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

IN THE COURT OF COMMON PLEAS

Laurie Ann Smith,)
) Doc. 298
Plaintiff,)
)
vs.) Case No. 76756
)
Cleveland Metropolitan)
General Hospital, et al.,)
)
Defendants.)

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Deposition of Doctor Mary Blair Matejczyk, called by the Plaintiff before Nancy L. Brezo, a Notary Public within and for the State of Ohio, taken at the offices of McIntyre, Oettinger & Winston, 330 Standard Building, Cleveland, Ohio, on the 2nd day of May, 1985, commencing at 2:20 p.m., pursuant to notice.

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APPEARANCES :

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On behalf of the Plaintiff;

Jacobson, Maynard, Tuschman & Kalur Co., L.P.A., by
Mr. Cyril J. McIlhargie
100 Erieview Plaza, 14th Floor
Cleveland, Ohio

On behalf of the Defendant, Dr. Mary Blair Matejczyk.

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DOCTOR MARY BLAIR MATEJCZYK

of lawful age, a witness herein, called by the Plaintiff for the purpose of cross-examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

MS. OETTINGER: Let the record reflect that this is an interrogatory of Dr. Mary Matejczyk, taken in the offices of Gail Oettinger and Tom McIntyre, attorneys for the Plaintiff, With Dr. Matejczyk, is her attorney, Mr. Cyril McIlhargie.

MR. McILHARGIE: And all formalities with respect to notice and service are waived,

MS. OETTINGER: The date is May 2, 1985. That's all.

EXAMINATION OF DOCTOR MARY BLAIR MATEJCZYK

BY MS. OETTINGER:

Q As I was going to say, for purposes of this deposition, I am not going to ask Dr. Matejczyk anything about her background. I have in my possession, her curriculum vitae and interrogatories that were submitted awhile ago.

And I'm not going to ask any questions concerning your training or the hospitals that you practice in or where you teach or anything.

MR. McILHARGIE: As well as the supplemental interrogatory to 92G, which I provided you.

MS. OETTINGER: That's corsect.

Q Okay. Calling your attention to June 28, 1983, do you know how Laurie Smith happened to come into Metropolitan General Hospital?

A According to the record of the emergency medical services, which picked her up at a bar, she was brought into the hospital by them with both legs splinted and lying on a back board.

MR. McILHARGIE: Mary, you're doing fine, but your voice -- do you need some water?

THE WITNESS: If you have some water, that would be fine.

MS. OETTINGER: I didn't see any of those.

MR. McILHARGIE: We're sorry for being late.

BY MS. OETTINGER:

Q Does the hospital get many accident cases?

A Yes, we do.

Q What about Welfare cases, do you get a lot of those?

A Yes, we do.

Q How is a doctor assigned to a Welfare case, for example?

A On the orthopedic service, the attendings are assigned to a rotating call schedule.

Q Are you an attending?

A Yes.

Q On some of the forms you signed it says, "visitant," will you explain what that means, please?

A I use that word synonymously with attending. It's the designation that Cleveland Metropolitan General Hospital has for the staff person that has supervisory capacity for the case.

Q Let me just repeat that, so I have it clear. A "staff person," which means you're on the staff of Cleveland Metro General --

A Right.

Q -- that has supervisory capacity over the case?

A Right. And each case, regardless of status, private or Welfare or staff, is assigned attending physician on the basis of the call

schedule.

Q And you were the attending physician for Laurie Smith at this time?

A Right.

Q All the way through her hospital stay from June 28th, until her discharge on August 3rd, is that correct?

A No. There is a period of time following the vascular surgery where she was on the general surgery service. So for that period of time, I was not the attending in charge of her case.

Q Do you recall what date that would have been?

A I can find them.

Q Well, the vascular surgery was performed July 1st, early in the morning, to refresh your recollection.

MR. McILHARGIE: She's got the hospital chart, Just go ahead and take a look.

A Following the vascular surgery? she was in the intensive care unit in the care of the staff unit who performed that operation. We were participating in her care, but with no longer primary responsibility.

Following her stay in the intensive care

unit, she was transferred to the general surgery floor. And according to the stamp on the chart, remained there until July 15th, when she came back to orthopedics,

Q And then when she came back to orthopedics, you were then the supervising doctor?

A Right.

Q At that time, those periods of time you just indicated when you were not the supervising doctor, were you aware of what was going on, did they notify you?

A Yes.

Q How often were you notified at that time?

