DOC. 197

IN THE COURT OF COMMON PLEAS

OF LORAIN COUNTY, OHIO

KATHY WENZEL

plaintiff :

vs. : Case No. 93CV110774

JUNG HUH, M.D., et al.,

Defendants :

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DEPOSITION OF JUNG HUH, M.D.

VOLUME I

FRIDAY, AUGUST 19, 1994

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The deposition of JUNG HUH, M.D., the Defendant herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel at the offices of Jung Huh M.D., 4520 Oberlin Avenue, Lorain, Ohio, commencing at 9:00 o'clock a.m. on the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiff

Becker & Mishkind, by

HOWARD D. MISHKIND, ESQ.

Skylight Office Tower

1660 West Second Street

Suite 660

Cleveland, Ohio 44113

On behalf of the Defendant

Jacobson, Maynard, Tuschman & Kalur, by

JOHN POLITO, ESQ.

1001 Lakeside Avenue

Suite 1600

Cleveland, Ohio 44114

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JUNG HUH, M.D., a witness herein, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, was deposed and said as follows:

EXAMINATION OF JUNG HUH, M.D.

BY-MR. MISHKIND:

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

A. Jung Huh J-U-N-G/H-U-H.

Q. You are a physician; correct?

A. Yes.

Q. My understanding is that you are an orthopedic surgeon?

A. Yes.

Q. Before I begin my formal questioning of you relative to Kathy Wenzel, I just want to give you a few precautionary instructions so as to aid you in fully understanding what I am going to be asking you.

A. Yes.

Q. Let me start out by asking you, doctor, have you ever given a deposition before?

A. Yes.

Q. On how many occasions?

A. I can't remember the exact numbers, but probably about, between five, ten times.
Q. Have any of those occasions been in connection with medical malpractice cases?
MR. POLITO: Objection.
A. Yes.
Q. Of the five to ten, how many times have you been deposed in medical malpractice cases?
MR. POLITO: Objection. Just show a continuing line of objection. Go ahead, doctor.
MR. MISHKIND: That's fine.
A. Probably about three, four times.
Q. In those three to four times, were you named as a defendant in a medical malpractice case or were you appearing in some other capacity?
A. I think three times as a defendant and the rest of it probably as a witness for other persons involved.
Q. Have you ever testified as an expert witness?
A. Yes, many times.
Q. Have you testified as an expert witness in medical malpractice cases?
A. No.

Q. You have testified as an expert witness in connection with one of your patients in a personal injury case; is that the capacity?

A. Yes.

Q. And that would make up the other occasions where you have had your deposition taken; correct?

A. If I include those, the numbers, a lot more than four or five. What I mean is, I have done many more depositions for my patients as a witness.

Q. Let me just try to clarify a few things, and this isn't intended to be tricky by any means. I understand that you have given a deposition where someone has filed a lawsuit against you on three prior occasions; today being now the fourth occasion; is that correct?

A. I believe so.

Q. You have given depositions on behalf of patients that were injured or were under your treatment and some lawyer came and asked you questions about your patient; correct?

A. Yes.

Q. And approximately how many times have you given depositions in that context? Roughly speaking.

A. Roughly, probably more than ten times. I misunderstood your first question. I thought it was strictly regarding medical malpractice.

Q. More than ten times during your career you have been asked to give deposition testimony concerning patients of yours that were pursuing a personal injury action?

A. Yes, that's correct.

Q. Initially, you had said somewhere between five and ten times you have had your deposition taken. I now know that three of those times related to cases where lawsuits were filed against you.

Tell me what the other roughly seven times or so, five to seven times or thereabouts, where you have had your deposition taken in medical malpractice cases, in what context were you being deposed? If you understand the question.

A. No.

MR. POLITO: I think what he meant and that's where he got confused, that it was three times in medical malpractice and all the other times have been on behalf of patients.

THE WITNESS: Yes, for my patients.

Q. Okay. I guess you confused me by saying five to ten times you have given depositions and just before we move off this area, is it fair to say that you have given depositions now four times, including today in medical malpractice cases? In all other situations the depositions that you have given have been related to personal injury actions on behalf of your patients?

A. That is correct.

Q. Thank you, doctor.

As I question you this morning relative to Kathy Wenzel, I will attempt to make my questions as clear and understandable as possible. If I don't, tell me, Mr. Mishkind, I don't understand what you are asking. I will attempt to rephrase it. If I can't make it more intelligible than I gave it to you the first time, I will ask Vivian to read the question back to you. We will do whatever we can so that before you answer the question, it's in a sentence that you understand.

A. Yes.

Q. So don't be bashful to ask me to rephrase it or read the question back, okay?

A. Right.

Q. If you don't know an answer, doctor, tell

me that you don't know. If you need to refer to your records, please feel free to do so. This is not a memory contest.

A. Yes.

Q. I give you these precautionary instructions, because sometime down the road, people may be looking at your deposition transcript and I don't want there to be any misunderstanding between you and me at a later point; you say I didn't understand what you were asking. I want to give you every opportunity now before you answer to make sure that you understand my question.

A. I understand.

Q. Okay. Thank you.

The three prior situations where you had your deposition taken in medical malpractice cases, did any of those matters go to trial?

A. Yes.

Q. How many, sir?

A. One.

MR. POLITO: Howard, just so the record is clear, I do have a continuing line of objection.

MR. MISHKIND: I did note that and

I would not argue that your objection fell off the edge of the page. It's continuing.

Q. The situation, doctor, that went to trial, what was the name of the patient in that case?

A. I think her name was Goforth.

Q. Goforth?

A. G-O-F-O-R-T-H, something like that.

Q. How long ago did that go to trial, sir?

A. Maybe about ten years ago.

Q. Was that here in Lorain County?

A. Yes.

Q. Was that -- did a jury return a verdict in that case?

A. Yes.

Q. Was it in your favor or the patient's favor?

A. It was in my favor.

Q. The other two cases did not *go* to trial?

A. No.

Q. Did any of those cases involve issues relative to the management of fractures of the forearm or issues relating to your management, I should say, of fractures of the forearm?

A. No. Do you mean including Goforth or those

two which were not brought to trial?

Q. All of the cases, doctor. Did Goforth involve a forearm fracture?

A. Actually close to the forearm. It's a fracture of the elbow. It's not forearm. It's close.

Q. And essentially, as I recall, and understand -- I understand it's been many years now since that case went to trial, but what was the issue relative to the elbow that the patient was critical of?

A. She had a fracture of the radial head and neck. She was, I think, about an 18 or 19-year-old girl. We treated her. The fracture healed all right.

I advised her to have her physical therapy, but she was very defiant and she did not want to have any treatment, physical therapy for a long time.

By the time she changed her mind many months later, she, even though she had the therapy, she had some limited motion.

And then six or seven months afterward, she went to another doctor and was found to have a fracture of the wrist; and at the trial -- I

remember because that was my first trial at the court -- she mentioned that the fracture of the wrist was not the issue, but she -- or was it the other girl?

Limited motion of the elbow was not the issue, but the fracture of the wrist was something that I did not treat. But she had X-rays of the elbow and wrist and even shoulder when I saw her and at that time X-rays were negative.

The fracture of the wrist that she later had was nothing to do with my treatment.

Q. Fair enough. You recall the details of that case fairly well. Do you recall who was the expert that testified on your behalf in that case?

A. There was no -- he did not testify in person, but I know through the PIE there was a professor in Cleveland, Brooks.

Q. Dennis Brooks?

A. Yes, I think he reviewed my case and he gave an opinion to the panel.

Q. Doctor, your office that we are at today is on Oberlin Avenue. Is this the only office that you maintain?

A. I also go to Oberlin Clinic in Oberlin.

Q. How do you divide your time between the two

offices?
A. I go to Oberlin Clinic every Thursday afternoon and then every other Saturday morning.
(Thereupon, a discussion was had off the record.)
Q. Do you have a subspecialty in the area of orthopedic surgery?
A. I have an interest and the practice I do more, but I don't claim that I have a subspecialty.
Q. What is your interest?
A. That I practice fractures and other orthopedic problems.
Q. Well, as an orthopedic surgeon -- well, why don't you define for me what the discipline of orthopedic surgery involves.
A. That involves the restoration and treatment of the function of the musculoskeletal system, that includes bones, joints, muscles, ligaments and tendons.
Q. And within the discipline of orthopedic surgery, you have an interest that focuses on fracture management?
A. Yes.
Q. Did you say something else besides fracture

management?
A. General orthopedics involving adults.
Q. So fracture management and adult orthopedics?
A. Yes.
Q. Now, do you have any specialized training in the area of fracture management?
A. No. Usually we don't require to have a special training in fractures for orthopedic surgeons.
Q. How have you evolved this interest in fracture management?
A. Well, the majority of my work involves fractures, I think that's why.
Q. What percentage of your practice involves fracture management?
A. Probably 60, 70 percent.
Q. What percentage of your practice involves general adult orthopedics?
A. About 20 percent, 25 percent.
Q. You are board certified; is that correct?
A. Yes.
Q. What country are you originally from?
A, From Korea.
Q. Did you do medical school training in the

U.S. or abroad?
A. I had two years in premedicine and then four years in medical school before coming to this country for postgraduate training.
Q. And was that all back in Korea?
MR. POLITO: The two years and four years?
MR. MISHKIND: Yes.
A, Yes.
Q. What medical school?
A. Yonsei Y-O-N-S-E-I University, College of Medicine in Seoul, Korea,
Q. What year did you graduate?
A. 1962.
Q. When you came to the U.S. then, you did your post or you did your graduate work then at an American institution?
A. Yes, that is correct.
Q. What city did you move to?
A. It was New York City in 1965.
Q. What did you do between '62 and '65, doctor?
A. I had served in the Korean Army as a medical officer for three years.
Q. '65, you then went to New York City and

started an internship someplace?
A. Yes,
Q. What hospital?
A. Jewish Medical Center and Hospital of Brooklyn, Brooklyn, New York, was for one year from July lst, 1965 to June 30th, 1966.
Q. That was a one year internship?
A. Yes, rotating internship.
Q. Did you then enter into a residency program after that?
A. Yes.
Q. At Jewish Hospital?
A, No. I moved to Elyria Memorial Hospital in Elyria, Ohio and I took two years in general/surgical residency.
Q. What additional residency or Fellowships did you pursue?
A. Then I took four years in orthopedic training.
Q. At Elyria?
A. Yes, at the same institution.
Q. Was this continuous after your two years of surgery residency?
A. Yes.
Q. Four years was exclusively orthopedics?

A. Yes.
Q. After completing your four years, did you then enter into the private practice?
A. Yes, that is correct.
Q. And have you continued in the private practice since finishing your four year residency in orthopedics?
A. Yes, the same location,
Q. Here and at the Oberlin Clinic?
A. Oberlin Clinic I started, I believe it was 1977 or '78.
Q. And when did you start here on Oberlin Avenue?
A. It was about 14 years ago.
Q. 1980?
A. Yes, about 1980.
Q. So you actually started Oberlin Clinic immediately after finishing your four year residency in orthopedic surgery?
A. No. I had established a practice here in town, Lorain.
Q. A different address?
A. Different address.
Q. Okay.
A. And then they invited me to come down. I

don't belong to the Clinic, but I had maintained my office there since then.

Q. Do you have any partners or associates that you practice with in your area of orthopedic surgery?

A. I used to have partners, but unfortunately after I joined two and a half years later, it dissolved.

But since then, I have been signing out to each other, one of the partners. He is not my partner, my associate. But on weekends, sometimes we sign out each other.

Q. So he will cover for you on specific cases?

A. Yes.

Q. And you will help him out on specific cases?

A. Yes.

Q. Who is that individual?

A. Dr. Sfeir S-F-E-I-R.

Q. Do you do any teaching, doctor?

A. No.

Q. Have you done any teaching?

A. No.

Q. You have hospital privileges at Lorain Community and St. Joe's?

A. Yes.
Q. And Elyria?
A. No. I don't go to Elyria, but I do have at Allen Memorial Hospital, Oberlin.
Q. Have you ever had privileges at Elyria Memorial Hospital?
A. No.
Q. Have you ever had privileges at any other hospital other than Allen, St. Joe's or Lorain Community Hospital, in the Ohio area?
A. I still have courtesy privileges at Amherst Hospital. I did not mention that.
Q. Any other hospitals?
A. No.
Q. Have you ever had privileges revoked or suspended at any hospital?
A. No.
Q. Tell me, doctor, have you done any writing at all in the area of orthopedic surgery?
A. I had one when I was a resident.
Q. What was the topic?
A. The topic was long term effect of epiphysiotesis and slipped capital femoral epiphysis.
Q. The slipped capital epiphysis, what was the

first part?
A. Long term effect of E-P-I-P-H-Y-S-I-0-T-E-S-I-S. That is a form of surgery which abolishes the growth plate.
Q. This is in pediatric cases?
A. Yes.
Q. Were you embarking upon a -- or were you planning on going into pediatric orthopedics at that time?
A. No. That term, actually the paper was for the preparation for the Ohio Orthopedic Society, and that subject was chosen by me and at that time the attending, and we presented it at the annual Orthopedic Society meeting.
Q. That's back into what, the middle '70s or thereabouts?
A. I think it was either 1970 or '72, I'm not sure.
Q. Since that time, doctor, have you published or submitted any articles on any topic in medicine for publication?
A. No.
Q. You have with you today your office records on Kathy Wenzel; correct?
A. Yes.

Q. You also have the original jacket and original films from St. Joe's here in Lorain for her -- relative to the films taken in the cast room or at the hospital when she went to the cast room postsurgical?
A. Correct.
Q. And I think you also have your own films?
A. Yes,
Q. You do not have the, immediate preoperative film taken on August 17th, 1991 or the immediate post-op film taken on August 18th, 1991 from Lorain Community Hospital?
A. No, we don't have.
Q. Okay. And just so that the record is clear, you attempted to get that, but learned that it had been signed out to another physician when you went or attempted through your office to get it for purposes of today's deposition?
A. That is correct.
Q. Okay. Do you have copies of the August 17th film and August 18th film? Not interpretations, but copies.
A. Actual films, no.
Q. You have radiological interpretations in your file for those films; correct? Take your

time, doctor.

A. They are in there.

Q. In a moment I am going to want to peruse your file just to see what you have there, doctor, but let me just ask you this.

In addition to what you have relative to Kathy Wenzel's treatment that you generated in your office, and what you got from the various hospitals by way of copies that were sent to you, have you had an opportunity to review the records from Suburban Hospital for the surgery that was performed by Dr. Morris in 1993 to correct the nonunion of her radius and ulna?

