IN THE COURT OF COMMON PLEAS

SUMMIT COUNTY, OHIO

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JAMES G. FARNER, et al.,)

Plaintiffs,)

vs.) Case No. CV96-08-3195

CUYAHOGA FALLS GENERAL)

HOSPITAL, et al.,)

Defendants.)

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Deposition of GREGORY HILL, D.O., a Defendant herein, called by the Plaintiffs for cross-examination pursuant to the Rules of Civil Procedure, taken before me, the undersigned, Michael G. Cotterman, a Notary Public in and for the State of Ohio, at Jacobson, Maynard, Tuschman & Kalur, 202 Montrose West Avenue, Suite 200, Akron, Ohio, on Wednesday, the 8th day of January, 1997, at 3:45 o'clock p.m.

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On Behalf of the Plaintiffs:

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On Behalf of the Defendant Cuyahoga Falls General Hospital:

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On Behalf of the Defendant Dr. Hill:

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I N D E X

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GREGORY HILL, D.O.

of lawful age, a Defendant herein, having been first duly sworn, as hereinafter certified, deposed and said as follows:

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CROSS-EXAMINATION

BY MR. RUF:

Q. Would you please state your name and spell your name.

A. Gregory Hill, G-R-E-G-0-R-Y, H-I-L-L.

Q. Dr. Hill, my name is Mark Ruf, I am representing James and Marilyn Farner in the lawsuit that's been brought against you and Cuyahoga Falls General Hospital.

If at any time I ask you a question and you do not understand my question, please tell me and I will try to rephrase it. Also if I ask a question that does not make sense medically, please tell me and please try to explain how my question is defective, then I will try to rephrase the question for you, okay?

A. Yes.

Q. Could you please state your address.

A. My home address is 2746 Smith Road, Fairlawn.

Q What is the ZIP code there?
A 04333
Q This is not the first time we have met, Doctor, correct?
A That s correct
Q Once before we met at your office, correct?
A. Yes
Q And we had a conversation with James Farquar, correct?
A Yes
Q Do you remember that you recorded that conversation?
A Yes, a portion of that conversation I recorded
Q. Thanks for correcting me What happened to this recording, do you still have the tape?
A My counsel has it, the tape
Q Okay Do you know, was the tape transcribed?
A - Yes
Q Did you give a copy of the transcription to counsel as well?
A Yes
Q Where did you go to medical school,

doctor?

A. Ohio University College of Osteopathic Medicine in Athens, Ohio.

Q What year did you graduate?

A 1985

Q What is you do following your graduation from medical school?

A Following graduation from medical school I served a one year rotating internship at Cuyahoga Falls General Hospital in Cuyahoga Falls, Ohio, followed by a four year residency in orthopedic surgery, graduating in 1991, followed by a one year post-graduate fellowship in hand and upper extremity and microsurgical reconstruction

Q What was your four year residency in?

A I said that already, orthopedic surgery

Q. What training have you had in infectious diseases?

A. Can you be more specific?

Q Sure Is your only training with respect to infections diseases limited to medical school or have you had training in infectious diseases outside medical school?

A What do you mean traioing?

Q Well, during either your internship or

residency did you do a rotation in infectious disease?

A. During medical school, not to my recollection. And I did not to my recollection do an infectious disease rotation during my residency.

Q. Is your knowledge about infectious diseases primarily from your experience as a practicing doctor?

A. Not exclusively, no.

Q. Okay. Where else did you get training on infectious disease?

A. If I could be more accurate, infectious disease encompasses microbiology basically, and in medical school we had a course in microbiology.

Q. How long have you been in private practice?

A. Four years and some months.

Q. Are you with a medical group?

A. An orthopedic surgery group, yes.

Q. What is the name of that orthopedic surgery group?

A. North Hill Orthopedic Surgery.

Q. That's a corporation?

A. No, it's an association of four individual

solo practitioners who share office space and

otherwise

Excuse me, it's five

Q Sure

A Five orthopaedic surgeons who share office space and otherwise

Q Over that four year period do you have certain days on which you perform surgery at the hospital?

A. Yes.

Q. Which days are those?

A In general I operate on Monday and Wednesday, although I have on occasion operated every day of the week

Q Approximately how many surgical cases do you have?

A I don't know for sure, it varies

Q Could you give me some kind of approximation, is it more than ten per week, less than ten per week?

A - It's less than ten per week.

Q Has that pretty much been what your surgical case load has been in your four years of private practice?

A. Pretty much, yes There have been times

where I have done I think more than ten cases or up to ten cases.

Q. Do you perform surgery in your office?

A What do you mean surgery? Can you be more specific?

Q Sure What kind of procedures could you do in your office as opposed to having someone admitted to the hospital or using a hospital surgical suite?

A Procedures performed in the office are usually minor, that do not require a lengthy anesthetic or I M or intravenous medication

But there occur approximately ten cases per week, those are cases that are done at the hospital?

A. Yes.

Q. In the four years you were in private practice, have you had any other patients that have had a positive Enterobacter cloacae culture after performing orthopedic surgery?

A - Not to my recollection

Since March 1st, 1995, have any of your orthopedic surgery patients had a positive Enterobacter cloacae culture?

A I am not sure I think there may have

been one other patient since March 1995.

Q. Was that patient also a patient of Cuyahoga Falls General Hospital?

A. Yes.

Q. Do you know approximately when this other patient was admitted to Cuyahoga Falls General?

A. No.

Q. Would it have been around March 1st, 1995?

A. I don't know, I don't remember.

Q. What was the other -- strike that.

What was the surgical procedure that was performed on this other patient?

MR. EDMINISTER: If you know.

THE WITNESS: The patient had a fracture surgically corrected.

BY MR. RUF:

Q. In what part of the body?

A. The hands.

Q. Are you on staff at other hospitals?

A. Yes.

Q. What other hospitals are you on staff at?

A. Akron General Medical Center, Summa Health Systems, Akron Children's Hospital Medical Center.

Q. Are most of your patients admitted to

Cuyahoga Falls General?

A. Yes.

Q. Have you had any patients at any other hospitals on which you are on staff have a positive Enterobacter cloacae culture?

A. Not to my knowledge.

Q. So pretty much your only two patients that you have had that had Enterobacter cloacae have been at Cuyahoga Falls General Hospital?

A. Yes.

Q. Do you know of other patients that had or have Enterobacter cloacae following March lst, 1995, at Cuyahoga Falls General?

A. Of whom?

Q. Of any other doctor.

A. I don't have that knowledge. I'm not privy to that knowledge.

Q. So the only two patients you know about that have had Enterobacter cloacae were your own two patients?

A. That's correct.

Q. Have you received any kind of notification or correspondence from Cuyahoga Falls General Hospital stating that Enterobacter cloacae has been a problem at the hospital?

A. Not to my knowledge.

Q. Do you pronounce it is cloacae or cloacae?

A. Cloacae.

Q. Okay. I'd like to talk about the bacteria Enterobacter cloacae. Do you know if that bacteria is naturally found in the human body?

A. To my recollection, yes.

Q. Where is it found naturally in the human body?

A. In the enteric organs.

Q. Could you please explain what the enteric organs are?

A. Well, near the intestine.

Q. Other than the intestine, is it found naturally in the human body?

A. Not to my knowledge.

Q. Do you know, do all humans have Enterobacter cloacae in their intestine or is that bacteria only limited to certain people?

A. I don't know about all people. I know it's an enteric organism but I don't know about all people.

MR. EDMINISTER: You've answered the question.

BY MR. RUF:

Q. Do you know, is Enterobacter cloacae found in large numbers or small numbers in the human intestine if it is found in the intestine?

A. I don't know the specifics of the colony count, things like that, I don't know that.

Q. Is Enterobacter cloacae a gram-negative or gram-positive bacteria?

A. Gram-negative.

Q. Would you agree that Enterobacter cloacae rarely causes primary human disease?

A. I'm not sure, I don't know that, that's not my area of expertise.

Q. Are you familiar with the term nosocomial infection?

A. Yes.

Q. What does nosocomial infection mean?

A. Nosocomial infection -- excuse me, nosocomial normally refers to an infection that is acquired in a hospital environment.

Q. Could you tell me whether Enterobacter cloacae is a nosocomial pathogen?

A. I don't know.

Q. Have you done any medical research on Enterobacter cloacae?

A No

Q By medical research, I mean have you reviewed any infectious disease texts, any orthopedic texts, conducted any periodical searches?

A. No.

Q Would you agree that it's very rare to have an enteroacter cloacae infection following an orthopedic surgical procedure?

MR ADMINISTER: Objection to the form of the question Answer if you can

MAN WITNESS: Would you repeat the question please

MR. RUF: Can you read the question back.

(Previous testimony read back as requested)

MAN WITNESS: Yes, I think it would be rare.

BY MR. RUF:

Q You would agree that infections are a risk of surgical procedure, correct?

A Can you be more specific?

Q Sure Well, I assume that before performing surgery you go over the risks of the procedure with the patient?

A. Correct.

Q. And one of the risks of a surgical procedure that you may go over with the patient is the risk of infection?

A. Yes.

Q. In going over the risk of infection for a patient with a surgical procedure, do you discuss the specific types of infections that may result or do you just generally discuss that infection may result from surgery?

A. Generally I will mention that infection is a problem or a potential complication. Most patients don't care about the specifics of an infection.

Q. What are -- what types of infection most commonly result from orthopedic surgical procedures?

A. Can you be more specific? It's a global question, can you be more specific?

Q. Well, how could I break that down? Do you think this question is too broad?

A. Yes.

Q. Well, I'm not really sure how to break the question down, why is the question a problem?

MR. EDMINISTER: Well, I think if he

told you he doesn't understand the question, you need to rephrase it. What more specific do you require than that?

MR. RUF: I am not sure why the question is a problem. If he can t answer it, that's fine. I would just like him to tell me why it's a problem so I can rephrase the question

THE WITNESS: What do you mean, kind of infection?

BY MR. RUF:

Q. Well, would you say that gram-positive bacterial infections are more common following an orthopaedic surgical procedure or gram-negative bacterial infections?

A. Gram-positive.

Q. What type of gram-positive bacterial infections most often follow an orthopaedic surgical procedure?

A. If they do occur, the most common gram-positive infections are related to Staphylococcus species and Streptococcus species

Q. What types of gram-negative bacterial infections most frequently follow an orthopaedic surgical procedure?

A I don't know t e answer to that

Q Do you know the ratio between gram-positive bacterial infections and gram-negative bacterial infections following orthopedic surgical procedures?

A No.

Q Would you say that more than fifty percent of the time infections would be gram-positive?

A You asked me that question in a different way. I don't know the answer to that Gram-positive infections are more common than gram-negative infections in general

Q So more than fifty percent of the time a post-operative infection would be gram-positive?

MR EDMINISTER: Well, now you're not -- he's answered your question You can't put words in his mouth. he didn't say that.

BY MR. RUF:

Q. Are you able to answer that question?

A. No.

Q. From the time you were in medical school until the time you completed your residency, did any of the patients that you were involved with have enterobacter cloacae?

MR EDMINISTER: Objection. you asked that question in a different way before

MR. RUF: I asked since he has been in private practice.

MR. EDMINISTER: Okay. Now you want to know from medical school on, that he is aware of?

MR. RUF: Yes.

THE WITNESS: I can't recall that information. I don't know.

BY MR. RUF:

Q. Do you know whether your first experience with a patient that had Enterobacter cloacae was James Farner?

A. As an attending orthopedic surgeon, my first experience to my recollection was with Mr. Farner.

Q. Would you agree that Enterobacter cloacae can be spread from hospital personnel to a patient?

A. Yes.

Q. What are the other ways in which a patient could wind up having Enterobacter cloacae in a part of their body other than the intestine?

