two records we have for physical therapy, the request for physical therapy, am I right, Doctor?

MR. GOLDWASSER: The chart speaks for itself. She doesn't know other than looking through the chart. If that is what it has, it has it.

Q. I don't see any other notes from physical therapy except those two sheets.

MR. GOLDWASSER: That is all we

have.

Q. Why was she sent to physical therapy, do you know, Doctor?

A. I believe that was one of the recommendations made by neurology.

Q. Neurology did?

A. Yes.

Q. And did you happen to see -- strike that.

Did you happen to read Cheryl Ola's deposition?

A. No.

Q. Do you know what her complaints are presently?

A. No.

MR. ILER: Okay. I have no other questions of the doctor.

MR. GOLDWASSER: Okay.

MR. ILER: Ask for a waiver of signature.

MR. GOLDWASSER: Don, we are going to not waive signature. As you know, that is my practice.

Are you going to have this typed or are you going to wait before you order it? You know I would like --

MR. ILER. Well, I think -- we can

go off.

TANYA S. HEYMAN, M.D.

C E R T I F I C A T E

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

I, Linda A. Astuto, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named TANYA S. HEYMAN, M.D., was by me, before the giving of her deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this _____ day of _____, A.D. 19 __.

_____

Linda A. Astuto, Notary Public, State of Ohio
650 Engineers Building, Cleveland, Ohio 44114
My commission expires October 24, 1992

UNIVERSITY HOSPITALS OF CLEVELAND

NAME	OLA, CHERYL E.				
HOSPITAL NUMBER	1-381-887			DATE OF ADMISSION	11/17/86
SEX	Female	AGE		RACE	
SERVICE	GYN	DIVISION	HH2		
ATTENDING PHYSICIAN	Dr. MacFee				
RESULT		DAYS IN HOSPITAL	5	DATE OF DISCHARGE	11/21/86

C.C. & H.P.I.: This patient was a 32 year old Gravida 2, Para 1 0-1-1 who was admitted for total vaginal hysterectomy. Five years prior the patient was evaluated by her family physician, Dr. Lee at St. Alexis Hospital who noticed an abnormal Pap. test, Patient states that she was being followed every six months by Dr. Lee for followup Paps. ,but did not keep her appointments. During the last six months she noticed some abnormal bleeding and she reported this to her family physician. Routine Pap. test was done and cone biopsy dilatation and curettage was also done at this time. The results of which showed carcinoma in situ at the cervix. Patient was then sent to Dr. MacFee for a second opinion and the decision to perform a vaginal hysterectomy was made, Past medical history significant for a male infant delivered in 1977 and two subsequent dilatation and curettages in 1981 and 1986. Patient denies any allergies.

P.E.: Significant for normal vital signa. General physical examination was normal. Uterus was noted to be normal size, anteverted, anteflexed. Adnexae normal. Uterus was mobile with good descent, Patient was then prepared and taken to the operating room on 11/17, She had a .vaginal hysterectomy that went without complications, Estimated blood loss during the procedure was 60 ccs. Postoperative course was remarkable for some complaints of a weakness in her right leg with difficulty straightening that leg. Neurology was consulted and the feeling was that she probably had a bilateral femoral neuropathy with the right being greater than the left, that this could have been related to the surgical procedure and was improving rapidly. The recommendation was for physical therapy and to followup with EMG if she did not have rapid improvement, however the patient regained full strength and was discharged on postoperative day #4 in good condition,

Postoperative diagnosis was carcinoma in situ, cervix.

Principal Diagnosis: Carcinoma in situ, cervix.