A. No.

Q. Have you seen the extra films from Beachwood Orthopedics? That's where Dr. Morris is a practicing orthopedic surgeon.

A. I just glanced for the first time yesterday. I did not see in the view box, but I just glanced.

Q. Well, I have them with me today, so that during the questioning, I may want to ask you some questions about them. I just wanted to see whether you had ever seen them before and I presume probably yesterday during your meeting

with your attorney, you glanced at them?
A. Yes.
MR. POLITO: Just for the record, he didn't glance at all of them. He glanced at a few of them, but go ahead.
Q. Have you ever seen the Suburban Hospital records for Kathy?
A. No, not at all.
Q. You are aware that she had surgery at Suburban Hospital, aren't you?
A. He told me yesterday. That was the only time I heard.
Q. Mr. Polito told you?
A. Yes.
Q. Have you seen reports from Dr. Jeffrey Morris outlining his treatment?
A. No.
Q. That hasn't been provided to you?
A. No, not at all.
Q. I take it then, doctor, as you sit here now on August 19th, 1994, you certainly have no basis to criticize Dr. Morris with regard to the surgery that he did to repair the nonunion of the radius and ulna in Kathy Wenzel's arm?
A. No, not at all.

Q. Certainly you have no basis to criticize the technique or the surgical approach that Dr. Morris undertook to repair her arm?

MR. POLITO: As he sits here today with what information he has?

MR. MISHKIND: Right.

A. I don't have any information. I know that she had the surgery, from Mr. Polito, yesterday. I glanced at the X-rays. I am glad she had the surgery, because I --

MR. POLITO: Doctor, you answered.

Q. We are going to get into that, don't worry. We are going to get into it in short order.

But from what you saw on the X-rays that were shown to you, did it appear that there was good reduction and good fixation of the ulna and the radius following Dr. Morris' surgery?

A. Yes.

Q. Okay. Are you board certified?

A. Yes.

Q. Which boards are you certified by?

A. American Academy of Orthopedic Surgeons.

Q. What year were you board certified?

A. That was in 1974.
Q. Were you successful in obtaining your board certification the first time?
A. No.
Q. How many times did you have to sit before you were successful?
A. I passed on the second try.
Q. The written part comes before the oral part; correct?
A. At that time, no. At that time, we had the oral and the written examination at the same time.
Q. So it was all combined together?
A. Combined together.
Q. And the first time you were unsuccessful in the oral and the written part?
A. I really don't know which part I failed.
Q. You were unsuccessful, period?
A. Yes.
Q. Okay. The second time around, you were successful?
A. Yes.
Q. Okay. Thank you.
Because of your interest, doctor, in fracture management, have you endeavored to obtain any specialized training or have you pursued any

specialized study to enhance your expertise in fracture management by way of specialized seminars, courses, anything that you as someone interested in fracture management might have available?

A. I think any ordinary orthopedic surgeon will endeavor in advancing their skills and knowledge by attending meetings and reading journals and periodicals, but all 1 can say is that I try. I attend annual orthopedic meetings every year and then I read current journals and books.

Q. Do you focus your reading, not exclusively, but primarily to areas of fracture management?

A. I always try to read more generous on the subject of fractures. But officially I am a general orthopedic surgeon. I like to be a well-rounded orthopedic surgeon, so I read and attend meetings on all subjects.

Q. Okay.

A. Even though I mention that I am interested in fracture management, a little more than other subjects --

Q. I am implying, perhaps, that because of your interest in fracture management that

personally behind closed doors when you do reading in journals and texts, do you look more to journals and texts dealing with fracture management than you do to general orthopedic topics?

A. Would you rephrase, please?

Q. Sure. I will be happy to do that,

We all keep abreast of developments. Lawyers keep abreast of the developments in the law. I trust you keep abreast of developments in orthopedic surgery?

A. Yes.

Q. And you do that by reading various journals, texts, peer review articles, and written information that is available to you as an orthopedic surgeon; correct?

A. Yes.

Q. And I presume a lot of stuff comes across your desk on a daily basis, either quarterly journals, textbooks, or newsletters; correct?

A. Yes.

Q. Do you endeavor to concentrate your study on fracture management articles and texts and journals more than just general orthopedic issues?

A. I try to, but I read the articles and

journals that come across to me. One journal may contain more fracture subjects at one specific time and the next would be other sports medicine, so I cannot read it pinpoint, I cannot really tell.

Q. Is it fair to say, though, that you do keep abreast of developments in orthopedic surgery as they relate to fracture management?

A. Yes, I do.

Q. And what journals do you refer to from time to time for information relative to fracture management and techniques that are out there for fracture management?

A. Actually there is a new journal which contains exclusively for fracture care. I subscribe, I read regular journals. There is no, like you mentioned, there is no journal which contains exclusively fracture matters.

Q. Well, as an orthopedic surgeon, doctor, when you want information on surgical techniques for reduction and fixation of forearm fractures, where do you from time to time go for information?

A. Well, of course you had the training, four years of training, and then throughout the years, just information appears on the journals or at the

meetings and you absorb and you study. I cannot really tell which journal I refer to when I have a fracture of the forearm.

Q. What about standard orthopedic texts? Which ones do you refer to from time to time for information relative to the management and treatment of forearm fractures?

A. Once in a while I defer to Campbell's.

Q. My recollection is there are chapters or a chapter in Campbell's Orthopedics dealing with forearm fractures?

A. Yes. I shouldn't say chapter, but it's regarding fractures.

Q. Okay. And in that chapter of fractures of the arm, there are discussions relative to the surgical techniques for the reduction and fixation of fractures of arms?

A. Yes.

Q. And from time to time, you will refer to Campbell's Orthopedics for information on that topic?

A. Yes.

Q. Okay. Campbell's is certainly considered to be an authoritative text in the area of orthopedic surgery, would you agree?

MR. POLITO: What do you mean by authoritative?

Q. Do you consider it to be authoritative, doctor?

MR. POLITO: Objection. Go ahead, doctor.

A. No. It's one of the popular textbooks.

Q. Do you consider it to be a good source for information, the area of orthopedic surgery?

MR. POLITO: Objection as to form.

A. Well, I refer to the book once and awhile.

Q. Do you consider it when you refer to it once and awhile to be a good source of information with regard to fracture management and treatment?

MR. POLITO: Objection as to form. Go ahead, doctor.

A. The problem with this textbook is that this has been published every three years or sometimes later, But by the time this is published, the content and the method already could be outdated a year or so,

Q. When you have referred to Campbell's Orthopedics with regard to fracture management of the arm, have you noted in the most recent edition

of Campbell's that the techniques are outdated?
A. There are some, yes.
Q. But some of them are still standard accepted procedures?
A. Oh, of course, yes.
Q. Okay. So that when you go to it, to the extent that they are standard accepted procedures, you would certainly consider the information in Campbell's to be a good source of information?
A. Yes.
MR. POLITO: Just objection as to form.
Q. You own Campbell's?
A. Yes.
Q. And it's in your office?
A. No. I have it at home.
Q. You have it at home, okay. And when the new edition comes out, you purchase the new edition?
A. Yes.
Q. What other orthopedic texts do you own?
A. I have numerous textbooks. I can't really name them.
Q. Campbell's is one that you are able to remember without any question?

A. Yes.
Q. You are not able to identify any of the other names of the ones that you consider to be the top of the list in terms of source of information for you as an orthopedic surgeon?
A. I subscribe regularly to journals.
Q. Let's talk about those, then. Which journals do you receive on a regular basis in the area of orthopedic surgery?
A. JB, Joint and Bone.
Q. Joint and Bone, that's the name of it?
A. Journal of Bone and Joint Surgery.
Q. Again, from time to time, you will refer to that journal for information in the area of fracture management?
A. Yes.
Q. And that would contain more current information on technique, on standard and accepted techniques in the area of reduction and fixation of fractures than perhaps Campbell's Orthopedics, would you agree with that?
A. It depends on the article. Again, sometimes the article can be about a year old. Sometimes we go to the meeting and the papers presented at the particular year's meeting,

published a year later, so we notice this quite often.

Q. There is also a book called Fractures, I think, by Green and Rockwood?

A. Yes.

Q. Do you own that book?

A. No, I don't.

Q. Do you refer to that book from time to time?

A. Yes.

Q. That's considered a well regarded text in orthopedic surgery with regard to fracture management, is it not?

MR. POLITO: Objection.

A. I have no opinion on that.

Q. Okay. You have, however, referred to it from time to time for information?

A. Yes.

(Thereupon, a recess was taken.)

Q. Doctor, the back of your file, there is a note that says New England Critical Care, or it's a little slip of paper with New England Critical Care embossed on the note pad. Then it says J.T. Knarley and an 800 number.

Do you have any idea who that is?

A. Yes. This is, I think, the insurance company. That's all I know.
Q. So this 271-G080 and the 1006340713, to your knowledge, dealt with some insurance company?
A. Yes.

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(Thereupon, HUH Deposition Exhibits 1 and 2 were mark'd for purposes of identification.)

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Q. Doctor, I am going to show you what I have marked for identification as Deposition Exhibits 1 and 2.

Can you identify what those two pieces of paper are?
A. Those two pages are from my office notes from Kathy Wenzel. They are copies.
Q. Are these accurate copies of what actually is the front and back of your office notes?
A. Yes.
Q. Now, in your file, you have additional information, and I am just going to narratively describe on the record what you have. I am going to ask Mr. Polito at a later point to just provide me with a complete copy of the file, just so I

have it, even though parts of it are excerpted from the hospital, but just so I have that.

In addition to the Exhibit 1 and 2, you have copies of cast room reports?

A. From St. Joseph, yes.

Q. You have a copies of radiological interpretations from St. Joe's and Lorain Community Hospital?

A. Yes.

Q. You have copies of reports which you generated when requested by certain people, a physician report that was sent, looks like you may have sent a report to an attorney who provided authorization from Kathy Wenzel, and Mr. Janik, and you have several letters that you sent to Kathy Wenzel requesting that she schedule appointments, and a copy of the complaint which has been filed against you.

Is that an accurate description of what is in your file?

A. Yes.

Q. Does Exhibit 1 and 2, doctor, constitute all of your notes, all of the entries that you made when Kathy Wenzel was here in your office?

A. That is correct.

Q. Any other notes that you would have made relative to Kathy would have been either in the hospital records at Lorain Community Hospital when she had her operation, or your notes in the cast room when you would see her for periodic checkups?
A. Yes.
Q. Are there any other written entries that you made relative to Kathy Wenzel anywhere else other than what we have just described?
A. No.
Q. Do you remember Kathy Wenzel?
A. Yes.
Q. How would you describe her as a patient?
MR. POLITO: Objection. That's broad, but go ahead, doctor.
A. She was quiet. She was a gentle person, not an aggressive person.
Q. I am sorry, not what?
A. Not aggressive person, a gentle person. I thought we had a good professional relationship.
Q. Was she compliant or noncompliant?
A. I thought she was, but at times I was not sure about that.
Q. At what times did you feel that she was noncompliant or were you unsure as to whether she

was compliant?
A. Well, she had a drinking history and when she comes to the cast room office, usually she has alcohol breath, alcoholic breath. But just when I told her to put this electric stimulator on a certain area and for how long, when I saw her at one time, the electric cord was way off from the fracture side. Also, she was not applying for the period of time I had recommended.
And at times when she comes, sometimes the fracture position, alignment changes, so I was not sure whether she had an injury or because of her personal habit had an accident or injury.
Q. I want to talk to you about what you just said, but I want to find out whether there is anything else in your mind or in your notes that you would raise as an issue concerning the possibility of her being less than fully compliant. Is there anything else?
A. No, not at this moment. When we discuss, it may come up, but --
Q. And certainly, you have had a chance to look through your records before the deposition today; correct?
A. Yes.

Q. Okay. If there was any evidence of injury from any external source, whether it be a fall, misuse or what have you by the patient after your surgery, would you agree that it would be important for you as the physician to note that an injury had occurred or that the patient had done something that had caused a misalignment of the fracture sites?

MR. POLITO: Objection. Go ahead, doctor.

A. Well, I should have, but many times when I rush, it causes, sometimes I omit and that's all I can say. I wish I could do it all the time.

Q. Let's talk about Kathy Wenzel and be very specific. Would you agree with me that you make no notations at all during any of the trips to your office or the trips to the cast room that indicate that she appeared to be intoxicated?

A. No.

Q. But it's your independent recollection that on one or more occasions, she did come with smell of alcohol on her breath?

A. Yes.

Q. And if that, if her consumption of alcohol in some manner had led to an injury to the arm or

likelihood of nonunion?
A, Yeah, that is correct.
Q. Okay. Doctor, I am going to hand you Plaintiff's Exhibit 12, and I will tell you that this is a film taken at St. Joseph Hospital, just nine days later, August 27, '91. And I want to talk about what you see nine days after the surgery, and whether or not what you see on this film, doctor, nine days later, in your opinion was acceptable, period.
Now, just for clarification purposes on the record, is that the August 27, 1991 film from St. Joe?
A. Yes, This was taken on August 2nd, '91.
Q. It's actually August 27, doctor. There is a 2 and a 7.
A. Yes, oh, that's a 27.
Q. Okay. On the right-hand side of the split film, what type of view are we looking at?
A. This is so-called anterior posterior view or front view of the forearm bone.
Q. Okay. And on the left side what type of view?
A, This is lateral view or side views.
Q. Okay. Now, using the AP view, which is on

the right-hand side, the bone that is on the right-hand side of that exhibit, are we talking about the ulna or the radius?

A. The right-hand side is radius.

Q. Okay. Now, looking at the -- look at the ulna for a moment, if you would. Tell me how many screws you see distal to the end of the fracture.

A. From fracture here, I see two screws distally.

Q. Now, the screw on the ulna that is most distal, this screw --

A. Yes.

Q. -- is that screw to you -- does that appear to be migrating or coming out at all?

A. No, it doesn't look like it. When a screw hole is made in such a way that when the screw is not going exactly 90 degree or perpendicular, you can see sometimes this kind of small tiny gap. It doesn't mean that it's not all the way down or is loose.

Q. Okay. So your testimony again -- and I just want to understand -- is the screw that is most distal on the ulna does not appear to be coming out at all?

A. No.

some inappropriate use of the arm that worsened the status of her healing, would you agree that that would be something that you as the physician treating the patient ought to note in the record?

A. Well, if it was a clear cut problem, I would and I should, I do. But there was sort of assumptions, suspicion -- I don't want to hurt my patients or other people's feelings by writing down.

Q. Can we agree then, that you do not have an opinion to a reasonable degree of probability more likely than not that anything that Kathy Wenzel may have done while consuming alcohol contributed to worsening of the healing of her radius and ulna?

MR. POLITO: Objection. Go ahead, doctor.

A. There is one instance where I record it.

Q. When was that, doctor?

A. It was on September 27th, '91.

Q. In the cast room or in your office?

A. The office note on September 27th, 1991.

Q. Okay. That my instruction was not to get a cast wet. She apparently got it wet and we told her to dry it with the blow drier, and I think

that was one indication that she may have been not compliant.

Q. Did that cause her ulna and radius not to properly heal?

A. I cannot say that this is the only problem, but she had, she did have extra external immobilization device which was cast, and when this was wet and cast becomes loose or weakened, this can, may contribute loosening or force motion at the fracture site.