A Let me explain a little bit about how an attending physician functions or visit functions with respect to the residents taking daily care. It depends on the features of the case involved, And in general, there is some contact made on a daily basis, so I was aware of what was happening with this patient during the time.

Q Everyday? Were you aware everyday of what was happening with the patient?

MR. McILHARGIE: As opposed to almost everyday?

A I would say, almost everyday.

Q How did you become aware of what was happening to the patient, by what means did you become aware?

A By means of communicating with the residents and making rounds with the residents --

Q So you were physically present?

A -- and review of the chart.

Q Were you physically present then?

A On occasion, but not everyday.

Q Were you called by telephone for various problems?

A Can you be a little more specific about when and where?

Q Did one of the residents call you, for example, on June 30th, for example, on July 2nd, for example, on July 15th?

A I think I can only answer that specifically day by day, according to what problems you're asking about.

Q Let me ask it this way: Occasionally, you were called by a resident and informed of Laurie Smith's condition?

MR. McILHARGIE: At what point in time?

Q From any point in time, from June 28th to August

3rd?

A Occasionally.

Q And, occasionally, you were present physically on the floor observing and examining Laurie Smith?

A Yes.

Q And, occasionally, you only looked at the records of Laurie Smith and did not actually see her physically and in her presence, was not in her presence?

A I would say if I saw her, personally, then I looked at the records simultaneously.

Q About how many times in the course of her being admitted to the hospital did you see Laurie Smith?

A I don't think I can answer that with certainty.

Q Well, she was in the hospital for about 36 days. And out of those 36 days about how many days did you actually see her?

A Well, let's take a period of time when she was on general surgery. I did not see her daily, by any means, during the period of time when she was on another service.

Q That was -- you're referring now to the time of the vascular surgery, which occurred sometime

during July 1st?

A July 1st to July 15th.

Q Okay.

A When she was returned to the orthopedic service, I generally make formal rounds with the residents once or twice per week. I am on the floor during the week on a daily basis, but, I don't see every patient everyday, unless there is a specific reason that I'm asked by the residents to see the patient.

Q Okay. Out of the 36 days then, that she was -- that Laurie Smith was in the hospital, 15 of those days you actually were not the supervisory doctor. That left 21 days when you were the supervisory doctor.

Out of those 21 days, approximately how often did you see Laurie Smith?

MR. McILHARGIE: With the understanding she occasionally saw her during the other 15 days. I assume that's what your question means?

MS. OETTINGER: I'll ask the questions.

A That's about a three week period?

Q Yes.

A I'm going to guess three times a week,

Q Okay. Approximately three times a week you saw her. And during the 15 days when you were not the supervisory doctor, how often did you see her?

A I would say during that period --

MR. McILHARGIE: Doctor, is there a simple reference, like a notation in the chart, that will aid you in giving an accurate answer?

THE WITNESS: I don't think so.

MS. OETTINGER: No. I didn't see any notation that would indicate that.

MR. McILHARGIE: Fine,

A I would say that I recall seeing her in the intensive care unit probably twice a day. So that's just for the first couple of days. When she was no longer in such critical condition and up on the general surgery floor, I would guess that I saw her probably twice.

Q How many days was she in the intensive care unit?

A I need to refer to the chart.

Q Just to refresh --

A Sorry.

Q

A Right.

Q

A

Q

A No.

Q

A No. She was in the recovery room and then up to the orthopedic floor for a short time.

Q Was she in the intensive care unit after the surgery July 1st?

A Yes.

Q For how many days?

A I will give you an exact answer in a moment. Okay. She was transferred to 10-C on the 5th of July,

Q Then, am I to assume from that she was in intensive care from July 1st to July 5th?

A That's correct.

Q And all of these nurse's notes that I too have in front of me, from July 1st to July 5th, are notes made in the intensive care unit, is that correct?

A Yes,

Q All right, Why did you-decide to do surgery on the left leg first? That was a removal of the patella, is that correct?

Q Patellectomy, am I pronouncing that correct?

A Yes. That was an open fracture of the patella, which is an orthopedic emergency, When you have an open fracture of any bone, you're obligated to debride it, clean out the dirt and deal with it on an urgent basis.

Q And debridement means that you cut away the --

A Took away the dirt, took out the ragged skin edges,

Q And take out the damaged tissue?

A The tissue that's damaged, yes.

Q During that surgery June 28th, you also examined the right knee, is that correct?

A Yes.

Q What exactly did you do at that time with the right leg?