Final Diagnosis:

Dr, T. Heyman
12/12/86
MRC#30
12/15/86
cc: Dr. MacFee
cc: Dr. T. Heyman
cc: Dr. Lee, St. Alexis Hospital

PENGAD-Bayonne, N. J.
PLAINTIFF'S EXHIBIT
1 A
HEYMAN

4# 12/18

PATIENT INSTRUCTIONS

ACTIVITY:	MEDICATIONS
DIET:	FOLLOW-UP

SIGNATURE OF RESIDENT:	SIGNATURE OF ATTENDING PHYSICIAN:	ATTENDING PRINTED NAME

5-0280-4

UNIVERSITY HOSPITALS OF CLEVELAND

NAME	OLA, CHERYL
HOSPITAL NO.	1-381-887
AGE	
DATE OF SURGERY	11/17/86
ROOM NO.	HH2
SERVICE	Gynecology

PREOPERATIVE DIAGNOSIS

Carcinoma in situ of cervix,

POSTOPERATIVE DIAGNOSIS

Same.

OPERATION

Total vaginal hysterectomy,

SURGEON

Dr. M. MacFee

ASSISTANT SURGEON

Dr. T. Heyman

ANESTHESIA

General endotracheal.

Estimated blood loss, 60 ccs. Complications, none. Specimens sent to pathology included uterus.

OPERATIVE NOTE:

The patient was taken to the Operating Room and after an adequate level of general anesthesia was obtained, the patient was placed in the dorsolithotomy position. The patient was examined and a normal sized, shaped and consistency uterus was found, the uterus was anteverted, anteflexed with good mobility, There were no adnexal masses and good descent, The patient was prepared and draped in the usual sterile fashion and hysterectomy was begun. A heavy weighted speculum was placed in the posterior vault of the vagina and the cervix was grasped with a single tooth tenaculum. Epinephrine solution was used to infiltrate around the cervix. This was done in a circumferential fashion and approximately 15 ccs. was used, Next, a knife was used to circumscribe the cervix, This was done with minimal bleeding, Next, a four by four was used to push the bladder off the cervix anteriorly and the rectum posteriorly, This was done with much care and hemostasis was maintained. Following this, the peritoneal cavity was entered posteriorly by securing the peritoneum using an Allis clamp and entering sharply, A retractor was then placed posteriorly. The same was carried out anteriorly with care, Next, the uterosacrals were identified bilaterally and a Heaney clamp was used, The pedicle was then clamped, cut and doubly suture ligated using #0 chromic. Next, the cardinal ligament was grasped using a Heaney clamp. This was then cut and once again doubly suture ligated bilaterally, Care was taken to clamp peritoneum to peritoneum on all of these pedicles, Next, the uteriaes were clamped, cut and suture ligated times two bilaterally and then finally the uterus was flipped and a clamp was placed across the utero-ovarian ligament and the tube bilaterally. A free tie was placed around the lower clamp and tied and then a Heany suture was placed. This was carried out bilaterally and the specimen was removed, All pedicles were examined closely for bleeding, After one figure-of-eight was placed, hemostasis was obtained, Next, the peritoneum was closed using a running pursestring suture of chromic. The vaginal cuff was closed by placing a

Form No. 5-0281 / 11/74

UNIVERSITY HOSPITALS OF CLEVELAND

NAME	OLA, CHERYL
HOSPITAL NO.	1-381-887
AGE	
DATE OF SURGERY	11/17/86
ROOM NO.	HH2
SERVICE	Gynecology

PREOPERATIVE DIAGNOSIS

figure-of-eight in the angles and then using interrupteds in a vertical fashion. Hemostasis was observed at all points and the hysterectomy was considered complete. No packing was necessary. The patient was awakened and taken to the Recovery Room in good condition and her specimen which included the uterus was taken to Pathology.

POSTOPERATIVE DIAGNOSIS

OPERATION Dr. T. Heyman for Dr. M. MacFee
11/17/86
MRC#30
11/18/86

SURGEON 11.20.86 D.A Heyman 5173

ASSISTANT SURGEON

ANESTHESIA

Form No 5-028 V 11/74

OPERATIVE REPORT

(12)

15

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University Hospitals of Cleveland

CONSULTATION SHEET

NAME Ola, Cheryl
HOSP NO 1381887 / 11/18/86
SERVICE
ADM PHYS
SEX & PCR

MacFee 180 1954

TO Neurology Date: 11/18/86
Consulting Physician or Service

Patient is being referred for R/o femoral nerve palsy s/p vag hyst in lithotomy position x ~ 2° (difficulty c̄ Ⓡ leg hip flexion - ?)