Q. Okay. Do you hold an opinion to a reasonable degree of probability as to whether that incident on September 27th, 1991 caused a loosening at the fracture site?

A. No, I cannot.

Q. And again, in fairness to you, doctor, had you felt that getting the cast wet on that one incident was a significant factor in the healing, that's something that you would or ought to note in your records; correct?

MR. POLITO: He did note it.

MR. MISHKIND: I am saying it was a substantial factor that caused or contributed to the loosening at the fracture sites.

nonunion in your opinion in this case?

MR. POLITO: Objection as to form. Go ahead.

A. If she was using this electric stimulator for more than eight hours every day as recommended, for at least four to six months period of time, my opinion is that she may have a good chance of healing, because there have been reports of success rate of achieving solid union of fractures in nonunion cases probably from 60 to even 80 percent success rate.

So 1 really cannot tell whether she was using properly all the time or not. I just cannot prove it.

Q. So, you won't be able to express an opinion one way or another as to whether her use or misuse of the electric bone stimulator caused or contributed to the nonunion; correct?

MR. POLITO: Objection. Go ahead, doctor.

A. I think it's difficult for me to answer your question that way, because we don't know whether she indeed had used this according to the recommendation or not.

If she did use all the time, every day, at

least eight hours, properly, then if we trusted reports that we have, she might have had at least 60 to 80 percent healing process with the electric stimulator,

Q. And you have noted one occasion where you questioned whether she was using the external bone stimulator properly; correct?

A. Yes, one occasion where I put a note on my record.

Q. No other occasion did you make a notation that would suggest or imply that she was using it improperly or wasn't using it at all; correct?

A. Well, a few other things --

MR. POLITO: Listen to his question, doctor.

A. No.

Q. When did you first prescribe the external bone stimulator?

A. That was April 7th of '92. That was the date we applied. It doesn't mean that I did not recommend to her, and it's not that we did not try to get it before. I did not dictate that or write on the chart.

Q. Okay. It was April of 1992 that it was applied?

A. Yes.
Q. Okay. So that is --
A. About eight months.
Q. Do you have any recollection of discussing the use of the bone stimulator prior to April of 1992?
A. Yes.
Q. When did you first start having such discussion?
A. I think it's between December -- I think around December of 1991. We discussed other treatment too.
Q. Is any of that recorded in your office records?
A. No.
Q. This is something that Dr. Huh remembers independently?
A. Yes.
Q. December of [redacted] is when the conversation started taking place?
A. I believe so.
Q. And why did conversations start taking place in December of 1991?
A. Because that particular date on December 17th, '91, we removed the cast and X-rays were

done and at this time it showed some angulation of the fracture site. And screws were loosened and I believe that's when we really, I forcefully recommended her to do something instead of trying to have this healed with a cast application.

Q. When you say forcefully tried --

A. Sort of, yes.

Q. Forcefully tried to persuade her to do something?

A. Right, yes.

Q. And are you suggesting or implying that she refused to do something?

A. Yes.

Q. What is it that she refused to do?

A. That it was not healing as fast as we would like to see and what I had in mind and recommended to her was to have open reduction with a bone graft, because we are dealing with a delayed union.

And the problem was that she did not have insurance. She went through a divorce right after this happened and she could not afford and she said she could not have the surgery.

Q. Did you note in your records --

A. No.

Q. -- that you recommended any type of bone grafting or further surgical intervention?
A. No.
Q. Did you feel at that particular time, in December of 1991, that based upon the status of her arm from August of '91, when you did your surgery, to December of 1991, that surgical intervention was indicated?
A. Yes.
Q. That surgical intervention was necessary?
A. Yes.
Q. That without surgical intervention, the patient was not in all probability going to heal?
A. Another second option and recommendation was if you could not afford surgery because of loss of insurance, then why not we try external bone stimulator.

Then again, we checked the price and it was prohibitive, so she also did not have it done.
Q. Are you saying that she refused surgery and refused the bone stimulator?
A. Yes. She just couldn't simply afford.
Q. And did you feel at that time without the use of the -- without surgical intervention or the use of bone stimulator that in all probability or

more likely than not, her radius and ulna was not going to heal?

A. I had doubt that without intervening there was a good chance that we would have a problem, but the best thing I could do was apply a cast and use external immobilization, conventional type of immobilization device to have this fracture healed.

Q. When you say the best thing that you could do, the best thing you could do because you weren't going to go ahead and do surgery and you weren't going to use a bone stimulator?

A. Yes.

Q. You would agree, would you not, that it was far from the optimal measure of treating her radius and ulna as of that time?

A. Yes.

Q. However, you would agree with me, would you not, that nowhere in your office records do you indicate or suggest or imply that the patient refused the bone stimulator or that the patient refused surgery?

A. Yes.

Q. And further, there is nothing in the records that indicates that you recommended

surgery or that you recommended the bone stimulator, would you agree with that, as well?

A. Yes, I do.

Q. Okay. Did you take any steps at all to assist the patient -- strike that.

You knew that it was in the best interest of this patient to have surgical intervention because there was nonunion or delayed union as of December 1991?

A. Yes.

Q. And you knew that it was more likely than not that with just use of cast treatment, without one or the other treatment, bone stimulator or surgery, that the outcome was going to be less than what you would consider to be acceptable?

A. Yes.

Q. Did you take any measures at all, doctor, to assist this patient in obtaining the surgery or in obtaining the external stimulator, the bone stimulator?

A. Yes, I did.

Q. And what measures did you take?

A. Well, she was back to her job, and I asked her if she could afford surgery, but she said no. And again, about this external bone stimulator,

still she said no.

So, what I did was by the time April arrived, I had in my hand a bone stimulator. So I discussed with her. It was not intended for her, but it was barely used, so I offered it to her and she took it. That's why I applied EBI, which is external bone stimulator.

Q. And where did you obtain this external bone stimulator from?

A. It was actually for one of my former patients who needed it for delayed healing of fracture. After maybe three weeks or four weeks time of use, then he got another one.

The thing is I remember, because this was an industrial injury, and when we applied for this external bone stimulator through Industrial Commission of Ohio it takes a long, long time. So he decided to have it purchased through his private insurance. So he got one.

Meanwhile, it was authorized from the Industrial Commission and the new one arrived, so he comes to me, hey, doc, you know, you do whatever you would like to do with this if somebody needs it. So I immediately thought of Kathy and so 1 did it.

Q. But in the meantime between December of '91 when you knew that the use of a cast was not going to lead to an acceptable outcome, we then went to April of 1992 without what you would consider to be appropriate management of her fracture?

MR. POLITO: Objection. He never said it wasn't appropriate. He said it was less than optimal. Go ahead.

A. The only thing I could. I was not happy, but I had to do something. And we both knew that there was no other things that I could do.

Q. You certainly didn't note any of this thought process at all in the records; correct?

MR. POLITO: Howard, it's been asked and answered.

A. A few other things I didn't document either.

Q. What other things?

A. Like she had a drinking problem and other things.

Q. Okay. What else didn't you document in the record?

A. That she, well, looked depressed and sort of sometimes was late for the appointment.

Q. Did her looking depressed or coming late to

the appointments, did that have anything to do with the outcome of this case?

A. No. We are discussing about things that we didn't register or dictate, whatever, Sometimes we miss to write or dictate.

Q. You would agree that recordkeeping is an important aspect of medical care?

A. Yes. I realize that.

Q. And that complaints by a patient, as well as findings by a doctor, should be recorded in the records?

A. Yes, but over this long period of time when you see every three weeks and almost the same things, repeats, repeats, repeats, then you just lose perspective, I guess.

Q. I understand what you are saying, doctor, but you would certainly agree that recommendations with regard to a course of treatment that will help the patient should be recorded in the records?

MR. POLITO: Objection. Go ahead, doctor.

A. Yes.

Q. Kathy had a comminuted and displaced fracture of the ulna and the radius?

A. Yes.
Q. These are the two large bones in the forearm?
A. Yes,
Q. Have you treated in the years of practice that you have had here in Lorain County similar fractures?
A, Yes.
Q. And you undertook to treat this through an open reduction and internal fixation; correct?
A. Not all of them.
Q. This particular one you did?
A. Right.
MR. POLITO: Listen to his question and we will get through this a lot quicker.
Q. In this particular case, did the open reduction and internal fixation technique that you used have a name?
A. Open reduction and internal fixation using compression plate and screws,
Q. This is a semi-tubular plate and screws?
A. Yes.
Q. And you used five screws in a semi-tubular on the radius?

A. Yes.
Q. And five screws on a semi-tubular plate on the ulna?
A. Yes.
Q. Commonly in medicine, certain surgical procedures bear the name of the doctor that invented the procedure, or they are as described as the Hauser procedure, for example.
A. Yes.
Q. Does this particular procedure have a name?
A. Yes. This procedure was originally from Europe. ASIF, Association for Studies of Internal Fixation, and this was originated from their group, actually a group of doctors in Europe.
Q. And as a consequence of that, when you refer to this type of procedure, what do you call it? Do you call it an AO fixation?
A. Some call it AO fixation.
Q. What does Dr. Huh call it?
A. I call it ORIF with the compression screws and plates.
Q. So you use the generic name for it. You just call it what it is, an open reduction internal fixation with compression plate and screws?

A. Yes.
Q. But you have seen it in the medical literature referred to as an AO fixation?
A. Yes.
Q. Have you seen it written in the medical literature with other captions or other titles?
A. I don't understand your question.
Q. Okay, fair enough. You have seen it indicated as an AO fixation; correct?
A. Yes.
Q. Have you seen it described under a different name, this particular surgical procedure?
A. I don't recall.
Q. Okay, fair enough.
When the AO fixation is done, would you agree that the standard of care requires that the semi-tubular plate be inserted in such a manner so that the screws that you are using have a balance so that there is purchase of the screws on the proximal and the distal end of the fracture sites?
A. Yes.
Q. Would you agree that when you are using five screws, it would not be appropriate and standard practice to have one screw on one end of

the fracture site and four screws on the other end of the fracture site?

MR. POLITO: Objection as to form.

A. I don't agree with your statement.

MR. POLITO: You don't agree, doctor?

Q. Tell me why.

MR. POLITO: Go ahead.

A. Five screws can be used offsetting one screw being further from the fracture site. That does not create any problem, except when it is way off balance, that may create a problem. But five screws has been used and even that AO group used to say that five screws and six holes for the forearm is good.

Q. But do you want to have of the five screws into the semi-tubular plate, four of them on one side of the fracture and only one on the other side of the fracture?

A. No.

Q. That doesn't provide good balance and fixation; correct?

A. Correct.

Q. That will permit or at least increase the

likelihood that there is going to be a nonunion of the fracture; correct?

A. Correct.

Q. So that when you as the surgeon go in to do the procedure, the standard practice is to make sure that that semi-tubular plate and the associated screws are situated on the bone or at the bone in such a manner that there is good balance on each side of the fracture?

A. Yes.

Q. Okay. That is your obligation and responsibility as the surgeon to see to it that there is good balance within the semi-tubular plate and screws are inserted?

A. When I treated her --

MR. POLITO: No, listen to his question.

Q. That's your responsibility and obligation as the surgeon; correct?

A. Yes.

Q. We are going to talk specifically about what you did in a moment. I just want to find out some basic orthopedic surgical matters at this point.

A. Yes.

Q. Do you have a copy of your operative report in your file?
A. Yes.
Q. You can keep seated, doctor, because I am going to ask you some questions about it. I have a copy, as well.
This surgery was done on August 18, '91; correct?
A. Yes.
Q. In the description of the operation, about halfway down in your report, you indicate the fracture had occurred just proximal to the incision area of the pronator teres, and under direct vision, anatomical reduction of the fracture fragments was carried out. I am not going to continue to read, but you see where I am at; correct?
A. It's insertion area of the pronator teres.
Q. So where it says incision area, it should be insertion area?
A. Yes.
Q. So that's a transcript error?
A. Partly my accent, I guess.
Q. Other than that, you are at the portion of the operative report that I was referring to;

correct?

A. Yes.

Q. All right. When you say that under direct vision, anatomical reduction of the fracture fragments was carried out, what do you mean as to what you were doing? What were you attempting to accomplish?

A. We go into the fracture site and we identify the fracture ends and we also strip off the covering of the bone, which is the periosteum and muscle, and check the fracture clinically. With the naked eye and then bring the major bone fragments together. Sort of put this into the interdigitation of fracture ends,

Q. You used the term interdigitation?

A. Yes. Or the minor edges of the fracture fragments, realign it and we check all around and I was satisfied that I had a good excellent reduction.

Q. And you are able, because this is an open procedure, you are able to visualize that bone fragment?

A. Yes.

Q. And you are able then, because of the skill and the training that you have, to manipulate the

bone to reduce the fracture. In this situation you are dealing with the radius first; correct?
A. Yes.
Q. After you reduce it and you have the interdigitation or the contact between the two bone fragments, the next step is to fixate that reduced bone?
A. No.
Q. What is next?
A. Then make another incision over the other bone and the same procedure, exposed bone fragments, check the extent of the injury and again reduce it, and then you proceed with putting plates and screws.
Q. Okay. So that it's reduction of the radius, reduction of the ulna. Then fixation of the radius and fixation of the ulna?
A. Yes.
Q. In that order?
A. Or the other way around. Either way is all right.
Q. But you want to do the reduction of the two fracture sites before you begin the fixation?
A. Yes,
Q. That's so you don't have cross fixation?

A. Not only that. If you reduce one bone and apply plate and screws, then try to reduce the other bone, you may have a difficulty in reducing it.

Q. Okay. Now, later on in your operative report, doctor, toward the bottom, you describe the use of the five hole semi-tubular plate and five different size screws were inserted one by one in the appropriate fashion.

A. Yes.

Q. What 1 would like you to do is tell me what is the appropriate fashion?

A. What we did do is, what 1 do is, the fracture was reduced in a satisfactory manner. Then hold the plate with the instruments.

Q. You hold the plate with an instrument?

A. Yes. But before that, we use a template and see how far the end of the plate extends from the fracture site.

Q. Okay.

A. We are looking at it, and we know where the major fracture fragment is. And then we contour it.

What 1 mean is, that because of radius having anatomical bowing, ulna usually straight,

so what we do is we have a bendable aluminum type of a thing, template, so we lay over and conform, bend it, and then we use that as a template and we bend or twist this plate and we put this plate, of course, we maintain, reduce the bone fragments in place.

And the first hole is made a distance from the fracture site. And we don't tighten all the way. And second step is then go to the opposite side of fracture, cross the fracture site and we tighten up.

And because of the plate shape and screw head shape made to compress, so we tighten up on both sides. That way we can achieve a one millimeter or even one and a half millimeter compression, and then we drill, tap. Tapping too before, but drill, tap through the hole, and then put side screws.

