State of Ohio, SS:
County of Cuyahoga.

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IN THE COURT OF COMMON PLEAS

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Feyruz Saadeh, et al.,

Plaintiffs, Case No. 441490

vs. Judge Burt W. Griffin

MetroHealth Medical Center, et al.,

Defendants.

- - -

THE DEPOSITION OF STEVEN M. HOUSER, M.D.

MONDAY, JANUARY 21, 2002

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The deposition of STEVEN M. HOUSER, M.D., a Defendant herein, called for examination by the Plaintiffs, under the Ohio Rules of Civil Procedure, taken before me, Michelle R. Hordinski, Registered Merit Reporter and Notary Public in and for the State of Ohio, pursuant to agreement, at MetroHealth Medical Center, Cleveland, Ohio, commencing at 3:00 p.m., the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiffs:

FRANCIS E. SWEENEY, JR., ESQ.
323 Lakeside Avenue, N.W.
Suite 450
Warehouse District
Cleveland, Ohio 44113

On behalf of the Defendants:

DEIRDRE *G.* HENRY, ESQ.
Weston, Hurd, Fallon, Paisley & Howley
2500 Terminal Tower
Cleveland, Ohio 44113

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STEVEN M. HOUSER, M.D.

a Defendant herein, called for examination by the Plaintiffs, under the Rules, having been first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION

BY MR. SWEENEY:

Q. Good afternoon, Doctor. My name is Francis Sweeney. I'm sure your attorney has filled you in on who I am and why I'm here.

A. Yes.

Q. I'll kind of dispense with -- have you ever given a deposition before?

A. No.

Q. Never? This is your first time sitting down?

A. Correct.

Q. Being deposed?

A. Correct.

Q. All right, well then I guess I won't dispense with those instructions.

I brought you here today to ask you some

questions regarding your care of my client, Feyruz Saadeh. I'm going to be asking you questions based on your treatment of him, surgical procedures that you performed, and any information that's in his

chart that you may have or have knowledge of.

If there's anything that you don't understand that I ask you, just tell me, and we'll clear it up for you.

A. All right.

Q. That's as simple as I can put that.

Please try to answer verbally so the court reporter can take it down.

If there's anything that you -- if you need to take a minute, if there's a question you need to confer with your attorney, just let me know, and we'll take it from there.

A. Okay.

Q. I'll assume you understand the questions otherwise, and we'll just start with some basic information

from you and move on from there.

A. Okay.

Q. Your full name again?

A. Steven Michael Houser.

Q. What is your current address?

A. Home address or work address?

Q. Both.

MS. HENRY: Well, can we just do his work address on the record, and I'll give you his home address off the record if you need to?

That and the Social Security numbers I don't permit to go on the record, because they are a matter of public record, all right?

MR. SWEENEY: All right.

MS. HENRY: His professional address is here. He's employed here

MR. SWEENEY: Yes, I understand that.

BY MR. SWEENEY:

Q. What city do you live in?

MR. SWEENEY: Is that okay?

MS. HENRY: Yes.

A. Cleveland Heights.

Q. How long have you lived there, in that city?

A. Total, during residency, so it would be seven and a half years.

Q. Where did you live before that?

A. Columbus, Ohio.

Q. How long were you in Columbus?

A. Four years.

Q. Did you go to school down there?

A. Yes.

Q. Where did you go to school?

A. Ohio State.

Q. Is that undergrad?

A. For medical school.

Q. Then where did you go to Undergrad?

A. Notre Dame.

Q. So you were up in Michigan --

A. South Bend.

Q. Or Indiana, excuse me?
A. Correct.
Q. So you went to undergrad at Notre Dame, so that would put you over there before -- where were you born and raised?
A. Born in Hartford, Connecticut and raised in Strongsville, Ohio.
Q. As of what age?
A. Seven.
Q. What high school did you go to?
A. Strongsville High.
Q. What year did you graduate?
A. 1985.
(Thereupon, a discussion was had off the record.)
BY MR. SWEENEY:
Q. You went to Ohio State Medical School, correct?
A. Correct.
Q. And what year did you graduate?

A. 1989.
Q. And went directly -- wait a second, where did you do your residency?

A. The Cleveland Clinic Foundation.

Q. From what period of time?

A. From 1989 until -- or no, no, sorry. I graduated medical school in 1993. So from 1993 until 1998 I was in residency.

Q. Did you do a fellowship?

A. Yes.

Q. Where?

A. University of Chicago.

Q. That would be in otolaryngology?

A. In rhinology.

Q. Rhinology?

A. Rhinology, allergy.

Q. What years?

A. '98 to '99, the academic calendar.

Q. Then you were hired by MetroHealth Hospital?

A. Yes.

Q. And you were hired in what year?

A. 1999.

Q. How did you go about finding that position?

A. I sent my curriculum vitae to University Hospitals looking for an academic position. They have a

joint residency program, basically, with MetroHealth, and that's how this job ended up being offered to me.

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

BY MR. SWEENEY:

Q. What states are you licensed in?

A. Currently Ohio.

Q. Have you ever been licensed in any other states?

A. Yes, in Illinois during my fellowship.

Q. Is there a process by which you keep that up while you're not working in the state, or do you let it lapse, or how does that work?

A. I allowed it to lapse, because I was not working there and saw no need to continue paying fees to keep my license up.

Q. And you've been licensed in Ohio since '99?

A. No, since probably '95 or six.

Actually, I may have it in my wallet, if you'd like, because I have a --

Q. Did your residency from '93 to '98 at The Clinic, so you were -- that makes sense, about '95?

A. You can --

Q. '96?

A. After you complete an internship, you can apply for your state medical license. This does not say when

I obtained my license, just the expiration (Indicating).

Q. Approximately, though?

A. Approximately '95 to '96, one of those years.

Q. And are you currently board certified?

A. Yes.

Q. In any disciplines?

A. Yes.

I'm currently board certified in otolaryngology.

Q. When was that board certification?

A. Board certification was in '99, May 10th.

Q. Is that an oral or written?

A. Both.

Q. So you sought employment through MetroHealth/University Hospitals in '99 in your specialty?

A. Yes.

I contacted University Hospitals, and they directed me to MetroHealth.

Q. What did they tell you, they are looking for people?

A. They told me that they had a potential position that I could fill, yes.

Q. I'm just going to refer to it as ENT, because it's shorter than otolaryngology.

A. Yes.
Q. In ENT?
A. Yes.
Q. That's what I'm referring to when I say that, just so we aren't confused.
Any other members of your family in medicine?
A. Yes.
Q. Who is in it, who and where?
A. My wife is a physician.
Q. Where is she?
A. She's currently working for Kaiser.
Q. As --
A. She works in the clinical decision unit in the emergency department area of the Kaiser portion of the ER at the Cleveland Clinic.
Q. Is that the ER -- you mean off of 90th there in Euclid, that Clinic ER, or is it --
A. It's on Carnegie and East 90th, perhaps.

Q. There's a Kaiser ER, and then there's a Cleveland Clinic ER?

A. They are in the same building.

Q. Correct. They are like right next to each other, and she works for the Kaiser portion?

A. Correct.

Q. As a --

A. She works in the clinical decision unit.

Q. What is that?

A. It doesn't necessarily fit any descriptor well, but she works -- she's a family physician.

Q. Okay. Sounds to me like that's some sort of title that has to do with insurance. Would that be --

A. Well, it's a 23 hour stay unit associated with the emergency department. That's where she works.

MS. HENRY: She sees patients, right?

BY MR. SWEENEY:

Q. She sees patients?

A. Correct.

Q. That come in emergently?
A. Correct. Patients that come in through the ER that they feel potentially need a longer time to sort out than the ER can provide are placed in the CDU until they can be either admitted --
Q. I got it.
A. -- or get sufficient testing to be discharged.
Q. Because of insurance issues?
MS. HENRY: Objection.
MR. SWEENEY: I'm sorry, you can strike that.
A. The Cleveland Clinic utilizes it, as well.

Q. Okay,
A. They both use it.
(Thereupon, a discussion was had off the record.)
BY MR. SWEENEY:
Q. Any other family members?
A. My mother was a nurse.
Q. Anybody else, brothers, sisters, that are in medicine?
A. No, no.

Q. So you were born in Connecticut, moved here when you were six?
A. Seven.
Q. Seven.
You lived in Strongsville, went there through high school, went to Notre Dame, went to Ohio State Med, fellowship back in Illinois --
MS. HENRY: No, Cleveland Clinic.
A. Cleveland Clinic
Q. Fellowship in Cleveland Clinic?
MS. HENRY: Residency Cleveland Clinic, fellowship --
Q. Fellowship up in Illinois?
A. Correct.
Q. And then to Metro?

A. Correct.
MS. HENRY: Employed by Metro.
BY MR. SWEENEY:
Q. Have you been here ever since?
A. Yes.

Q. You've been employed at Metro?
A. Correct.
Q. Do you occupy any teaching positions?
A. Yes.
Q. Where?
A. I'm an assistant professor of otolaryngology at Case Western Reserve University School of Medicine.
Q. How many other teaching positions are over there?
A. Excuse me?
Q. In ENT, are you the only one teaching?
A. Where?
Q. Over at Case.
A. No.
Q. So how many other ENT's do they have over there teaching this discipline, this specialty?
A. Well, that's, I guess, difficult to answer in a fashion.
There are how many full-time people?

Q. Yes.
A. Currently, there are five full-time faculty at University Hospitals that are associated with

Case.

Q. Okay.

A. At MetroHealth, there are currently three full-time faculty that are associated with Case. There are multiple part-time people associated with Case.

Q. You get a paycheck. Does that come from MetroHealth Medical Systems?

A. Correct.

Q. Do you also get paid through Case Western Reserve?

A. No, I do not.

Q. Or University Hospital?

A. No, I do not.

Q. How does that position work, then?

You occupy a teaching position, and it's unpaid?

A. Basically.

Q. What do you get out of it, then?

A. We get the enjoyment of working with residents and teaching them. It's satisfying.

Q. Any other monetary remuneration?

A. From Case Western?

Q. Yes.
A. No.
I mean, we also work with the medical students, you know, as well.
Q. Okay.
A. In other specialties other than otolaryngology.
Q. Do you have any other specialties?
A. None that I'm board certified in.
Q. Any that you're practicing or interested in?
A. I do allergy as my fellowship, was in allergy, which is considered within the realm of otolaryngology.
Q. Would that be ID, as well, or --
A. ID?
MS. HENRY: Infectious disease.
BY MR SWEENEY:
Q. Would it be infectious disease, as well?
A. No.
Q. I didn't know if it falls under that or not.
A. No.
Q. Anything else?
A. No.
Q. When you were hired by Metro Hospital, what is your understanding of the position you would occupy and

your duties?

A. I would be a staff physician providing general otolaryngology care, but specifically providing coverage of rhinology and allergy.

Q. Is that what they requested of you, or is that what you told them that you would be specializing in?

A. This is what they were looking for.

They had an active allergy practice without a physician to cover it, and they wanted someone interested in treating the nose.

Q. What textbooks do you use in your teaching?

What do you rely on?

A. Which textbooks do I rely on?

Q. Or use.

A. For what purpose?

Q. Well, you teach students in otolaryngology, right?

A. Yes.

Q. You must reference from a textbook, I assume?

A. There are a great number of textbooks in otolaryngology that cover the broad basis of otolaryngology, and --

Q. Those would be --

MS. HENRY: Let him finish his answer. Go ahead.

A. None of them are considered the absolute standard. They are all useful.

ENT is such a rapidly developing field that, in a lot of ways, you really require medical literature rather than textbooks, because they typically, by the time they get out in print, tney are out of date.

Q. Why is it advancing rapidly?

A. Well, specifically the area that I work in in the nose is advancing rapidly. Perhaps some areas are not advancing as rapidly as others.

Q. Is there any three or four textbooks in ENT that are most useful to you, just to give me some idea of where these students are learning from or what you use?

I'm just talking about basic ENT here.

A. Useful for general ENT, not specifically sinus?

Q. Exactly.
A. Sinus work?
Q. Exactly.
A. There are multiple texts that are useful. I wouldn't say, though, that any is standard.
Q. Well, what are some that you respect?
A. I can give you some names. I can't say that I

respect. I can just tell you some names, if that's what you would like.
Q. Well, ones --
A. I can give you a list of --
Q. Go ahead, then, shoot.
A. A list of textbooks.
Bailey's Textbook of Otolaryngology is a textbook which frequently will be used.
Cumming's is frequently used.
Q. Okay.
A. There's English Guide to Otolaryngology.
Q. Okay.
A. Those are three very general textbooks.
Q. What about texts more specific to the sinus?
A. That's where specifically textbooks fall off and

are not -- they are not really present or very useful, because, again, it's such a rapidly developing field.