Referring Physician [illegible], M.D.

CONSULTANT'S NOTE

Fisher for MacFee

Asked to see pt for eval of difficulty in hip flexion after vag hysterectomy. Pt is 32 yo WF s/p vaginal hysterectomy on 11/17 for CIS of Cx. Dx on pap of abnl cells made 5 y ago. Dx of Ca in situ made on cone bx during 1st wk of Oct. Pt is otherwise s̄ medical problems. Hysterectomy performed on 11/17 under GET c̄ pt in lithotomy position x ~2°. On 11/18 noted pt had difficulty c̄ Ⓡ hip flexion c̄ straight leg raise. On 11/18 pt noted going to BR — that "Ⓡ leg gave out" in area of knee. Denies Δ's in sensation no dysthesia. ? Numbness over knee ∅ MEDS Laboratories — nl

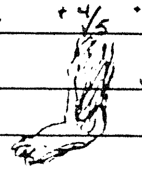
PE T37 P80 R18 BP 110/60

MSE: AO×3 s̄ deficits Speech & language nl

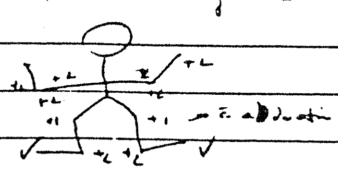
∅ Spinal tenderness, neck c̄ full ROM ∅ restriction in spinal ROM

Gait: slow c̄ nl base step Motor: Ⓛ & Ⓡ UE 5/5 bilat nl tone, bulk

	iliopsoas	hams	quads	add	abd	plantar	dorsif	inv	evert
Ⓛ	5/5	5/5	5/5	5/5	5/5	5/5	5/5	5/5	5/5
Ⓡ	+4/5	5/5	+4/5	+4/5	5/5	5/5	5/5	5/5	5/5

Sensory ↓ pinprick over  medial aspect of Ⓡ leg in saphenous nerve distribution; sl. ↓ in lesser distribution of saphenous on Ⓛ

Coor: FTN, HTS Romberg intact

DTR's 

CN's — s̄ deficits

Impression: Pt c̄ post op weakness of iliopsoas, quads & adductors of Ⓡ leg & sensory loss over distribution of saphenous N (L3-4) probably 2° to injury to nerve at level of inguinal ligament however involvement of iliopsoas suggests a higher involvement. Higher involvement could be 2° to a mass compressing or vascular event which are both unlikely in this woman. Per her report she has improved in the past 24° bilat. femoral neuropathy ?

RECOMMEND ① Physical Therapy as in & out patient to facilitate full recovery

Signature: , M.D. Date

② EMG to document recovery in 3 wks and eval for any residual nerve injury c̄ Neuro f/u

Printed Name: , M.D.

We will follow c̄ you.

5 0216 2(1/86)

ORIGINAL—TO MEDICAL RECORDS

[illegible] 19

CONSULTATION

UNIVERSITY HOSPITALS OF CLEVELAND

PATIENT'S NOTES

OLA, CHERYL E.
1381887 11 17 86 B
024 HH 002 2198
F 1 30 1954 P O
MACFEE MICHAEL
DPM 51659 MS

11/16/86 Progress Note POD #1
0700 @ "feels better, ≠ complaints, pain meds adequate
@ VS: T 36° HR 110 Resp 20 BP 120/68
I's 2400 IVcc V.O 1750cc Drain 25cc
lungs: clear
Cor: RRR
ABd +BS, soft
Ext: non tender, no cords
@ Pt stable s/p Vag hyst, improving
@ 1) clear liquids
2) ambulate
3) DC foley