A When the patient is under an anesthetic, the muscles are relaxed, which gives you an opportunity to check the ligament in a much more precise fashion than when the person is awake and in pain. We simply did a standard knee examination, found that there was some ligament disruption and I believe documented that by, an x-ray in the operating room.

Q That x-ray, did it also show a broken tibia?

A It showed a minimum and displaced fracture of the tibia plateau.

Q What preliminary steps were taken prior, to determine just exactly what the damage was to both her legs?

A 1 think we should divide that into two parts. The left leg with the open patella fracture.

Q Okay.

A Could you repeat the question,

Q Yes. What preliminary steps were taken to determine the injury of her legs, to the legs?

MR. McILHARGIE: Now, we're just confining it to what preliminary things were done,

MS. OETTINGER: Before the surgery.

MR. McILHARGIE: We're confining it to the left leg.

MS, OETTINGER: That's fine. We'll do the left leg first,

A Before the surgery, she was brought to the emergency room, evaluated from a general overall standpoint from the emergency room personnel. X-rays were taken of both legs and an examination was conducted by the orthopedic residents.

Q Did you conduct an examination of the patient?

A At that time?

Q Yes.

A No,

Q Now, we're talking about June 28th, is that what we're talking about?

A We're talking about the day she arrived, June 28th.

MR, McILHARGIE: In the emergency room?

A In the emergency room,

Q At that time, the resident examined her and took x-rays and did just a general overall examination, is that correct?

A Right.

Q Were any other tests taken, blood tests, for example?

A Yes. I mentioned that as part of the general evaluation done by the emergency room personnel.

Q Was an arteriogram performed?

A On that day, no. There was no indication for doing one.

Q Was there any occasion at that point that there was any damage to her arteries in her right leg?

A Only the suspicion that must exist in the back of anyone's mind concerning a knee ligament injury. There was no clinical indication. There wasn't any damage at that point.

Q If you had some kind of suspicion that was apparent, would you then have performed an arteriogram?

A If you mean a suspicion on the basis of direct clinical evidence, such as loss of pulses, complaints of pain in the foot by the patient, tingling, if there is any clinical evidence, then yes. If there is no clinical evidence for that suspicion, then I think you would not do an arteriogram.

Q Okay.

A But what I was mentioning before, is that with

any extremity injury, hips down, shoulders down, there always exists the possibility of a vascular injury, which may or may not be detectable at that time.

Q This is one thing a doctor -- a surgeon cutting into the patient's extremity would be totally aware of, is that correct? That there is a possibility of some arterial damage, perhaps?

A Yes.

Q And at that point, you would be watching for the artery to identify it?

A At which point?

Q After you've cut into the person's anatomy, you would be watching for this artery?

MR. McILHARGIE: I'm going to object to the loss of continuity here. You asked her what preliminary things were done before the surgery and we haven't gotten to the right leg and the left leg. We just got through the preliminaries of the emergency room, You cutoff the opportunity to really respond to that.

MS. OETTINGER: I don't see any objection to that. However, I can ask the question in any order that I wish.

MR. McILHARGIE: I want the record to reflect that you have not given her an opportunity to answer that before you moved ahead to the surgery.

BY MS. OETTINGER:

Q It's my understanding there were x-rays done to the left leg and a general examination done, overall on the left leg. And my understanding is, this was also done in connection with the surgery on the right leg, is that correct?

A Let's go back to the evaluation there. The right leg was also evaluated --

Q Yes.

A -- in the emergency room --

Q That's correct.

A -- by some method, history, clinical exam and x-rays. And determined that there was probability of damage to the ligaments. There was an interarticular fracture, neither of which required urgent care, in contrast with the left knee, where we were dealing with an open fracture.

Q Okay. Now, the surgery on June 28th, the notes to that surgery were dictated on June 28th and typed on June 28th, according to the notes that

I have here in front of me.

Could you tell me who was present at that first surgery?

A The personnel listed on notes is Dr. Barre, Dr. Moller. And I was present in a supervisory capacity, but not actually scrubbed.

Q Are you suggesting, then, that you did not perform that surgery at all?

A That's correct.

Q And Dr. Barre and Dr. Moller performed the surgery?

A That's correct.

Q And you watched, is that correct?

A Can you tell me what you mean by, "watched"?

Q Well, did you actually have any instruments in your hands?

A No.

Q Did you supervise?

A Yes.

Q And what exactly -- when I say, "supervise," did you tell Dr. Barre, for example, how to proceed at any given time?