Q. Sure.

But as a student, you have to get your basic information somewhere, so --

A. As a student, you get your basic information from your residency training as well as from reviewing articles.

Q. Okay.

A. Specifically when we're discussing sinus.

Q. Endoscopic sinus surgery by Levine & May, is that a text that you've seen before?

A. I have looked at it before.

Q. Are there any other sinus textbooks that you would consider to be helpful?

A. Again, I would say that the medical literature as well as the training that I had at the Cleveland Clinic are most useful to me. So I would have to

answer --

Q. I understand those are the most useful things, but the basic information is put down in general textbooks for use by students and by lay persons. I'm just trying to get an idea of -- let's say I'm a first year med student, okay, or I'm an attorney, and I'm trying to figure out what's going on with the sinus. What's a good textbook for me to take a look at just to get a start?

A. There's a textbook by Bhatt, Endoscopic Sinus Surgery, New Horizons.

Q. Do you have any idea how to spell that?

A. B-H-A-T-T is the last name.

Q. Okay, any others?

A. That's all that I can think of as one that potentially might be helpful.

Q. You stated that it's such a rapidly expanding field that you rely on journal articles, is that correct?

A. Correct.

Q. What journals do you rely on or do you read regularly?

A. Regularly, American Journal of Rhinology, The Journal, Otolaryngology: Head and Neck Surgery. As well I will review the allergy literature periodically.

Q. Is that a journal?

A. No, no.

Q. Okay.

A. I look at various allergy journals, as well.

Q. Are there any other periodicals that you receive more frequently or that aren't organized into journals such as these?

A. ENT Journal.

Q. How often does that come out?

A. That's monthly.

Q. Are there any sites online that you rely on?

A. No.

Q. As reference?

A. No.

I purview briefly other ENT journals, as well.

Q. That would include --
A. Laryngoscope would be an additional one.
Q. Okay.
A. That would probably be it. That would probably be a fairly reasonable list.
Q. Doctor, what body would you consider to be on the cutting edge of ear nose and throat medicine, including surgery, sinus surgery?
A. Which body?
Q. Is there an American Board of Functional Endoscopic Sinus Surgery, for example?
A. There's an American Academy of Otolaryngology - Head and Neck Surgery.
Q. Does this academy disseminate or issue information regarding the latest in this field?
A. The journal that I had mentioned, the Otolaryngology: Head and Neck Surgery journal, is the official publication of that organization.
Q. Okay. So that's the place to go, then.
MS. HENRY: For what?
BY MR. SWEENEY:
Q. When you want to know what's going on in head and neck surgery?
A. It's a decent journal.
Q. One of the best?

A. It's a decent journal.
Q. Is there one better than it?
A. It's a decent journal.
Q. So then there are none better than that or equal to?
A. I can restate my response if you'd like.
Q. Are there any equal?
A. It's a decent journal.
Q. Okay, Doc, this is the first time you've given a deposition, correct?
A. Correct.
Q. So I assume you've never been a Defendant in a medical malpractice lawsuit before?
A. No.
Q. So you have?
A. Correct.
Q. When?
A. During residency.
MS. HENRY: I'm going to object but go ahead and let him answer.
BY MR. SWEENEY:
Q. That would be at The Clinic?
A. Correct.
Q. What year?
A. That would be '94.

Q. What year resident were you?
A. An intern.
Q. You were an intern?
THE WITNESS: Should I not be --
MS. HENRY: No, you can.
MR. SWEENEY: She's made an objection.
MS. HENRY: I'm objecting for the record, but I'm going to let you go ahead and answer so we can investigate whether it has any relationship to the issues in this case.
THE WITNESS: Okay.
BY MR. SWEENEY:
Q. You were an intern at the time?
A. I can give you the story if you'd like.
Q. Sure, just real briefly.
A. I was the intern recording the operative note, so my name was named to the suit and eventually dropped.

A woman wearing pantyhose had her Bovie pad put over the pantyhose by nurses, and a nurse in the pre-op area did not have her take off her pantyhose. The Bovie pad resulted in a burn to her

thigh, and the Cleveland Clinic settled out of court. And my name was dropped from it, and I had nothing to do with --

Q. How serious was the burn?

A. It was a dime-sized burn.

Q. You were named as a Defendant, and then you were later taken off the lawsuit, correct?

A. Correct.

Q. But you were named because you were the --

A. I recorded the operative note.

Q. What does that mean?

A. That means that I was the extreme underling in the operating room that did nothing but paperwork.

Q. Okay.

A. Did not touch the patient.

Q. Any other lawsuits?

A. No.

Q. That you've been a part of or been named in?
A. No, none.
Q. Any lawsuits in any other states?
A. None.
Q. Have you ever been an expert witness, acted as an expert witness?
A. I have given medical opinions in cases.
Q. On patients that you did not treat?

A. Correct.
Q. Tell me about those.
A. I gave an expert opinion on a patient that had packing placed in the nose that was slippery packing, not secured to the nose. And following surgery the patient aspirated the pack into their trachea and had brain damage as a result.
Q. Did somebody hire you to be an expert?
A. Yes.
Q. Who?
A. The patient's side.
Q. The Plaintiff's attorney?
A. Correct.

Q. Me?
A. Right.
Q. Okay, so you gave an opinion.
What did the opinion consist of, that there was
negligence?
A. Basically that standard of care would have been to
secure the packing.
Q. And how was that resolved?
A. I do not know.
Q. Was that settled? You have no idea?
A. I do not know.
Q. Were you paid?

A. Correct.
Q. Any other expert work like that either for the Plaintiff’sattorney or for the defense?
A. That was only for the Plaintiff. And I’vehad several for defense.
Q. When was the most recent?
A. Probably a year ago.
Q. What kind of case was it?
A. It may have been that one, the one I had mentioned.

MS. HENRY: Well, if you were giving it for the Plaintiff --

BY MR. SWEENEY:

Q. That was the most recent case?

MS. HENRY: He wants the most recent defense case you've done.

Q. Yes, the most recent defense case,

A. I do not recall. I think that there was a very -- no, I do not recall.

Q. That's all right. Do you remember who hired you?

A. No.

Q. Was it a law firm?

Did Weston Hurd hire you as an expert?

A. Not that I'm aware of.

Q. Have they ever?

A. No.

THE WITNESS: Is that your law firm?

MS. HENRY: Yes.

BY MR. SWEENEY:

Q. Have you ever been a witness in a lawsuit?
A. No.
Q. Not a Defendant or a named party, but someone who is called in to tell them what you saw or what happened?
A. No.
Q. So then I can assume that you've never been a party as a Defendant in litigation which involves functional endoscopic sinus surgery?
A. Correct.
Q. Either as a doctor or during your residency?
A. Correct.
Q. Would you consider MetroHealth Hospital a teaching hospital?
A. Yes.
Q. Why?
A. There are a great number of residency programs here.
Q. Why are some hospitals teaching hospitals and others not?

A. The presence or absence of students/residents.

Q. Doctor, what literature did you review prior to this deposition?
A. Literature?
Q. I'm not talking about the medical records. I'm talking, for example, did you review any textbooks or any journal articles?
A. Well, I did review his record.
Q. Correct.
Other than this record, did you review any other text, journal articles?
A. No.
Q. Nothing?
A. Nothing.
Q. Did you talk to any colleagues?
A. No.
Q. You met with your attorney, I assume?
A. Yes.
Q. And you did review the record, correct?
A. Correct.
Q. Is there anything, as you sit here now, missing from that record?
A. One of the notes when I had seen Mr. Saadeh does not appear to have been dictated.
Q. What note is that?

A. There is a handwritten note, because I always jot down notes to help me dictate. But the note -- I believe it would be 3-28-2000.
Q. And what does that note consist of?
A. That was the note where I obtained his consent for surgery and discussed his CT scans with him.
Q. And what did that note contain?
A. That note would have contained our discussion of his risks and benefits, discussion of possible complications, discussion of his CT scan.
Q. Hold on one second. Discussion of risks and benefits, discussion of --
A. CT scan.
Q. -- CT scan.
What CT scan?
A. I'm not sure what you mean.
Q. Sinus CT scan?
A. Obtained --
Q. I don't know. You reviewed it with him.
MS. HENRY: Well, it's the one that was done here, obviously.
BY MR. SWEENEY:
Q. Well, if that's the case, then what --
A. Yes, I did not --
Q. There apparently was a CT scan done?

A. There was a CT scan, correct.
Q. Now, which one did you go over with him?
A. Which CT scan?
Q. Yes.
A. He had a CT scan done 3-21-2000.
Q. You went over that with him?
A. Yes.
Q. What else did you do?
A. Discussed the risks, discussed the fact that his eye appeared a little more sunken on the left than the right, possibly related to a fracture shown on the CT scan.
He mentioned dizziness to me, and I obtained an audiogram, which was normal, and scheduled him for ENG testing.
Q. If you can look in the chart and tell me where that note would have been or should have been?
A. This is his initial visit. It should be in here after that (Indicating).
Q. Okay, and it's not?
A. This is when his audiogram is, so it would have been here (Indicating).

Q. Is that it (Indicating)?
A. Yes.
Q. All right.

A. Yes.
Q. Just so we know that that note has been found, correct?
A. That written note.
Q. So that is a written note that you just talked about?
A. Correct.
Q. I'll come back to that.
Doctor, did you do any independent research regarding endoscopic sinus surgery or complications before this deposition?
A. No.
Q. Did you review any depositions from similar cases that may have occurred in the past?
A. No.
Q. Did you speak with any, quote, experts in the field?
A. No.

Q. What independent recollection do you have of this patient, if any?
A. He was a pleasant individual. He was very concerned about his health issues, and he listened very closely to everything I said.
Q. How was this patient referred to you?
A. I believe he was self-referred.

Q. Did he come directly to you?
He didn't come directly to you, did he?
A. Excuse me?
Q. He didn't come into MetroHealth Hospital and say, I want to see Dr. Houser?
A. I'm not aware of -- all I know is --
Q. Can we assume he came into MetroHealth Hospital Systems and then was referred to the ENT department?
A. I believe I was the first physician he saw at MetroHealth.
Q. Okay.
A. So I believe he must have called our department -- actually, no. He had been seen in the emergency

department years ago. He initiated the appointment.

Q. Okay.

A. I believe.

Q. Is there anything else in the record that's missing?

A. Nothing of mine.

Q. And of what you reviewed, are there any inaccuracies?

A. Not that I'm aware of.

Q. Doctor, could we assume that, if there is

information that is not contained within the medical record, that you don't have any independent recollection of that information?

In other words, is ail the pertinent information that occurred during the period of your care of Mr. Saadeh, is it in the medical record?

A. I fail to understand

Q. Well, you just stated to me that there was a missing note, which we have since found, that you

hand wrote the discussion of risks, benefits. You discussed the CAT scan of 3-21. You discussed his, quote, sunken eye, possibly related to a fracture. You discussed his dizziness. You ordered an audiogram, and you scheduled ENG testing?

A. You misquoted me.

I said that this was a handwritten note which I utilized to help jog my memory when I dictate a note.

MS. HENRY: It's a dictated note.

A. The dictated note is not present in the chart.

Q. Oh, well let's go back, then.

There is a dictated note that is not present in this chart?

A. That is not present in the system. It's not in the computer. It's nowhere. It must have been -- I'm not sure what happened.

Q. So there was information that you discussed with

Mr. Saadeh that is not in this written note?

A. Correct.

Q. But is on this dictated note that is now missing?

A. I would have dictated the note, and apparently it was lost and never transcribed.

Q. You would have, or you distinctly remember dictating the note?

A. I did dictate a note.

Q. Okay.

A. And it's not available.

Q. Doctor, was this procedure necessary?

A. In my medical opinion, yes.

Q. Why?

A. Mr. Saadeh satisfied my clinical judgment that he had medical -- he had chronic rhino-sinusitis.

Q. What are those criteria?

A. Basically that he had positive CT scan evidence of rhino-sinusitis. He had positive physical exam findings for rhino-sinusitis. He had positive history for rhino-sinusitis.