Of course, after we drill, we put that instrument which checks for the proper length for the screw and then we use that one.

Q. And you want to make sure when you insert the screw that you have sufficient --

A. Purchase.

Q. -- purchase of the cortices?

A Yes.

And then do you continue to move in a distal manner from the fracture?

Yes, to the peripheral.

To the peripheral end of the semi-tubular plate?

A Yes.

So in simple terms, if we were to picture a football field, the 50 yard line is where the fracture is. What you are doing is, you start with a screw hole on the 40 yard line on each side of the middle of the football field and then you move to the 30 yard line on each side and perhaps to the 20, depending upon how many screw holes, but you want to have it balanced from the 50 yard line where the 50 yard line is the fracture?

A That's correct.

Q Okay. I don't know whether it's ever been described that way, but it seems to be a simple way to describe what you have just done or what you are attempting to do.

A. Yes.

Q Okay. And that's done on the radius and on the ulna?

A. Yes.

Q. What does post reduction apposition and alignment mean to you as an orthopedic surgeon?

A. Would you repeat that again, please?

Q. What does the term post reduction, apposition and alignment mean?

A. It means that the position and alignment of the fracture fragments after reduction, that means how, where the fracture ends meet together.

Q. Okay. Does good apposition of the fracture sites have anything to do with the location of the plate?

A. No. He did not mention about the position of the plate.

Q. He being the radiologist.

A. They are knowledgeable on all aspects of fractures and surgical procedures. Not all of them, but they are familiar with orthopedic procedures.

Q. Before you complete your surgical intervention on the fractures, is it your responsibility and obligation to make sure that the plate and screws are properly positioned on the bone?

A. Yes.

Q. And in fact, it's your duty and

responsibility to make sure that they are properly positioned before you tighten the screws into the bone?

A. Yes.

Q. Okay. So that if there has to be some adjustment of the position of the plate, you want to do it before you have closed up the patient and left the operating room?

A. If the surgeon noted that the fracture was accurately anatomically reduced, and the fracture on clinical examination, there was no other loose fragments or unstable fragments in those days on visible examination of fracture fragments, main fracture fragments are well protected or stabilized, and after we do this reduction and internal fixation and then go through with a range of motion and check stability, if they are stable, then the surgeon should really rely on his clinical judgment at the time.

Q. And certainly that clinical judgment that you call into place in assessing the success of the surgery permits you to visualize whether you have placed the semi-tubular plate and screws in the proper anatomical position?

A. I thought I did a good job.

before

you close up the patient, you have the responsibility to make sure?

A. Oh, of course.

Q. Is that it is in a good anatomical position; correct?

A. Of course.

Q. And if it's not in a good anatomical position, that increases the likelihood that there is going to be a nonunion of the bone; correct?

A. There is circumstances, when you think that this is a very minor hairline fracture involving, extending beyond or across to the end of the plate with adequate immobilization, external immobilization, it just can go on healing, so it doesn't mean that just because you see tiny hairline fracture, tending proximally or distally close to the plate end, it doesn't mean that it has to be done all over.

The reason is, in this particular case, this lady in spite of her size and age, the bone was very, very small, very tiny, and if I did remove the plate and make a screw hole on there,

have a disaster. So I thought we had a good fixation, we achieved good stability, and I thought this was really satisfactory.

Q. You mentioned something about a hairline fracture. Did you discover something with her radius or ulna after putting the semi-tubular plate in place?

A. No. It was way later when we had a repeat X-ray. It's not uncommon to show up the very tiny line a week or two weeks later and when we see at the time of the surgery, we cannot really visualize it. It doesn't show to the naked eye, that's what I am referring to.

Q. At the time of the surgery, though, was there any evidence of any hairline fracture or any other fracture, other than the fracture of the radius and the fracture of the ulna?

A. I don't recall. I wish we had X-rays, but at that time, I was not sure. I can answer that question.

Q. Is it fair to say, though, that at the time that you closed up the patient or completed your orthopedic end of the case, that it's your responsibility and obligation to make sure that that semi-tubular plate and the screws are in

proper purchase, proximally and distally to the fracture sites, so as to maintain the reduction of the bone?

A. All I can say is that I was comfortable and I was satisfied. I don't know whether with a five hole screw you can exactly balance. That I cannot tell, but I thought it was enough, that it was strong enough.

Q. Well, with a five screw hole, you are going to have three on one side and two on the other is the best balance that you can get?

A. That is a clinical judgment. You decide which side you place a little more distance and that is clinical judgment.

Q. Okay.

A. By looking at major fracture fragments and you try to balance and you try not to be too close, what I mean is that first screw hole from the fracture site, not too close to the fracture site, again not too far away, and you have to use, one has to use clinical judgment how to place it.

Q. Okay.

A. But if your question is, how can you put this five hole screw in perfectly balanced matching way, that, I don't think I can answer

that.
Q. And that really wasn't my question, but I understand there is clinical judgment in terms of how much purchase you have on each side of the fracture site. It can be adjusted according to what you believe to be adequate?
A. Oh, of course. If I thought that it was inadequate, yes, I have done it and I would do it and I do it, but again, this is clinical judgment.
Q. And I understand that you are saying clinical judgment, but there is a point where there is at least a minimal amount of purchase that has to be obtained, otherwise there is a high likelihood that the plate that you have inserted at the fracture site will not maintain adequate fixation?
A. I agree with you, yes.
Q. So that part of it is clinical judgment in terms of the fine tuning of where exactly the plate should go. There are certain basics that you don't have, if top heavy on one side, that 50 yard line situation, have part of it just at the 45 yard line on one side and the rest of it extending down to like the ten yard line on the other side. That's not appropriate reduction, is

it?

A. Right, I agree to that.

MR. POLITO: Objection as to form.

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(Thereupon, HUH Deposition Exhibit 3 was mark'd for purposes of identification.)

- - - -

Q. Doctor, for the record, we have reviewed the sleeve of films which are from St. Joseph's Hospital in Lorain, Ohio.

Did you obtain the sleeve with the X-rays for purposes of the deposition?

A. Yes.

Q. And to your knowledge, are these original films?

A. Yes.

Q. Would you agree with me that there is an interpretation of an August 27, '91 film which would represent the first cast room X-ray taken at St. Joseph's Hospital, but yet in the sleeve that we have here today, there is no actual radiological film?

A. Yes.

Q. Do you know the whereabouts of that August 27, '91 film?
A. No, I don't have any idea. We got this jacket a few days ago and all we did was reviewed it. And we found that a few films were missing.
Q. And did you find that the August 27th, '91 film was missing, or did you just learn that as I was putting that up on the view box?
A. I don't recall seeing that yesterday.
MR. MISHKIND: Mr. Polito, do you have copies of the August 27th?
MR. POLITO: As a matter of fact, what I want to do is I want to make copies of all these films. The only films I have are the films that you sent me.
MR. MISHKIND: Okay.
Q. In any event, right now at St. Joseph's, the first film that we have other than the interpretation is September 3, '91, which I have marked as Deposition Exhibit 3. Would you agree?
A. Yes.
Q. Okay. What does Exhibit 3 show us?
A. It shows AP, anterior posterior and lateral views of the left forearm, including the elbow and

wrist joints. And there are fractures involving the mid shaft area of radius and ulna and there are two plates and screws in place.

Q. Are these the plates and screws that you inserted at the time of the surgery on August 18th, '91?

A. Yes.

Q. Now, on the left-hand side of Exhibit 3, we have got one view and on the right-hand side we have another view. Which is the AP and which is the lateral?

A. The left-hand side showing two distinctive, two forearm bones is the AP view or anterior posterior view and the picture on the right side is side view or lateral view of the forearm.

Q. Let's concentrate on the AP view.

Which bone is depicted on the left side of the AP view?

A. It is the radius.

Q. As you look at that film, are you satisfied with the reduction of the radius?

A. Yes.

Q. Are you satisfied with the fixation?

A. Yes.

Q. As you look at this film, do you believe

that this reduction and fixation as depicted in this X-ray complies with what you understand to be the standard of practice for an AO fixation procedure?

A. Yes.

Q. Let's talk about the ulna. Is there a fixation?

A. Yes.

Q. Is that in your opinion acceptable fixation?

A. Yes.

Q. What about the reduction of the ulna?

A. That looks good.

Q. That looks good to you, doctor, in your opinion?

A. Yes.

Q. Now, would you agree with me, doctor, that the location of the fixation device -- strike that.

How many screws are there proximally, proximal to the fracture site on the ulna?

A. Well, you have to -- well, there are two screws distal to the fracture site. Now, when I reduced, fracture site is right here, between the second from the lower part and the third from the

top part. The fracture was here. And then the fracture extends through the middle inside here. And when 1 see that the surgery, this bone and this one is one fragment, this one is one fragment. So that actually three screws are at the major fracture end.

And what you are seeing is there is also fracture line hairline going up like this. That, like I mentioned, a few times in the past, I don't think this should be healed in time.

Q. Did it heal in time, the one that's proximal?

A. No, I don't think so. 1 think that's why we had a problem.

Q. So you believe that the line which shows up on X-ray on September 3, 1991, which is the area with the most proximal screw, is the area where the nonunion developed?

A. Yes.

Q. Okay. And it's your testimony that as you look at the film of September 3, 1991, and you look at the fixation and you look at the position of the screws, and you look at the amount of cortices that are involved with regard to the screws, all of this in your professional opinion

represents standard and acceptable orthopedic surgical reduction and fixation?

A. Yes, as of this time, yes.

Q. And do you believe that this fixation and reduction, as shown on this September 3, 1991 film, which would represent about two weeks postoperative, that this would be something that would be acknowledged reduction and fixation in standard medical texts?

A. Yes.

Q. And you would find support for this if you looked in Campbell's Orthopedics?

MR. POLITO: Objection. Go ahead, doctor. If you recall,

A. Campbell's textbook doesn't describe this kind of thing. It's just the general principle. Every fracture is different. Every fracture has different characters and personalities and we have to treat differently. As of now, I was comfortable.

Q. As of September 3, 1991, were you seeing evidence of a complication following the surgery of August 18, 1991?

A, I would not call it complication at all.

Q. You would call this what you reasonably

anticipated seeing two weeks after performing the surgery?

A. I was comfortable with what I have done.

Q. So your testimony is you were comfortable with the surgical procedure that you used and as you look at the September 3, 1991 film, you did not have any concern whatsoever as to the integrity of the Eracture lines or the probability that the patient would heal?

MR. POLITO: That's a couple multiple questions there.

Q. Were you satisfied at that point with the integrity of the reduction and fixation of both fractures?

MR. POLITO: I think he already indicated yes.

A. Yes, I said yes,

Q. And were you satisfied that there was a probability that based upon what you were seeing as of September 3, 1991, that the patient, to a reasonable degree of probability, would heal without a nonunion?

A. I felt comfortable that this would go on probably healing, especially when we had external cast fixation.

Q. And certainly with the external cast fixation, there would be nothing that the patient would have done between August 18, 1991 and September 3, 1991 that would have caused any of your work at the time of surgery to become undone?

A. No.

- - - -

(Thereupon, HUH Deposition Exhibit 4 was mark'd for purposes of identification.)

- - - -

Q. Doctor, I am going to mark the December 17, '91 X-ray from St. Joe's as Exhibit 4.

MR. POLITO: There is two from 12-17-91.

MR. MISHKIND: Two sheets?

MR. POLITO: Yes.

MR. MISHKIND: Would you prefer to --

MR. POLITO: I just don't want -- well, it's been marked, so don't worry about it. I wasn't thinking, so go ahead.

Q. I recognize in the sleeve that there is another film for December 17th. We can easily put that one up as well. But my question to you is,

this is the film where you indicate that th screws have loosened and what caused the loc of the screws?

A. I really can't answer. Meanwhile we shortened the cast to give her motion exercise of the elbow.

Q. Does a short arm cast increase the likelihood that screws will loosen?

A. It will allow rotation of the forearm and it may, when there is no solid fixation, it may contribute to loosening of the plate and screws.

Q. So if one is uncertain as to whether there is a solid fixation, it would be inappropriate to use a short arm cast?

MR. POLITO: Objection.

Q. Correct?

A. No. I want to make sure that she does not end up getting stiff elbow, *so* as a precautionary measure, I shortened *so* she could move the elbow.

Q. Well, let's go through the films, just *so* we don't miss the sequence of events.

I will take down the September 3 film and if you would put up what you believe to be the next film in sequence.

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(Thereupon, HUH Deposition Exhibits 5 and 6 were mark'd for purposes of identification.)

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Q. We now have Exhibits 5 and 6. Are these the December 25, 1991 films?

A. Yes.

Q. Maybe it's September 25.

As you look at the September 25, 1991 films, were you satisfied that the reduction that you believe you had achieved at the time of the surgery was maintained?

A. Yes.

Q. Was there any loss of reduction or any change in anatomical position?

A. No, not at all. Especially the ulnar, we can see the major fracture fragment here is right at the center of the plate here.

In this view, we don't see the tiny hairline fracture lines we used to see and I thought it was healing at the time.

Q. You were satisfied then with the reduction and the fixation?

A. Yes.

Q. As of September 25, '91?

A. Yes.
Q. What about on the lateral view?
A. Again, the plates and screws in place and I was comfortable and I did not do anything different, except cutting short the cast and the exercise,
Q. So at this point on September 25th, you put her into a short arm cast?
A. Yes. The cast was shortened and I advised her to start moving the elbow.
Q. Is this the first time that she had had a cast below the elbow?
A. Yes,
Q. Prior to that, it had been what, halfway up the humerus?
A. Yes, it goes up there.
Q. Not all the way up to the shoulder, but just to the mid humerus?
A. The mid part of the arm, humerus, yes.
Q. Okay. Let's go on to the next film, doctor. What is the next film that you have?
A. It was October 15.
Q. And you have two films for October 15th?
A. Yes.

- - - -

(Thereupon, HUH Deposition Exhibit 7 was mark'd for purposes of identification.)

- - - -

Q. Or one film?

A. One film.

Q. And we put an exhibit sticker number 7 on the October 15th film. Were you satisfied with the healing?

A. Yes. On AP view, we can see that fracture line is being obliterated here. It's fuzzy here and here, and also I thought that there was a fairly good healing on the ulna side. If you see, this is fuzzy and the line is much less distinct than before.

And the front view looked okay, but at this time on the lateral view, my concern was that she is developing a little bowing there, so I said, you know, we should not do it, she didn't accept it, so I put a long arm cast at this time.

Q. On the lateral view, you saw some bowing?

A. Yes, very subtle.

Q. Now, on October 15th, would you read to me what you said in your --

A. Repeat X-rays. Some more healing in slight

angulation. Long arm cast applied, recheck in two weeks.