A No. At this stage, Dr. Barre is or was a senior resident. And with the problem he was dealing with, he was perfectly capable of carrying out

appropriate treatment. And I go into the room to check and make sure things are going well. If there is no particular reason for me to get more involved in that, then I don't, because we're dealing with senior level orthopedic residents.

Q What exactly is a senior level orthopedic resident, what does that mean to a lay person?

A Well, an orthopedic training program involves -- in our program, five years, So the junior level people are considered years, let's say, one two, three, And the senior residents are years four and five.

And the more time that goes along, the more experience they get and the more capable they are of dealing with an increasing level of difficult problems.

Q So after five years of training, then they're considered to be regular MD's and can go out and establish a practice with an office?

A No. A person is an MD at the very start of this whole process.

Q Okay. I understand that. Well, explain to me what the difference is between the senior residents and a person such as yourself?

A A senior resident is still in a formal training program.

Q Okay. So then Dr. Barre was still in a formal training program?

A Yes.

Q Would he have been able to go out into the private world and hang a shingle on his door and say, "I am now an orthopedic specialist," before he was through with his five years of training?

A He could say that. He could not claim that he was board certified or board eligible until the formal completion of his training.

Q So after five years then, you're board certified, is that correct?

A No. After five years, you are board eligible.

Q And then how does one become board certified?

A You become board certified by practicing for a period of time on to passing a review by the orthopedic board, which consists of information gathered about you from the community and passing an exam.

Q How long do you have to practice before you can become board certified and pass that exam?

A The present rules require two years of practice.

Q At the time of this surgery, were you board

certified? .

A Let's see the dates. Yes. I was certified in 19 -- I need to look at my CV. I think it was 1982 I finished,

Q Now, what nurses were present in the room, in the operating room, at this time?

A I don't know. I think that that probably is somewhere in the records from the operating room,

Q I didn't see it. How many people were present in the operating room at the time of that first surgery on June 28th?

A I can't give you an exact number, because I don't know about the nurses, but, generally, there is. a scrub nurse, circulating nurse, at least one or sometimes more personnel from the anesthesia department. The people listed on the operative report. And an x-ray technician would have been in there for part of the time,

Q Who was the anesthesiologist on present?

A I think I can find that on the anesthesia record.

Q I have it, but I cannot read the signature.

A Okay,

MR. McILHARGIE: Maybe Mary can

help you. It's the first page. It's this one,

A Let's make sure that's the right surgery. Yes, This is Dr. Prisanaumba, P-r-i-s-a-n-a-u-m-b-a,

Q Was he present also at the surgery on the 30th of June?

A She,

Q She, Okay,

A No, On that date, the anesthesiologist is listed as Dr, Sung, S-u-n-g,

Q Now, am I correct to assume that Dr. Barre and Dr. Moller are no longer at Metro General Hospital at this present time?

A Yes. Dr. Moller has moved out of town. And Dr, Barre is finishing a program this year.

Q Then he still is at Cleveland Metro?

A He's not at Cleveland Metro at the moment.

Q He is not at Cleveland Metro?

A Yes,

Q But he is here in Cleveland?

A We operate as part of the University Orthopedic Program, so he is on a rotation. I don't really know right at the moment where he is.

Q It's possible he would be at University Hospitals?

A He's somewhere,

Q Somewhere,

MR. McILHARGIE: Somewhere in the county?

A He's either at the University Hospitals or at the VA.

Q Okay, NOW, in your professional opinion, did the surgery of June 28th go well?

A Yes.

Q The patient -- it said here, "The patient tolerated the procedure well." In your professional opinion, that was correct?

A Yes,

Q I also notice that you signed all of these surgical reports. Are you the one that dictates them, also?

A NO.

Q Who dictates it?

A Generally, one of the residents.

Q Do you know which resident dictated this particular report on June 28th?

A Peter Barre.

Q How do you know that?

A Because his name appears at the bottom of that note,

Q Well, you also signed it, so obviously you've taken responsibility for these notes, is that correct?

A Responsibility in what sense?

MR. McILHARGIE: I'm going to object.

Q Well, that you have read through them, that you agree with everything that is in them, is that correct?

A Yes, I think so.

Q Well, wouldn't that be an unqualified yes, considering the fact your signature is at the bottom of the page?

MR. McILHARGIE: I'm going to object to that, "you agree," to which she is responsible for the contents and the accuracy of the contents. It is something you can inquire, but I don't think you can assume.