A. Could you repeat the question, please, I'm sorry.

MR. RUF: Sure, could you read it back.

(Previous testimony read back)

THE WITNESS: Other than the intestine. I don t know.

BY MR RUF:

Q. Well, we have already discussed the bacteria can occur naturally in the intestine?

A Right.

Q And we have already discussed that patients can have -- have Enterobacter cloacae in parts of their body other than the intestine?

A I m not sure I said that Enterobacter cloacae is a gram-negative found in the intestine or the gut.

Q. If a patient has Enterobacter cloacae in a part of their body other than the intestine --

A Okay.

Q -- what would be the possible ways that that bacteria would get into that part of the body?

MR SAMINIAMER: Objection. If you know, he is asking you for a -- all of the possible ways

THE WITNESS: I don t know about all the possible ways of how the bacteria could.

BY MR. RUF:

Q What ways do you know about?

A I think that certainly contamination or bacteria on the hands, a bandage, the pad, the pad can, the medicine cabinet, and if those items came into contact with the patient, then certainly the patient could be inoculated

Q If a patient had Enterobacter cloacae in the knee, can you think of ways other than contamination that that bacteria could get into the knee?

MR HANNA: Objection to the form of the question.

MR. MD INSMR: I will join in that objection.

BY MR. RUF:

Q Please answer if you can

A If the -- I m not sure who knows, if the bacteria was blood-born, if it was in his blood stream it could certainly get into his knee

Q If Enterobacter cloacae was blood-born, would you expect a positive blood culture?

A. Would I expect so, probably, but probably not in all cases.

Q Could you elaborate on that?

A Yes, that every single blood culture should

not necessarily be positive because a patient had a bacteria in his blood stream.

Q. Do you know how Enterobacter cloacae can get into the blood stream?

MR. EDMINISTER: Objection.

THE WITNESS: No.

BY MR. RUF:

Q. Do you know whether any blood culture was done on James Farner during either the first or second admission?

A. I would have to look at the record.

Q. Please do that. Also if at any time I ask you a question and you need to refer to either your notes or the hospital records, please do so.

A. (Witness doing as requested.)

Q. Maybe I can speed things up, I have two forms here, I don't know if you want to look at those.

A. From the first hospital stay, here's a report, the end of a report dated 3/15/95, it suggests no growth.

Q. When was that blood collected?

A. It's hard for me to read this, this is a copy of a copy. I can't tell. I can't tell, part of the numbers are cut off here.

Q Does it look like 3/5/95?

A I can't tell really. I can't tell

Q So there was one culture, blood culture done during the first admission, and that culture was negative?

A. Yes

Q. Any other blood cultures that you are aware of that were done during the first admission?

A There appears to be at least two additional collection times, although I m not sure what the date is, but there seems to be two different time frames here

Q So based on the information you have, three samples were collected. is that correct?

A Yes, at least three

Q Does the report indicate whether all three samples were negative for growth?

A Yes.

Q Okay I'd like to go to the second hospital admission. I d like you to tell me if any blood cultures were done during the second hospital admission

MR WAINISMER: Well, it's either here or it isn't, do you know of any?

MR RUF: I'm not aware of any, I just wanted to confirm that with you

THE WITNESS: No, I don t see any documentation of that here in this second admission.

BY MR. RUF:

Q. Given that Mr. Farner had a negative blood culture during the first admission, can you state whether or not his Enterobacter cloacae was blood-born?

A. No, I cannot state that

Q Why can you not state that?

A Because I don t know. We have had results that suggest that but I don't know for sure

Q The last result suggest what?

A The last results suggest that the blood cultures were negative on at least three days

Q Do you know whether or not it is documented medically that Enterobacter cloacae can be spread throughout the human body in the blood system?

MR. ADMINISTER: Documented medically where?

THE WITNESS: Where?

MR RUF: Either in medical texts or

medical periodicals

THE WITNESS: You previously asked me about my reading on Enterobacter. I have not done any reading on Enterobacter so I don t know the answer to that question.

BY MR. RUF:

Q Are you familiar with the medical treatise Campbell s Operative Orthopedics?

A Yes.

Q Do you consult that medical treatise?

A On occasion

Q Would it surprise you if I was unable to find any discussion of Enterobacter cloacae in that medical treatise?

MR SAMINIAMER: Objection

THE WITNESS: No

BY MR. RUF:

Q. Why would it not surprise you?

A Because we already stated, you previously asked me whether in my opinion Enterobacter was a common organism for orthopedic procedures. I said no

In a textbook like that it will give you general guidelines as to problems/complications, those that are most common,

not those that are most rare.

Q. Would it surprise you if I was unable to find through a Medline search any articles which discuss Enterobacter cloacae as a post-operative orthopedic complication?

MR. EDMINISTER: Objection.

THE WITNESS: No, it would not surprise me

BY MR. RUF:

Q. Why would it not surprise you?

MR. EDMINISTER: Objection

THE WITNESS: Because of my last answer is it related to Campbell s orthopedic textbook

BY MR. RUF:

Q. Do you know whether or not Enterobacter cloacae is documented as a known complication for an orthopedic surgical procedure?

MR. EDMINISTER: Objection, documented where?

THE WITNESS: Documented where?

BY MR. RUF:

Q. In any medical literature.

MR. EDMINISTER: Objection.

THE WITNESS: I am not privy to any and all medical literature.

BY MR RUF:

Q What periodicals do you subscribe to?

A Can you be more specific? Periodicals to me refer to journals, there is journals, there's clinics, there's hardcover textbooks, so could you be more specific?

Q Sure. Shall don't we first discuss journals

A. The journal Bone and Joint Surgery, the journal Knee Surgery

Q Do you regularly review those journals?

A. Yes.

Q Do you ever remember Enterobacter cloacae being discussed in any articles in those journals?

A Not to my recollection.

Q You also said you review medical texts or treatises?

A. Yes

Q What medical texts or treatises do you review?

MR MINISTER: You mean in general, on a daily basis, as part of his ongoing edification, what do you mean?

You know, already established this is a rare complication Now, you know, are we

going to be here all day beating into the ground the fact that, you know, he hasn't seen it in some, you know, in the entire body of medical literature. We could spend all day talking about this, going through these journals one by one

BY MR. UF:

Q. Do you remember reading about Enterobacter cloacae in any medical treatises?

A In the orthopedic textbooks that I commonly look at, I have not I don't have a recollection of reading about Enterobacter cloacae

Q. I'm sorry, I forgot, what was the last area that you divided medical periodicals into?

A Textbooks, journals, clinics

Q What are medical clinics?

A Medical clinics are smaller textbooks, they are a compilation of articles that are written by authorities in the field on a regular basis

Q What medical clinics do you subscribe to?

A. Hand Clinics.

Q. Do you read that publication on a regular basis?

A. Yes.

Q. Do you ever remember reading about

Enterobacter cloacae in Kane Clinic?

A. Not to my recollection.

Q. What did you review prior to coming here today?

A. Can you be more specific?

Q. Sure. In the last week, did you review any materials in preparation for this deposition today?

MR. ED INISTER: He means anything that I have given you or discussed with you

THE WITNESS: No

BY MR. RUF:

Q. Have you given any depositions prior to today?

A. Yes

Q. How many depositions have you given?

A. More than one

Q. More than ten or less than ten?

A. Less than ten.

Q. In the two depositions that you have given, how many times were you a party to an action?

MR. EDMINISTER: Kane did he's given less than ten, you just stated he gave --

MR. RUF: I'm sorry, I will rephrase

the question.

BY MR. RUF:

Q In the last ten depositions that you have given, in how many of these depositions have you been a party to a lawsuit?

A To my recollection, I believe two But I do have to check with my carrier to be sure

Q Were those cases Akron cases?

A Yes.

Q Filed in Summit County?

A Yes.

Q Do you know what years those depositions were given?

A '96 And I'm not sure before that, I would really need to check the records

Q Were the other depositions that you gave on behalf of patients because of injuries?

A In general?

Q Yes.

A Or the ones that I have been a -- how do you term it, a party to?

Q Right, a party to an action

A Okay Can you ask your question again?

Q Frequently orthopedic doctors give testimony in injury cases I am asking you, were

the other depositions that you gave on behalf of patients because of injuries they had sustained and not the result of medical malpractice?

A. There was a case last year that I was involved in and asked to testify.

Q. Do you review medical malpractice cases?

A. No -- can you be specific about that?

MR. EDMINISTER: He means as an expert witness.

THE WITNESS: As an expert witness?

BY MR. RUF:

Q. Yes.

A. That's what I was referring to, there was a case last year that I was called as an expert witness.

Q. Were you an expert witness for the plaintiff or defense?

A. Defense.

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

MR. EDMINISTER: I am going to object to this line of questioning. Mark, let's get more specific.

THE WITNESS: Can you be really specific about the subject matter, what do you

mean?

BY MR RUF:

Q. Sure did this case in which you testified as an expert, did that involve an infection?

A. Not to my recollection, no That was not the basis for -- no

Q In these two cases that you have given opinions, where you have been a party to the action, what was the subject matter of those cases?

A. You know, r Ruf, really I don t recall the specifics of that case I have been preparing for this case And I really would go to counsel and look that information up I am sure it s available but I really don't, I don't want to give you inaccurate information

Q Thank s fine

A. Because that's then, really that's then and I don't want to give you false information about some case

Q. That's fine If you don't know, just tell me you don t know.

A I really don't

Q Thanks Can you tell me how many open

reductions for how done in your four years of private practice?

A. No, I cannot tell you how many I have done

Q On a weekly basis, how many do you do?

A I can t tell you that I do cases that come in, I do emergencies that come in, so I don t -- I can t tell you the amount that I do on a regular basis I'd have to look at my logs from the hospital, or either my office

Q So how couldn't tell me on a monthly basis even?

A No, I cannot, I really cannot

Q What are the risks of performing an open reduction on a patient?

A. An open reduction of what, can you be more specific?

Q Of the lower leg or knee area

A. Normally any risk that I will give to a patient is not inclusive of every potential complication because I don t know every potential complication

Those that are most common, most likely would include soreness, stiffness, swelling, thromboembolic phenomena, infection, cardiac

arrest, wasting of extremity, unsightly deformity, scarring, wasthar sensitivity, infection -- excuse me, I said injection The risk of non-union, malunion, should also be mentioned

Q You performed an open reduction on James Farner, correct?

A. Yes.

Q Did you discuss the risks of performing the open reduction with James Farner?

A Yes

Q Are there risks that you discussed with him the ones that you just listed?

A. For which?

Q For the March 1st, 1995, procedure

A I am looking for the consent, the operative consent

MR SCHMIDT: Look under the first yellow tab in the front Of the record

(Discussion had off the record)

BY MR RUF:

Q. What potential complications did you discuss with Mr. Farner?

A Those that are listed on page hare include pain, stiffness, swelling, damage to joint, arthritis and infection

Q And those are listed on what page of the hospital record?

MR. EDMINISTER: Well, you know, as far as a page number, there's a 90 on the bottom right I don't know if that is the hospital number or not But 'Reasonable Patient Informed Consent' is the title of the form.

BY MR. RUF:

Q. Do you remember discussing any risks or potential complications with Mr. Farner other than those listed on the page which has a 90 on it?

A In all probability I did because again there is no way that I can write down on this form every potential complication that exists I will normally write down and discuss -- I normally will write down those that are most common relative to the potential complications

But again there is really no way that every potential complication that is not as common is written down, I don t normally do that

Q - You would not have discussed Enterobacter cloacae as a possible complication with Mr. Farner, correct?