Addendum Pt fell this AM
@ hip flexion difficulty ≠ straight leg raise - must adduct leg to raise leg.
A/p R/O femoral nerve palsy
Neuro called

10/19/86 Progress Note POD #2
0645 @ Pt denies H.A., N&V, SOB and reports less numbness in left leg ≠ Rt leg, unchanged, I. Kau
@ VS: T° 37 HR 88 Resp 19 BP 110/60
I's 1750 OSLR + 1000 OS½ + PO 320 = 3070 cc
O's: V.O 2250 cc, perispad 20cc
Lungs: clear
+BS: diminished BS, soft, non tender, non dist
(over)

5-1825 5(12/85)

IE 10

Cx: RRR x ∞ @ ⓑ
Neuro: Ox3, straight leg raise unchanged c difficult
flexion of rt hip. No demonstrable sensory
loss

Labs: 137 / 104 / 119 / 09 39 / 89 7.3 3.8 11 4 M 9 AL
4.0 / 26 / 4 254

(A) (P) S/p IVH requiring multi segmental infusion
1) ~~re-start~~ Dc / Heparin 5000 U SQ BID
2) Neuro consult for rt leg weakness
3) consider advancing diet
4) consider hearing if unstable for gaad

T. Stahl JMS

MDC

Neurology attending Note

11/19/96
7:00 A.M.

Case discussed c/ Dr. [illegible] who has visited pt
c/ R quadriceps (4+/-) and (R) psoas (4/5)
Also d/ recent changes in the distribution of the
symptoms since R/C. Knee reflexes are
the best preserved in the extremities arms
and ankles.

I suspect she has bilateral femoral nerve
palsy R>L the lesion is pre-bifurcation
(related to the surgical procedure). The
patient also has [illegible]

Rec: 1) Physical therapy
2) Ortho eval with f/u xrays and
if [illegible] 2-3 weeks from time
3) If she doesn't improve I would get a
lumbar CT scan.

[illegible]

11

(F)

ANESTHESIA RECORD MO DAY YR

ANESTHETIST Spagnuolo

ANESTHETIST Downs/Friello

SURGEON McFee

SURGEON E+A-1.

PROCEDURE: Vaginal Hysterectomy

POST-OP DIAGNOSIS: Ca In Situ

J. A. E. T. Spagnuolo M.D.

OLA, CHERYL E.

1381887 11 17 86 8

024 9 999 0001 RDRT

F 1 30 1954 P O

MACFEE MICHAEL

141 31659

ANESTHESIA TIME 1210 TO 1340

OPERATION TIME 1145 TO 1320

ASA: EL EM 1

POSITION ON TABLE CODES

TYPE OF ANESTHESIA: ☑ GENERAL ☐ SPINAL ☐ EPIDURAL ☐ NERVE BLOCK ☐ LOCAL STAND BY ☐ NONE

SPECIAL TECHNIQUES: ☐ HYPERCARBIA ☐ HYPOTHERMIA ☐ HYPOTENSION ☐ BYPASS ☐ OTHER

REGIONS: ☐ INTRA-ABDOMINAL ☐ INTRATHORACIC ☐ INTRACRANIAL ☐ O.B. ☐ C. SECTION ☐ OTHER

TIME: 12⁰⁰ 13⁰⁰ 14⁰⁰ 15⁰⁰

AGENTS
- OXYGEN Lpm: 2 2
- N_2O Lpm: 3 3
- Ethrane % Fisio: 1.5 1.2 – 1.6%
- Pentothal Sux. mg: 250 60
- Curare II Pav. mg: 3
- Midaz. mg: 1
- MS mg: 5
- D-Lopridol mg: .63

FLUIDS
- D5RL: 2000 2500

TEMP. S E R: 36 36 36 36

EKG ☑ PRECORD STETH ☑ ESOPH STETH ☐ TUBE SIZE 7 2 ORAL TUBE? ☐ NASAL TUBE? ☐ AIRWAY SIZE: 0 3 BLADE: 3

EKG: RST RST RSR WSR

ETCO2: 39 32 32 33

O2 mon: .4 .4 .4 .40

Foley: 180 60 / 240 290

COMMENTS: IV warmer used.