Q. When you say slight angulation, is that the bowing?

A. Yes.

Q. You said she said something. She being Kathy?

A. Yes.

Q. What did she say?

A. What did I say?

Q. I thought you referenced her in your discussion. Did she request something to be done at that point?

A. No.

Q. You put back on the long arm cast?

A. Yes.

Q. Because of this bowing or this angulation?

A. Yes.

Q. What was your concern at that point as to what was developing?

A. That she might be doing too much when the cast was shortened below the elbow, allowing too much motion at the fracture site.

Q. The next film. Is that October 29th?

A. Yes.

- - - -

(Thereupon, HUH Deposition Exhibits 8 and 9 were mark'd for purposes of identification.)

- - - -

Q. We have two films for October 29th, correct?

A. Yes.

Q. And we now have Exhibits 8 and 9, which represent October 29, '91. Tell me, if you would, whether you were satisfied with the fixation and the alignment?

A. The alignment looks real good, The position looks good. But what I noticed here was that fracture of the radius shows a lot more healing. The fracture before, the line was very distinctive, like a V line, a letter V type and now we see a lot of obliteration and the fracture lines are very fuzzy now, so I was happy with the progress. And then again on the ulna side, this looks again like progressive healing.

Q. Were you satisfied with how things looked?

A, Oh, yes,

Q. What did you write on October 29th in your note?

A. That we check examination of the X-rays. Good alignment, but no healing yet. What I meant was not complete healing yet, but there is progressive obliteration of fracture lines visible here.

Q. Was she at a stage as of October 29, 1991 in your professional opinion that that was acceptable to you based upon the surgery that you had performed on August 18th?

A. Of course. And the lateral view, we can see that the alignment is good. There is no bowing.

Q. The next film is Exhibit 10, which is November 26, 1991.

- - - -

(Thereupon, HUH Deposition Exhibit 10 was mark'd for purposes of identification.)

- - - -

Q. Doctor, on this occasion, were you satisfied?

A. Yes, again, I was actually more satisfied, because we see less distinctive fracture lines every time she comes now and it's fuzzier and fuzzier. And even on the lateral view, this is

all knitting now, I would describe it as knitting of fracture. There is continuity established and there is the healing process going on, so I was satisfied.

Q. As far as the position of the screws and the number of cortices that were involved, is it your testimony that all of this was well within accepted standards?

A. Yes. Again, we go back to the issue that major fracture line was right in the middle of screw here. This fracture --

Q. Which bone are you referring to?

A. The ulna. The one we are discussing before. And the fracture we had was longitudinal or going along the axis, within the axis of the ulna, and then going side ways, and then there was a very faint hairline before.

Right now, it looks like the fracture of the particular area seems to be all healed up, or almost healed up.

Q. Okay.

A. So I had no concern at all at this time.

Q. Okay.

A. And I was happy. And then again I was concerned of her mobility, so I cut down the cast

below the elbow.

Q. So you were happy such that the bone was showing good position *so* that you felt that you could confidently cut down the cast --

A. Yes.

Q. __ to allow mobility?

A. Yes.

Q. If you did not have sufficient reduction and fixation, you would not have cut down the cast; correct?

MR. POLITO: Remember what he said earlier. He said you are worried about the elbow stiffness, so I think he has already answered that question, but go ahead.

A. Even if the fracture is not completely healed, during the healing process we usually like to consider the function of the limbs involved at a later date, *so* it is not uncommon to start rehabilitation during the active part of treatment, so I had to be concerned about late effect of the major joint, so I cut down. I don't deny that there was not complete healing.

MR. MISHKIND: At this point it's my understanding that the doctor has a

commitment that he has to get to at the hospital. It's now 11:30.

What we are going to do is adjourn the deposition and we will reconvene, hopefully sooner than later, and we will also make arrangements so that we have all of the films.

MR. POLITO: That's fine.

MR. MISHKIND: In addition to adjourning the deposition, we also agreed that Mr. Polito will take with him the original films from St. Joe's, which we already realize are not all of the films; the very first film in the cast room not being present. But we know we have 13 films from St. Joe's.

John is going to take them and he is going to duplicate them, making a copy for me and a copy for himself and then returning the films to Dr. Huh for use at the next deposition and then ultimately back to the hospital.

And as far as Dr. Huh's films, there are three films from your office that I would like to have copies of that

John is going to take with him, as well.

MR. POLITO: Could I ask a favor of you? I would like to get the films from Lorain Community Hospital, at least copies of the copies that you have.

MR. MISHKIND: I will call my expert.

(Deposition adjourned at 11:30 o'clock a.m.)

CERTIFICATE

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

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named JUNG HUH, M.D., was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was adjourned; that I am not a relative or attorney for 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 23rd day of November, 1994.

Vivian L. Gordon, Notary Public
Within and for the State of Ohio

My commission expires May 22, 1999.

IN THE COURT OF COMMON PLEAS

OF LORAIN COUNTY, OHIO

KATHY WENZEL .

Plaintiff .

vs. : Case No. 93CV110774

JUNG HUH, M.D., et al.:

Defendants .

- - - - -

CONTINUED DEPOSITION OF JUNG HUH, M.D.

THURSDAY, JANUARY 26, 1995

- - - - -

The videotaped deposition of JUNG HUH, M.D., the Defendant herein, called by counsel on behalf of the Plaintiff for examination under the statute, taken before me, Vivian L. Gordon, a Registered Merit Reporter and Notary Public in and for the State of Ohio, pursuant to agreement of counsel, at the offices of Jung Huh, M.D., 4520 Oberlin Avenue, Lorain, Ohio, commencing at 1:00 o'clock p.m. on the day and date above set forth.

- - - - -

VOLUME II

APPEARANCES:

On behalf of the Plaintiff

Becker & Mishkind, by

HOWARD D. MISHKIND, ESQ.

Skylight Office Tower

Cleveland, Ohio 44113

On behalf of the Defendant

Jacobson, Maynard, Tuschman & Kalur, by

CHERYL O'BRIEN, ESQ.

1001 Lakeside Avenue Suite 1600

Cleveland, Ohio 44114

ALSO PRESENT

Barry Hersch, video technician

- - - - -

- - - -

(Thereupon, HUH Deposition Exhibits 11 thru 13 were mark'd for purposes of identification.)

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MR. HERSCH: We are on the record.

JUNG HUH, M.D., a witness herein, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, was deposed and said as follows:

EXAMINATION OF JUNG HUH, M.D.

BY-MR. MISHKIND:

MR. MISHKIND: Please let the record reflect that this is the continuation and hopefully the conclusion of the deposition of Dr. Huh.

The deposition had begun on August 19, 1994. It has been rescheduled on a number of occasions due to scheduling problems; that the deposition is being taken, at least the conclusion of the deposition is being taken both by

stenographic and by videotape means and that a notice to take deposition had been issued to Mr. Polito advising him of plaintiff's intention to take the deposition both by videotape and by stenographic means.

BY-MR. MISHKIND:

Q. Doctor, you know I am Howard Mishkind. We met previously for several hours and talked about Kathy Wenzel.

A. Yes.

Q. Since we were together last, which was on August 19, 1994, have you had a chance to read over your deposition?

A. No.

Q. Have you ever seen the transcript of your deposition, sir?

A. No.

Q. Okay. Did you know that it had been transcribed?

A. I did not know it.

Q. I have a booklet here with your deposition. You have not been provided with anything similar to this?

A. No, not at all.

Q. Okay. I take it then, doctor, you can't tell me whether there is anything in the deposition transcript that needs to be corrected or modified, because you haven't read the deposition; correct?

A. Correct.

Q. Okay. Recognizing that, though, I am going to ask you whether there is anything that stands out in your mind -- obviously, independent of having read of the deposition, but is there anything that you recall having said in the previous deposition that at this point you want to say, Mr. Mishkind, I need to correct what I said, what I said before was incorrect, it needs to be changed or modified?

Is there anything you can think of independently at this point?

A. I cannot answer your question because I did not have a chance to review the transcription. It has been fairly long and I really can't think of anything that I should have corrected or --

Q. There is nothing that you can think of independently that needs to be corrected?

A. At this time, no.

Q. Fair enough.

Now, since the deposition, have you reviewed in any greater detail the Suburban Community Hospital records for the surgery that was performed by Dr. Jeffrey Morris back in March of 1993?

A. No.

Q. Okay.

A. I was not provided with documents provided by the doctor.

Q. Okay. Mr. Polito did not provide you with copies of any of Dr. Morris' operative reports or any of the X-rays from his surgery?

A. He just showed me once and we just glanced over the room light. That's about it. We did not discuss or he did not provide any medical records or operative notes.

Q. Have you had occasion to talk to Dr. Morris about Kathy Wenzel at any time?

A. No.

Q. Do you know Dr. Morris?

A. I'm not sure. I don't think so.

Q. Dr. Morris is an orthopedic surgeon on the east side of Cleveland affiliated with Beachwood Orthopedics. Do you know any of the doctors that are affiliated with Beachwood Orthopedics?

A. No.
Q. Okay. Thank you.
We are going to move into specifics on Kathy Wenzel and then finalize the deposition. In fact, we have to be in court this afternoon on the case. So I am not going to go over things that we have already discussed previously, or at least I am not going to intentionally do that, I assure you of that.
I do want to ask you whether you have reviewed anything, doctor, that you believe to be relevant to the Kathy Wenzel case since we were last together by way of any medical records or medical literature; anything that you believe to be relevant to this case, sir.
A. I have read new journals and also reviewed other articles, not specifically for Kathy Wenzel, but those are all related to traumas and other orthopedic surgeries.
Q. I'm sorry. Repeat that. Those are what?
MS. O'BRIEN: Related to trauma and other orthopedic surgeries.
A. Trauma and other orthopedic problems.
Q. You didn't review those with specific reference to Kathy Wenzel, though, did you?

A. Well, not particularly, keeping in mind we got this case, but I have read articles.
Q. Are there any articles that you read that you believe support the method or manner in which you did your reduction in fixation in Kathy Wenzel's case?
A. No, I can't recall any specific articles.
Q. Okay. Did you see any references in any of the literature that you may have viewed since our last deposition that in any way indicates that the choice of the plate and screws for the type of fracture that Kathy Wenzel had was appropriate?
A. Again, I reviewed the articles, but not specifically for this type of plate and screws.
Q. Okay. So is it fair to say that there is nothing that you saw in the literature that supports or says that what you did in the Kathy Wenzel case was appropriate?
MS. O'BRIEN: In the literature that he has reviewed since you last deposed him?
MR. MISHKIND: Correct.
A. Well, you are asking me whether -- would you mind repeating your question again.
Q. Not at all.

With regard to anything that you have reviewed in the literature, is there any article section in a text, section in a chapter that you came upon since the time of our last deposition that in any way supports the surgical approach, the orthopedic management of Kathy Wenzel's fractured radius and ulna in her arm?

A. No. I did not review any specific article on this subject matter.

Q. Okay. As you sit here today, recognizing that you may not have gone through the Suburban records with the kind of detail that you might otherwise want, but do you have any criticism, Dr. Huh, of the method or manner of treatment provided by Dr. Morris to treat the nonunion or the malunion of the fractures?

MS. O'BRIEN: Objection. Asked and answered at the last deposition. You may answer.

A. I don't think it's a fair question, because I have not reviewed his records. I cannot answer that.

Q. As you sit here right now, though, can you voice any specific criticism of Dr. Morris based upon anything that you have reviewed?

A. I cannot say anything because I don't know what he has done to her and I can't answer your question.

Q. Okay, You reviewed your records just preparatory or prior to the deposition today; correct?

A. Yes.

Q. Okay. We had talked in December -- or when we took your last deposition, we had talked about that by December of 1992 that you were concerned about the fixation and the reduction that existed in the ulna and the radius in Kathy Wenzel's arm; correct?

MS. O'BRIEN: Are you talking about December of '91 or December of '92, Howard?

MR. MISHKIND: I'm sorry, December of '91. I wanted to see whether you were awake or not.

MS. O'BRIEN: I won't be for long,

MR. MISHKIND: Okay. I'm trying.

Q. Excuse me, doctor, I meant December of '91. Remember we talked about at that point in December of '91 you were considering the use or

you felt that either surgical intervention or a bone stimulator was necessary?

A. Yes.

Q. Correct?

A. Yes, that's correct.

Q. Okay. Would you agree, doctor, more likely than not, that as of December of '91, based upon what you saw on X-ray and your clinical findings, that Kathy Wenzel was going to need to be operated on regardless of the success of any bone stimulator?

MS. O'BRIEN: Objection. I think this area was inquired into at his last deposition, Howard. I was under the impression we were just finishing up with the X-rays, so --

MR. MISHKIND: With all due respect, I don't believe it was, and again I am not intending to go into areas that have been inquired upon.

A. Would you repeat the question again.

Q. Sure. As of December 1991 --

A. Yes.

Q. -- would you agree more likely than not that Kathy Wenzel was in need of surgical, further

surgical intervention regardless of the success of the bone stimulator?

A. If the bone stimulator is working and creating some bone formation, the surgery is not necessary.

Q. Would you agree that in order for the bone stimulator to be effective, that there has to be rigid fixation of the bones?

A. Well, you just can't categorically say that there has to be a rigid fixation to have this bone stimulator be effective. Sometimes there is no rigid internal fixation, just a cast or other forms of external mobilization, plus bone stimulator can be effective.

Q. I am talking about when you have an internal fixation, knowing in December of 1991 that you did not have rigid fixation of the bone --

A. Well, that is not, again, a true statement. We had good rigid internal fixation when we did the surgery and we don't know what happened, but it became sort of angulated and one, maybe two screws became loose, but we really don't know what happened. We are not saying that to start with that it was not rigid internal fixation. I don't think it's a fair statement.

Q. In December of '91 --
A. Yes.
Q. -- when you started thinking about the use of a bone stimulator, you knew, did you not, that you did not have adequate fixation of the fractured bones. For whatever reason, it was not adequate as of December, 1991?
A. Yes, as of December, yes, there was some angulation of bone fragments.
Q. Okay.
A. Even though there has been a healing process going on slowly, and then I thought that she needed the further procedures, either surgery or external bone stimulator. My first choice was surgery.
Q. Okay. Can, doctor, a bone stimulator be effective where a patient has angulation of the bone where the patient does not, in your professional opinion, have adequate fixation of the fractured bones?
A. Sure, yes.
Q. Okay. Is that supported in any of the medical literature that you consult from time to time?
A. There are numerous articles, even in

nonunion case, with a bone stimulator applied, in time, bone in 70 percent healing rate documented and reported in many, many literatures.

Q. Even where there has been an open reduction internal fixation and for whatever reason the fixation is not deemed to be adequate?

A. Sure.

Q. Okay. Can you cite me to any texts or any articles that you know of that support that position?

A. Oh, there are many. I cannot offer any to give you, but it is a well-known common knowledge among orthopedic surgeons.

Q. So that it would be -- I recall that one of the texts that I believe you indicated that you own and consult from time to time is Campbell's Orthopedics; correct?