R HANNA: Object to the form of the question

THE WITNESS: In the preoperative discussion with Mr. Farner, I listed and discussed with him infection, period.

BY MR. RUF:

Q But you did not discuss the specific infection Enterobacter cloacae?

A No, I did not

Q Okay. I'd like to go to the history and physical for the first admission. Were you involved in conducting the history and physical for the February 27th admission?

A Can you be more specific?

Q When did you first see James Farner?

A I first saw Mr. Farner on the 27th of February, the day that the -- the day the informed consent was signed.

Q And you saw Mr. Farmer at the time the history and physical was done?

A By whom specifically?

Q Well, there is a history and physical form, correct?

A. That's correct.

Q. And the history and physical form is dated over through seven of the record?

A Yes

Q. Did you sign that history and physical form?

A. Yes. I did

Q Did you perform this history and physical or did some other doctor perform this history and physical?

A. This particular, this history and physical in which you are referring to, according to this was dictated by a medical student, Curtis Biggs

It is normally customary for the orthopedic surgeon or the attending surgeon to sign the H & P, as it s called, or the history and physical, by the student or the house officer person

Q. Did you review the history and physical for the first admission?

A. Yes.

Q Was there anything that you disagreed with in the history and physical?

MR ADMINISTRATOR: Do you have some specific issue or a more specific question? That's pretty global.

MR RUF: Okay Let's limit the question to the section marked Gastrointestinal and the section marked

urologic

MR RUF: Same question?

MR ADMINISTER: Does he have any disagreement with anything that is listed in any of those sections?

MR RUF: Yes

MR ADMINISTER: Objection to the form of the question. Can you answer that, have you looked at this thing carefully enough so that you can answer that question?

THE WITNESS: I was signed this X & P the medical student or the house officer person normally does a very detailed, systematic, programmed history and physical examination that requires that narrative that you see in front of you

Normally the attending surgeon does not look in the ears and the eyes unless it's pertinent to the care of which you are taking care of the patient

BY MR. RUF:

Q. So what is --

A. Therefore I was not there when this particular X & P was transcribed

Q. So what does it mean when you sign off on the history and physical?

A. It means that I am the attending surgeon for the patient, I am the doctor of record.

Q. Prior to the open reduction, did Mr. Farner have any skin abnormalities?

MR. EDMINISTER: Objection.

THE WITNESS: Over his whole body?

BY MR. RUF:

Q. In the leg area.

MR. EDMINISTER: What do you mean by an abnormality?

THE WITNESS: Mr. Ruf, to my recollection, when I saw Mr. Farner first of all he had a dressing on, a splint that was supportive.

Secondly, with every fracture of this variety there will be some swelling of the skin, bruising of the skin, potential discoloration of the skin.

BY MR. RUF:

Q.- Was there anything about the condition of Mr. Farner's skin prior to the open reduction that would make him an increased risk for infection?

A. Not to my recollection.

Q. Do you know whether Mr. Farner had a

problem with diarrhea at any time prior to the March 1st operation reduction?

MR EDMINISTER: Objection, at any time prior to, in is life, during the admission?

MR RUF: During the admission.

EXE WITNESS: Can you rephrase the question, please, or repeat the question?

BY MR. RUF:

Q Let's first start with the history and physical According to the history and physical it states that patient denies any recent change in bowel habits, denies any nausea, vomiting, diarrhea or constipation, as well as food intolerance, dysphagia, ulcer, pancreatitis, cholecystitis, hepatitis, abdominal pain, hernia, despite his hernia repair in 1988.

Do you have any reason to believe that is inaccurate?

A. No, I do not.

Q Do you know whether or not r Farner had any problems with diarrhea following the March 1st, 1995, procedure?

A Can you be more specific, please?

Q During the first hospital admission.

A Not to my recollection, no

Q Did he have any other type of bowel abnormality during the first hospital admission?

A What do you mean bowel abnormality?

Q Well, how could I break that down, what's the proper term I should use?

A Bowel abnormality could be diarrhea, could be constipation, could be blood in your stool

Q To your knowledge did Mr. Farner have any problems with incontinence during the first hospital admission?

A No, not to my knowledge

Q Did he have any problems in involuntarily releasing fecal material during the first hospital admission?

A. You just asked me that

Q So the answer is no?

A No

Q Do you know, did Mr. Farner have any problems with urination during the first hospital admission?

A - Not to my recollection.

Q Do you know whether Mr. Farner urinated on his leg following the March 1st, 1995, procedure?

A I wouldn't know that information specifically unless I was there at the time

Q. During the first hospital admission, was it reported to you that Farner had urinated on his leg?

A No, it was not reported to me

MR KING INISMER: Do you include any reference that may exist in the records by nurses as reporting to him? Does your question encompass that?

BY MR. RUF:

Q. I am just asking what your recollection is I am not asking you what every nursing note says, what every single progress note says, I am just asking as we sit here today what your recollection is

A I don t have a recollection as to whether a nurse reported to me that Mr. Farner urinated on his leg

Q Were you ever concerned during the first hospital admission that Mr Farner had contaminated his wound with either fecal material or urine?

A I am always concerned about things like that, when a patient has a complicated fracture like this and is bedridden and cannot ambulate, plus use a bed pan, I am always concerned about contamination like that

Q. To the best of your knowledge, was there fecal or urinary contamination of Mr. Farner's wound from March 1st until the time he was discharged during the first admission?

MR. EDMINISTER: Does he know, does he have a recollection as we sit here today whether or not that was reported to him or whether he observed it do you mean?

MR. RUF: Could you read back the question, please, I forgot what the question was.

(Previous testimony read back as requested.)

THE WITNESS: To the naked eye, I was not aware of any potential contamination with either urine or feces, although a wound -- skin can certainly be contaminated with microscopic contaminants.

Feces has been known to dry on the skin and not be noticeable, urine has been known on a dressing to be dry and not noticeable. It's been also my experience that patients can have contamination via urine on the skin and you not see it.

BY MR. RUF:

Q. Was there any information to indicate that there had been a post-surgical contamination of the

surgical wound during the first hospital admission?

A Was there any -- can you repeat your question?

Q. Sure Was there any information to indicate there had been a post-surgical contamination of the surgical wound?

MR EDMINISTRATOR: You mean excluding the records from the second admission?

MR RUF: Yes. I am just asking at the time of the first admission

MR SIMMONS: Would you mind repeating the question.

BY MR. RUF:

Q. I will just repeat the question during the first admission, was there any information to indicate that there had been a post-surgical contamination of the wound?

A No, not to my knowledge

Q Okay I'd like to talk about the arch 1st, 1995, procedure Do you have a specific recollection of performing the open reduction on James Farner?

A Yes.

Q Do you remember everything that happened

in the operating room?

A Relative to what?

Q Well, who don't you tell me what you remember about the open reduction on March 1st, 1995

A Can you be more specific, that s really a broad question, I mean from what point?

MR EDMINISTRER: Do you mean does he have any recollection independent of the record?

MR. RUF: Yes.

THE WITNESS: No No, other than what s in the records, I don t have a recollection.

BY MR. RUF:

Q. I mean that's what I am asking you, is there anything you remember about the procedure that s not stated in the records?

A No.

Q I'm sorry, that may have been an inartful question I asked.

- Do you remember who touched the surgical site during the March 1st open reduction?

MR EDMINISTER: Well, object, he just told you he didn t have any recollection of the procedure, other than what's contained in the

record. So answer the question if you can.

BY R RUF:

Q If to any of these questions you do not have an answer, just tell me, or you don t remember

A. Your question is, do I specifically remember who touched the surgical wound?

Q. Yes.

A. At what point?

Q At any point during the operative procedure, from the time his leg was opened up until the time his leg was closed

A The attending surgeon touched the leg and the two assistants, and possibly the instrument nurse

Q The instrument nurse can also be identified as the scrub nurse?

A That s correct

Q What about the hardware that was put into James Farner s leg, who would have touched the hardware during the surgical procedure?

A The previous people that I just mentioned.

Q So the three doctors --

A The attending surgeon, the two assistants,

who are resident orthopedic surgeons And if I may extract, we did have -- I need a point of clarification

According to the operative records, those in attendance were Dr. Jeff Mhere, and Dr James Fordyce As it relates to your question as to who may have -- is that what you asked?

A Well, do you remember who touched the ort opedic hardware?

. The instrument nurse had to touch the har ware

Q Why would she have to?

A She has to give it to Dr

A Okay Now does the orthopedic hardware come in other words is it packaged when it gets to the operating room, does it come open, how is it when it's first in the operating room?

A What procedure may -- that procedure may vary, depending on whether there's a piece of equipment, a piece of orthopedic equipment in stock and sterile

If that piece of equipment is not in stock or if it's in stock and not sterile, then it has to be obtained by someone else, sterilized,

then given to the instrument nurse, who then gives it to the attending surgeon.

Q. Okay. As you are in the operative suite and this orthopedic hardware is in there, how do you know whether or not that orthopedic hardware has been sterilized?

A. For every surgical procedure of the type that I do, the instruments are normally sterilized prior to the case.

Q. Do you take responsibility for making sure that the hardware and instruments have been sterilized?

MR. EDMINISTER: Objection to the form of the question.

BY MR. RUF:

Q. Or do you rely on the scrub nurse to do that?

MR. EDMINISTER: Objection, same.

THE WITNESS: It's not my sole responsibility or independent responsibility to make sure, it's the responsibility of the operative team or the department of surgery to make sure that the instruments for a surgical procedure have been properly sterilized and packaged.

BY MR. RUF:

Q. IS it your routine or procedure to check on whether the orthopedic hardware or instruments have been properly sterilized?

A. Can you be more specific as to what you mean by me checking?

Q. Well, do you do anything to make sure that either unsterilized hardware or instrumentation is not used on a patient during an orthopedic procedure?

A. If I may say, for a given operation it is -- we have a team, that team consists of an attending surgeon and his assistant, an instrument nurse, a circulating nurse and an anesthesia person.

It's the responsibility of the team to make sure that sterility, aseptic technique is maintained, which includes equipment usage.

Q. So you would agree it's the responsibility of the team to maintain a sterile surgical field?

MR. EDMINISTER: Objection to the form.

THE WITNESS: Yes.

BY MR. RUF:

Q. And you would agree it's the responsibility of the team to follow asepsis

techniques?

MR. EDMINISTER: Objection.

THE WITNESS: Yes.

MR. HANNA: Objection to the form of the question.

BY MR. RUF:

Q. And you would agree it's the responsibility of the team to minimize the risk of infection to a patient during a surgical procedure?

MR. EDMINISTER: Objection.

THE WITNESS: Can you repeat that?

BY MR. RUF:

Q. Sure. Would you agree it's the responsibility of the team to minimize the risk of infection to a patient during a surgical procedure?

A. Yes.

Q. Would you agree it's the responsibility of the team to try and prevent surgical wound contamination?

MR. EDMINISTER: Objection.

THE WITNESS: Mr. Ruf, you just asked me that, your last question was the same question.

BY MR. RUF:

Q. So your answer would be yes?

MR. FEINISMER: Objection, answered and asked and answered.

BY MR. RUFF:

Q. Would you agree that proper sterile technique is designed to minimize the risk of infection to a patient?

A. Would you mind repeating the question?

Q. Sure. Would you agree that proper sterile technique is designed to minimize the risk of infection to a patient?

A. That's correct.

Q. Would you agree that the hospital environment is conducive to the development and spread of infection?

A. What specific, what specific hospital environment are you referring to?

Q. Well, at the hospital that's a lot of sick people, correct?

A. Yes.

Q. And there is a lot of people with infections at the hospital, correct?

A. Possibly.

Q. There's a higher concentration of sick people and people with infections at the hospital than there is outside the hospital?