Vent = (V) 600 x 9 @ 20cm H2O = EF

Bulb

600 cc

TOTALS: EBL 150 URINE 300 2500

PREMEDICATION EFFECT: ☐ HEAVY ☒ ADEQUATE ☐ LIGHT

SYSTOLIC V DIASTOLIC Λ PULSE • RESP ○ CVP ▲ PREP P ANES A OPER ⊙ FINISH X

REMARKS: A E 600 cc

A IV: 18ga - inside @ arm

B Symptoms IV infiltration + Extravasation

C Tylenol 650 mg = ORAL route

D Ointment + TAR to eyes

E Lifeline Asym BGSc =

F Xylo 1% 5 cc 100 cc Ringers Lactate

G Local infusion by surgeon

H

I

J

K

M

N

O

P

Q

R

S

T

U) Pontocaine Lot Number

V) Dextrose Lot Number

W) Other Lot Number

X) Birth Time

Y) Placenta Time

Z) Tape Number

a) 1 Minute Apgar

b) 5 Minute Apgar

c) Sex of Child

d)

PLAINTIFF'S EXHIBIT 2 Heyman

PENGAD-Bayonne, N. J.

17

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UNIVERSITY HOSPITALS OF CLEVELAND

THORIZATION FOR MEDICAL PROCEDURE AND
WLEDGMENT OF RECEIPT OF RISK INFORMATION

OLA, CHERYL E
Hosp. No. 1381887 Date 11 17 86 B
S 024 Age HH 002 D 219B
Service 1 30 1954 P O
MACFEE MICHAEL
Doctor 51659 Rm. No. N S

ME Cheryl Ola AGE

PITAL NUMBER 1 DATE TIME AM/ PM

PLEASE READ THIS FORM CAREFULLY, ASK ABOUT ANYTHING THAT YOU DO NOT UNDERSTAND.

ing asked to sign this authorization confirming that the proposed procedure has been discussed with you, and that you have been information about its risks, benefits and alternatives to make a decision. We wish to fully inform you and will be pleased ing you wish about the procedure.

uthorize Doctor(s) MacFee

or assistants to perform the following surgical, diagnostic or medical procedure on myself

, as we have agreed upon: total vaginal hysterectomy,
(relationship)
bilateral salpingo-oophorectomy possible exploratory laparotomy anterior

uthorize the doctors to perform any other procedure that in their judgment is advisable for my well being. Details of this e been explained to me. Alternate methods of treatment, if any, have also been explained to me, as have the advantages and of each. I am advised that though beneficial results are hoped for, the possibility and nature of complications cannot be fully d that, therefore, there can be no guarantee expressed or implied as to the result of the procedure or as to cure.

r has explained to me the most likely complications or undesired results that might occur in this operation or medical I UNDERSTAND THEM. The doctor has also offered to explain to me the LESS LIKELY COMPLICATIONS.

authorize the abovenamed physician with associates and assistants to provide such addtional services as they may deem d necessary including, but not limited to, the services of the Department of Anesthesia, the Department of Radioiogy, or d I hereby consent thereto.

d and understand this consent form. Aft blanks were filled in prior to my signature.

F PATIEMT X Cheryl Ola

F RELATIVE
NTATIVE (where required)

hat I have personally completed all blanks in this form and explained them to the patient or representative before requesting the esentative to sign it.

F PHYSICIAN Steven Weightman

PLAINTIFF'S EXHIBIT 3 HEYMAN
PENGAD-Bayonne, N. J.