A. Yes, I think I mentioned that, yes.

Q. Okay. And do you believe that it would be referenced in Campbell's Orthopedics, that use of bone stimulators, even in the face of a fractured ulna or fractured radius that does not have rigid fixation is effective?

A. I don't think Campbell's Orthopedics mentioned that. I don't think so.

Q. Where would you look specifically if you wanted to get information to support this position?
A. Well, common orthopedic journals.
Q. Such as?
A. Periodicals. Even throw away journals off and on have this report.
Q. What are some of the common orthopedic journals that you as an orthopedic surgeon would look to?

THE WITNESS: Should I give him --

MS. O'BRIEN: He knows that you can't cite him to any specific text.

THE WITNESS: Right. At this time I can't.

MS. O'BRIEN: -- or book or article, but if you have a list of journals that you refer to from time to time, which I think you have already given Mr. Mishkind in your first deposition, you can go ahead and repeat that list. I don't know exactly what that list was, but --

A. It's JBJS and orthopedic journals.
Q. Journal of Joint --

A. And Bone.

Q and Bone Surgery?

A And Bone Surgery, yes,

Q Okay. So you would consult the journals that we talked about during your first deposition, you believe that those journals would have support for the position that we are just talking about?

A Yes.

Q Okay. In your first deposition, you told me that had she used the electrical stimulator, the bone stimulator for eight hours a day for a period of four to six months, that there was a 60 to 80 percent success rate, statistically that you are aware of, of achieving a solid union of fractures in nonunion cases. Do you recall giving me those statistics? It would have been on page 41 of your deposition.

A Yes, I believe so.

Q Okay. Can you tell me doctor, again, where you believe those statistics are memorialized, what texts or what journals would have that support?

MS. O'BRIEN: Well, I am going to object

I mean, first of all, this has all

percent.

Now, if your answer is that the 60 to 80 percent success rate is set forth in the texts which you previously cited to me to be authoritative, then, fine, I'll accept that. If you are referencing some specific text or article when you gave me that percentage, that's what I would like to know.

MS. O'BRIEN: Well, he didn't cite anything as authoritative, but if you can answer Mr. Mishkind's question in terms of if there is a specific cite that you know of that refers to these percentages, go right ahead.

A. First of all, there is not one, only one, like you said.

MR. HERSCH: Off the record.

(Pause.)

MR. HERSCH: Back on the record.

A. First of all, there is no one single authoritative paper on that, but there are numerous, many articles. And I cannot pinpoint. It's not that I'm trying to avoid you, you know, your question.

Q. Can you tell me one or two of the better sources that you consider that would have the statistics or support the statistics that you previously cited?

THE WITNESS: Off the record.

MR. MISHKIND: No, doctor.

THE WITNESS: Could I check with her first?

MR. MISHKIND: Pardon me? You want to talk to your attorney first?

MS. O'BRIEN: You have already answered the question. You have already told him you can't cite him to a specific reference, so, you know, you can just tell Mr. Mishkind that again and we can move on.

MR. MISHKIND: Well, no, that's not accurate. I asked you whether --

Q. You said that there is no one particular source.

Can you cite me to one or two of the sources that you consider to be the better sources that you know have the statistics that we previously talked about in terms of 60 to 80 percent

success rate? If you can't, then simply tell me that you can't and we will move on.

A. Yeah, I cannot really remember specific articles.

Q. Okay. Do you have any literature at all in your file?

A. No.

Q. Okay. Doctor, would you agree that the likelihood of achieving a solid union of the fractures was significantly less by December of 1991 because there had already been displacement and the screws and the plates have loosened, at least according to the X-rays that we looked at previously, which if you recall in October of '91, we talked about that there was some displacement. Would you agree with that?

A. Would you repeat your question?

Q. 1 would be happy to.

Would you agree that the likelihood of achieving solid union of the fracture was significantly less by December of '91 because by that time there had already been displacement and the screws and the plates had loosened?

A. Yes.

Q. Would you agree that with the plates and screws having loosened, that it was more likely than not going to require removal and replacement and grafting at some particular point in the future?

A. Yes.

Q. Okay. You used a five hole screw plate; correct?

A. Yes.

Q. Why did you use a five hole screw plate in this case?

A, Well, when I did surgery, I saw the size of the fracture line and the size of the bone, and I laid out the template, and there was adequate, And when we had the training and when we had this literature available, indicated that for the forearm fractures, five hole screw is the minimum size, and then I used it. I thought this was adequate for her at the time of the surgery.

Q. Okay. We can agree that the minimum size plate that would be used for a forearm fracture is exactly what you used?

A. Yes.

Q. Okay. There are larger plates, are there not?

A. Of course.
Q. And the larger the fracture, the larger the plate; correct?
A. Yes.
Q. You had available to you at the hospital plates larger than five hole plates; correct?
A, Yes.
Q. And certainly there was nothing preventing you from having used a five hole, a plate larger than five hole on that particular day --
A. Yes.
Q. -- was there? Nothing preventing?
A. Nothing.
Q. Okay. Now, you told me a moment ago that you can have some benefit or healing using a bone stimulator, even if you don't have rigid fixation. That's what we have talked about a little while ago?
A, Yes.
Q. Can we at least agree that if the bone is not rigidly fixated that the effectiveness of the stimulator is reduced?
A, If there is a constant motion, I should say gross motion, even with a cast or even with some other forms of fixation, there can be micro motion

or a small amount of motion, but without having gross exaggerated, you know, force motion at the fracture site with external bone stimulator, like I mentioned before, external bone stimulator can be effective.

Q. Would you agree that the more -- strike that.

Would you agree that the less rigid the fixation, the greater potential there is for movement of the bone fragments?

A. I believe so.

Q. And that the less rigid the fixation, the less effective that bone stimulator is going to be?

A. Yes.

Q. Okay. And would you agree that if you don't see progress with the bone stimulator after a certain period of time that other options have to be explored?

A. Yes.

Q. Okay. And is there a standard that you follow or that you are aware of in terms of a maximum period of time that you would use a bone stimulator on a patient who has evidence of plates and screws having loosened and some angulation of

the bone having already occurred?
A. I don't understand your question.
Q. Fair enough. We know that you used a bone stimulator in this case and we know further that you knew when you used a bone stimulator that there had already been some angulation of the bone and the screws; some of the screws had loosened; correct?
A. Well, for your question, using of this bone, external bone stimulator was my second choice.
Q. I understand that, doctor.
A. Right.
Q. And I am not talking about --
A. Number two --
MS. O'BRIEN: Let him finish.
A. Number two, there was angulation at -- in December, so we corrected it. We manipulate it and we put the cast and we have other X-rays and there was decent. It was not grossly angulated and it's not unacceptable.
Q. Okay. We will talk about what you did in December in a moment.
A. Yes.
Q. My question to you, however, was if you

have angulation and you know that the screws have come loose, is there a period of time that you will continue to use the bone stimulator a maximum of before which you will proceed to explore other options of treatment?

A. It was not, we set maximum period of time for the usage of external bone stimulator. I had recommended to her to have surgery with the bone recommended to have surgery with the bone -- excuse me, bone grafting, but she, by this time, lost her insurance and she did not want to have the surgery; so I just couldn't help her, except using the best choice to help her.

Q. What is the maximum period of time?

A. The maximum? There is no set maximum. The recommended usage of this bone stimulator is at least three months, sometimes they use six months, sometimes longer than that.

Q. So certainly in December of '91, you knew that the use of the bone stimulator was the lease efficient option available in terms of treating her problem; correct?

A. I should say second effective method.

Q. Most effective being surgical intervention?

A. Yes.

Q. Okay. And certainly as of December '91, you knew that the surgery that you had done in August of 1991 had failed to accomplish its intended purpose?

A. Well, for about six months time, if the fracture doesn't heal, then we usually record delayed union. Then we are worried and we try to do every efforts to make this particular fracture heal and still it's not hopeless.

You know, even you have bone changes showing very dense fracture margin and other changes showing nonunion, then you are really alarmed, but again, since we are talking about this external bone stimulators, this method has been used also in nonunion case, which is more than a one year old fracture.

Q. Doctor, going back to my question again, I asked you as of December, '91, would you agree that the surgery that you had performed in August of '91 had failed to accomplish the intended purpose?

A. Has not healed as of this time, yes.

Q. Had it accomplished what you had intended it to accomplish as of December, 1991?

A. We were disappointed but it's not

completely failed.
Q. All right. Did you express your disappointment to Kathy Wenzel?
A. Yes.
Q. Did you offer to redo the surgery at no cost?
A, Yes.
Q. You did offer to redo it?
A, Yes.
Q. Okay. Doctor, where in your records did you offer to redo the surgery? You told me that she didn't want to have it done because she lost her insurance, Where does it say in your records that you said, Kathy, don't worry about not having insurance, I will redo it at no cost?
A. Well, 1 think I told you the last time during the, when we had the deposition, I have told her, not only once, a few times, but I didn't write it down. There were some notes on her during the cast room visits. And for some reason, I have written few lines sometimes, and you are correct, I have not written anything about that.
Q. But it's your independent recollection that you felt disappointed that it had not accomplished everything that you had intended it to accomplish

and you offered to her to do the surgery at no cost?

A. Yes.

Q. And what was her response when you made that offer?

A. That she does not have an insurance. Even though I offer no cost, but she has to pay all other doctors, including radiologist, pathologist, anesthesiologist and the hospitals and all this. My surgical fee, I don't think is really big. Actually it's the hospital cost. So I just didn't have any heart to push. But when she does not want to have surgery, how can I do it?

Q. Okay. Well, is it your testimony that she didn't want to have surgery or is it your testimony that beyond what you claim to be your gesture of doing the surgery free or at no charge, that she was still concerned about the other costs that you could not control?

A. I thought there was a reason she said, because she did not have any surgery, she can't -- I'm sorry. Since she did not have insurance, she couldn't have surgery.

Q. Kathy Wenzel didn't tell you that she didn't want to have the surgery, did she?

A. That is my interpretation, when she says, I don't have insurance and I cannot have surgery.
Q. Did she in fact tell you that even if all costs were free or if there were other arrangements could be made, that she wouldn't under any circumstance want to have the surgery or was it an issue of being able to afford to have the surgery?
A. I think the answer is clear. She does not have insurance. She was working at the time and she cannot afford it. She is divorced and that's what she said.
Q. But Kathy Wenzel didn't say to you, doctor, thank you very much for that offer, but I am not interested in having the surgery? She never said anything like that to you, did she?
A. Well, she did not say exactly what you said, but she said I can't have surgery because I don't have any insurance.
Q. Okay. Did you make any effort, doctor, knowing as you claim --
A. Yes.
Q. -- that you were willing to do the surgery free, did you make any effort to contact the hospital and to see whether there could be any

arrangements made to permit this patient to have the surgery given the circumstances that we talked about and given the fact that you told the patient you would do it at no charge?

A. I did not do it because I know it's a futile effort because I have done a few times in the past on other patients.

This patient has a job. This patient -- the hospital, even medical staff is late for payment, they usually send to a collection agency. We know that. So we, I knew that this was a futile case; there is no use to even check with the hospital administration.

Q. Your testimony is that you did not make any attempt --

A. No, right.

Q. -- in connection with Kathy Wenzel --

A. Right.

Q. -- to find out whether circumstances or a circumstance could be worked out whereby she could make some payment arrangements, given the fact that she was employed? You didn't contact anyone at the hospital and find out --

A. No.

Q. -- whether that was possible, did you?

A. No.
Q. Okay. And given the fact that Kathy Wenzel could not afford to pay for the hospital and the allied services of anesthesia, the surgery was not done; correct?
A. Well, I didn't think that far at the time, but it's common sense. It's not the hospital, there is anesthesiologist, there is pathologist for laboratory studies, there is also radiologist, anesthesiologist and pathologist.
Q. Do you know what those costs would have been, doctor?
A. I don't know.
Q. Did you bother calling the doctors, the anesthesiologist, the pathologist to find out what the cost would be?
A. No.
MS. O'BRIEN: I am going to object to this whole line of questioning. You have been beating him up, you know, about this for a long time now, Howard, and he has no obligation to call anybody and try and make those arrangements, not to mention the fact that he has told you that he has done in this the past for

other patients and gotten nowhere.

MR. MISHKIND: Is this an objection or are you making a closing argument, Cheryl? I mean, I am not beating the doctor up.

MS. O'BRIEN: You are.

MR. MISHKIND: I object. I am offended by your objection on the record, which is precisely why we have it videotaped.

MS. O'BRIEN: Well, I am offended by the inference you are making by continuing this line of questioning and making this doctor feel as if for some reason he has failed this patient because he doesn't have any control over how much the hospital charges and who they are going to charge and who they are not going to charge.

MR. MISHKIND: Are you done? I would like to get on with the deposition.

MS. O'BRIEN: I am done. I am waiting for you to get on with the deposition.

MR. MISHKIND: I am waiting for you to stop your speeches so I can ask questions.

MS. O'BRIEN: As long as you move on to other more pertinent material we can get going.

MR. MISHKIND: I am glad you have now set the rules for how I'm going to conduct the balance of this deposition, Cheryl.

MS. O'BRIEN: No, the rules were set before I came here, they are just not being followed,

MR. MISHKIND: No, you are rewriting them.

Q. The stimulator, the bone stimulator, this was an EBI stimulator?

A. Yes.

Q. Okay, What part of the body was the stimulator originally customized for on your other patient?

A. It was for the fibular.

Q. I am sorry, what?

A. Fibular. F-I-B-U-L-A-R. This is a smaller bone of the two leg bones,

Q. These bone stimulators have to be specifically customized for particular patient and a particular bone involved, correct, to be effective?

A. I don't think so. I asked the salesman and they said it doesn't really make a whole lot different for the size of the bone or location.

Q. When did you ask the salesman about that?

A. I think it was before I recommended, I asked.

Q. Did you tell the salesman that you were using someone else's bone stimulator, another patient's, that was being used on his leg for another one of your patients?

A. Yes.

Q. Okay. And was that acceptable to the EBI representative?

A. No. I didn't ask about that. I just asked him about the size and the location, and whether it would be -- make it any different.

Q. You personally don't set the gauges or the wires for the bone stimulator, do you?

A. No.

Q. That's something that's done by the EBI technician; correct?

A. Not the technician. It's already made at the factory and all we do is we apply and give instructions to the patient.

Q. Okay. But the factory prepares it based upon the specifications that you give as to what type of patient, what type of bone it's going to be used for?

A. Yes.

Q. Okay, And it's your testimony, doctor -- I just want to understand -- that you spoke to an EBI representative who told you that the coils and the settings on the bone stimulator that had been used on the fibular bone could be used on a forearm fracture, as well, without any adjustments being made?

A. What I asked him was whether it could make any big difference, and he thought that there was not much difference. It could be used for the forearm bone too. Because the size of the bone is almost the same.

Q. Well, isn't it important that the coils and the settings on the bone stimulator be set specifically for the particular patient's needs to be effective?