A. I don't know that for sure.

Q. You wouldn't be willing to say that?

A. I don't know that for sure. I can't prove it, I can't quote you a study on that. There might be instances where those in an extended care facility, i.e. a nursing home, they may have.

Q. Excluding other medical care facilities, would you agree that the hospital environment is more conducive to development and spread of infection than outside the hospital?

A. Yes.

Q. Would you agree that some patients acquire infections while in the hospital?

A. Yes.

Q. Would you agree that some patients acquire infections while in the hospital due to contamination?

A. Possibly.

Q. Have you observed breaks in sterile technique while at Cuyahoga Falls General Hospital in the surgical suite?

A. Ever?

Q. Yes.

A. Yes.

Q. Have you observed breaks in sterile

technique at Cuyahoga Falls General Hospital during a surgical procedure in 1995?

A. I don't have a recollection of that.

Q. What types of breaks in sterile technique did you observe?

MR. EDMINISTER: At Cuyahoga Falls General?

MR. RUF: Yes.

MR. EDMINISTER: At any time?

THE WITNESS: Those that I recall may have been a defect in a glove or a hole in a glove.

BY MR. RUF:

Q. Anything else?

A. As it relates to the specifics of what you are asking me, other than that is probably the most common, one of the more common things that a surgeon may experience.

However, we have a lot of people on -- in a surgery, that includes residents, interns, students, who may break technique at some point that the attending surgeon does not see.

Again it's the responsibility of the circulating nurse, in addition to the instrument nurse, to monitor the technique. Meaning that I

may be specifically involved in a portion of the procedure and not see what s happening behind me or next to me.

Q Do you know whether any tears occurred in any surgical glove during Dr. Farner's open reduction?

A. Not to my recollection

Q So you have a specific recollection of whether or not any tears occurred?

Probably the way -- I think the answer came across as unclear. I think it was the way I phrased the question.

Basically what I am asking is do you know whether or not a tear occurred in a surgical glove during Dr Farmer's open reduction?

A No, not to my recollection

Q Well, I guess I am still a little unclear. Are you saying that no tear occurred in a surgical glove or are you telling me you don t recall whether or not a tear occurred?

A I am saying that I don't recall specifically, as related to r Farner s case, whether there was a hole in a glove of mine or anyone at the table I don't know that information, I don't have recollection of that

information.

Q Is it your routine or practice to put in your operative note whether there has been a tear or a hole in a surgical glove?

A No

Q Do you know whether or not that is something that is regularly recorded somewhere in hospital records?

MR EDMINISTER: Do you know?

THE WITNESS: No, I don t know.

BY MR RUF:

Q If a tear occurred in a surgical glove during a procedure, what would you do?

A Change my glove

Q How would you do that?

A How would I do it technically?

Q Yes Say you are standing in front of a patient at the surgical table and you notice there is a hole or a tear in your surgical glove, what s the procedure that you follow?

A - I immediately step back from the table, state to the instrument nurse and the circulating nurse I have a hole in my glove, I need a new glove, or set of gloves

Q Has it happened during the four years you

have been in private practice?

A. Yes.

Q. When you get a tear in your surgical glove, is there anything that you put inside the patient to try and reduce the risk of infection?

In other words, do you pour some type of antiseptic material inside the patient if you notice you have a hole or a tear in your surgical glove?

A. Preoperatively the patient is given antibiotics, intravenous antibiotics. As a routine, other than normal saline, I do not put any other liquid material into the part of the body that I am operating on.

Q. So you rely on I.V. antibiotics that are given prior to surgery?

A. Can you finish your question?

Q. Well, maybe I should ask it this way, why don't you pour any type of antiseptic material into the patient during the procedure?

A. I'm not convinced, nor have I been -- nor have I read, nor during my experience in practice, from clinical practice, reading articles and journals, that because you have a hole in your glove, pouring of an antiseptic solution decreases

infection.

Q. So during your surgical procedures, if anybody who is involved in touching the surgical site develops a hole in their glove, they step away from the patient, get a new glove, then step back and the procedure continues?

MR. EDMINISTER: He didn't say that, he said he does that. You are now enlarging that to be anybody, unless I missed something.

BY MR. RUF:

Q. What if you notice that somebody else had developed a hole in their surgical glove, what would you do?

A. I notify them that they have a hole in their glove, I ask them to step back and I continue my work. I also will ask the person were they stuck or were they punctured, because of other potential problems.

Q. Have you had a problem with surgical gloves tearing at Cuyahoga Falls General Hospital?

A. Not to my knowledge.

Q. Do you know what brand of surgical gloves they use?

A. No.

Q. Okay. I'd like you to tell me about your

scrub procedure, I'd like you to go through step by step what you do in scrubbing for a surgical procedure.

MR. EDMINISTER: Such as this procedure, a scheduled surgical procedure?

BY MR. RUF:

Q. Yes, for an open reduction involving the leg, what would be your scrub procedure?

A. If it's an open reduction involving the leg for a fracture and it's the first case of the day, the technique involves obtaining the brush, the surgical scrub brush with an impregnated soap from the dispenser, opening the pack, turning on the water, moistening the pack, moistening the sponge.

There is a preliminary hand wash involving one's choice of soap, that soap is rinsed off with water, then the hands, wrists, forearms, elbows are rinsed. At that time the nails are cleaned with a plastic nail cleaner and then a systematic scrub technique is carried out until both extremities are surgically scrubbed, at least two inches above the elbow.

Q. Do you know how long this scrub procedure takes generally?

A Again I was taught for the first case of the day, a ten minute surgical scrub is recommended, recommended but not required

Q So you know was either an antimicrobial agent or Betadine as part of your scrub?

A Yes

Q Which do you use?

A Betadine On most occasions I use Betadine, on some other occasions I may use another antimicrobial soap

Q Why would you use one as opposed to the other?

A. Some of the soaps are harsh to the skin, you have rashes, itching, flaking of the skin, that kind of thing

Q Would you agree that hand washing is a very important procedure in preventing nosocomial infections?

A Yes

Q Would you agree that skin provides a natural barrier to infection?

A Yes

Q Would you agree that when you cut open a patient's skin, you make that patient more vulnerable to infection?

A In theory

Q Who do you just say is

surgically incised, that is his skin or her skin surgically incised, do you also have an infection

Q No, what I am asking is when you cut open the human skin, does that make the patient more vulnerable to infection?

A I am saying yes, in theory

Q Would you agree that the risk of developing a gram-negative bacteria to a patient is greatest after a hospital personnel has had contact with human excretions?

MR KANNA: Object to the form of the question.

THE WITNESS: I suppose

BY R RUF:

Q Would you agree that patients at the greatest risk for bacterial contamination are those undergoing surgical procedures?

A - Could you repeat your question, please

MR. RUF: Sure, could you read the question back, please

(Previous testimony read back as requested)

THE WITNESS: Yes

BY MR RUF:

Q Is that the reason why you follow the same procedure and you want to explain a little bit during the surgical procedure?

A Yes.

Q Do you know whether or not any of the physicians that participated in James Fernier s open reduction performed a rectal exam on Mr. Fernier prior to the procedure?

A At any time prior to the procedure?

Q Let s say within two hours of the procedure.

A. Not to my knowledge

Q Do you know whether or not James Fernier had been catheterized prior to surgery?

A Yes

Q Was he catheterized prior to surgery?

A Yes.

Q Where would that be in the records?

A. Normally it would be in the operative, in the perioperative -- not perioperative but the OR nursing

Q How do you know he was catheterized prior to surgery?

A. Because in my reading of this body of

information, according to the nurses' notes, the patient returned to the floor with an indwelling Foley catheter.

Q. That was after the surgical procedure?

A. That was a floor nursing entry.

Q. I guess I am a little confused. I'd like to know whether he was catheterized prior to the open reduction or after the open reduction?

A. Let me look and see.

According to the perioperative nursing records in surgery, there was not a Foley inserted.

Q. So he was catheterized during surgery?

A. According to this record, he was not catheterized during surgery.

Q. Okay. So would we have to assume that he was catheterized after the surgery?

A. Yes.

Q. Because he returned to the floor with the catheter?

A. Yes.

Q. Do you know when he was catheterized, was there a problem with urine running down Mr. Farner's leg?

A. I don't have that knowledge.

Q. Is that something that would routinely be reported somewhere in the hospital record?

A. I hope so. I'm not absolutely sure but I would hope so.

Q. Would you agree that surgical wounds are the most common portal of entry for Enterococcal bacteria in'to the human body?

A. Would you repeat the question please.

(Previous testimony read back as requested.)

THE WITNESS: We have already established that Enterococcus is -- you are asking me about Enterococcus, I don't know.

BY MR. RUF:

Q. Do you know whether or not Mr. Farner had any septic episode during surgery?

A. What do you mean septic episode?

Q. Did he display any signs of sepsis during the open reduction procedure?

A. What do you mean signs of sepsis?

Q. If a patient has gram-negative sepsis, would-they display certain signs or symptoms?

A. You have to be more specific because sepsis, what do you mean by sepsis?

Q. Well, I'm not sure how to rephrase the question, what's the problem with the term sepsis?

A. Sepsis is a general term. I am not sure if you mean septicemia, what do you mean by sepsis?

Do you mean a break in technique, do you mean contamination of a wound, that's what I am trying to see, what you specifically are referring to, because sepsis implies, to me, my interpretation, that's a general.

Q. Well, during a surgical procedure can a patient show signs and symptoms of an infection?

A. Most commonly during a procedure a patient will not show signs of an infection, unless the patient is septicemic, meaning in the blood stream prior to coming to surgery.

Q. Do you know, did James Farner show any signs of infection during the open reduction of March lst, 1995?

A. What do you mean? Specifically what, I mean can you be more specific?

Q. Was there anything to indicate that an infectious process was going on in Mr. Farner during the March lst, 1995, open reduction?

A. No. But again bacteria are microscopic, you can't see them. They are in this room right now, on this table, you can't see bacteria, so you

don't know whether a septic event is occurring at that time or whether -- I'm sorry, you just don't know.

Q. Well, maybe that's the term I should use. Was there anything to indicate that a septic event was going on during the open reduction procedure for Mr. Farner?

A. No.

Q. Do you know whether or not anybody in the operating room left the room during Mr. Farner's open reduction?

A. Anybody like whom?

Q. Anybody in the operating room left the operating room during that procedure?

A. As it relates to anybody in the room, I cannot speak for the anesthesiologist, I cannot speak for the circulating nurse, nor the scrub nurse.

Normally, however, the attending surgeon and the residents are there until completion of the procedure.

Q. Do you have a specific recollection of whether or not anybody left the operating room during the procedure?

A. Anybody like whom?

Q. And of the three doctors or the scrub nurse?

A I just said that

Q Let me rephrase the question. Do you have a specific recollection of whether yourself, or. Mhardy, or Forbyce or the scrub nurse left the room during the open reduction procedure of r Farner?

A. We did not leave the room.

Q How do you know that?

A Because first of all, first of all it is not customary for the attending surgeon to leave in the middle of an operation, the attending surgeon and the senior resident, the assistants that are there.

Now is it relative to the instrument nurse, she may or may not have been relieved If she were I would have thought would have been documented on the handwritten notes by the circulator.

Q.- Do you know whether anybody had to leave the room to go to the bathroom during the open reduction?

A. No

Q No, you don't know whether anybody left?

A Yeah. I know. We don't leave the room to go to the bathroom.

Q Have you ever left the operating room to go to the bathroom in your own years of private practice?

A. No. I have not

Q Have you ever observed anyone leaving the room to go to the bathroom during a surgical procedure?

A. At what point in time?

Q In your own years of private practice

A To beginning of the case, in the middle of the case, at the end of the case?