And I think that if you have a specific question, as to a particular entry, she's more than happy to answer your specific question, but I don't think she has an obligation to answer that.

A There might be typographical errors we

overlooked, We see hundreds, literally, of these coming across our desk.

Q I do see on the second page of the report there is something written in here, written rather than typed, "multiple sutures of vicryl."

There was apparently something left out there, but am I correct in assuming that when you sign one of these surgical reports, that you have read it, that you agree with it and that you put your signature to it, signifying that you have read it and that you agree with it?

A In general, yes.

Q Okay. What was the condition of the patient on June 29th, was she still in -- was she in the recovery room that whole time?

A Oh, no.

Q Okay. How long was she in the recovery room?

A I'm not entirely clear where the recovery room notes are. She had an uncomplicated recovery from this first surgery.

Q Let me go --

A Here is a recovery from anesthesia note and she was readmitted to 7-B on 1:15 p.m. So early in the afternoon on the 28th, she went to the regular orthopedic division.

Q You said that she had a normal recovery and there was nothing that indicated any problems at all. By "normal recovery," what exactly are you looking for?

A Recovery from anesthesia.

Q All right. What about recovery from the surgery on her left leg, what signs were you looking for to indicate to you that she was having a normal recovery- from the surgery?

MR. McILHARGIE: During this immediate postoperative two days?

Q Right. During this immediate postoperative two days during the late June 28th and June 29th?

A Well, at this point, I was not specifically looking for anything personally. But if you want to generally know what sort of things you look for following surgery --

Q Let me ask you then, was she febrile?

A I need to look at the temperature chart to tell. Shall I?

Q Yes.

A Give me an idea where it is. Thank you.

MR. McILHARGIE: We're referring now to the graphics.

Q Oh, that graphics -- I don't believe I have

that. Was she febrile?

A At what time?

Q While she was in the recovery room?

MR. McILHARGIE: On 6-29?

Q 6-28, if she was in the recovery room 6-28.

MR. McILHARGIE: We can give you the temperatures as recorded on 6-28 ,and 6-29, which would answer your question.

A She was not febrile in the recovery room. Later that evening she had a temperature of 38.3, which for an immediate postoperative patient is not unusual. She was febrile by the next morning. And on the evening of the 29th, again, had a temperature spike.

Q Of what degree?

A 38.4.

Q Now, normal is 37?

A 37, 37.5.

Q Could you translate for me into Fahrenheit 38.5, approximately?

a No. Not without a scale.

Q No, you couldn't?

A 38.5, would be about 99 to 100.

Q Okay.

A I wouldn't -- when you deal in one system,

you're dealing --

Q And I only deal in Fahrenheit. I'm sorry.

A -- you don't readily convert.

Q So basically, she was --

A Not a serious temperature elevation in the first.

Q No serious temperature elevation on June 28th or June 29th. What about the color of her leg and foot?

MR. McILHARGIE: We're talking about the left or right?

MS. OETTINGER: Left. We haven't gotten to June 30th yet, the second surgery.

A There is nurse's notes to the effect the color was good. And I have no reason to believe that there was any cause for concern on the 28th or the 29th.

Q By "color good," you mean the color was more or less pink?

A The color of skin,

Q The color of skin. Okay. What about movement in her toes, was there that?

A No. There were no problems at that time according to the record.

Q This is in the left leg there was no problem with movement in her toes. Okay.

What about the pulse, did she have a good pulse?

A These answers to these questions, I can only refer to the hospital records.

Q That's fine. Take your time.

A I may be a little slow doing it.

Q That's okay. If you look on 6-28, at 12:25 p.m., you will see the note that I'm referring to.

A 6-28 to 12:25 p.m., good pulse.

Q Where would you take the pulse, can you show me?

A When you have bandages on the legs, we generally try to leave the top of the foot uncovered. There are two places to feel, the top of the foot, which is the dorsalis pedis pulse.

MR. McILHARGIE: Show it on my foot.

A It's up here somewhere. [Indicating.]

Q You can actually feel a pulse there?

A Oh, yes. Just like you can in your wrist.

Q Okay.

A And then you can usually feel one just behind the ankle bone on the inner side.

Q Okay. Quite often there was referral to a Doppler pulse?

A A Doppler pulse is a pulse taken by a machine that bounces sound waves off of the vessel and then detects those waves coming back. It's useful in cases where, technically, it may be difficult to feel a pulse, but the Doppler machine detects flow through the vessel that -- it's used as a supplement to a clinical test.