Q. What other criteria led you to make a decision that

this procedure was indicated?
A. Those --
Q. I mean, is there anything else?
A. No. Those three factors.
Q. *Any* other factors?
A. None that I can think of.
Q. You mentioned that there was a positive history of rhino-sinusitis?
A. Correct.
Q. Can you tell me where that is in the chart?
A. My initial note.
Q. What date?
A. 2-15-2000.
Q. All right, let's look at your assessment toward the bottom of the page of the chronic rhino-sinusitis.
A. Correct.
Q. What does the word chronic mean?
A. Chronic means his symptoms have been in existence for three months or longer.
Q. What if the rhino-sinusitis existed for two months, would that be chronic?
A. It would be more -- technically you would refer to that more as subacute rhino-sinusitis.
Q. So we're talking two to three months is the line of

demarcation there, correct?

A. Perhaps.

Q. Let's just read along together.

Patient is a 48 year old male who presents with complaints of sinus infection that had been more persistent worsening for approximately three to four years, his last being two weeks ago.

He reports that he will have bloody drainage each morning and feel congested each morning requiring him to blow his nose. He reports he has yellowish green drainage at the time that he will blow, as well.

He did undergo a CAT scan of his sinuses with an emergency room evaluation in the past, approximately one year ago.

Have you ever seen that CAT scan, Doctor?

A. Yes.

Q. When did you first take a look at that scan?

A. From my note, I do not believe that that was present at this visit.

Q. I just asked you, when was the first time you looked at the scan?

A. Most likely the next visit.
Q. And that would be when?
A. That would have been the 2-28.

Q. 2-28?
A. I believe, or 3-28.
Q. 3-28, okay.
Just show me where in the chart it's reflected that you reviewed the scan of 4-2-99.
A. That would be in the note that is not present.
Q. That's also in the note that's not present?
A. Most likely.
Q. You testified earlier that you discussed the CAT scan of 3-21 of 2000, and I asked you what CAT scan.
Now you're also telling me that you discussed and/or noted in this note that is now missing a CAT scan of 4-2-99, is that correct?
A. Briefly I pulled that out and looked at it, because that was an older CAT scan. That's less important.
Q. I'm not asking you its importance. I'm just asking

you if you looked at it

A. Yes.

Q. And that is in this note that's missing, correct?

A. Correct

Q. Let's go through that report further.

In the ER he was told -- about half way down the first paragraph -- he was told that he had

sinus infection and was given antibiotic to treat this. He reports his nose seems to actually burn with inhalation. It seems very irritating to have that air. He denies any --

MS. HENRY: Have that air pass through it.

BY MR SWEENEY:

Q. He denies any coryza. What is that?

A. Coryza symptoms would be allergy symptoms.

Q. And reports there's no history of atopic disease.

I would assume that's something that you're genetically --

A. Allergy disease within his family.
Q. Okay. Something genetic, I would assume?
A. There's a genetic pre-disposition to allergic disorders.
Q. Occasional cigar smoke, though it's not a daily habit. He has not smoked any significant degree for ten years.
How does that affect your examination?
A. We know that tobacco smoke can be an irritant and can decrease mucous clearance, which can worsen sinus disease.
Q. Reports only occasional alcohol use.

Does that affect sinuses in any way?
A. No.
Q. Or the condition?
A. No.
Q. He reports no significant past medical history, and he's on no medications.
So based upon this examination and the information that's in this report, you decided to, at the bottom, treat with Augmentin for four weeks,

correct?

A. Correct.

Q. Flonase and Duratuss?

A. Correct.

Q. And will undergo CAT scan of his sinuses and follow up with me in six weeks for a repeat evai., right?

A. Correct.

Q. At that time you weren't recommending endoscopic sinus surgery, were you?

A. No.

Q. When is the next time you saw him after that?

A. 3-28-2000.

Q. 3-28-2000.

Now, would the dictated note that is missing be similar to the one that we just reviewed, similar in appearance?

A. It would be typed.

Q. Similar to the one we just read, correct?

A. I'm not sure what you mean. It would be typed.

Q. In other words, if we go back to the 2-15 -- would

it look like this (Indicating)? Would it have history, exam, assessment, plan, or would it look differently (Indicating)?

A. Typically my initial evaluation is much more -- has more information in it.

Q. So this would be longer than this missing dictated portion of the record that we cannot find?

A. Most likely, correct.

Q. The only records I have from 3-28 are this handwritten note?

A. Correct.

Q. And this is the visit where you decided to recommend functional sinus surgery?

A. Correct.

Q. Let's go through that note. That's your handwriting, correct?

A. Correct.

Q. Can you just read through that for me?

Increased pain?

A. "Increased pain at left side of face. Blew nose. Bloody stuff. Ears hurt, pressure. Tylenol,

little help. Sudafed helps a little. Complains of dizziness with head back on ladder."

Q. Okay.

A. Hallpike negative.

Q. What's that?

A. That's doing a brief look at his dizziness, bending him back and looking for a nystagmus, and he had none.

Q. You didn't find that?

A. There was no nystagmus.

Q. When did you dictate this note that we now cannot find?

A. That was dictated that day.

Q. Is this a specific recollection that you remember?

A. Yes.

I always dictate all my notes.

Q. Because in this handwritten note, there's no reference to the procedure, let alone any of the risks or the CAT scans, can we agree on that?

A. Correct.

Q. Is there anywhere else in the record, or is there anywhere else in any other records in his entire chart, anything that would reflect anything that you spoke about with him that day other than what we have here (Indicating)?

A. We have his signed consent form for that surgery.
Q. Okay, anything else?
A. We have a note later on when I was discussing with him what was going on that he recalled having the discussions with me.
Q. Okay.
A. A note that took place after the surgery.
Q. You didn't sign this (Indicating)?
A. Correct.
Q. You usually sign your notes?
A. Not always, no.
Q. What determines whether you sign it or not?
A. Basically, the little handwritten notes for the most part are not as important. They are not detailed. They are only to jog my memory.
Q. Okay.
A. So I don't bother to sign them.
Q. But sometimes you do?
A. Correct.
Q. For example, the next note is April 6th, which is the next visit that you had?
A. And that one I did not dictate, either. That was a

very brief visit.

Q. Well, wait. You testified that you dictated the last one, but it's lost. And now you just said you

didn't dictate that one, either?

MS. HENRY: The next one.

BY MR. SWEENEY:

Q. So what's the answer?

MS. HENRY: The next one.

Q. Yes, this one (Indicating).

You said, I didn't dictate that, either, is a what you just stated?

A. Correct.

Q. So that means you didn't dictate the one before that?

A. No. You're catching -- that one there's no dictation for. That one there's no dictation for (indicating).

Q. Doctor, I don't want you to think I'm trying to trick you here, okay?

A. You are trying to trick me.

Q. I'm not. I'm just asking you some questions.

The note on 3-28 --

A. Was dictated but is not present.

Q. -- was dictated but is now gone.

The note on April 6th was not dictated?

A. And I know that, because I put no D up at the top.

Q. Okay.

A. Which I purposely did not dictate that.

Q. Why not?

A. It was a very brief visit.

Q. But that was the visit where you scheduled him for the surgery, correct?

A. No.

MS. HENRY: No. You're talking about a subsequent one.

BY MR. SWEENEY:

Q. Schedule for --

MS. HENRY: What are we --

MR. SWEENEY: Hold on.

MS. HENRY: We need to follow, yes.

MR. SWEENEY: If I'm mistaken,

I'll go back.

MS. HENRY: Yes.

Q. I'm sorry, I was wrong. We'll get to that. We'll get to that.

So doctor, would you agree with me that the most important record in my client's chart is missing, correct?

A. No.

Q. Would you agree with me that an important record in my client's chart is missing?

A. I would say that it's unfortunate that that note

did not come through the transcription service.

Q. But you didn't answer the question.

A. I think I did.

Q. I asked you if that note that we cannot now find was an important record in my client's chart.

MS. HENRY: Go ahead, answer.

BY MR. SWEENEY:

Q. It's pretty simple. It's a yes or no.

MS. HENRY: Well, no, it isn't necessarily a yes or a no.

A. The important item is his signed consent.
Q. Doctor, we'll get to that. I just need a simple answer.
Is the record that's missing important, or is it not important?
A. Yes.
Q. We were talking about the indications for surgery here, and you had mentioned that my client met all of the criteria which would be an indication for this procedure, and that is a CAT scan, which had positive findings, the physical exam, which had positive findings, and a positive history, correct?
A. Yes.

Q. Why did you treat my client with Augmentin, Flonase, and Duratuss for four weeks or six weeks?
I'm not sure which it was.
A. This is a combination of medications to combat the symptoms of chronic rhino-sinusitis and potentially

avoid surgery.

Q. How do you know when they are not combating the rhino-sinusitis?

A. Excuse me?

Q. How do you know when they are not working, when these medications aren't working?

A. When the patient has a positive CT scan following this treatment and still has complaints following this treatment.

Q. That positive CAT scan you would be talking about would be March 21st, correct?

A. Correct. That was obtained after he was on these medications.

Q. So essentially, and correct me if I'm wrong, but what you're saying is he's not getting any better?

A. Correct.

Q. Let's take a look at the CAT scan.

MS. HENRY: Do you have another copy of that handy, by any

chance?

MR. SWEENEY: Yes.

MS. HENRY: Oh, you have it, okay. Let's just refer to that.

MR. SWEENEY: That's a copy of what I have here. I'm at 3-21, CAT scan, 3-21.

BY MR. SWEENEY:

Q. The scan was made on March 22nd of 2000, and it is compared to a CAT scan made on 4-2-99?

A. No.

Q. Comparison is made to a prior screening?

A. It's made on March 21st, 2000.

Q. What did I say?

A. March 22nd.

Q. All right, March 21st, 2000.

But it's compared to a prior screening on 4-2-99?

A. Correct.

Q. So actually you're kind of lucky here. You have something to compare it to, correct?

A. Correct.

Q. You don't usually have that, do you?

A. No.

Q. So you're already ahead in the count.

There's a moderate mucosal thickening in the left maxillary sinus worse than on the prior screening. So that's worse?

A. Correct.

Q. So he's getting worse, okay.

Next paragraph, the right maxillary sinus is clear and shows interval improvement. Wait a second. Now it's getting better?

A. Correct.

Q. The right ostiomeatal unit is patent, which means there's no disease, correct?

A. No.

Q. What does that mean?

A. The ostiomeatal unit is an area that is impacted by the ethmoid air cells. Sinus thickening can be seen to come and go, to swell and recede with treatment.

Q. Where does it say that?

A. One CAT scan, which is a snap shot in time, can only be taken as a snapshot in time in combination with their medical history and their physical exam.

Q. I just asked you what patent means.

A. Patent?

Q. Patent.

A. Patent refers to open.
Q. So it's clear. It's open.
The right ostiomeatal unit is patent?
A. I would have to see the CAT scan to look at it.
Q. Well, do you have any reason to doubt the expertise and competency of the radiologist?
A. No.
Q. Okay.
A. But I enjoy looking at the films myself to assess the disease.
Q. Okay, fair enough.
So then patent does not mean clear?
A. Patent means an opening. Patent does not mean clear. Patient can still have thickening and have patency to have air go through the area.
If you took your hand --
Q. Does my client suffer from any polyposis that you can tell?
A. No.
Q. From this CAT scan?
A. No.

Q. Polyposis is more serious than mucosal thickening?

A. No

Q. It's just different?

A. Polyposis and mucosal thickening sometimes can go

hand in hand, and sometimes do not. But you can't make judgment on someone's state of disease based on that.

Q. What do you make it on? What do you base it on, then?

A. Basically on their degree of complaints, their symptoms.

Q. Okay.

A. Their physical exam findings.

Q. Okay.

A. And their CT scan realistically does not directly predict how poorly they feel. And that's been shown.

Q. But the subjective feelings -- you make decisions based on subjective feelings of a patient?

A. I absolutely utilize those in helping me decide

how

to treat a patient, yes. I add in a lot of factors in treating patients.

Q. Okay, fair enough.

So we have the right ostiomeatal unit is patent. Mild mucosal thickening is noted in the ethmoid air cells bilaterally.

That's the area where the lamina papyracea is, correct?