Q At any time while the wound is open.

A Who specifically are you asking me about?

Q I am asking, have you ever observed that at Cuyahoga Falls General Hospital?

A On occasion I have noticed that someone had become lightheaded or syncopal and had to be removed from the room. Other than that, it is not customary for my team to go to the bathroom and come back, for my cases.

Q Okay. Say somebody was suffering from diarrhea that was involved in the surgical procedure and they had to leave to go wash

diarrhea. Would you then tell that person to stay out of the operating room or would they be allowed back in?

A. Absolutely not, they could not be admitted back to the operating room.

Q. Why is that?

A. They may have to go again. It breaks the continuity of the operation for one, and two, I don't have time for it. If they are ill, they need to be where they need to be to take care of their problem, see a doctor, go to the E.R. or whatever.

I am there to do an operation. If you can't cut the mustard, then they leave. Cutting the mustard may mean being sick, being lightheaded, being dizzy, if they are then they go out. It's my discretion who is in my cases.

Q. And while you have been at Cuyahoga Falls General Hospital, has a person had to leave to go to the bathroom and then been allowed to come back and participate in a case?

A. No.

Q. What type of fracture did Mr. Farner have?

A. A tibia fracture.

Q. Did that tibial fracture break the surface of the skin?

A Not to my recollection

Q Do you know why the decision was made to perform an open reduction on Mr Farner as opposed to a closed reduction?

A Because of Mr Farner's age and what we call or what is described as fracture pattern, the anatomy of the fracture, dictated that surgical stabilization or an open reduction would be indicated.

Q. Was there anything about Mr. Farner s medical or physical condit on that would have made his risk for an nterobacter infection?

MR KANNA: Object to the form of the question.

THE WITNESS: Not to my knowledge

BY R RUF:

Q Do you remember anything unusual that occurred during the open reduction on Mr Farner?

A. No.

Q. Following the open reduction, did Mr. Farner have any signs of infection?

A. Can you be more specific?

Q During the first hospital admission.

A Can you be more specific?

A Well, following the March 1st procedure he

had a temperature.

A. Correct.

Q. And that was from the time of surgery up until the day before he was discharged.

A. Okay.

Q. Would you agree with that?

A. Correct.

Q. And --

A. May I, he had not a persistent temperature, one that went up, came down, went up and came down.

Q. Do you **know,** did he have a fever from the time of the surgical procedure up until the day before **he** was discharged?

A. As I just stated, there were times Mr. Farner had a normal temperature, there were times where it was elevated. When you say temperature, to me you are implying it's constant. According to the records, it was not constantly up.

Q. Is an elevated temperature a sign of infection?

A. It can be but not always.

Q. Were you concerned about a postoperative infection with Mr. Farner?

A. As indicated in the -- in your earlier

questioning about the risks, I am always concerned about an infection. Yes, I was concerned about an infection in Mr. Farner.

Q. Were there any signs to indicate that an infectious process was going on in Mr. Farner after the open reduction procedure until the time he was discharged?

A. Can you be more specific?

MR. HANNA: I am going to have to step out. I assume there's no problem with reservation of rights. Send me the transcript.

- - -

(Mr. Hanna left the deposition.)

(Short recess had.)

- - -

BY MR. RUF:

Q. You have already indicated that infection is a concern in any patient following an orthopedic procedure.

A. Correct.

Q. Was there anything about Mr. Farner's condition following the March 1st procedure which led you to believe that an infection was actually going on in Mr. Farner?

A. No.

Q. Well, let's look at the progress note from March 3rd, 1995. Down at the bottom of the page, under assess, it states increased temperature, post-op atelectasis versus infectious -- is that infection, says infectious --

A. You are referring to page fourteen?

Q. Page fourteen down under 1300. I think you need to turn the page.

A. I'm sorry, now?

Q. Under 3/3/95, 1300, assess, it states increased temperature, post-op atelectasis versus infectious.

A. Yes, that's what it looks like.

Q. Basically what I want to ask is were you concerned that an infection was actually going on in Mr. Farner following the March lst, 1995, procedure?

A. I think you just asked me that but I will answer you again. Yes, I was concerned, I am always concerned about any patient that goes into surgery, I am concerned about infection.

Q. Do you know whose signature this is on the March 3rd progress note?

A. Yes.

Q. Whose?

A James Forsyce

Q Did you discuss Mr. Farmer s elevated temperature with Mr. Forsyce?

A You are asking me specifically a year and a half ago. I am almost positive we discussed the case because we do that on a routine basis but the specifics of that particular conversation I don't recall

Q So you remember whether you had a concern that Mr. Farner had a postoperative infection during the first admission?

A No. Talking the first admission or specifically relative to this date still in question?

Q. Why don t we first start with March 3rd

A Yes, now asked me that already. Did I have a concern in general for my surgical patients and I did have a concern at that time.

Q. Other than an elevated temperature, did Mr Farmer show any signs of infection during the first admission?

A. No.

Q Did you not agree r. Farmer on antibiotics following the March 1st operation?

A. Yes.

Q. Was he on antibiotics from March 1st up until the time he was discharged?

A. Yes.

Q. And did you have him on antibiotics because you were concerned that he might have a postoperative infection?

A. No, every surgical patient that has a procedure of that magnitude is covered with routine postoperative intravenous antibiotics.

Q. Why did you decide do discharge Mr. Farner on March 6th, 1995?

Maybe I should ask this question first, was it your decision to discharge Mr. Farner on March 6th, 1995?

A. It was a collective decision between the orthopedic department and his primary care physician, Dr. John Robinson.

Q. Why was he discharged on March 6th?

A. Can you be more specific?

Q. Sure, why was that date picked *to* discharge him, why wasn't he kept for a longer period of time?

A. There's a whole host of reasons, particularly government regulations these days,

DRGs that really preclude keeping patients in a hospital for inordinate amounts of time. Years ago you could do that, you can't do that these days.

If there is some reason to keep a patient in the hospital, and you are doing something for the patient that you cannot do at home, then you keep them in. If you are not doing something definitive that can't be done, then you send the patient home.

Q. So was it your feeling that he could receive the care he needed at home at that point?

A. On the day that Mr. Farner was discharged, I evaluated him, that is on 3/6/95. I noted that he had intermittent febrile episodes. The evaluations were underway per the internal medicine department, specifically Dr. Robinson. At the time of discharge there was no reason to keep Mr. Farner in the hospital.

Q. When he was discharged, was a cast put on his leg, or before he was discharged?

A. The day of discharge, Mr. Farner had a cast on.

Q. Where did the cast run from and where did it run to?

A. According to the notation on 3/6/95, it

does not state specifically where the cast went from/to

Q. does it state the type of cast?

A Normally, no, it s not necessary to state the type of cast because the orthopedic department members, they staff, are the only ones that monitor the cast

Let me rephrase that, it's implied by virtue of the procedure that was done to r Farner the type of cast that was applied

Q Would the cast have completely covered the surgical wound area?

A Most likely

Q Did you give either Mr Farner or Mrs Farner any Comegoing instructions?

A Yes.

Q What were those instructions?

A Mr. Farner was seen by Dr Fordice on 3/6/95, follow-up instructions to see me in seven to ten days, to see Dr. Robinson in two weeks as was given a prescription for pain medicine to control his pain postoperatively as well

Q Do you know whether or not you told either Mr. or Mrs Farner to keep a record of Farner's temperature?

MR. EDMINISTER: When? You have to be more specific, Mark. Ever?

BY MR. RUF:

Q. Well, basically what I want to know is do you remember during the first hospital admission instructing either Marilyn Farner or James Farner to keep a record of his temperature once he went home?

A. I don't recollect. At the time -- at the time of Mr. Farner's discharge I was not present, one. Two, I need to see whether there is another discharge instruction sheet.

Q. Do you know whether or not Marilyn Farner kept a written record of James Farner's temperatures once he was discharged?

A. I don't know.

Q. Do you remember whether or not Marilyn Farner ever gave you a piece of paper which listed James Farner's temperatures once he was discharged?

A. Do I have that? Can I go off the record?

MR. RUF: Sure.

(Discussion had off the record.)

THE WITNESS: Would you reask the question, please?

BY MR. RUF:

Q. Sure. Where is Karen Farmer now that Jamie Farmer's temperatures on a daily basis, that she recorded his temperatures three times a day from the day he was discharged from the hospital up until the time Jamie Farmer went to your office

Do you remember seeing any kind of records kept by Marilyn Farmer?

A No

Q Can you say whether or not she gave you her written records of temperatures?

A I don't have that recollection and it's not documented that that is the case in my office notes, in his post-operative visits dated the 14th of March and the 21st of March, 1995

Q If such a record was kept, would you have any idea where that record would be?

A No

Q Do you know whether or not Jamie Farmer has a temperature from the day after he was discharged until the first time he followed up with you?

A Mr Ruf, I can only attest to what's in front of me at this point in time I don't have a

specific recollection about whether he had a temperature from the day of discharge up until the time postoperatively, I don't have that documentation nor do I have that recollection.

Q. So basically what you are telling me is you can't say one way or the other whether he had a temperature from the day after discharge up until the time he saw you at your office?

MR. EDMINISTER: He's answered the question.

THE WITNESS: No.

BY MR. RUF:

Q. When was the first time James Farner came in for a follow-up visit?

A. March 14th, 1995.

Q. On March 14th, 1995, did Mr. Farner have a temperature?

A. I can only attest to my office, what was done in my office.

Q. Okay. What was done in your office on that date?

A. He was examined and X-rayed, placed back in a new dressing.

Q. Do you know whether or not James Farner had serous discharge from the operative site from

the day after discharge up until March 14th, 1995?

A I can only attest to the 10th of March, he had sero-sanguinopal draining in his incision site

Q Was there anything about the March 14th visit that led you to believe that Mr. Farner might have an infection in his leg?

A Can you be more specific or rephrase the question in a different manner?

Q Why did Mr. Farner go to you on March 14th?

A His routine postoperative visit

Q So that was a visit that was scheduled as a matter of routine?

A That's correct

Q He didn't come to you because he was having any type of special problem postoperatively?

A No, this was his first postoperative visit

Q. When would that office visit have been scheduled?

MR ADMINISTER: We've already been through that, it's right in the discharge note

MR RUF: Okay

BY R RUF:

Q. Do you remember telling the Farners, either Marilyn or James Farner, that you thought he had an infection in his leg on March 14th, 1995?

A. According to my notes, no.

Q. Was it your impression on March 14th, 1995, that Mr. Farner had an infection in his leg?

A. I was concerned about it.

Q. Well, see, I guess I don't understand. I understand that a doctor is always concerned about postoperative infection in a patient but what I want to do is separate that general concern for -- from a suspicion that a patient actually has an infection or making the diagnosis that a patient actually has an infection.

Was the serosanguineous drainage on March 14th, 1995, a sign of infection or a potential sign of infection?

A. Yes, it was a potential sign of infection.

Q. Was there anything else about your examination on March 14th, 1995, that would be a sign or a potential sign of infection?

A. No.

Q. Did you record Mr. Farner's temperature on March 14th, 1995?

A. No. I did not It is not customary in my specific orthopaedic practice to monitor the patient's temperature

Q Could you tell me, did Mr. Farner have a temperature on March 14th, 1995?

A At my point on that day, I don t know.

Q At the time he was at your office?

A I just said that, I didn t take his temperature

Q - So you don t know whether he had a temperature?

A. I don t know.

Q Could I see that note please

A (W tness handing documents)

Q Why did you remove the cast on March 14th, 1995?

A It is customary to examine a postoperative wound following a surgical procedure

Q Other than the serosanguinous drainage, did you notice anything else about the surgical wound?