Q Is there a record, a line, that would show the Doppler somewhere, is it recorded?

A Generally, the Doppler pulse, that they're referred to in this record, are done with a little portable type thing. And you hear it, you hear a whoosh, whoosh sound. And in this setting, there is no record.

Q What is it, pedal or pedal pulse?

A Pedal.

Q Pedal pulses, what are those?

A The two pulses that I just described.

Q Okay. NOW, her leg was immobilized after the surgery on the 28th?

A Yes. Both legs were immobilized.

Q And they remained immobilized for her entire hospital stay; am I correct to assume that?

A Except for dressing changes and that sort of thing.

Q Okay. So she was not able to get out of bed and go to the toilet herself, is that correct?

A Not on her own, no. Until, I think, at the end of the hospital stay she was able to get up and use crutches, because then her left leg was healed well enough that she could use that to bear weight.

Q So the end of her hospital stay, would you say about August 1st, then?

A Let's see. We should have a record from the physical therapist. If I can find the date on this. August 1st, she was begun on weight bearing types of physical therapy, ambulation training.

Q Back to the signs that we were discussing, as to her tolerance of the surgery and her recovery in the recovery room and on June 29th, we've gone through the fact she really wasn't febrile to any extent, her color was good, she had movement in her toes.

What about pain, did she complain of pain at that time?

A Again, I'm going to refer to the record.

Q If you refer to 6-28-83, 12:25 again, I believe you'll find it there,

A Okay. This is the note made in the recovery room, just prior to transfer.

Q What, the one I just referred to?

A Yes.

Q Okay,

A No pain in the present,

Q What about any kind of drainage, any serious drainage?

A There is a note here, I think, that mentions some drainage in left knee area, left splint.

Q Does it indicate whether there was a lot, a little, normal amount or what?

A It doesn't indicate a quantitative amount, but I'm certain that in the recovery room, in the nurse notes, "Excessive amounts of drainage," then the patient would not be discharged from the recovery room.

Q Okay,

MR. McILHARGIE: So you would conclude from that, what, so to be clear on your answer?

A I would conclude that there was no indication of any problem, whatsoever, at this stage.

Q So after the June 28th surgery, her recovery seemed to be good, normal, as normal -- whatever that means. And if she just had the surgery on June 28th, when would you think, in your professional opinion, she would have been able to go home?

How long would her recovery have been in the hospital and she would have been discharged?

MR. McILHARGIE: I'm going to object. Are we assuming that no treatment was going to De done on the right leg or at all?

MS. OETTINGER: No. Assuming just treatment to the left leg.

MR. McILHARGIE: Fine.

A I would estimate between one and two weeks, but you shouldn't forget the left injury itself had the potential for being a devastating injury as well as the open fracture. There is something that just caught my eye here on the note. When she was transferred to the orthopedic floor, which went on to be a fairly significant part of her management. And that is it states: "She is awake, angry."

There is hostility expressed by the

patient all the way throughout here, which made her a bit more difficult to manage. And even if she had only had the injury to the left leg, she may not have recovered from that in a routine fashion, too.

Q Are you suggesting then, that because she was angry and throughout the notes, difficult t,o manage, so they said, that this affected her recovery rate from her surgery?

A I think in any type of orthopedic surgery, the patient's attitude postoperatively influences the recovery rate.

Q I want to get back to the patient's attitude later, but I'm going to forego discussing it now.

A Okay.

Q But are you suggesting that the fact that she's angry and upset about all these things that are happening to her is actually affecting her recovery rate; is that what you're suggesting?

MR. McILHARGIE: I'm going to object. I think the doctor has said it can affect it in terms of cooperation, in terms with her physician, in a total outcome. I think she's answered your

question.

Q Okay. Would you say, in your professional opinion, when surgery was due on the 30th now, that the patient was in a -- was in physical condition to withstand that surgery?

A Yes. I don't think there was any indication that there was any contraindication -- excuse me. That contraindication for doing surgery on the 30th.

Q And who was present at the surgery on the 30th? I have their names in front of me. There is a new name. You already told me about Dr. Barre and Dr. Moller, Haller -- no, we haven't discussed Dr. Haller. We discussed Dr. Holler. There is two Figgie's and Dr. Haller?

A There is two Dr. Figgie's.

Q That's right. There is an H. Figgie and an M. Figgie?

A They are both residents in our program.

Q Are they senior or junior residents?

A At this stage, they were senior residents.