A. Correct.

Q. So we have mild mucosal thickening. Nothing is serious, right?

A. No.

Q. Worse on left and not significantly changed from the prior study?

A. Correct.

Q. There's also mild mucosal thickening in the sphenoid sinus, which is above the ethmoid, correct?

A. No.

Q. There's the frontal, excuse me. Where is the sphenoid?

A. In the extreme back part of the nose.
Q. Behind the ethmoid?
A. Correct.
Q. The sphenoid sinus appears unchanged. That's also unchanged. And frontal sinuses, which are the ones up on top, they are aplastic, which means what?
A. Not really formed.
Q. You mean there's no diseased mucosa in there?
A. It means the frontal sinus did not aerate.
Q. Could you put that in more common terms?
A. The sinuses did not form. The frontal sinus did not form.
Q. They don't exist?

A. Correct.
Q. Really?
A. It's a variant.
Q. That happens?
A. Yes.
Q. You see that all the time?
A. Yes.
Q. Does that impact on the overall sinusitis?

A. No, not necessarily.
Q. Okay. I'm just trying to think if there's anything here -- so basically he has no function up there.
What are the frontal sinuses? What do they process?
A. What are they for?
Q. Yes. What are they --
A. The frontal sinus likely -- the purpose of the sinuses likely are for a number of things, to make the head lighter as man evolved, allowed them to stand upright, to act as a crumple zone so that, when man is hit in the face, his brain is not injured. They perhaps act as a resonance cavity for speech.
Q. But that's not something that's abnormal, it's just a deviation, as you said?

A. it's not common, but it's not rare, either. it's uncommon.
Q. Is there anything here that he should be worried about?

A. No.
Q. Let's move on.
There was a deformity of the medial wall and floor of the left orbit consistent with remote fracture?
A. Correct.
Q. What does that tell you?
A. Basically he had the appearance that he had suffered a fracture in the past that had gone on to heal.
Q. Does that tell you anything else?
MS. HENRY: About what?
A. I'm not sure what you're getting at.
Q. If it doesn't tell you anything else -- I mean, you know, that's a finding, correct?
A. Correct.
Q. Is it a significant finding?
A. It's a very significant finding.
Q. It's a very significant finding, okay.
Why is it a very significant finding?
A. Because his anatomy on the left side was not likely

what it was prior to the accident.

Q. Prior to what accident?

A. Prior to whatever caused this fracture, this supposed fracture.

Q. Did you ask him about it?

A. Yes.

Q. What did he tell you?

A. He vehemently denied that there was any history of a fracture.

Q. Well, was he lying to you, or --

A. I did not take it as lying.

I just discussed the fact that it appears that you have a fracture, and he stated emphatically that that was not the case.

Q. Okay, well let's assume that that is what he stated, okay? You're looking at a CAT scan. YOU say you like to look at them yourself.

Did you look at this one?

A. Oh, yes.

Q. This showed a prior fracture?

A. I explained it to the patient.

Q. I understand that, but it showed a prior fracture, correct? Now that's unmistakable, correct?

A. It certainly has the appearance of a fracture.

Q. Okay.

A. And this is what I described to him.
Q. What else could it represent?
A. Well, as he was so strident that he had never had a fracture, there are diseases that can cause the eye to sink, maxillary sinus hypoplasia, which he really did not fit. But I mentioned that to him.
Q. This is all coming from your memory, correct?
A. Correct.
Q. Okay.
A. I distinctly remember him being upset when I discussed the possibility of an orbital fracture. I don't know why. People develop orbital fractures while riding a bike and --
Q. Well, did you tell him that?
MS. HENRY: Tell him what?
BY MR. SWEENEY:
Q. That, okay, maybe you didn't have anything wrong with it, but it looks like it's a fracture?
A. Yes, I did.
Q. And what did he say?
A. He very much reported that he had never had a fracture.
Q. All right, so I'm going back to your handwritten

note, the only note that we have.

Increased pain, left side of face. Blew nose,

something stuff?

A. Bloody stuff.

Q. Bloody stuff. Ear hurt. Pressure. Tylenol little help. Sudafed helps a little. Complains of dizziness with head back on ladder.

You did this whole Hallpike test?

A. Yes.

Q. But there's no mention of a fracture, which you said is a very important finding?

A. Not in this written note, correct, there is none in my brief notes.

Q. Okay.

A. But it absolutely entered into our discussion while obtaining consent for surgery.

Q. So did you have a discussion with Mr. Saadeh regarding the decision -- apparently he made a decision to go ahead and have the surgery?

A. Correct.

Q. And that was made on the 28th?

A. Correct.
Q. Well, let's go back to your brief treatment. You gave him six weeks of Augmentin, Flonase, and Duratuss, correct?
A. No. Four weeks of Augmentin.
Q. I'm sorry, four weeks of Augmentin?

A. Correct.
Q. Anything else?
A. Flonase and Duratuss.
Q. Right.
Flonase, that's a steroidal-based --
A. Nasal spray.
Q. Inhaler?
A. Correct.
Q. And Duratuss is -- I don't know what that is.
A. Duratuss is a decongestant with a mucolytic.
Q. What does that do?
A. To try to thin his mucous to allow it to flow out of his sinuses and a decongestant to try to reduce the swelling at the sinuses to allow things to flow

out, as well.

Q. Did you ever prescribe him anything oral other than the Augmentin?

A. No.

Q. Did you ever consider oral steroid therapy?

A. I did not feel that it was appropriate in his case.

Q. Why not?

A. He already had a CAT scan from years ago that was positive. And in my training, basically steroids work very effectively in the brief period. But

with him having documented all this time, he likely would relapse.

Q. Did you discuss with him the option of continuing with that line of treatment?

A. Yes.

Q. And what did he say?

A. That the medication had not worked, and he was interested in surgery.

Q. Where is that noted in your chart?

A. That would be when I obtained consent.
Q. Was that in the note that we don't have?
A. It would have been there, yes.
Q. All right, *you* stated before that he met the criteria, and that was physical exam, positive history, and a CAT scan. But that was only the CAT scan of 3-21. Now you just mentioned a CAT scan of 4-2. Does that also come into play in your decision?
A. You're misquoting me when I said CAT scan. I did not refer to which CAT scan. And, yes, both CAT scans play a role here.
Q. Let's go to the first CAT scan of 4-2-99.
By the way, how would you categorize his sinus disease, serious, moderate, mild?
A. Acute exacerbation of chronic rhino-sinusitis when I saw him initially.
Q. So in terms of other cases of rhino-sinusitis that you see, was this a bad one, or was it on the lower

range, or where?

A. Fairly typical.

Q. So about medium range, about moderate in severity?

A. I suppose.

Q. So there's nothing to keep you from going ahead and trying out another course of treatments, correct? Augmentin, Flonase, Duratuss, correct?

A. If he had opted for longer medical therapy? We could have.

Q. Okay. Did you recommend that to him?

A. I gave him his options.

Q. Did you say, listen, we got this procedure in front of us, already some risks involved, do you want to go ahead and try this for a little bit longer conservatively?

Did you tell him that?

A. I gave him his options.

Q. You remember telling him that specifically?

A. Yes, yes.

MS. HENRY: The statement you made? Do you want to know if he said that statement?

MR. SWEENEY: Well, anything that's close to that statement.

A. Basically, I discussed the fact that his medical therapy had been unsuccessful thus far. I'll tell you what I basically say to people all the time. I tell them, well, your medical therapy has not been successful thus far. It can be continued. We can be conservative and continue that, or at this point we can enter into a discussion about sinus surgery.

And typically the patient wants to know what that would entail, and then we discuss that.

Q. Isn't it true that you told my client that the surgery was a simple procedure?

A. No.

Q. You never told him that?

A. That is not correct.

Q. Okay.

A. I would never make that statement.

Q. Why not?

A. Because sinus surgery has serious risks.

Q. Such as --

A. Would you like me to give you my spiel that I tell patients?

Q. Sure.

A. The risks of sinus surgery are similar to risks of any surgery in that there's a risk of bleeding and infection. But then there are always risks which will be specific to any procedure, as well, specific to sinus surgery.

As you can tell from the CAT scan -- I always do this looking at the CAT scan and pointing to them -- here are your eyes. Here is your brain. The risks include damage to the vision, at the extreme being blindness, which could be permanent, and, as well, damage to the brain, including leakage of CSF fluid, which leakage would potentially be able to be repaired.

Q. Anything else?

A. I discuss the risks of septoplasty when we go over that, as well.

Q. What are those risks?

A. The risk of septoplasty being, again, bleeding, infection, leaving a hole in the septum that could whistle, crust, or bleed, and risk of anosmia has

been reported.

Q. What's that?

A. Loss of sense of smell.

Q. Did you mention diplopia to him?

A. Diplopia would be part of damage to vision.

Q. So we have bleeding and infection, blindness slash damage to vision --

A. Damage to vision, at the extreme being blindness.

Q. Okay, and injury to the brain, leakage of --

MS. HENRY: CSF fluid.

A. Cerebrospinal fluid.

Q. Cerebrospinal fluid?

A. Correct.

Q. What else?

A. The septoplasty has different risks that have to be gone over, as well.

Q. So those are additional risks that you explained, correct?

A. Right.

Specifically with Mr. Saadeh, going over his

CAT scan, he had changes on his CAT scan with this possible fracture that put him at additional risk.

Q. What are those?

A. Basically what we went over, just the chances of injury are higher.

Q. So the chances of all the things you just mentioned are now increased, correct?

A. The chances of those risks are quite, quite low. But on the side that he has had the fracture, he is at greater risk.

Q. So let me see if I get this right.

You sat him down and looked at the CAT scan and said, listen, I've treated you with this for four weeks. Do you want to go ahead and do it? He said yes, and you say okay?

MS. HENRY: Wait a minute. That's not quite what he said.

A. This is not the way I --

MS. HENRY: You're truncating

it.

MR. SWEENEY: I'm just paraphrasing.

MS. HENRY: Still, I don't want to see this later in a trial.

MR. SWEENEY: This is for my understanding.

A. I'm a little offended. That's not the way I talk to patients. I'm very serious about the way I talk to patients.

Q. I'm not saying that you're not, Doctor.

A. Let me finish.

Entering into an agreement to do surgery is a very important, sacrosanct physician-patient bond, and I don't take it lightly.

Q. I understand.

A. Okay.

Q. I'm just talking about this patient, okay?

You sit down, and you explained the risks to him. And the risks include bleeding, infection, a

whole host of injuries to the eye, the extreme being blindness, brain injury, leakage of spinal fluid. What is that? You get meningitis from that, right?

A. You could.

Q. Then all of the risks involving the other procedure of septoplasty?

A. Correct.

Q. And then you say, now, you've got something in your eye here, and it shows that it might have been broken. So I want to tell you something. There are more risks with that

That's essentially what you're telling this guy, right?

A. No.

As I'm going over the risks, I point out the fracture and say, you are at more risk because of what we see on this side.

Q. You also tell him, well, we can go ahead and treat you with some more antibiotics and some more steroidal sprays, and he goes, no, I want to go

ahead and get this surgery?

A. That occurred prior -- I told him basically, you could consider further medical therapy, or you could consider at this point surgery, discuss surgery with him completely and openly and honestly, and I allow him to weigh the odds and risks and decide which way he'd like to go.

Q. Did you feel he understood you as you were going through this?

A. Yes, I did.

Q. In your pre-op, did you request a consult by an ophthalmologist?

A. No.

Q. You felt that wasn't necessary?

A. Correct.

Q. Why not?

A. He told me that he had seen an ophthalmologist in the past and that his vision was okay.

And to my exam, other than his eye looking a little more sunken, it seemed fine.

Q. Where is your office?

A. Across the street in the Medical Specialties Building.

Q. What room?

A. I think the number on the door is 2131. That's my

office. It's in the ENT area.
Q. Do you have a nurse or a secretary or assistant that assists you?
A. Assists me where?
Q. In your duties in your office.
A. I have a secretary.
Q. What is her name?
A. Carmen.
Q. Carmen what?
A. Pagan, P-A-G-A-N.
MS. HENRY: Are you talking in the clinical part, that assists him in the clinical part, or just somebody who answers the telephone?
MR. SWEENEY: Whoever.
A. She answers the telephone.
Q. Was she there on this date?
A. No.
Q. Who was there on this date?
A. On which date?
Q. 3-28 of 2000.
A. Which secretary was there? Annette Golkowski.
Q. How do you spell that?
A. G-O-L-K-O-W-S-K-I.
Q. She's no longer with you?