A. Yes.

Q. What else did you notice about the wound?

A There was, according to my notation, there was mild erythema, there was serosanguineous

drainage as stated, there was edema

Q What is erythema, redness?

A Yes

Q Is erythema a sign of infection or a potential sign of infection?

A Erythema is not exclusively a sign of infection. It is a potential potential sign, yes.

Q. Is edema a sign or a potential sign of infection?

A. No.

Q So on March 14th, 1995, the only potential signs of infection you noticed were the serosanguinous drainage and the erythema?

A Correct

Q Is there anything else you noticed about the surgical wound?

A I think you just asked me that

Q Other than what was discussed?

A I read to you my objective information from the chart, he had mild erythema, he had serosanguinous drainage, he had moderate edema

Q When was the next time Mr Farner saw you?

A The 21st of March

Q. Do you know why you saw him on March 21st?

A. That was his next visit.

Q. Was that a routine visit or was he scheduled again because he was having problems?

A. Can you delineate routine?

Q. Do you typically have three or four office visits following an open reduction?

A. Absolutely, absolutely.

Q. So this would have been just another routine office visit?

MR. EDMINISTER: Well, call it what you want, I am going to object to the form of the question. You use the word routine, it was a regularly scheduled office visit.

THE WITNESS: According to the notation on 21 March, I stated in the first sentence, Mr. Farner was back in for his follow-up evaluation of his right leg.

BY MR. RUF:

Q. What did your examination on March 21st, 1995, reveal?

A. Revealed the incisions were healing well, the central or middle third was not doing as well, and I am reading from the notation, I stated that

there was blood-tinged cloudy fluid, T-I-N-G-E-D, however, no purulence noted, circulation was checked, I am paraphrasing now, and that's it.

Q. Mr. Farner was admitted to Cuyahoga Falls General Hospital on March 21st, 1995, correct?

A. Yes.

Q. Was there something about the office visit of March 21st which led you to believe that Mr. Farner needed to be readmitted to the hospital?

A. Yes.

Q. What was it about that office visit that led you to believe that he needed to be readmitted?

A. What led me to believe that?

Q. Yes.

A. The objective findings on the examination.

Q. What objective findings?

A. I just went over that, blood-tinged cloudy fluid, and the central third of the incision, and I quote,- was not doing well, end of quote. Those were my concerns.

Combining all of the information that has occurred in Mr. Farner's care, I felt he needed to be hospitalized because of a potential

infectious problem.

Q. Let's go to the admission of March 21st. Do you know whether or not Mr. Farner had continuous serosanguineous drainage from March 6th, 1995, up through March 21st, 1995?

A. No, I do not know.

Q. Well, I'd like you to take a look at the history and physical form. Under history of chief complaint, it states patient states that since he had -- wait, patient states that since then he has had continuous drainage and that his orthopedic surgeon suggested he come to the hospital.

Do you know whether or not Mr. Farner had continuous serosanguineous drainage from March 6th up until March 21st, 1995?

A. Now, according to the history of chief complaint, certainly that suggests that, according to his information given to the history taker.

There is evidence in the chart that Mr. Farner said to me, that was documented, he had intermittent episodes of drainage, which implies to me it was not continuous.

Q. What was Mr. Farner's temperature at the time of admission?

A. According to whom?

Q The history and physical form.

A According to the h story and physical, on 3/21/95 his temperature was 99 F

Q Did you sign the history and physical form for the second admission?

A Yes

Q It states at the end of that form, tentative diagnosis, postoperative infection, most likely cellulitis?

A Uh-huh

Q Are you the one that came to that tentative diagnosis?

A This, as it indicates above my signature, this report, that is this H & P, history and physical examination, was dictated by Richard Anderson, who was an extern at the time at the hospital. That was his impression or tentative diagnosis.

Q. Did you concur that the tentative diagnosis was postoperative infection, most likely cellulitis?

A. Mr Farner was admitted from my office directly following the 3/21 visit, that was my concern initially for sending him back to the hospital to begin with

You already gave me that. Was that my concern, yes, that was my concern, that s why I admitted him the second time

Q What was done to determine whether or not James Farmer had an infection in the second admission?

A. In the hospital?

Q. Yes.

A Well, prior -- the orthopedic resident saw the patient, which included specifically labs drawn, cultures of wound as well Patient was -- that s it.

Q Were cultures of the wound taken prior to the surgical debridement procedure?

A At any time prior to?

Q Yes

A Cultures were taken on 3/21/95 in my office

Q. Of the surface of the wound?

A Yes

Q - What was the result of those cultures?

A Can you be more specific?

MR MINISTER: What are you referring to, the cultures taken in the office?

BY MR RUF:

Q Yes, you stated you took the cultures at your office, right?

A That s correct.

Q What were the cultures taken of?

A. His incision, the skin in the incision area and the drainage

Q. And what was the result of those cultures?

A. The result of that particular culture I don t know, it s not documented here There is no documentation that I can tell that suggests that the result came from my office and went to the hospital, unless I am just misreading it.

Q Well, do you know, was a result obtained for the culture of March 21st, 1995, that was taken at your office?

A. The preliminary report of 3/21/95 suggested there were moderate numbers of gram-negative rods cultured

Q does it state the specific type of gram-negative rods?

A The name?

Q Yes

A No, the report dated 3/21/95 does not state specifically the name, it describes the

negativity of it and the shape.

Q. At some point during this second admission you decided that you needed to cut open Mr. Farner's leg and take tissue samples, correct?

A. Yes.

Q. When did you perform that procedure?

A. 3/24/95.

Q. What types of tissue samples were taken during that procedure?

A. Necrotic tissue that was identified was sharply removed from the wound.

Q. Where was the necrotic tissue focused?

A. Can you be more specific in asking me that?

Q. Sure, was the necrotic tissue around the orthopedic plate that had been inserted into Mr. Farner's leg?

A. No.

Q. Where was the necrotic tissue in relation to the orthopedic plate?

A. We're talking about a small area here. There is soft tissue, there is bone, there's a fracture, there's hardware or plate. The necrotic tissue was identified as muscle, that muscle is over the bone normally.

The necrotic tissue was sharply removed from that area. The area of your concern, the plate, was examined and according to this did not have any evidence of necrotic tissue present.

Q. Okay. I'd like to hand you some copies of anatomical diagrams. Could you look at those and tell me whether you could point out to me the location of the orthopedic plate and the location of the necrotic tissue?

MR. EDMINISTER: Do you want to mark those?

THE WITNESS: No, I can't, I mean I can only infer because I can't, I can't, not from this drawing I cannot.

BY MR. RUF:

Q. Can you show me on any of those anatomical diagrams where the location of the orthopedic plate was?

THE WITNESS: Do we have X-rays here?

MR. EDMINISTER: No.

THE WITNESS: Okay. The plate or hardware was placed on the lateral aspect, the lateral aspect of the proximal tibia.

MR. RUF: Could you mark an X -- let's mark this piece of paper.

(Plaintiff's Exhibit No. 1 marked for identification.)

BY MR. RUF:

Q. I am handing you what's been marked as Plaintiff's Exhibit 1. Could you show me by marking with a red pen where the orthopedic plate was put?

MR. EDMINISTER: As best he can, doing it from memory?

MR. RUF: Yes.

MR. EDMINISTER: Doing it from his review right now of the operative notes and without the benefit of X-rays?

THE WITNESS: First of all this -- the drawing is incomplete in that it doesn't show the majority of the tibia.

It was placed on the lateral aspect, this refers to the medial, M refers to medial, L refers to lateral. The plate was placed on the lateral aspect of the proximal tibia.

BY MR. RUF:

Q. So that's where you marked the X?

A. The X refers to the general lateral position of the tibia, the lateral surface of the tibia. However, it's only a general region of

where the plate was applied. To be more accurate I would have to look at the X-rays specifically.

Q. Was the necrotic tissue around the area of the fracture?

A. According to the operative record, no.

Q. Could you explain to me where the necrotic tissue was in relation to either the fracture or the orthopedic plate?

A. It is difficult to pinpoint that. There is normally muscle, muscle and other soft tissue covering the bone. In the body of the operative report I mentioned a portion of the muscle that is the tibialis anterior muscle was necrotic. What's, the necrotic tissue was sharply excised.

Q. Do you remember during the March 1st, 1995, procedure when you were doing the open reduction, did you observe any necrotic tissue in Mr. Farner's leg at that time?

A. Not to my recollection.

Q. Did you notice anything abnormal about Mr Farner's leg tissue when you observed the open reduction on arch 1st, 1995?

A. What do you mean by "normal"? You previously asked me about what I saw of his skin.

Q. Now I am talking about after you cut open

his leg and you were looking at the tissue inside his leg during the March 1st procedure. Did you notice anything abnormal about that tissue?

A Not to my recollection, no

Q During the surgical debridement procedure, a number of tissue samples were taken, correct?

A More than one

Q And eventually the diagnosis was made of a deep wound infection, correct?

A Where do you get that from?

Q Why don't you look at the progress note of 3/24/95?

MR EMINISTER: Which, 3/24/95?

MR RUF: 2:00 o clock

MRE WITNESS: Okay

BY MR RUF:

Q. I've had some trouble reading that note This is not your writing, is it?

A No.

Q Can you read the writing in that note?

A - A portion of it.

Q What can you read from that note?

A In general or specifically? Do you want me to read the whole thing or as much as I can read?

Q. Yes, as much of it as you can read.

A. The top of the page, dated 3/24, looks like 2:00 p.m., post-op note, preoperative DX period, which implies or means preoperative diagnosis, superficial wound infection, S slash P, which means status post or after the fact, tibial plateau fracture with -- tibial plateau fracture, looks like O dot F.

Under that, the next line, post-op DX period or dash, same with deep, looks like wound infection, procedure, dash I, letter I, capital I, two dots, capital D wound. Next deep tissue culture, I can't read the next line. The next line is P-O-S-T splint.

Q. Okay. We can stop at this point. Do you know, were both the surface wound cultures and the deep wound cultures positive for Enterobacter cloacae?

MR. EDMINISTER: What was your question again?

MR. RUF: Were both the surface wound and deep wound cultures positive for Enterobacter cloacae?

MR. EDMINISTER: If you know. The reason I object to your question is I'm not sure

that from the lab report you can tell, because you have different -- unless you have a different lab report than I do.

MR. RUF: Well, if you want, you are free to look at these. These were produced in response to a request for production of the hospital, I asked for all lab slips.

MR. EDMINISTER: These are copies of their slips, they are not contained in the medical records.

MR. RUF: Then they're not contained in the medical records.

MR. EDMINISTER: I have not had an opportunity to see these.

THE WITNESS: So they retrieved this from their computer file?

MR. RUF: I don't know how they retrieved it but these were not actually in the hospital records.

MR. EDMINISTER: Because I can tell from my review of the chart, the wound cultures I see that are contained in the lab don't identify the site from which the culture was obtained, do you agree with that?

MR. RUF: I'm not sure, that's one of

the reasons I am asking Dr. Hill.

THE WITNESS: Would you reask the question, please?

BY MR. RUF:

Q. Sure. Were there any surface wound cultures that were positive for Enterobacter cloacae or were the positive cultures only limited to deep wound tissue?

A. According to the hospital record that I was -- according to the hospital records that I reviewed before, it did not state whether it was superficial or deep.

According to -- looking at what you just gave me, additional information obtained from the hospital shows -- has associated comments on some reports, deep wound right tibia, rare colonies of Enterobacter, gram stain reports, no organism seen, type wound.

Q. Let me clarify this, can you tell me whether or not any surface wound cultures were positive for Enterobacter cloacae?