Q Okay. Are they stili here in Cleveland?

A One is.

Q Which one?

A Hark.

Q Where is he right now, do you know?
A Again, he's in the University Hospitals Orthopedic Program.
Q Has he been board certified, yet?
A No, Residents are never board certified.
Q He's still a resident?
A Right,
Q Was he a senior resident at the time of the surgery? This is 1985.
A Yes.
Q He's just completing, then, his last few months of his residency, is that correct, I would have to assume that?
A Right, I'm not sure exactly what level he is right now,
Q Well, if he was a senior resident in June of 1983, and you became a senior resident in the last two years of service and this is already May of 1985, he has to be completing his last few months of residency, am I correct?
A Yes, you are. You have to do surgery, so that it precisely correlates with the senior-junior designation.
Q All right. Excuse me. Let me go back. Who is Dr. Haller?

A He is another orthopedic resident.
Q And is he a junior or a senior?
A I think at this stage he was a junior resident.
Q And where is he now?
A He's still in the program.
Q And, again, you were present in the operating room, is that correct?
A Yes.
Q And were you present in a supervisory capacity again?
A Yes.
Q Did you scrub?
A For part of the c se, yes.
Q Which part?
A The part -- from the completion of its exposure, to the part where the repair had been substantially completed.
Q When you say, "its exposure," what part of the leg are you talking about that was exposed?
A Of the surgical exposure.
Q All right. I understand. Was it the back of the knee that was exposed at that time?
A If you read through the operative notes, you can see where the incisions are, medial incision, and then you dissect down and look at what

structures you're looking at.

Q Medial --

MR. McILHARGIE: Inner aspects of the knee?

A Medial incision and lateral incision on the left side.

MR. McILHARGIE: Let the record reflect, by, "medial incision," meaning inner aspect of the knee and by the last, which one is lateral?

A Lateral meaning the out side of the knee.

Q And those are the only two incisions that were done at that time?

A Made for the repair. Those are standard incisions for knee ligament repair.

Q What kind of surgery was going to be performed on that day, on June 30th?

A The planned surgery was to repair the posterior cruciate ligament. Lateral capillary damage and to inspect the area of the fracture and determine whether any further fixation was necessary for that injury.

Q At that time, did you take an arteriogram?

A Prior to the surgery, no. There was no clinical indication that that was necessary.

Q What about during the surgery?
A During the surgery?
Q Yes.
A No. There was, again, no clinical indication that that was necessary. Surgery of this type is performed under a tourniquet, which is a bandage placed around the upper thigh, so that blood flow is completely stopped. You need to do that, because you need a bloodless field to reconstruct these ligaments.
Q And how long was the ligament in place so that the blood flow was stopped?
a How long was the --
Q I'm sorry. The tourniquet. I'm sorry.
A Well, the exact amount of time is documented in two places. One on the anesthesia record with the little arrows, that notes when it's up and down. And I believe it was just short of two hours the first time and approximately two hours for the second time, with a rest period in between of about 20 to 30 minutes, which is standard practice.
Q Why would the rest period in between --
A It's considered dangerous to leave a tourniquet fully inflated for more than two hours at a

time.

Q Why is it considered dangerous?

A Because during that period of time, there is no blood flow to the muscle. And the probability of damage to the muscle increases with the longer period of time that the tourniquet is left up, so most surgeons conventionally will deflate the tourniquet after a two-hour period no matter whether they're done or not and allow the tissue to profuse for awhile and reinflate the tourniquet.

Q When you say, "Use the tourniquet," let the blood go through the leg and get the blood supply, again, for about 20 minutes, you said?

A Yes.

Q Then you put the tourniquet on again and completed the surgery, is that correct?

A Correct.

Q On page 2 of the surgical notes for June 30th, there is a statement that the nerve, the peroneal nerve, was identified and protected.

Now, were there any other nerves that were identified or protected besides that one?

A No. For this exposure, the peroneal nerve is really the only nerve that is in direct line of

the incision. This is the lateral incision.

Q While you are repairing these ligaments and tendons, do you also identify other kinds of -- well, let me be more specific.

Do you also identify arteries and veins in the leg and then protect them?

A For these two approaches, surgical approaches, no.

Q Why is that?

A Because the popliteal artery is behind the knee, and when the knee is flexed, it falls back out of the way. And, also, you're right beside it, then you have no particular reason to dissect it out and identify it, which was not the case for this procedure.