A. I really -- I cannot answer that specific

questions, because these are all technical things.

Q. In November of '92, in your office records, you have a note that says external bone stimulator was applied, instructions given by company rep.

A. Yes.

Q. Now, that's the first time that I see any reference to a company rep. And we know that you had been using the bone stimulator since, I believe, April of '92. Can you explain to me what occurred in November of 1992?

A. Probably you recall during the last deposition, I told you that I had this EBI bone stimulator available. Since Kathy could not afford any bone stimulator, let alone surgery, I used it.

Q. All right. That was this other patient's from a Workers' Compensation claim?

A. Right, right. And Kathy knew that too.

And somehow she had a problem with using it. It was supposed to be used at least eight hours a day and the placing that round coil right over the fracture site, so once in a while when I see her, either she has not been using it quite eight hours, according to her.

And then again when I check her, sometimes

A. I forgot. I can get it later, but I cannot remember now.
Q. There is a way to determine whether or not a patient has been using the bone stimulator time-wise as prescribed; correct?
A, Yes.
Q. There is a clock on it?
A. Not all the types, The old ones, EBI had no built in clock or amount of time they used. The new ones, they have it. You turn on and then the date, the built in clock runs and you can measure how many hours, how many minutes you have used it.
Q. Was the EBI that this other patient had that you let Kathy use, did that have a clock?
A. I don't think so.
Q. Do you have that bone stimulator now?
A. No. It was returned,
Q. Okay. Who was it returned to?
A. I think it's the company.
Q. To EBI?
A. Yes.
Q. Okay. Was it rented?
A. No. All this bone stimulators after being used, whether the patient has successful outcome

or not, after a certain period of time, if the doctor decides that it should be used no longer then they are being returned to the company.

Q. Are they normally purchased or are they rented?

A. Well, actually you call it purchased, but they say it's by law you cannot keep it, so, we are required to return them.

Q. Now, did you have to notify the Industrial Commission that you were loaning this bone stimulator from another patient to Kathy Wenzel?

A. No, Actually I got a permit from the patient, who said I don't need it because I got another one, so you use it for other patient who cannot afford it.

Q. Eventually, though, you had to return that bone stimulator to EBI, whether it was from that patient or from Kathy Wenzel; correct?

A. Yes.

Q. Doctor, I'm going to hand you what has been marked for identification as Plaintiff's Deposition Exhibit 11. And just for the record, I will tell you that this is a portable film dated August 18, 1991 from Lorain Community Hospital for Kathy Wenzel post-op after your surgery.

If you would just take a look at it and make sure that I have not misrepresented things and then I want you to put it up on the view box.

A. I think we went through before. It's August 18th, '91.

Q. We did not go through this film before, doctor.

MS. O'BRIEN: It's all right.

Q. Can we agree that this is the portable film that would have been taken by you or in the course of your treating of this patient immediately after the surgery on August 18th, perhaps even while she is in the OR?

A. Yes.

Q. Okay, Now, what is cross compression, doctor?

A. Cross compression is when the fracture line is longitudinal or cross to par-alignment to the cortex of sides. That fragment is being fixed,

Q. With regard to the ulna, doctor, would you agree that there was a small butterfly fragment that extended almost the full length of the fracture?

A, No. I wouldn't say so. I would say -- I see on the radial side, not the ulna side.

the coil is off the center, and again, there was no satisfactory progressive healing taking place, so I --

Q. No satisfactory progressive healing as of November, '92.

A. Yes.

Q. Okay.

A. So I called this rep from a different company, not EBI, and I asked him -- I told him that since he has helped me in the past with other delayed and nonunion cases, so I asked him if he could help me.

This type is slightly different from EBI. EBI is post stimulator which goes over the cast. It's fairly big, like I told you, it could be misplaced if you are not careful.

The company where I contacted was producing different kind of a stimulator. He has a two coils and there is small contact which can be applied right over the skin, and he thought that this is more effective, so we put it -- that is the reason why we now have a rep -- not EBI, a rep from the bone stimulator company.

Q. What is the name of this bone stimulator company?

Q. You see what on the radial side? A small butterfly fragment that extends --
A. Yes.
Q. -- almost the full length of the fracture?
A. Yes,
Q. Is that small butterfly fragment, can we call that butterfly fragment as being displaced?
A. No. It's not, maybe about, on the proximal side, maybe one millimeter and on the other side maybe about two, three millimeter. It's very minimal.
Q. Okay.
A. Insignificant, I would say.
Q. Insignificant?
A, Yes,
Q. Okay. Now, looking at the radius -- now, for purposes of our viewing of this film, the bone on the right side of the X-ray, is that the radius or the ulna?
A. From your right, this is radius.
Q. Okay. On that film, which is a post-op film, how many screws are there to the proximal end of the fracture?
A. Actually, we don't see the major fracture line of the radius. We see just a small sort of a

sliver type of fracture line. You can call it butterfly fracture, but clinical there was transverse type of fracture, probably just below or above from your point of view to this third screw, so if you say where is the fracture, major fracture line, it's between second from the top and third from the top, but I can see -- see, if you -- how many screws do I see from the major fracture line? I see at least two here and the two up and down.

Q. Now, when I said proximal, doctor, proximal is, on this X-ray, proximal would be at the bottom?

A. Bottom, yes.

Q. Okay, all right. Now, on the radius where you are looking at the butterfly fragment, does the screw that is on the proximal end of the fragment of the fracture fragment, the major fracture fragment, does that fully purchase the opposite cortex?

A. No.

Q. Okay. There is a, what appears to be a drill from, a drill hole from one side of the cortex through to the other side; correct?

A. Yes.

Q. But yet the screw does not fully purchase or occupy the drill hole through and through or from one side of the bone to the other, does it?
A. I can see the drill hole, but I may have used -- there is, you know, a drill hole here, but I can see that it's not filled in fully.
Q. Okay. And, doctor, you are the orthopedic surgeon, so tell me whether that's of any significance to you as you look at the film proximal to the radial fracture where you see that there is a screw in the plate that purchases one side or one cortex, but does not go through to the other cortex. Is it of any significance?
A. At this time, one screw is completely filled in. On this view, the opposite screw, opposite cortex is not completely filled in, that I can see.
Q. Is that appropriate or acceptable surgical technique to drill a hole through to the other cortex and not to have the screw purchase to the other cortex?
A. Well, what we do is, after we drill it, we put gauge, depth gauge, we measure it, and we select the appropriate size screw and put it in.
Q. Okay.

A. And when we have this kind of a picture, I thought that it's a little bit of a tilting rotation can sometimes show that the screw is not showing to the end, even though there is enough purchase of the opposite cortex,

Q. Can we agree that the standard of care requires that the screw, that you choose a screw so that the size of the screw occupies the drill hole from cortex to cortex?

A. Yes, That is correct.

Q. Okay. And can we agree that at least as we look at this film, immediately post-op, that the screw, the proximal screw on the radial fracture does not purchase the opposite cortex?

A. I believe that, I thought that there was enough purchase, but because of a rotation, it's showing that way,

Q. Can we agree that based upon what we are looking at in this X-ray that the screw proximal to the radial fracture does not purchase the opposite cortex?

A. I think it's hard to tell, because like I told you, when you have a rotation, when you don't have an exact 90 degrees, we don't see the screw going all the way to the -- showing exact larger

view. When you rotate it 30 degrees, 45 degrees or even less, even though the tip of the screw is purchasing the opposite cortex, sometimes it shows that it's a little off.

Q. And, doctor, just so we can move on, can we agree that what is shown here, at least shows that the tip of the screw is a little bit off and doesn't purchase the entire cortex?

A. It's possible,

Q. Well, you are looking at the same film that the video camera is looking at and we are talking about the screw that is on the right side of the two bones and the screw that is the closest to the -- we are talking about this screw right here, correct, doctor?

A. Yes.

Q. Okay. And can we agree that there is a screw hole, a drill hole that goes from the, where the screw head is here all the way through the bone to the opposite cortex? That's what that space is; right?

A. Yes.

Q. Okay, And can we agree that the screw does not, at least on this film that we are looking at, fill the entire space; that there is a hole on the

opposite cortex, but no screw going through it?
A. Yes, that's correct.
Q. Okay. And can we agree that that is not the standard method that you as an orthopedic surgeon employ in terms of purchasing and fixating a bone; that what you do is you choose the screw, you drill the hole and you choose the screw so that the screw goes from cortex to cortex and fills the opposite cortex?
A. Yes.
Q. Okay.
A. They like to do it that way.
Q. I'm sorry, doctor?
A. Yes.
Q. Okay. Is there a rule of thumb that you generally follow in terms of the number of cortices that need to be purchased on each side of a mid shaft fracture in order to have adequate fixation?
A. Well, we like to have probably two to three times of the width of bone.
Q. I'm sorry, could you repeat that. You like to have what?
A. That the plate size would be two to three times the size of the fracture, so they can be

covered. We are talking about not this fracture line which is vertical or longitudinal. I am talking about the fracture which took place separating the two bones.

Q. Okay. And my question was, as a rule of thumb, in terms of the number of cortices that you want to purchase on each side of a mid shaft fracture, and is there such rule of thumb in terms of the number that you as an orthopedic surgeon employ?

A. That's what I said. We would like to have two to three times the size of the fracture line extending proximally and distally.

Q. I guess what I am getting at is, and maybe I'm off base on it because I am just a lawyer and I am not an orthopedic surgeon, but my understanding that there is a rule of thumb that generally you want to have four to five cortices on each side of the mid shaft fracture that's purchased in order to have adequate fixation of the bone? Does that help you at all in terms of where I am going?

A. Yes.

Q. Is that a generally accepted practice?

A. About -- what you are saying is the size of

the cortex of, the one and the two, counting two at one level.

Q. In other words, when you go through the bone --

A. Yes, correct.

Q. If the screw goes from one side of bone to the other, that's purchasing two cortices; correct?

A. Yes, uh-huh.

Q. Okay. Is there a rule of thumb that you follow or that you are aware of in orthopedic surgery when dealing with a mid shaft fracture in terms of the number of cortices that need to be purchased in order to have adequate fixation?

A. Yes.

Q. Okay. What is that rule of thumb?

A. That's between four to six is enough.

Q. Okay.

A. But here I thought the fracture was just below this screw here, so we have at least one, two, three, four, five, possibly six or five and a half.

Q. What about distal?

A. Yes. We have four. That's why we -- if you are questioning their way, counting cortices,

but again, when we are using the size of the plate with five holes, then that doesn't count. We can't really count number of cortices, how many proximal and how many distal to the fracture site.

Q. Why? Because the plate is the minimal size that you could use?

A. Yes.

Q. Okay. So that when you use a minimal size plate, you are limited in terms of how much purchase you can have on each side of the fracture?

A. Right. Again, the same token, if we use a longer plates, we strip off all this muscles and cause loss of blood supply to the bone, and that can also cause nonunion or delayed union.

Not only that, when we again strip off all this to expose more bone, just to put the longer plate, we can also damage the vessels and nerves, so we have to find a happy medium and that's why we have medium size plates.

Q. Well, you would agree that you have to choose a large enough plate in order to have the fixation balancing the neuro vascular status of the bone. But certainly you don't want to choose an overly small plate that's going to increase the

likelihood of nonunion?

A. Yeah, that is correct.

Q. Okay. Doctor, I am going to hand you Plaintiff's Exhibit 12, and I will tell you that this is a film taken at St. Joseph Hospital, just nine days later, August 27, '91. And I want to talk about what you see nine days after the surgery, and whether or not what you see on this film, doctor, nine days later, in your opinion was acceptable, period.

Now, just for clarification purposes on the record, is that the August 27, 1991 film from St. Joe?

A. Yes, This was taken on August 2nd, '91.

Q. It's actually August 27, doctor. There is a 2 and a 7.

A. Yes, oh, that's a 27.

Q. Okay. On the right-hand side of the split film, what type of view are we looking at?

A, This is so-called anterior posterior view or front view of the forearm bone.

Q. Okay. And on the left side what type of view?

A. This is lateral view or side views.

Q. Okay. Now, using the AP view, which is on

the right-hand side, the bone that is on the right-hand side of that exhibit, are we talking about the ulna or the radius?

A. The right-hand side is radius.

Q. Okay. Now, looking at the -- look at the ulna for a moment, if you would. Tell me how many screws you see distal to the end of the fracture.

A. From fracture here, I see two screws distally.

Q. Now, the screw on the ulna that is most distal, this screw --

A. Yes.

Q. -- is that screw to you -- does that appear to be migrating or coming out at all?

A. No, it doesn't look like it. When a screw hole is made in such a way that when the screw is not going exactly 90 degree or perpendicular, you can see sometimes this kind of small tiny gap, It doesn't mean that it's not all the way down or is loose.

Q. Okay. So your testimony again -- and I just want to understand -- is the screw that is most distal on the ulna does not appear to be coming out at all?

A. No.

Q. Okay. What about the screw most proximal to the fracture site on the ulna? Can we agree that that screw nine days after the surgery is already coming out?

A. I have to see the previous one. No, Again, this is possible that it's not screw or was not made exactly 90 degree perpendicular and this could be sort of a tilting when the screw was put in.

Q. Well, is the screw in your opinion in an adequate position from what you see on the X-ray, the proximal screw?

A. I want you to understand that when we put this plate over the bone, this cannot be because of the shape of the bone placed straight in the middle of the bone, and when there is a tilted in the one corner or one end, the screw head cannot be inserted perpendicularly,

So when we take picture, the other screws can show straight 90 degree in two or three plane or two planes, but one can show the kind of tilting. So as of now, I was not really concerned.

Q. Doctor, can we agree that there is only one screw to the proximal end of the fracture on the

ulna on that X-ray?

A. There is reason. When I put the screw, I saw only this fracture line, and when I saw it, there was on the naked eye or on vision, I did not see this fracture line; otherwise 1 could have gone all the way up, but that was after the surgery and the X-rays were done.

Yes, if you are saying there is one screw and if we count this one also, yes, there is only one screw proximally.

Q. Can we agree, again, nine days after the surgery, when we look at this X-ray that there is only one screw that is proximal to the fracture of the ulna?

A. Yes. Just make it short, yes. But there was my explanation.

Q. And your explanation is you didn't realize that the fracture extended as far as it did.

A. I did not see it at the time of surgery.

Q. Okay. And in order to properly fixate a fracture, you as the surgeon have to adequately visualize the fracture, especially when you are doing an open reduction?

A. Of course, of course.

Q. Okay.

A* But when we see -- many times we cannot on a naked eye can see the line. Sometimes after immobilizing for a while, the bone becomes sort of osteoporotic and then the fracture line shows up. It's not unusual not to see the fracture line nearby.

Q. On that X-ray, doctor, when we talk about having four to six cortices purchased on the proximal or the distal end of the fracture, can we agree that as of nine days after the surgery that on the ulna that we had at most one cortex which was purchased proximal to the fracture?