A. She's here.
Q. She's in a different department?
A. No. She's there. At that time --
Q. I'm sorry, Carmen is no longer here?
A. Carmen is here now.
Q. Carmen is here now. Annette is no longer here?
A. Annette is here now. Annette was here throughout.
Q. I got you.
A. Annette's job description changed over time.
Q. Where do you meet with patients when you do -- well, when you met with Mr. Saadeh, where did you meet with him?
A. In my patient exam rooms.
Q. That would be where, same place we're talking about?
A. Not in my office, but in the --
Q. But there's exam rooms off of that, correct?
A. In the exam rooms off of that, correct.
Q. And who would be assisting you?
Does a nurse go in there and say, hi, the doctor will be right with you. Take off your clothes, or whatever?

A. The nurses would have been placing the patient in the room.

Q. What nurses would have been doing that at that time?

A. At that time, potentially Henry Wheeler or Kathy O'Hearn, or it could have been an MTA.

Q. Who is that, or what is that?

A. She's a medical assistant, Sandy -- what was Sandy's last name? Sandy has left.

MR. SWEENEY: I just want to mark one of those, but you can look at it.

MS. HENRY: What's the date?

MR. SWEENEY: This is the informed consent.

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

MS. HENRY: Are we done with 3-28 now?

MR. SWEENEY: I suppose.

BY MR. SWEENEY:

Q. The 3-21 CAT scan, Doctor, can we agree that the findings on that CAT scan are not severe?
A. No, we cannot agree to that.
Q. Okay, why not?
A. It documents absolute evidence of rhino-sinusitis following a medical treatment. You cannot utilize a CAT scan to tell you how bad someone is in terms

of their rhino-sinusitis. That's been shown in multiple studies.
Q. Doctor, I understand that.
A. I don't think you do understand that.
Q. I'm asking you to take it within the four corners -- believe me, I understand it.
I'm asking you, within the four corners of the CAT scan, which is a snapshot, your words, the disease that is reflected in the findings here from Dr. Simon are not severe, yes or no?
A. No, no. You cannot --
Q. No, they are not severe, or yes, they are severe?

A. Severe connotates a patient's symptoms.
It's been shown time and time again that patients' symptoms do not correlate directly with a CT scan.
Q. We'll let your attorney worry about that, okay? I'm just asking you to answer that specific question.
A. What is your specific question?
Q. Specific question is, within the four corners of the impression, the findings of the CAT scan of March 21st of 2000, the sinusitis, or the disease process that's going on in my client's sinus, is it or is it not severe?

A. It is severe.
Q. Doctor, what is informed consent?
A. Informed consent implies that a patient has been fully appraised of all the potential indications, contraindications, risks, and possible benefits from surgery, that they are able to understand what you've discussed with them and agree to that

surgery full well knowing that those risks are extant and --

Q. Are what?

A. Are -- exist and could occur.

Q. Let's take a look at Plaintiff's Exhibit 1.

MS. HENRY: We'11 just look at our copy. It's better.

BY MR. SWEENEY:

Q. Doctor, what is this?

A. This is the patient's informed consent page.

Q. Can I take a look at the original?

A. Yes.

Q. Doctor, where on this does it list the risks of this procedure?

A. "I understand the nature and purpose of the treatment/procedure. I also understand the expected benefits and complications of the treatment and/or the procedure, discomforts and

risks that may arise, as well as possible alternatives to the treatment/procedure, and the risks and consequences of no treatment/procedure. I've been given an opportunity to ask questions,

and all of my questions have been answered to my satisfaction."

Q. Would you consider this a general consent?

A. Yes.

Q. Where on this form does it list the additional risks which exist because of the preexisting fracture to the orbit?

A. It does not. Those were verbally conveyed to Mr. Saadeh.

Q. And where is that reflected in the chart?

A. This would have been on 3-28 when we discussed everything.

Q. The dictated note that we can't find, correct?

A. Correct.

Q. Doctor, how many functional endoscopic sinus surgery procedures have you performed in your career?

A. Four to 500.

Q. That's from when to when?

A. From the time I started residency until last week.

Q. How many functional endoscopic sinus procedures

have you performed with a microdebrider of that four or five hundred?

A. Most of them. 90 percent of them.

Q. What are the other 10 percent?

A. If a patient had a lesion that did not require a microdebrider, for example, an endoscopic sphenopalatine artery ligation.

Q. I won't even go there.

MS. HENRY: Why don't we spell that right now so we don't lose it?

A. S-P-H-E-N-0-P-A-L-A-T-I-N-E artery ligation.

Q. Of that 90 percent, how many of those were performed with a Hummer?

A. We had a Hummer during residency, and that's what I had Metro buy when I came here during my fellowship. They did not have a Hummer. They had a different machine. So perhaps 85 percent.

Q. How many -- what percentage -- so now we're getting down to --

MS. HENRY: 85 of 90.

BY MR. SWEENEY:

Q. 90 percent of -- was it 400 or 500?

A. It's hard €or me to estimate. I'm making a rough estimate. I have not surveyed and seen how many.

Q. All right. Let's give you the benefit of the doubt. Let's go 500.

Out of the 450 of the 500 that were done with a Hummer, 85 percent of those -- or with a microdebrider, 85 percent of those were done with a Hummer?

A. Yes.

Q. All right. So now we're down to about 400 now, right, give or take 25?

How many of those that were done with a Hummer were done on patients with preexisting orbital fractures?

A. Probably in the order of 25.

Q. Out of those 25, what number represented procedures done with a Hummer on patients with preexisting fractures to their orbital sockets that also showed evidence of a bulging lamina papyracea?

A. That's a sign that someone has had a fracture.

Q. Okay.

A. So basically it would --

Q. So it's the same thing, then?

A. Right.

Q. All right, so it's 25, then.

So they all show a bulging lamina papyracea?

A. Correct.

Q. Then, by nature of where it is, it would always be in the ethmoid sinus?

A. Correct.

Q. And of that 25, in how many of those procedures were there complications?

A. Mr. Saadeh's.

Q. Just one?

A. Yes.

Q. How do you explain that?

A. We were extremely careful, despite that we observed orbital fat.

Q. All right, I'm getting ahead of myself here. Let's move back to the informed consent.

Doctor, would you consider this an invasive technique?

A. Yes.

Q. Invasive procedure?

A. Yes.

Q. Would it be a major invasive procedure or a minor

one?

MS. HENRY: Or somewhere in between?

BY MR. SWEENEY:

Q. Well, yes, or somewhere in between?

A. It's somewhere in between.

Q. Moderately invasive?

A. Yes, yes.

(Thereupon, Plaintiff's Exhibit 2 was marked for identification.)

BY MR. SWEENEY:

Q. Doctor, Plaintiff's 2 is the MetroHealth Medical System informed consent policy?

A. Yes.

Q. Have you ever seen this before?

A. I do not recall.

Q. Does that mean you might have seen it when you first came on board and just forget?

A. Correct.

Q. Let me direct your attention to --

MS. HENRY: Why don't you give me the Bates number on the bottom?

MR. SWEENEY: Page 20.

Q. At letter E there it states, "A general consent to examination and treatment is not sufficient as consent for surgical procedures, invasive techniques, blood transfusions," and so on.

A general consent is what you said that Mr. Feyruz Saadeh signed, correct?

A. Correct.

Q. So that would be in violation of the policy, then,

as set forth in subsection letter E?

MS. HENRY: Well, go ahead.

This is a consent for this procedure, right?

It's not like an overall, general consent,

you can treat me.

BY MR. SWEENEY:

Q. Doctor, how do you understand that to read?

A. A general consent to examination and treatment is not sufficient as consent -- this states that a general consent to examine and treat is not enough

for you to operate on someone. *You* need to do a surgical consent, is what they are implying, which is what we did.

Q. Let's go down to number 2, then, below that.

"Any medical regimen or procedure performed that is of substantial risk requires informed consent."

Would you consider this to be a substantial risk procedure?

A. Yes.

Q. Closed reduction, that's the example there. The procedures are classified as follows: major and minor invasive, so on and so forth.

A signed consent form should be obtained for major procedures?

A. Yes.

Q. Did you actually hand this consent form to the patient?

A. Yes.

Q. So he would be incorrect -- he would be mistaken if he claims that a nurse gave him this form to sign?

A. That would be false.
Q. Okay. I sensed you wanted to use stronger language.
MS. HENRY: As in not true?
MR. SWEENEY: A little bit stronger than that.
MS. HENRY: I think they are all the same, no matter what way you put it.
A. As you can see, this is my handwriting filling this out. I fill this out, discussing everything thoroughly with the patient, and then allow him to ask questions. And then he signs it.
Q. Why do you have to have these in the chart?
A. Have a consent form?
Q. Yes.
A. To document that all the risks were explained and understood by the patient.

Q. What I have here doesn't explain all the risks?
A. To document that it was explained. I didn't say

that it had everything written down.

Q. Well, I don't know. I'm getting a little frustrated, because the most important single medical record in my client's chart doesn't exist.

Doctor, what's your complication rate for this procedure?

A. I have exposed orbital fat several times. No one has ever gone on to have any serious sequelae. so it depends on what you consider a complication.

I strive for perfection in all of my patient outcomes. So exposing orbital fat to me is a complication.

The literature would typically designate that as a minor complication. So I think that that would be Mr. Saadeh and two patients that I have exposed orbital fat in, as well.

Q. Was there any medial rectus muscle involvement in those two?

A. NO.

Q. As there was here?

A. I'm not aware of any medial rectus involvement in this case.

Q. You would have no opinion on that one way or another?
A. I would have no opinion on that.
Q. Did you tell Mr. Saadeh that you had had two prior problems with exposed orbital fat in patients?
A. These were subsequent to Mr. Saadeh.
Q. Oh, when did those happen?
MS. HENRY: Objection, because they are not relevant.
MR. SWEENEY: I know. He can give me generally. Last week, today?
A. No. Probably six months ago and probably a year ago.
Q. Was there any double vision involved in either of those cases?
A. No.
Q. Have they resolved?
A. Completely.
Q. Are you aware of any pending litigation or claims?
A. No. The patients are healed and fine. And I have had follow up with them to know that there was no sequelae.
Q. How many procedures do you think you performed since you've been here, since '99?

Let me ask you this, you reserve a surgical suite for these functional endoscopic sinus surgery procedures, correct?

A. Correct.

Q. Is that a particular day of the week?

A. Typically Fridays at MetroHealth proper and Tuesdays or Wednesdays at the surgery center.

Q. And that's every week?

A. Correct.

Q. So you're doing this procedure two days a week?

A. Possibly. I do other surgeries, as well.

Q. But you have the suites reserved on those days?

A. I have priority time on Fridays, and Tuesdays we have departmental priority time at the surgery center.

Q. And how many procedures would you do on a typical Friday?

A. How many different types total?

Q. Yes.

A. Varies if they're short or long procedures.

Q. On the average?

A. On the average?
Q. Two, fifteen?
A. I believe four.
Q. All right. Just so we're clear here, there is no

indication in the record, let alone the informed consent, of the risks involved in this procedure?
A. No.
MS. HENRY: Written down?
A. No.
MR. SWEENEY: That's what a record is for.
MS. HENRY: Okay.
BY MR. SWEENEY:
Q. No?
A. Incorrect.
Q. There are not?
A. Later, during one of my discussions with Mr. Saadeh, I reminded him of the fact that we had discussed all this preoperatively, and he agreed that, yes, we had, in fact, discussed all this. And that is documented.
Q. Why do you do that?

A. Because I felt it was important to document that.

Q. Document something that you already told someone?

A. Yes.

Q. For what purpose?

A. He and I had had a discussion on the phone, and I felt it appropriate to document the contents of our discussion.

Q. What was the discussion, and when did it take place?

A. You should have the note.

Q. Well, I'm asking you.

A. I can look it up. I'm never going to find it in this chart.

Q. Is it 4-25? I don't have it marked, but it's -- well, no, because it says here that you didn't -- you discussed this with someone else.

MS. HENRY: Let me see here.

Hold on. Here it is (Indicating).

A. It was written 5-3-2000.

Q. Go ahead and read it. I'll find it.
A. Basically I spoke --
MS. HENRY: Just read this (Indicating).
A. "Mr. Saadeh, during yesterday's phone conversation, did recall our pre-op discussion regarding possible, though rare, injury to the eye, vision" --
Q. Okay, I've never seen this. Can I take a look at this, please? Where is this in the chart?
MS. HENRY: I don't know, but I have it, so --
MR. SWEENEY: Where is the

original?
MS. HENRY: Why don't we take a break while we look?
(Thereupon, a short recess was taken.)
BY MR. SWEENEY:
Q. Doctor, let's take a look at this. There's another record here which I've just been provided which

wasn't in the chart that I requested from MetroHealth Hospital.