A. Surface meaning what, the skin?

Q. Yes, were some cultures taken around the skin area?

A. At what point in time? I obtained

cultures preoperatively in my office, those results are not clearly documented on the chart. The patient had cultures obtained in surgery, there was tissue sent, cultures obtained, which we have the results here.

Q. Well, let's look at the progress notes for 3/26/95 at 10:30.

A. Okay.

Q. It states pre-op deep wound infection right leg, post-op same. Who is that note signed by?

A. Dr. Fordyce.

Q. Do you concur that the pre-op diagnosis was deep wound infection, right leg, post-op wound -- post-op diagnosis was deep wound infection, right leg?

A. Do I concur with what's written in in this chart in front of me, yes. If you look, I wasn't there.

Q. Did you make a differentiation between a deep wound infection and a surface wound infection for Mr. Farner?

A. Ultimately my concern was that he had a deep wound infection because he was taken to surgery and his wound was debrided. That's my --

that was my ultimate concern.

Q. Was there anything to indicate that he had a surface wound infection?

A. He could have had a surface infection, he had drainage. But that's not the point, the point is I am concerned about a deep wound infection, that's why we took him to surgery. We have vague information in the chart regarding cultures, lab results.

Whether it was superficial or not, we took him to surgery and cleaned it out. That's the main point here. I mean I'm sorry but that's the point, so why are we belaboring the point of whether it's superficial or deep? It's semantics.

Q. I am just trying to clarify whether the infection was limited to deep wound tissue or was there tissue on the surface that was also infected with Enterobacter cloacae?

A. Well --

Q. Or don't you know?

A. I don't know. We have documentation from my office notes that a portion of the incision was open; there was communication between the outside and the inside, okay. There is drainage that comes out of the wound onto the surface of the skin,

okay.

Q. To the best of your knowledge, were any of the surface wound cultures positive for Enterobacter cloacae?

MR. EDMINISTER: He already answered, he doesn't know.

THE WITNESS: I don't know.

MR. EDMINISTER: Let's move it along, Mark.

BY MR. RUF:

Q. So you did not differentiate as to whether the infection was a deep wound infection or whether it also included the surface?

A. There is really no point in differentiating. If I -- if I may digress a moment, our concern is whether Mr. Farner had ultimately an infection that involved the bone, which he did not.

He had bacteria, proven by culture, within the soft tissues of his leg. Whether that was deep, superficial, is semantics. The ultimate result is that we took him to surgery, cleaned it out, had cultures, got him on the right antibiotics, got the consult and treated him appropriately.

Q. Have you reviewed Dr. Francis' records? Let me read some portion of his records, I want to talk to you about it?

A. Thank you.

Q. For his office notes of April 11th, 1995, it states at this point in time I think I need to speak to Dr. Hill and Dr. Lehman, the plastic surgeon, whether foreign bodies were left in and if there was any residual evidence of infection.

Do you remember talking to Dr. Francis about that topic?

A. Specifically I don't recall a conversation with Dr. Francis, in general I know I talked to him about the case.

Q. Do you know whether you talked to him about whether foreign bodies were left in the leg?

A. Yes.

Q. And what was the substance of that conversation?

A. They were left in -- excuse me, what do you mean foreign bodies?

Q. When you say foreign bodies were left in?

A. The hardware, the plate and the screws were left in the bone.

Q. Did you notice any other foreign bodies in

Mr. Farner's leg when you did the debridement procedure?

MR. EDMINISTER: For example, other than what they intended to be there you mean?

MR. RUF: Other than the orthopedic hardware.

THE WITNESS: No.

BY MR. RUF:

Q. During the debridement procedure you observed some necrotic tissue, correct?

A. Correct.

Q. Was that necrotic tissue deep in the leg or was it on the surface of the leg?

A. Muscle is underneath the fatty layer of the skin, deeper is the bone and the hardware. As indicated in the body of the operative report, I mentioned that there was a portion of the tibialis anterior muscle that was necrotic, which was sharply excised.

Q. Would that tissue have been closer to the bone or closer to the surface of the leg?

MR. EDMINISTER: It's muscle.

THE WITNESS: It has to do with layers and as I was just saying, the muscle is underneath the fatty or subcutaneous layer in that particular

portion of the leg, the muscle overlies the bone.
BY MR. RUF:
Q. So was it the muscle that was around the bone that was necrotic?
A. You just asked me that, I just read that. I mentioned in the operative report, if I can go to the operative report, I am reading from the body of the operative report on 3/24/95 about half -- about a third of the way down.
I quote, we then sharply debrided as much of the necrotic tissue as possible and also used a bone rongeur, R-O-N-G-E-U-R, which is a surgical instrument, to remove necrotic looking soft tissue as well.
Q. Okay.
A. If I may go one line above that, I state, however, we did note that there was evidence of necrotic muscle, which appeared to be the fascia over the tibialis anterior, period.
Q. Okay. In Mr. -- Dr. Francis' note of April 18th, 1995, it states, I spoke to Dr. Hill, he still has the plate in. It is their feeling that they would like to leave it in for eighteen to twenty-four months if they can, period.
Since he has, I believe, a chronic

focus there, I would like to encourage it for at least six months before discontinuing it, so the fracture can heal as well as possible

Do you agree or disagree that there was a chronic focus at the location of the plate?

A You read to me Dr. Francis evaluation and interpretation as a infectious disease consultant I have a different area of expertise than he does: we use our knowledge together I would not necessarily use that terminology

Q Okay What terminology would you use?

A. Relative to what specifically?

Q Well, are you telling me you're not qualified to agree or disagree with his opinion?

Q No, I didn't say that Ke gave his opinion as an infectious disease consultant We do not necessarily use the same lingo, semantics, as it relates to plates and screws and hardware I may have more specific and stringent terminology than he does.

Q. Would you agree or disagree that the infection was focused around the orthopedic plate?

A Around is a very general term, okay I have outlined to show the layering of the skin in that area of the leg, there s several layers

In this situation we have, starting at the deepest layer we have the bone, we have a plate, which is applied to the bone, occurring at the fracture Around the plate there is muscle, around the muscle there is additional soft tissue, below that layer is fat, above that layer is skin

Q Well, can you tell me, was the site -- scratch that.

Was the of focus of infection at the surgical plate or -- let me -- I'm getting confused

Was the focus of infection at the orthopedic plate?

A. No, it was not

Q Why not?

A Again I refer to my body of the operative report, I mentioned the area of tissue that was of concern to me, that was the necrotic looking soft tissue I also mentioned there was necrotic muscle, which appeared to be fascia overlying the tibialis anterior muscle

Q. Do you remember a conversation in which Dr. Francis told you how he believed there was a chronic focus at the plate?

A Do I remember that conversation, no I

have his office note right here but specifics as to a conversation saying he thought that, no.

Q. So do you think that Dr. Francis' impression is inaccurate when he states he believes there is a chronic focus at the plate?

A. Do I think he is inaccurate? We're using different terms here. I mean do I think he's wrong, no, I don't think he's wrong. Our semantics may be different. Do I think he is necessarily wrong, no.

Q. Let's go to his note of June 20th, 1995.

A. Dr. Francis' note?

Q. Correct. Under impression it states Enterobacter infection of foreign body, paren, the rods. Do you know what that means?

A. No, that is what I am saying, I am an orthopedic surgeon, he is an internal medicine specialist, we didn't use any rods, that's not correct.

That's why I am saying that we have different semantics in terms of what we use, whether I thought there was a chronic focus or not.

Q. How many debridement procedures did **you** perform on Mr. Farner?

A. Can you be more specific?

Q. During the second admission.

A. That I performed?

Q. Yes.

A. During the second hospitalization, I took the patient to surgery one time.

MR. EDMINISTER: Is this a question that you asked because you are unclear about the accuracy of the medical records, because you are just -- you don't understand the records, or are you just testing him?

MR. RUF: I'm not testing him, I want to clarify how many times he performed a debridement procedure on Mr. Farner.

THE WITNESS: Okay. I performed, in the second hospitalization, I performed a surgical debridement once. However, my senior associate, Dr. Josof, also performed a debridement on the patient's extremity on 3/26/95.

BY MR. RUF:

Q.- Did any of the other doctors at Cuyahoga Falls General Hospital perform a procedure in which they removed tissue from Mr. Farner's leg surgically?

MR. EDMINISTER: If you know.

THE WITNESS: Other than what is in front of me, I don't know. Dr. Lehman, the plastic surgical consultant, took the patient to surgery on the 28th of March and performed a reconstructive procedure but I cannot attest to what was or was not performed at that time

BY MR RUF:

Q. At the end of the March 1st open reduction procedure, you swore up Mr. Farner's leg, correct?

A. His leg was splinted, most likely it was not by me.

Q. Based upon your experience, how long does it take for the skin to grow together after a surgical wound has been sutured?

MR ADMINISTRATOR: Grow together? Object to the form of the question

THE WITNESS: Can you be more specific please?

BY MR. RUF:

Q.- Did Mr Farmer still have an open surgical wound when he came to your office on March 14th, 1995?

A. What date?

MR ADMINISTRATOR: arch 1 th

MR. RUF: What was the first date he came back to your office

THE WITNESS: Correct, that was the first date he came to the office after surgery

MR. ADMINISTRATOR: Your question was, did he have an open wound?

MR. RUF: Yes.

THE WITNESS: What do you mean open?

BY MR. RUF:

Q Well, when you cut someone's leg open and sewed it up, eventually the surface of the skin grows back together, correct?

A Yes

Q I am asking you, based on your experience as a doctor, how long would it take for that skin to grow back together?

A That is a difficult question because the edges are intact at the time you close the wound with the sutures Over the next seven to twenty-one days there is a continual healing process with respect to a surgical wound

Q Do you know when Mr. Fixner was discharged on March 6th, 1995, whether foreign material could have gotten into his leg through the surgical wound?

MR. EDMINISTER: Objection, the form of the question.

THE WITNESS: Can you be more specific as it relates to foreign?

BY MR. RUF:

Q. In other words, if fluid had been poured on Mr. Farner's leg on March 6th, 1995, would that fluid go through the incision area down into Mr. Farner's leg?

A. That's a difficult question. I mean it depends on what was poured on there, assuming there was something poured on there.

Q. Do you remember having a conversation at Cuyahoga Falls General with Marilyn Farner, with other people present?

A. Not specifically, no.

Q. There's been some testimony that you met with some people out in the lobby of Cuyahoga Falls General Hospital. Do you remember that?

A. Specifically, no.

Q. There's been some testimony that you had a discussion and that Marilyn Farner was present, Jan Farner, the Farners' daughter was present, and another woman named Betty Brothers was present.

A. Who is she?

Q She's --

MR. ADMINISTER: Well, let's get to the question, will you, it's 7:00 o clock

BY MR. AWF:

Q. Do you remember having a conversation out in the lobby --

MR. EDMINISTER: Objection, asked and answered

BY MR. RWF:

Q. -- with those people present?

A I don't remember that

Q Do you remember whether the Farners questioned you as to how this injection occurred?

MR. ADMINISTER: At what time?

MR. AWF At any time

THE WITNESS: They may have done that but the specifics of whether I recall that discussion, no, I do not

It is very customary for me, in every operation that I do, that I talk to the family after-surgery Now the specifics as to who was there, other than the initial contact family, I'm not specific

I know I talked to Mrs Farner there after the surgery. her daughter may have been

there. I don t recall. the other person I don t remember.

BY MR. RUF:

Q. Do you remember a discussion with Mr Farner?

A - Which discussion?

Q A discussion after surgery

A No. I do not the specifics of that discussion I do not

Q Do you have an opinion as to how the Enterobacter cloacae got into Mr Farner s leg?