A. Yes.

Q. Okay. And that certainly is not an acceptable fixation, is it?

A. If we look back, having this delay union and nonunion, then we can say that, yes. But as of now, after surgery, the alignment is straight and the screws are in place, except maybe this one. I was not really overly concerned. And then we had a cast mobilization for protection.

Q. Well, if there is adequate fixation after an open reduction and an internal fixation, is cast mobilization even necessary?

A. Not absolutely necessary, but usually for

four weeks or so, be immobilized and put half cast or regular cast.

Q. How long in months or years was Kathy Wenzel in a cast while she was a patient of yours?

A. She had a cast until I saw her last in December 15th, '92.

Q. So she had 16 months of cast, long, short, while she was a patient of yours?

A. Yes.

Q. Never out of a cast?

A. Yes.

Q. And you took a cast off, you put it right back on or a new one back on?

A. Yes.

Q. Okay. On that August 27th film, doctor, on the distal end of the ulna, how many screws are there at the distal end of the fracture?

A. There are two screws.

Q. Okay. Now, looking at the radius for a moment, when we talk about the size of the screws, did you have various screws that were available to you?

A. Yes.

Q. Okay. So that just as you had various size plates, you also had various size screws?

A. Yes.
Q. Okay. When you have a comminuted fracture of the radius and the ulna, is stability of the fracture of both bones critical in order to achieve acceptable results?
A. Yes.
Q. Okay. Sometimes when you have a fracture of the ulna, but not the radius, you can just let it heal on its own?
A. Yes.
Q. Okay. But when you have both fractures, that requires extra care to make sure that the fractures are stabilized; correct?
A. Yes.
Q. Is there sort of a dynamic effect of the two bones are working together and when both of them are fractured, you have to be even more careful?
A. Yes.
Q. Okay. I am going to hand you, doctor, the October 20, 1992 film from St. Joe, and again, ask you if you would put that up on the view box.
MS. O'BRIEN: What Exhibit Number is that?
MR. MISHKIND: Pardon?

MS. O'BRIEN: Exhibit number? Is that 13?

MR. MISHKIND: Yeah, whatever. I can't count.

Q. Now, on Exhibit 13, doctor, on the right-hand side, would we be calling that the AP view?

A. Yes.

Q. Okay. And describe for me, if you would, perhaps starting with the ulna, and perhaps using your finger, if you could start on the AP view?

A. Yes. I'll --

Q. Reverse it?

A. I will reverse it, because this is reversed.

Q. Okay. So we are now on the left side of the film, but we are still looking at the AP view.

A. Yes.

Q. Starting with the ulna, if you could tell me from the distal end, moving down to the proximal end, what this X-ray designates or signifies to you in terms of the fixation, the position of the screws and the position of the plate, starting with the ulna.

If I see the ulnar, the major fracture fragment which I showed you before at the middle part of the plate on this X-ray, which -- August 27th, I don't see the line any more, so I interpret that as healing fracture there.

And if we go up proximally, the fracture which I thought it was minimal, because when I did the surgery' I didn't see the line at all and now it becomes major that 1 see a fracture line there, but still this is a straight and in between this fracture line there is a fuzzy bone sticking up, so I was optimistic at the time. And there is some evidence of some loosening of screw in the most proximal one.

Q. So on the -- and we have got on the proximal screw, there is only one screw proximal to the ulna fracture; correct?

A. Yes.

Q. Okay. And again, that is not the way that you would have designed the fixation to only have one screw proximal to the fracture; correct?

A. No. It was not my intention to do it that way.

Q. Okay. Because if you did that, if you designed it that way, that would increase the

likelihood of there being a nonunion; correct?
A. It's possible that it could go delayed union or nonunion.
Q. Well, isn't it increasing the likelihood when you only have one screw that's proximal to a major fracture fragment?
A. Yes, it is possible, yes.
Q. It increases the likelihood of there being nonunion or delayed union; correct?
A. Yes.
Q. Okay. And we know as of October 20th, that the screw, the only screw that's proximal on the ulna fracture is now migrating out more; correct?
A. No. I wouldn't say it's migrating more. Like I mentioned before, the line is a very hazy. If you see, you can barely see there is a fracture line. Maybe you see some dark area on the opposite cortex. If you see between this two proximal screws, there may be just a dark area, but I don't see any fracture, distinctive fracture line, so I was optimistic.
Q. You were satisfied with how the radius looked given the size of the fracture fragment, given the amount of purchase that you had on each side of the major fracture fragment?

A. The radius or ulna.

Q. I am talking about the ulna.

A. Ulna. As of now, since I saw that healing process of the major fracture line, and then the unexpected line, I found after the surgery, still there has been progressive healing so I was not really very much concerned at this time.

Q. And this unexpected line that you found after the surgery, when did you first become aware of it?

A. There was after surgery.

Q. Would it have been during that portable film immediately after the surgery?

A. That we didn't find it, but previously or during surgery. I think it was after, much after the surgery was done.

Q. But it's reflected on the post-op portable X-ray, is it not?

A. Yes. There was a slight displacement, but there was a really impacted and there was not clear, if you recall back.

Q. Well, at the time, though, if there is a displacement, so that the fracture fragment is larger than what you had visualized it as, that portable X-ray that's taken, is the patient --

have you already closed up the patient?
A. Yes.
Q. Okay. Have you ever had occasion where you have -- strike that.
What is the reason you take a post-op X-ray?
A. I want to see the shape of the condition of the reduced fracture fragments,
Q. And you as an orthopedic surgeon look at those X-rays, don't you?
A. Yes.
Q. You don't rely on the radiologist for a post-op film; correct?
A. I do, but I check myself.
Q. Okay. And you do, because you have the patient right there in the operating room and you are talking a post-op X-ray and you want to make sure that everything is okay?
A. Yes.
Q. Have you ever had occasions where you have gone back in and reoperated, based upon what you see on a post-op X-ray?
A. On fracture cases like this?
Q. Yes.
A. 1 don't recall having this kind of

problem. I have never had that problem like this.
Q. You have never had a problem like Kathy Wenzel's before?
A. No.
Q. Let's talk about the radius for a moment on that film that's on the left side of the view box.
A. Ulna.
Q. No, we are done with the ulna now?
A. Yes.
Q. Let's talk about the radius,
On that film, distal to the major fracture fragment, what, how would you describe the purchase? Is there adequate fixation?
A. At this time I see the middle screw if we go back, which was done on August, now is loose and butterfly fragment we had talked about before shows at least two third of ulna here, proximal side line here is all healed up and the lower two third part is still, they are not here, and major fracture line was I think about here, and you can see dark lines is still not here.
I was concerned about this loosened fragment, but as long as those two screws, proximal, those two screws distal are still

holding, plate is in place, and then there has been progressive healing taking place, so I was not again alarmed much.

Q. But you did have some concerns at that point?

A. Yes.

Q. Was there some angulation at that point?

A. No, I cannot say. Maybe, it looks like there is angulation because of more bone formation close to the tip of the plates so it looks like a little curve, but overall alignment seems to be okay.

Q. Okay. So you won't describe it as having slight angulation at that time?

A. If we measure with, yes, you may call it, but it's not gross or a bad angulation at all.

Q. Well, I mean, would you, you refer to it as slight angulation or not?

A. Very, very minimal angulation.

Q. You would call it minimal angulation?

A. Very minimal, yeah.

Q. What is the date on that film, again, doctor?

A. That was October 20th, '92.

Q. Okay.

A. And then, until then it's not that I did not protect this forearm. I had the cast all along to minimize any further injuries or gross motions.

Q. You were concerned that the fixation, even as of October, that the fixation that you had hoped to accomplish to both fractures was not occurring in the manner in which you had intended it; correct?

A. No. It's not correct. The patient had the surgery in August and it's only October, and there has been a fair amount of healing taking place, so I was, like I told you, I was not really alarmed, but concerned because of one loose screw.

Q. So all you were concerned about was one loose screw? You weren't concerned about the adequacy of the purchase on the proximal and distal ends of the major fracture ends?

A. No. Well, like I mentioned before, I was concerned, but I was not really alarmed, but I was protecting that forearm so that it could heal.

Q. And did you want to keep the arm in a long arm cast because you were concerned about whether or not the fixation was going to be, the internal fixation was going to be adequate?

A. Yes.
Q. Why then did you switch to a below elbow cast in November?
A. Because I was concerned about motion and function of the elbow. Since there has been progressive healing process going on and I want to make sure that she does not end up having stiff elbow, so I cut down and I asked her to do exercises.
Q. Doctor, in your office notes on December 15, '92, you say which is your last note -- you indicate repeat X-ray examination was done and this seemed to show some healing process for the first time. What did you mean by that?
A. I should have mentioned that the first time, probably for a past month or two, it is not during the course of treatment I saw that healing process for the first time, it's not, that's not what I meant.
Q. Okay. So what you want the record to reflect is when you said healing process for the first time in December of '92, what you meant was the first time you seen a healing process for the last several months?
A. Yes.

Q. But there had been healing process before that?
A. Yes. As of even in October 20th, as I mentioned before, there has been healing process,
Q. Okay. There is a -- let me ask you this, doctor. When you would see the patient at the cast room at St. Joe, would you review the X-rays before you would make your notation in the record or would you make your notation in the record and then look at the X-rays that were taken on that particular day?
A. I review the X-rays first and then make a notation.
Q. Okay. So that when you would write whatever you would write, you would have the benefit of having seen personally the X-rays for that particular day?
A. Yes.
Q. Correct?
A. Yes.
Q. Okay. And presumably have the benefit of comparing that film serially to at least a prior film to see whether or not there is any improvement or worsening in the status?
A. Yes.

Q. Okay.

MS. O'BRIEN: Howard, it's after 2:30.

MR. MISHKIND: I do know that. Let's go off the record for a second,

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

MR. MISHKIND: Let's go back on the record.

MR. HERSCH: Back on the record,

Q. Doctor, did there ever come a time where you consulted with any other orthopedic surgeons concerning the condition of Kathy Wenzel's arm?

A. No.

Q. When you would see Kathy at the hospital at St. Joe, did you ever have a resident or an assistant with you when you actually physically examined her, or a nurse?

A. We don't have a residency, residents, but we do have nurses and cast room technician to help me.

Q. Did you personally ever discuss -- not necessarily consult with, did but did you ever discuss with any nurses, technicians or other physicians the status of Kathy Wenzel's recovery?

A. No. There was no need, because we, the problem is after December '91, we knew that we were having problems, so I had recommended to her surgery. And then I was doing other things, like external bone stimulators, in addition to cast manipulation.

The answer was obvious. We needed to do surgery. That was the best way for her,

We couldn't do that. So we are doing the second best thing. And I, again, to have a consultation with the other surgeons, I thought it was, again, added expense and futile effort.

Q. You talked about doing manipulation on the bone in December of '91.

A. Yes.

Q. Okay. When exactly was that in December of '91 that you manipulated the bone?

A. There was on December 17th, '91.

Q. And at that time, you had -- the X-rays showed angulation, the screws had loosened; correct?

A. Yes.

Q. Now, which bone were you manipulating?

A. There is no way we can manipulate only one. When we manipulate means we do forearm

manipulate.

Q. Which bone were you primarily concerned about that caused you to manipulate?

A. I would have to see the X-rays. I don't recall.

Q. Okay. I will hand you these and you can grab the film.

MS. O'BRIEN: You are looking for December of '91?

THE WITNESS: Yes, I have the before and afterwards.

MR. MISHKIND: Why don't we go off the record for a second.

MR. HERSCH: We are off.

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(Thereupon, HUH Deposition Exhibit 14 was mark'd for purposes of identification.)

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Q. Doctor, while we were off the record, you had a chance to look through some films and we found a post reduction film on December 17th; is that correct?

A. Yes.

Q. Okay. And you have that up on the right-hand side?
A. Yes. On the right side we have a post-manipulation X-ray.
Q. And which bone were you mostly concerned about that caused you to do the manipulation?
A. It was the radius.
Q. Okay. And are you satisfied with the reduction that you were able to obtain from the manipulation?
A. Yes. It looked much better.
Q. Was there any continued angulation as of December 17th?
A. There was a slight angulation on the radius part. I can see that there was very slight angulation. Before it was obvious angulation.
Q. And is that, what, the dorsal angulation?
A. Yes.
Q. Both fractures; correct?
A. If you see ulna, it's almost straight here,
Q. Now, so you are saying the ulna does not have dorsal angulation as of December 17th?
A. Very minimal. Again, I shall say very, very minimal.
Q. Okay. And the purpose then that you had in

terms of putting the patient in the cast was to maintain what reduction you are able to get through your manipulation?

A. Yes.

Q. Okay. We know, though, that she continued to have increasing amount of angulation and increasing problems as 1992 went on, based upon the serial X-rays that were taken?

A. Yes,

Q. Okay. So that the manipulation that you did in December, while it may have been well intentioned, it didn't solve the problem, did it?

A. Oh, no, no, we are -- and she also knew that too.

Q. Okay. Now --

MS. O'BRIEN: Howard, it's a quarter to 3:00.

MR. MISHKIND: I am about two minutes from being done, Cheryl.

Q. Doctor, we have a pretrial to go to, so you and I are going to be parting ways momentarily. I am going to be completing the deposition. I just want to ask you just a couple final questions.

The last visit you had in December of 1992, did you at that time tell Kathy Wenzel that you

were still willing to do the surgery for her?
A. Yes.
Q. And that you were still willing to do the surgery free of charge?
A. Yes,
Q. Okay. We know in your office records and we know in the hospital records that there is never a mention of your offer to do the surgery free of charge.
My question to you is, did you ever write a letter to Kathy or did you ever have anyone present with you when you made this offer to do the surgery free of charge?
A. I have never written any letter to her, but I am sure a nurse or a cast room technician was there whenever I mentioned this to her.
Q. Can you tell me the name or the title of anyone that you specifically remember being present during any one or more of your offers?
A. I cannot recall, because sometimes we have other nurses, but most of the time it's the cast room technician.
Q. Is it the same casting technician all the time?
A. Yes.

Q. Have you ever -- is that same casting technician at the hospital now?
A. Yes,
Q. Who is that casting technician?
A. Felix Vasquez.
Q. Felix is the first name?
A. Yes.
Q. Vasquez?
A. Vasquez, yes.
Q. Have you inquired of Felix as to whether he heard your specific offers to do the surgery free of charge?
A. No. I never discussed it with him, anything about this patient.
Q. Okay.

MR. MISHKIND: Doctor, I have no further questions for you. I thank you very much for your time.

MS. O'BRIEN: He will read.

(Deposition concluded at 2:45 o'clock p.m.; signature not waived.)

Jung Huh, M.D.

CERTIFICATE

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

I, Vivian L. Gordon, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named JUNG HUH, M.D., was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for 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 10th day of February, 1995.

Vivian L. Gordon, Notary Public
Within and for the State of Ohio

My commission expires May 22, 1999.