I was wondering if you could go ahead and just read this beginning with May 2nd?

A. "I called Mr. Saadeh with radiologist's interpretation of CT orbits. Musculature normal, evidence of old fracture. Patient vehemently denies any orbital trauma in past. Dr. Caramen feels strongly only trauma could produce results as seen on original and follow up CT scan, i.e. floor fracture, medial wall, bowing. Mr. Saadeh is understandably very distressed with his vision difficulties. Will be two weeks post-op tomorrow. I asked him to give more time to recover. I remained very up front and attentive to his needs. Attempted to contact Dr. Ross today to see if any plan as to his recovery." I signed that.

Following that, "Mr. Saadeh, during yesterday's phone conversation, did recall our pre-op

discussion regarding possible, though rare, injury to the eye, vision, or brain/CSF leak. We had discussed at that time the significance of his CT findings and the appearance of old fracture. The possibility of enophthalmos over time was discussed."

Q. Why didn't you put that in the day before note?

A. I talked to him late in the evening and basically wrote down at least a portion of what we had discussed. And I was driving home, and I realized, you know, we also discussed that. I probably ought to put that in the record, too.

And so the following day I entered that making it very clear that this entry was from yesterday's conversation -- from the previous day's conversation.

Q. So we go from handwritten notes that take up maybe six or seven or eight lines to a full page specifically setting forth what happened after the fact?

A. Correct.

MS. HENRY: Well, you also have this full --

BY MR. SWEENEY:

Q. It sounds like the note taking is getting a little bit more detailed, doesn't it?

MS. HENRY: Well, his note on 4-26 is very detailed, too, and it's handwritten.

MR. SWEENEY: We'll get to that.

Q. Let's go through this again. "May 2nd, I called Mr. Saadeh with radiologist's interpretation of CT orbits."

Now, this refers to the CAT scan which was taken on May lst, correct?

A. Correct.

Q. And what did you call him for?

A. I called him, because he had seen Dr. Ross. Dr. Ross had ordered the CT scan, but Mr. Saadeh felt that he was not getting back to him. He was very worried about his status. And caring deeply for him, and wanting the best for him, I took it upon myself to track down the CAT scan and inform him of the results.

Q. Fair enough.

"Patient vehemently denies any orbital trauma in the past." Sounds like he's getting pretty

angry here.

A. Yes.

Q. Did you explain to him, hey, listen, don't worry about it. This could have occurred for a number of different causes?

Did you explain that to him?

A. Early on, originally, yes, and -- yes.

Q. I guess I'll have to ask him that.

Who is Dr. Caramen?

MS. HENRY: Caramen.

BY MR. SWEENEY:

Q. Caramen?

A. He's a neuroradiologist here at MetroHealth.

Q. "He feels strongly that only trauma could produce results as seen on" --

A. Original and follow up CT scan.

Q. Why does he feel strongly?

A. It was his medical opinion when I discussed the

case with him. This CAT scan, as you know, was done on the 1st. It was not dictated yet.

Q. Okay.

A. So I tracked down Dr. Caramen and discussed the CT with him. I wanted to get very rapid results

Q. Okay.

A. And I wished to convey those to Mr. Saadeh.

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

BY MR. SWEENEY:

Q. "I.E. floor fracture, medial wall, bowing." That means the lamina papyracea is protruding?

A. Correct.

Q. As in the April 2nd of '99 CAT scan?

A. Correct.

Q. "I remained very up front and attentive to his needs."

Were you not before?

MS. HENRY: It says, "I remain."

A. I remain.

Q. I don't understand why you go from jotting down

a

couple of words to explaining things that really don't need to be explained. I don't understand that.

MS. HENRY: Objection.

You know that what you think is important or what you don't think needs to be explained isn't really relevant.

MR. SWEENEY: Well, I was going to ask him a question.

MS. HENRY: That was a statement and prefacing it with a statement.

You don't get to say to the jury, well, I don't understand why this is. That's sort of the golden rule, isn't it?

MR. SWEENEY: All right.

MS. HENRY: See what I'm getting at, Francis?

MR. SWEENEY: Let me cover a couple more questions regarding the informed

consent.

BY MR. SWEENEY:

Q. It says here, Doctor, "Only authorized forms may be used for this purpose," which is the informed consent.

MS. HENRY: Can we see what you're referring to?

MR. SWEENEY: On Bates 21.

MS. HENRY: Bates 21?

MR. SWEENEY: Three-quarters of the way down, letter F.

MS. HENRY: Letter F. What subnumber, or are you just in the first paragraph?

MR. SWEENEY: First paragraph of F.

MS. HENRY: Okay

BY MR. SWEENEY:

Q. Towards the bottom, "It is also advisable that the physician/provider places a separate note

discussing the substance of the informed consent discussion with the patient in the progress notes."

That, you're stating, was done, correct?

A. Correct, was dictated and lost in the system.

Q. Do you know if it ever was in the chart --

A. I am not aware.

Q. -- as these other notes that have been dictated are in the chart and we've been going over? I don't understand how this works.

A. I do not recall seeing it.

Q. All right. Since you brought it up, *let's go* to the 4-26 note.

MS. HENRY: Are we done with this (Indicating).

MR. SWEENEY: Yes. I'm not going to mark this.

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

Q. I think you can read along with this. All right, this says May 26th. So this is --

MS. HENRY: April 26th?

MR. SWEENEY: April 25th.

Q. This is nine days after the surgery,

approximately?

A. Yes.

Q. "Last night I discussed Mr. Saadeh's case with Dr." --

A. Steinman.

Q. Dr. Steinman. He's an ophthalmologist?

A. Correct.

Q. "His brief assessment was that no problem should remain long-term, but that Dr. Ross, orbital trauma expert, would be the most experienced person to examine Mr. Saadeh?"

A. Correct.

Would you like me to read?

MS. HENRY: No. Just let him ask you a question.

BY MR. SWEENEY:

Q. Let's go ahead and read that.

A. "Today I removed the splints and cleaned his nose endoscopically. No problems. Left lamina with mild clot overlying it. No fat visualized." Mr. Saadeh does not report -- or excuse me, "Mr. Saadeh does report some diplopia with extreme lateral or medial gaze before the second OR case. Unchanged after that second OR case. Physical exam has not

changed. Extraocular missiles intact, and pupils

equally round and reactive to light. Left eye still appears enophthalmic versus the right eye."

Q. What's that?

A. It looks a little sunken.

Q. Okay.

A. "Same as noted, though not documented, before the first operation."

This is when I had realized that that note from a long time ago was not in the chart. We discussed a possible orbital fracture.

Q. Wait, it says not documented or not dictated? There's a difference.

A. This says not documented. So it's not in the chart.

Q. Right.

So it's not documented, correct? Isn't that --

MS. HENRY: That's what you meant?

BY MR. SWEENEY:

Q. Shouldn't you have said --

MS. HENRY: Don't tell him what he should do.

MR. SWEENEY: All right, then I'll ask you some questions.

MS. HENRY: Fine.

BY MR. SWEENEY:

Q. You've been telling me this whole time that you dictated it.

When was the first time you realized that it wasn't in the chart?

A. Likely around this time when I was writing this note (Indicating).

Q. Well, that doesn't make sense to me.

Why would you go looking for -- why would you go looking through a chart -- I mean, do you specifically recall discovering that this dictated note that we're all looking for didn't exist back then, or was it just recently?

A. This note would suggest that I realized it at that time, that it was missing.

Q. Okay.

A. But I can't manufacture an old note.

Q. Okay. Now you're relying on the chart. Up until now, you've been relying on your memory, which has been pretty damn good.

So let me ask you --

MS. HENRY: I'm going to ask that also be stricken. Why don't you just ask the question without prefacing it with

something, your editorial comment?

MR. SWEENEY: All right.

A. I'm not sure where you're going with this.

Q. You don't have to be sure.

A. Okay.

MS. HENRY: I'm simply asking that he just ask you a question instead of prefacing it with his editorial comments.

MR. SWEENEY: I will do that.

MS. HENRY: Thank you.

BY MR. SWEENEY:

Q. Back in your note it says, right eye, same as noted, in parenthesis, though not documented, correct?

A. Correct.

Q. That's what that states?

A. That's what that states.

Q. Documented means not placed down and/or written down, dictated, or in any way reduced to paper, correct, or computer?

A. It means that I could not find the entry that I had made in the past in the chart.

Q. Why didn't you say that, then?

A. I was being brief, attempting, in this long note.

Q. All right.

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

BY MR. SWEENEY:

Q. Let me see if I have this correct. Same as noted,

though not documented. Let me back up. Maybe I'm getting ahead of myself.

What are we referring to? What is, same as noted, though not documented?

A. That I had recognized it, but I could not find in my chart my note that should have been there.

Q. That stated what?

A. That stated the appearance of his eye at the time of 3-28.

Q. You mean the same note that we're talking about?

A. Right.

Q. That we have been talking about?

A. Right.

Q. That note, the note, the missing note?

A. Correct.

Q. That's what you're referring to here, as well, right?

A. Correct, yes.

Q. Okay.

A. That's why it's not documented, because I couldn't find anything in there -- I knew his eye had had those findings.

Q. But it sounds to me like you just didn't put it down, from this wording.

Can you understand why I'm thinking that?

MS. HENRY: Objection.

BY MR. SWEENEY:

Q. It says, "though not documented."

MS. HENRY: Francis, he's explained it to you like three times.

A. Yes.

MR. SWEENEY: Okay.

MS. HENRY: If you want to go on along this line, then we'll go back to the court, and we'll get him to say whether you can ask it a fourth or a fifth time. Let's just move on.

MR. SWEENEY: Okay.

Q. "I contacted Dr. Ross today, who agreed to add him to his busy schedule. Mr. Saadeh was agreeable to this plan." Recommended that he contact --

A. That he continue to exercise his eye.

Q. Continue to exercise the eye.

A. "Keep his extraocular muscle active, even though he has some pain with looking about."

Q. "Dr. Ross was concerned with possible muscle entrapment, but I assure him that any lamina

perforation" --

A. Is about six millimeters round.

Q. "Very unlikely for this to be an issue?"

A. Correct.

Q. Do you have any opinion as to the subsequent diagnosis and the opinions of Dr. Ross? I assume you read his reports.

A. Yes, I have read his report.

Q. You know part of his diagnosis included muscle entrapment?

A. Possible muscle entrapment, yes.

Q. You disagree with that?

A. That was certainly in the differential.

Q. Go ahead and just read.

A. "I suspect orbitai edema slash inflammation is responsible for all these symptoms, pain, blurry, diplopia with extreme lateral/medial gaze and they will resolve with time with no sequelae. Certainly the amount of fat extruded from his lamina was minuscule compared to the amount which is exposed to spill into the nose during endoscopic orbital

decompression for Grave's disease." That's a big procedure compared to exposing orbital fat, a little tiny bit.

"I had made Feyruz full aware of the fat

exposure immediately post-op, and I've been closely monitoring him and obtaining follow up with myself and Dr. Ross. This evening we discussed Mr. Saadeh's case at departmental morbidity mortality conference. My colleagues, Dr. Tucker, Carter, Antoine, agreed that no breech of standard of care has taken place, and ophthalmologist follow up is wise. My honesty with the patient is vital, which it has been. No sequelae is expected, but continued monitoring is necessary."

"I will see Feyruz next week to re-assess his surgical site and to follow his progress. I will provide Dr. Ross with full records."

Q. Were you concerned that you breached the standard

of care?

A. This is a patient that was very upset, and I had had a complication. There was no doubt we had had a complication. I felt badly that I had had a complication.

Morbidity and mortality, we basically discuss any complications, and it was pointed out to me by my colleagues that this was minor.

Q. Did they review the records?

A. They reviewed the CT scans, and I explained everything to them fully.

Q. Were they aware that he had had a prior fracture which pre-disposed him to an increased risk of injury to that eye?

A. Yes.

Q. They all agreed that no breech of standard of care had taken place?

A. That was their wording to me. I came to them to ask them about this complication.

Q. Doctor, have you ever treated patients with

rhino-sinusitis when they come under your care for more than six weeks?

A. Excuse me?

MS. HENRY: Before what?

BY MR. SWEENEY:

Q. My client came under your care on February 15th of 2000, correct?

A. Yes.

Q. You treated him for a period of six weeks. Then you scheduled surgery?

A. Correct.

Q. Is that your customary treatment plan and schedule for patients that come to you with sinusitis?

A. That is how some patients are treated and not how all patients are treated, no.

Q. How are others treated?

A. Others may have extended antibiotic therapies. Others may go on allergy shots.

Q. Did you offer allergy shots to Mr. Saadeh?

A. He denied coryza symptoms talking to him symptom-wise. He did not make me feel that he

had

allergy as a component.