A No

Q I want you to assume that the infection was only a deep wound infection, that the surface of Mr Farner s leg was not infected with Enterobacter cloacae

Can you tell me whether it is more probable than not that under these circumstances the Enteroactor cloacae in the leg would be the result of contamination during surgery?

MR ZAK INISMER: Objection

THE WITNESS: I don t know that answer.

BY MR RUF:

Q. If the focus of the infection was the

orthopedic plate. Do you know whether that has an impact on the probability of whether or not there was contamination during surgery?

A. No.

Q Do you remember whether or not at any time you told either Marilyn or James Farner that you believed the only explanation for this infection was contamination during surgery?

A Do you mind. I'm sorry?

MR RUF: Sure. Would you please read that question back

(Previous testimony read back as requested)

THE WITNESS: I don t remember specifically telling Mr and Mrs that and I never would have said only contamination as the etiology for the infection That would have had to be proven.

BY MR RUF:

Q Could you have said it was the most likely explanation for the infection?

A - We re talking semantics about what I may have said. I don't know. Mr. and Mrs Farner and I had discussions regarding his care The specifics as to whether I said something was only due to Enterobacter and how it got there. I don't recall

that conversation.

MR. RUF: Could you mark this as Plaintiff's Exhibit 2.

(Plaintiff's Exhibit No. 2 marked for identification.)

BY MR. RUF:

Q. I am handing you what has been marked as Plaintiff's Exhibit 2, it's pictures of Mr. Farner's leg. Do you believe that the medical condition shown in Plaintiff's Exhibit 2 is an acceptable complication from an open reduction?

MR. EDMINISTER: Objection.

THE WITNESS: What I am looking at now is not -- I am looking at four photographs of a gentleman's leg who had surgery.

The photographs do not confirm that he had, you know, an infection. The photographs only show that he had something done to his leg in the area of the knee and he had something done in the area of the thigh.

BY MR. RUF:

Q. Do you have an opinion as to whether the Enterobacter cloacae infection in Mr. Farner's leg was an acceptable complication?

MR. EDMINISTER: Objection to the form

of the question

THE WITNESS: Mr. Farner had a very difficult case, a very complicated fracture The fracture ultimately healed without any problem. The last visit that I saw r. Farner, his fracture had healed, his soft tissues had healed, there was no evidence of any residual pain or superficial infection

And the complication that he had, that is an infection, was a recognized complication of the procedure that was clearly documented in writing and verbally with the family and the patient.

BY MR. RUF:

Q. Over the course of your experience as a doctor, have you had any other patients that have wound up with a leg looking like the leg as shown in Plaintiff's Exhibit 2 following an open reduction?

MR NISMER: Objection.

THE WITNESS: Of what, a tibia?

BY MR RUF:

Q. Of a tibia

A No

MR RUF: Thank you, doctor That's

all I have.

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(Deposition concluded at 7:10 o'clock p.m.)

- - -

I, GREGORY HILL, D.O., do verify that I have read this transcript consisting of one hundred and sixteen (116) pages and that the questions and answers herein are true and correct with corrections as noted on the errata sheet.

.....
GREGORY HILL, D.O.

Sworn to before me, _____,
a Notary Public in and for the State of _____,
this _____ day of _____, 19__.

_____

Notary Public in and for the
State of _____.

My commission expires _____.

C E R T I F I C A T E

STATE OF OHIO,)
) SS:
SUMMIT COUNTY.)

I, Michael G. Cotterman, Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, GREGORY HILL, D.O., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the witness was by me reduced to Stenotypy in the presence of said witness, afterwards transcribed upon a computer; and that the foregoing is a true and correct transcription of the testimony so given by the witness as aforesaid.

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

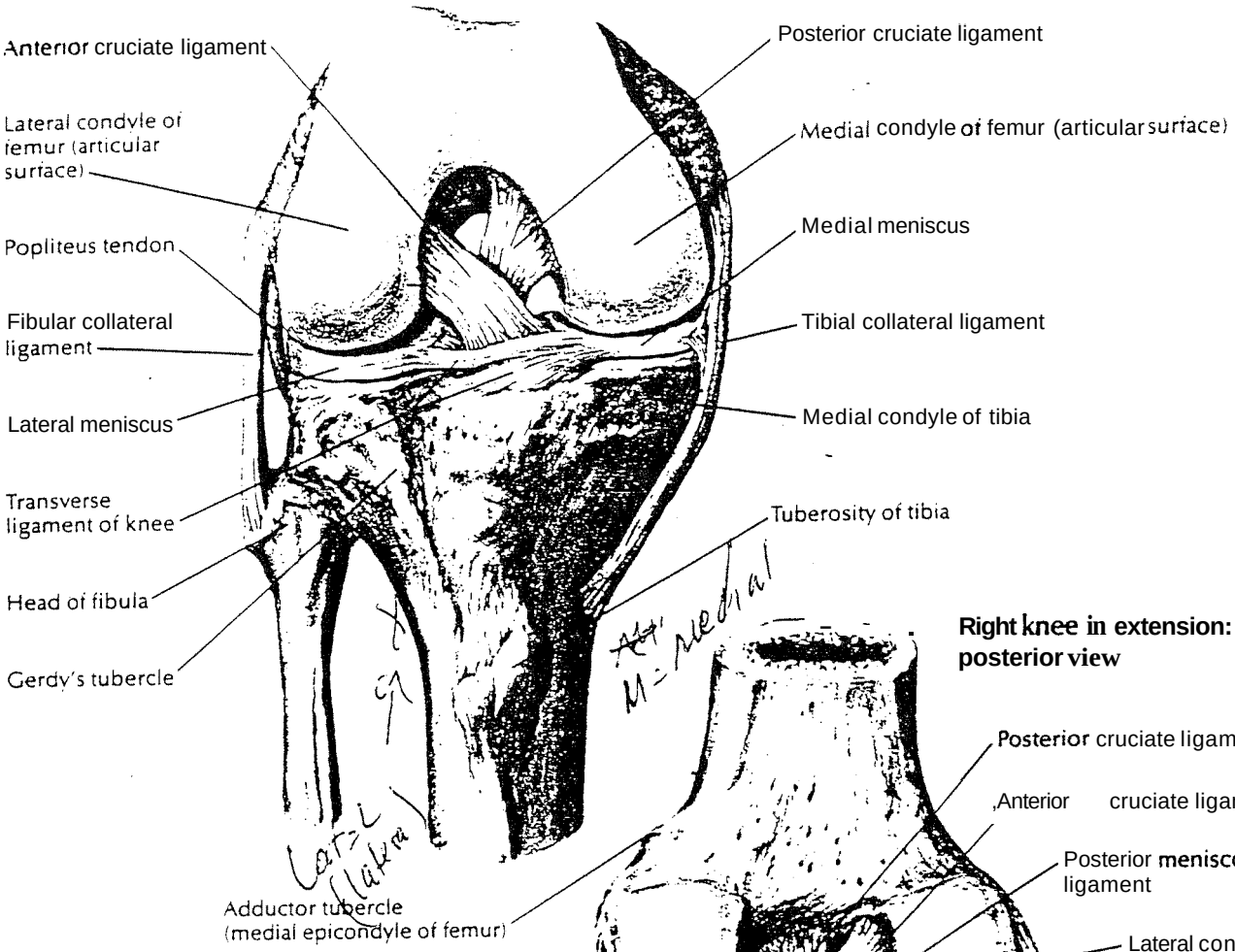
I do further certify that I am not a relative, counsel or attorney of either party, or otherwise interested in the event of this action.

IN WITNESS HEREOF, **I** have hereunto set my hand and affixed my seal of office at **Akron**, Ohio on this 15th day of January, 1997.

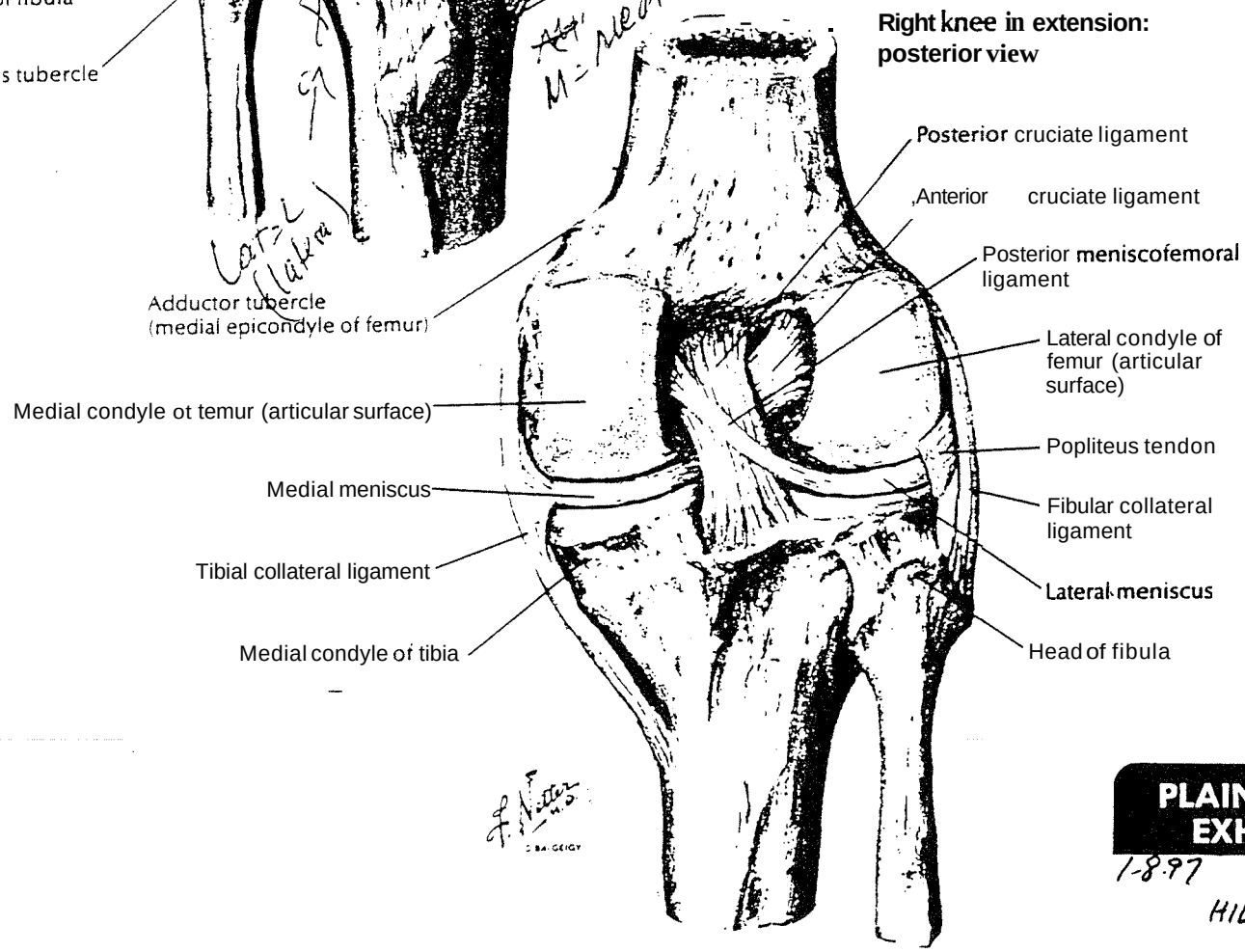
Michael G. Cotterman, Notary Public in and for the State of Ohio.

My Commission expires October 25, 1997.

Right knee in flexion: anterior view



Right knee in extension: posterior view



PLAINTIFF'S EXHIBIT
1-8-97 / MC
HILL

PLAINTIFF'S
EXHIBIT

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