Q. That's not in the record, though, anywhere.

MS. HENRY: Yes, it is, on the first day.

A. Yes, yes.

MS. HENRY: It was way back in the beginning.

A. "Denies coryza symptoms. No family history of allergy."

Q. Coryza, you're right, that tough word?

A. Yes.

Q. Doctor, did you perform all stages of this procedure?

A. Excuse me?

Q. Did you perform all stages of this procedure?

A. All stages of this procedure were performed under my guidance, yes.

Q. Did you perform all stages of this procedure, yes or no?

A. This is my procedure. Perhaps you could restate.

Q. Simple question, doc. You've got, you know --

MS. HENRY: Why don't we just ask who actually did the procedure? Maybe that would be easier.

BY MR. SWEENEY:

Q. Who did it?

A. This is my --

MR. SWEENEY: Maybe Defendants will be changing soon.

A. This is my procedure. And did I have a resident assisting me in the case? Yes, I did.

Q. Who?

A. Paul Scolieri.

Q. Anybody else?

A. No.

Q. Okay. What did he do?

A. Dr. Scolieri worked on performing the endoscopic work and septoplasty.

Q. Was he operating the endoscope when the lamina papyracea breech occurred?

A. It was in his hand.

MR. SWEENEY: Deirdre, you could have saved me three hours. Do you realize that?

MS. HENRY: You asked for

this guy.

MR. SWEENEY: Excuse me for a second. You know what I'm talking about.

MS. HENRY: Actually, I don't. You asked for this guy.

(Thereupon, a short recess was taken.)

(Thereupon, the record was read.)

BY MR. SWEENEY:

Q. Are you aware, to your knowledge, of how many procedures he had performed prior to this?

A. On patients?

Q. How many endoscopic sinus surgeries, yes.

I'll ask him, but do you have any idea?

A. I would just be guessing.

Q. Okay.

A. I'd rather not guess.

Q. Dozens, a hundred?

A. I'd rather not guess.

Q. Well, I mean, you have some idea of residents that are in his similar situation and how many they have done, don't you?

A. I was relatively new to the program, so I have to say I'd prefer not to guess.

Q. Nowhere in this chart does it say that Dr Scolieri

performed this procedure?

A. You have to understand, this is my procedure It's done on a TV screen. Everything that takes place is at my direction.

Whether my hands are on an instrument or somebody else that I'm telling them what to do, it's me controlling the surgery. This is my complication.

Q. Correct.

A. Dr. Scolieri is negligible to this entire case.

Q. Did you ever inform Mr. Saadeh that Dr. Scolieri would handle any part of this surgery or be in any way involved in his care with this extremely risky endoscopic procedure?

MS. HENRY: Objection.

BY MR. SWEENEY:

Q. Did you ever tell my client --

MS. HENRY: Wait a minute. You're trying to say extremely.

MR. SWEENEY: I'll rephrase.

Q. Did you ever tell my client Dr. Scolieri was going to do anything on him?

A. My informed consent clearly documents "Dr. Houser or his/her designee or assistants to initiate the following treatment and/or procedure."

Q. Doctor, I'm just asking you a question

Did you ever tell him, listen, I'm not going to be doing this. I'm going to be assisting. I'm going to be supervising someone. I'm going to be in there, but this resident, this third year medical student, will be performing this procedure on you under my supervision?

Did you ever tell him that?

MS. HENRY: Wait a minute. He's not a third year medical student.

BY MR. SWEENEY:

Q. is it in that missing note?

MS. HENRY: You are misstating. He's not a third year medical

student, and you know that very well. You know he's already graduated from medical school and --

MR. SWEENEY: Excuse me, I'm sorry. He's not even the chief resident. What is he?

MS. HENRY: I do listen to the questions that are asked, you see.

MR. SWEENEY: That's good.

MS. HENRY: Yes.

Q. All right, let's make this very simple.

A. Mr. Saadeh was informed that I worked with

residents. MetroHealth is very well known for being a teaching program. It is not hidden in any fashion that MetroHealth is a teaching hospital.

Mr. Saadeh signed a consent that very clearly states that I may have an assistant with me. And that is precisely what he is if he's holding the instrument.

Q. Let's go back to the consent again.

A. If he's holding the instrument, he is still the assistant, and I am in control.

Q. Doctor, we know what the practical meaning of that is. And we know what the legal meaning of it is.

MS. HENRY: He doesn't know what the legal meaning of anything is.

BY MR. SWEENEY:

Q. I hereby authorize Dr. Houser to do this procedure. He was under the impression you were doing it.

MS. HENRY: It says or his or her designees or assistants to initiate the following procedure.

If your client didn't read this, it's not our problem.

MR. SWEENEY: Did you ever --

tell that to the jury.

MS. HENRY: He said I informed him I work with residents.

MR. SWEENEY: Okay.

MS. HENRY: Didn't he?

THE WITNESS: Yes.

MR. SWEENEY: Yes.

MS. HENRY: He did say that.

MR. SWEENEY: He did.

BY MR. SWEENEY:

Q. Was that put down in your note that we can't find?

A. Probably would not have bothered to enter into that, no.

Q. So you're saying that you're not hiding the fact --

A. No.

Q. -- that this is a teaching facility?

A. No.

Q. That's good. If you were, that would be fraud.

MS. HENRY: Objection. You know --

A. Right.

THE WITNESS: It's very --

MS. HENRY: Doctor, just

be

quiet.

MR. SWEENEY: I'm trying to be professional here.

MS. HENRY: Well, that wasn't a professional comment.

MR. SWEENEY: I apologize.

MS. HENRY: Along with several of the other ones that have been made here.

BY MR. SWEENEY:

Q. Doctor, what is the single most important element of a successful endoscopic sinus procedure?

A. Single element?

Q. Or one of the most important.

MR. SWEENEY: I'm just trying to give him some leeway here.

A. Preservation of mucosa.

Q. Would experience of the endoscope operator be up there?

A. As what? Be up there as what?

Q. Well, would a more experienced endoscopist --

A. More experience than who?

MS. HENRY: Let him ask the question. It's his job to do here

BY MR. SWEENEY:

Q. This whole time I'm sitting here, and I'm asking you questions, and I'm asking you these questions specifically referring to what you are personally doing. And you answer these questions when you physically did not have any control over the endoscope that was in my client's sinus cavity.

MS. HENRY: Wait a minute. You know what, Francis --

MR. SWEENEY: Frankly, I'm frustrated.

MS. HENRY: Wait a minute, Francis. Stop right there. You have not asked him one question about what actually happened in the procedure until very recently.

The two and a half hours that we have spent in this deposition you have spent discussing, what did you find, what are the indications, you know, what about this note, what about that note, what were your discussions with anybody. You haven't asked a single question until just now about

this

procedure at all. You haven't even asked any questions about the surgery.

MR. SWEENEY: Deirdre, make an objection, and just move on, okay?

MS. HENRY: You're trying to say for this whole deposition you've been under the misimpression somehow that he's actually doing the procedure, the actual physical procedure itself.

MR. SWEENEY: I can't imagine why I would do that.

MS. HENRY: Because none of the questions you've asked to this point have to do with the procedure. Isn't that true? All these visits leading up to and all his follow up after were his. That's what you've been spending all this time asking questions about. And the record is going to show that.

MR. SWEENEY: Let's move on.
Let's move on.
MS. HENRY: Once again, you've got the editorial comment that caused me to do that.
MR. SWEENEY: Let's move on.
MS. HENRY: Aside from the fact that it's late.

BY MR. SWEENEY:
Q. All right, Doctor, tell me what happened in the procedure. What happened?
A. We knew that Mr. Saadeh's left side would be the more complicated side. Basically we have his CAT scans up in the operating room on the screen for us to look at.
Looking at that, it appeared that most appropriately would be approach the right side, the more accessible, less risky side. So we did that.
Also his septum was deflected toward the left, so

the right side was more open.

We performed that side. And again I say we. Dr. Scolieri did a healthy portion of it. I mean, he physically had his hands on it a healthy portion. And I observed everything, watched everything like a hawk from a TV camera, from a video monitor, whether I am the one physically on the instrument or observing.

And I am in control of all his moves the entire time telling him, go here, go here, go there, go there, pointing out on the screen. So the right side went very well. Dr. Scolieri did an excellent job.

Then performed septoplasty basically to help

straighten his nose and to gain access to the left side, and then performed the left side.

Q. So his hands were on the controls the duration of the procedure, correct?

I understand you were watching and right there,

but his hands were on the controls, correct?

A. His hands were on the physical instrument. My mind was the control.

Q. Understand. But his hands were at --

A. I'm getting from your phrasing that you are not agreeing with me.

Q. No. I'm just trying to get this straight.

MS. HENRY: We don't care if he agrees.

BY MR. SWEENEY:

Q. I understand that you were there. You were watching. You were directing. You were supervising. You were the captain of the ship, okay?

A. Correct.

Q. But he is the one that is actually moving the endoscope through the sinus at all points of this procedure, correct?

A. Not at all points.

Q. What points is he not maneuvering the endoscope?

A. At some point, I always will take the scope myself

and look around to get an assessment, is there something the resident missed, et cetera.

Q. Did that happen here?

A. Yes.

Q. When?

A. On the right side, when he had completed that side, I inspect it.

Q. So you go over, and you actually take control and say, let me look around in here, right?

A. Correct.

Q. I'm just trying to get this on a lay level, okay? Because some of the wording is pretty difficult for me.

And then on the left side --

A. On the left side, then, we set off to again take down the uncinate, which we did, in standard fashion.

Q. I mean just when were your hands on the controls on the left side?

A. On the left side, my hands were on after we exposed fat.

Q. Okay. So Dr. Scolieri was at the controls when the lamina papyracea was violated, blown out, perforated, however you want to put it?

MS. HENRY: Objection.
Q. Well, whenever it occurred.
MS. HENRY: Well, I'm going to ask that you rephrase.
MR. SWEENEY: How do you want me to say it?
MS. HENRY: I'd ask you to rephrase.
BY MR. SWEENEY:
Q. When the complication occurred involving the lamina papyracea, was Dr. Scolieri at the controls?
A. His hands were on the instruments. He was at the controls.
Q. That's all I'm trying to find out here.
After that, after that happened, you took over the controls?
A. Correct.
Q. What did you do, and why did you take over?
A. I wanted to look in there again to see, had fat spilled out, et cetera.
Q. Anything else? So you went in there, and you looked, right?
A. Yes.

Q. Then did you hand the controls back to him?
A. No. We were basically done at that point, done

with the sinus portion for sure.
Q. Was Dr. Scolieri aware of the prior orbital fracture?
A. Yes.
Q. Was he aware of the bulging medial wall, lamina papyracea?
A. Yes.
Q. Had he ever operated, to your knowledge, on a patient with similar prior history to the orbit?
A. I cannot answer that. I do not know.
Q. You don't know?
A. I do not know.
Q. Then he's never done it with you, then, correct?
A. I do not recall doing a case like that with him before.
Q. How long had he been in your suite or your team -- how does that work? Is a resident teamed up with you?
A. No.

They spend a certain amount of time at Metro and a certain amount of time at various hospitals.

Q. How many other procedures similar to this -- or endoscopic procedures in general had you been involved with him at the same time?

A. I would estimate ten.

Q. How did those come out?

A. Perfect.

Q. No complications?

A. Perfect implies no complication.

Q. Okay. I just want to be sure.

For functional endoscopic sinus surgeries, is there a certification procedure?

A. No -- actually, I take that back. When we are board certified, it's part of that.

Q. The implication is that you are competent to practice FESS surgery?

A. Correct.

Q. Obviously Dr. Scolieri is not board certified?

A. Correct.

Q. In otolaryngology?

A. Correct.

Q. That takes care of a lot of these questions
A. The captain of the procedure obviously is.
MR. SWEENEY: What?
MS. HENRY: Board certified.
MR. SWEENEY: Yes, we know that.
BY MR SWEENEY:
Q. I mean, my question is, is the man whose hands are on the controls when this happened, is he board

certified? And the answer is no, he's not?
A. No.
Q. How often had Dr. -- well, I'll ask Dr. Scolieri these questions. I don't have too much more for you, Doctor.
MR. SWEENEY: Although, I'm afraid not to ask him some of these questions, because he may know more than Dr. Scolieri.
MS. HENRY: Go ahead. Ask away. I'm just assuming -- you aren't going

to ask all these things, what happened at the first visit, what happened at the second visit to Dr. Scolieri, because he wasn't there.

MR. SWEENEY: I don't know. I'm crazy. I might.

BY MR. SWEENEY:

Q. Doctor, the Hummer, is it a microdebrider, a back biter?

A. it's a microdebrider. It's not a back biter.

Q. It's not a back biter?

A. No.

Q. i had **a** picture of one. Is it kind of like this? I'm going to draw it

just so we don't get any objections here (Indicating).

MS. HENRY: That's all right. I'll object to your drawing.

BY MR. SWEENEY:

Q. Is it kind of like that (indicating)?

A. Correct.

Q. Is it an oscillating, or is it a rotating blade?
A. Oscillating.
Q. Which means it goes back and forth?
A. Correct.
Q. Instead of around and around (Indicating)?
A. Correct.
Q. You have an oscillating blade.
Are there different sizes of these Hummers?
A. Yes.
Q. And how are they sized, in terms of diameter, 1ength?
A. It terms of diameter.
Q. What are the sizes?
A. I know which one would have been used in this case.
Q. That would be --
A. A sharp edged 4.0
Q. Sharp edged 4.0?

MS. HENRY: Sharp, S-H-A-R-P, edged 4.0.
A. Right.
Q. What's 4.0?

A. That's the diameter.

Q. Four millimeters?

A. Correct.

Q. So the diameter *of* the entire tube which it's housed in is 4 millimeters?

A. Correct.

Q. Wow. And there's a blade in there?

A. Correct.

Q. There's not a light in there, is there?

A. No.

Q. The light is provided by --

A. The endoscope.

Q. -- the endoscope itself, okay.

So you have both these instruments in there?

A. Correct.

Q. Do they both go through one sheath?

A. No.

Q. They are separately inserted?

A. Correct.

Q. Why did you choose this type of Hummer?

A. This blade tends to do less trauma to the tissue.

Some of the other blades have serrated little

sharp things. And passing it in and out of the nose and against tissue can give cuts and so forth.

Q. What's the variant in terms of sizes, from what to what?

A. Four millimeters, 2.7 millimeters. I think there might be a 3.5.

Q. But 4 is the largest?

A. Four is the largest that I utilize. I'm not aware that there's larger.

Q. Is the oscillation rate adjustable?

A. Yes.

Q. And there's suction in this, as well, correct?

A. Correct.

Q. Is the suction rate adjustable?

A. Yes, yes.

Q. And do you have any idea what the oscillation rate or the suction rate was during this procedure?

A. The standard oscillation rate is like 2,400 rpm, I believe.

Q. And what was the suction rate --

A. That wouldn't be rpm.

Q. That's tech stuff.

A. RPM would be revolutions per minute. I'm not sure what 2,400 actually means.

Q. Pretty fast?
A. No. Much slower than if it's unidirectional.
Q. Okay.
A. Then it's like 10,000 rpm.
Q. Okay. It has to travel longer to get back around.
Here it just has to go back and forth, so -- it's about the same, I would think.
MS. HENRY: Objection to your --
MR. SWEENEY: I'm sorry.
MS. HENRY: You just can't resist doing that, can you?
MR. SWEENEY: I'm sorry.
BY MR. SWEENEY:
Q. What was the suction rate set on?
A. The suction rate at the time of the surgery would have been on full.
Q. Full suction rate?
A. Yes.
Q. So Dr. Scolieri, armed with this knowledge, as well --
A. Correct.
Q. -- breached the lamina and exposed the orbital fat

and may have done damage to the medial rectus muscle?

A. During our careful dissection, we unexpectedly encountered orbital fat.

Q. The contents of the suction, can you visualize them as they come out?

A. Yes.

Q. Are they collected in some sort of a bin or a pan or something?

A. Yes.

Q. Do you keep an eye out for what comes out?

A. Yes.

Q. Is that part of it?

A. Yes.

Q. And can you see when fat comes out as opposed to when mucosa comes out, or tissue?

A. Absolutely.

Q. And was any noticed?

Did you look down and go -- is that how you first noticed?

A. We basically, carefully dissecting along his

ethmoid area, pushed in with a straight suction into an area that looked as though it should have air behind it, and did not encounter any fat at that point, and so then proceeded to place the Hummer through that small hole to widen that hole to put the Hummer in. And in the process, we saw a

small globule of fat that appeared disconnected and went into the suction.

Q. Okay.

A. Turned off the suction, took the microdebrider out, looked at the suction tubing.

Q. Who noticed it, you or him?

A. Both.

Q. Okay.

A. Immediately.

Q. Is this procedure videotaped?

A. There was not a video tape made, no. Sometimes we have a video tower that could have a VCR capability, but --

Q. But this isn't documented anywhere?

A. No.
Q. Doctor, did you feel it was important to inform my client that a resident would be actually performing the procedure, or should I say have his hands on the controls?
Did you feel that was necessary, to tell him that beforehand?
A. No.
Q. Why not?
A. Because this is my case, and I am in control of it.
Q. On your informed consent form, or the notes that we

have, or the notes that were dictated that we don't have, on any of those documents, does it state the percentage of occurrence of each complication?
A. No.
Q. So then it wouldn't state the increased percentage of complication with the orbital wall fracture preexisting?
A. It would have stated that he was at greater risk

due to his old fracture, but there are no percentages that would ever be stated.

Q. On the note we don't have, because we already know what we do have, on the note that we don't have, does that state that you discussed it with the patient, which you said you have, and you did, but that you discussed the increased risks of all the complications?

A. On the side of the orbital fracture, yes.

Q. That was stated in that note?

A. Right.

I can tell you my standard dictation, if you'd like.

Q. Well, with regard to patients who have preexisting orbital trauma, which increases their risks, sure, go ahead.

Which you've had what, 25 of them?

A. Basically -- well, what I can give you is a standard approach. And then what I would have --

what I said --

MS. HENRY: We already went through that.

BY MR.. SWEENEY:

Q. If there's anything additional. If you already stated it, we already have it in the record.

MS. HENRY: Didn't we go through this? You have these risks. And because you have this, you have a little more of a risk.

Q. You stated that to him?

A. Yes.

MS. HENRY: I think, if you go back in the transcript about an hour ago, it was in there.

MR, SWEENEY: I know.

A. Yes, it was in there.

Q. Does the informed consent, or the attachment notes, dictation, state any alternatives that are available in dealing with this sinus disease?

A. Informed consent mentions that alternatives were gone over.

Q. Okay.

Are there any other alternatives other than the continued conservative management through medication?

A. Well, I already went over those with you.

Q. I forgot. I'm sorry.

MS. HENRY: About an hour ago.

MR. SWEENEY: I'm sorry.

BY MR. SWEENEY:

Q. Conservative treatment with the medications, that we discussed. What other alternatives are there?

A. Well, if he had allergies, then to work with that.

Q. Okay.

A. Simply irrigating his nose, continuing to irrigate, continuing to live with his symptoms.

Q. He didn't want any of that?

A. He did not want any of that.

Q. Okay.

A. He chose to accept the risks and undertake the surgery.

Q. Would you agree that the informed consent was used in an effort to limit your liability?

A. No.

Q. You don't think so?

A. I think the informed consent was to document that he and I had discussed everything.
Q. Okay.
A. I don't think of legal in every step I take with a patient.
(Thereupon, a discussion was had off the record.)
BY MR. SWEENEY:
Q. Doctor, when was the first ophthalmological consult subsequent to the occurrence, the fat bulging?
A. That would be the note from Dr. Ross.
Q. He saw the patient on 4-28 -- just to make it quicker. Would that be right?
A. Right.
Q. So the ophthalmologist saw the patient ten days afterwards?
A. Correct.
Q. Did you not consider a consult within the hospital on that day or that evening?
A. I carefully assessed his eye and felt it to be free from complication and did not feel it required.

Q. Do you know what the standard of care is for this procedure with a prior orbital fracture?

MS. HENRY: Well, objection. I think standard of care is a legal term, don't you think?

THE WITNESS: Yes.

BY MR. SWEENEY:

Q. Doc, first mention of standard of care was way before I got involved here. I'm asking you. It's in your records.

MS. HENRY: I think he told you that's what those doctors told him. He went to them to ask about a complication.

Q. Are you familiar with that term?

A. Standard of care?

Q. Yes.

A. I have heard that term.

Q. What does it mean to you?

A. That's a legal term implying what a reasonable and prudent physician would do.

Q. In like or similar circumstances?
A. Correct.
Q. Just to round it out.
Doctor, isn't it true that anatomical landmarks in the sinus, and knowing where those landmarks are, are critical to maintaining your spatial orientation as you maneuver through?
A. Correct.
Q. Isn't it true that most complications that do occur occur due to lack of visibility within the sinus?

A. Correct.
Q. Was there a poor visibility during the period --
A. No, no. We were able to see. We had done septoplasty to give us more room, and there was no undue bleeding.
Q. You have the standard anatomy in the sinus, correct?
A. Correct.
Q. Which is pretty similar from person to person, patient to patient?

A. It varies a lot from patient to patient.
Q. That's the reason for the CAT scan?
A. Right.
Q. So you have to study each scan, correct?
A. Correct.
Q. For each patient, which you said that you did here?
A. Correct.
Q. Did you give the scans to Dr. Scolieri to take a look at before this ever started?
A. Before the surgery, he and I went over the CAT scan at some length.
Q. Okay.
A. Yes.
Q. Did you explain to him, listen, this is going to

change the lay of the land in there, because he's got this bulging because of the fracture?
A. Correct.
Q. He was aware of that?
A. Correct.
Q. So you would not say that lack of visibility in that area played any role in this occurrence?

A. No.

Q. What do you believe explains it, then?

A. That it was unexpected, so I'm not sure I have an explanation for you.

Q. Okay, that's fine.

Is Dr. Scolieri still with the --

A. He's a resident still in the program.

Q. Do you still see him?

A. Yes.

Q. Have you talked to him about this?

A. No, no.

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

A. A letter did arrive for him, and I informed him of that fact, that your letter -- that was what I told him a long time ago.

Q. Okay.

MS. HENRY: That's the lawsuit, I think.

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

BY MR. SWEENEY:

Q. How experienced would you say Dr. Scolieri is in this procedure?

A. Well, again, it goes back to my experience, though. I'm controlling the case, and I am experienced, and I can take someone through that that has had very little training.

So the question comes down to, am I experienced in this? And the answer is yes.

MR. SWEENEY: This is why I ask questions four times, I just realized.

MS. HENRY: Well, I guess -- no, because he said that earlier. But I think you'll have to ask Dr. Scolieri, you know, his experience.

Q. I will. I'm asking your opinion here. And I understand that you're under adversarial circumstances here, but you do have an opinion?

A. As to what?

Q. At the time of this, on March 17th of 2000, how experienced was Dr. Scolieri in conducting this procedure with a Hummer debrider at maximum suction with an oscillating blade in an area where he knew or should have known that there was a

bulging lamina papyracea which could do damage if breached?

A. He was more competent than the average otolaryngologist out in practice. So he was up to standards of --

Q. That still leaves a lot of variant.

MS. HENRY: Well, I guess that's going to be.

MR. SWEENEY: That's fine, that's fine.

I'm still looking for the original here.

Let's take one quick look, and I think we're done.

MS. HENRY: And the CV.

MR. SWEENEY: And the CV.

Doctor, thank you. Sorry I have to put you through this. I have no more questions.

MS. HENRY: When you transcribe this, one week is never enough.

Can I have two weeks to get him to review it?

MR. SWEENEY: oh, yes, *yes,*

that's fine.

MS. HENRY: One week is never

enough to get these things reviewed.

_____

Steven M. Houser, M.D. date

(DEPOSITION CONCLUDED AT 6:20 P.M.)

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

CERTIFICATE

I, MICHELLE R. HORDINSKI, a Registered Merit Reporter and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, STEVEN M. HOUSER, M.D., was by me first duly sworn to tell the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was reduced to stenotypy in the presence of said witness, and afterwards transcribed by me through the process of computer-aided transcription, and that the foregoing is a true and correct transcript of the testimony so given by

him as aforesaid.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 21st day of February, 2002.

_____

Michelle R. Hordinski, RPR and Notary Public
in and for the State of Ohio
My Commission expires January 22, 2006