Q I'm sorry, I didn't understand that last part, "Which was not the case for this procedure,"

A Basically, we were not operating directly in the vicinity of the popliteal artery.

Q Weren't you repairing the popliteal tendon, the popliteal tendon?

A Yes, But that's on the lateral side of the knee and not next to the artery.

Q The artery is deep within the knee, is that correct, deep within the leg?

A Depends on what -- let me just clarify where it is. It runs straight down the back --

Q I understand.

A -- the back of the knee, outside the knee joint.

Q But is it deep within the tissues of the leg?

MR. McILHARGIE: For clarity, can you feel it from the skin?

A You can feel in many, but not all people, a popliteal pulse directly in back of the knee. But it's superficial to the knee, but "deep," you know, I don't understand what you mean by, "deep."

What are you looking for?

Q It would be muscles and there would be tendons, and would the artery be within those muscles and tendons on the outside of the leg, the back of the leg?

A Okay. It's deep to those.

Q The artery would be inside those?

A Deep to those structures.

Q Okay. Is it one artery -- is the popliteal one artery as it transcends down the leg?

A It is one artery above the knee and somewhere below the knee, splits into three arteries.

Q Okay, Is that the only artery that is in the

leg, in the popliteal, until it splits into three, or are there others?

A I can't give a dissertation about the circulation around the knee, but there is extensive collateral circulation around the knee area.

Q And from the popliteal artery branching or by trifurcating?

A From the branching and femoral vessel --

Q From the femoral vessel, also?

A From the superficial femoral artery, there is contribution to the meniscus around the knee.

Q All right. You said there is a lot of collateral circulation around the knee, what about into the lower part of the leg?

A It's variable.

Q Variable?

A Variable. It would depend on the age, the particular anatomy of the person, et cetera, et cetera.

Q Does the popliteal artery trifurcate in the same place on all individuals?

A I don't believe that it does but I think that a vascular surgeon or an angiologist could answer that better. There is some variability, but

it's in the same general region,

Q Where does it usually trifurcate, as it relates to the knee and the lower part of the leg?

A Generally just below the knee.

Q Okay. So you're saying that for this kind of surgery, it was not necessary to identify or protect any of the arteries to the leg?

MR. McILHARGIE: I'm going to object. "Arteries," what she's saying is the major artery in the leg is your popliteal, branches into three parts and then it becomes multiple.

MS. OETTINGER: Which is microscopic.

Q We're talking about the surgery in the general injury, of the area of the surgery, which I have to assume is within the area of the knee. And I'll get to that,

I want to know how big the incision was in that particular area. Was it not necessary to identify or protect any of the arteries or veins in the legs?

A No, it was not.

Q How long were these incisions?

A I need a ruler. Probably the medial incision

was approximately six.

Q No. That's a little longer than six,

MR. McILHARGIE: Approximately six to eight inches.

Q All right. That's the medial incision?

A The lateral incision is similar, I don't recall the exact length of incision. They're generally a little smaller in thin people and a little larger in large people. But they're long incisions, required to get exposure for this type of surgery.

Q Why were there five doctors present in the operating room on June 30th, as opposed to only three on June 28th?

A I don't know that I can give you an exact answer, but I think that part of the answer is that this was an interesting and difficult case, And the other people that were on the service at the time were probably free and interested in participating, observing and learning.

Q Are you suggesting that these kinds of cases, where you repair the popliteal tendon and the posterior cruciate ligament, is that a rare kind of surgery?

A No, it's not rare,

Q But what made it so interesting then?

A Repair of the posterior cruciate ligament is not a daily event, but I wouldn't say it's a rare operation.

Q What about the repair of the fibular collateral ligament, is that a fairly rare surgery?

A In the whole, speculative knee surgery, lateral side disruptions are less common than medial and interior, so from that point of view, a bit out of the usual for a knee ligament injury, but by no means rare.

Q How long was the surgery, approximately, how many hours did it take?

MR. McILHARGIE: Look at the anesthesia record,

A According to the anesthesia record. Okay. Going from the time when the tourniquet was inflated, which is the time the incision is made, that was at three o'clock. And let's see the end of the case, the last time interval is when the patient is out of the room, so that's 7:30. So three, four, five six, seven -- four and a half hours,

You also need to consider that at the end of the case, a certain period of time is

required for the dressing and plaster, which is not actual surgery time, but the patient is still under the anesthetic while that's done.

Q In other words, she was put into a cast at that time on her right leg? You said, "plaster," I have to assume the plaster means a cast?

A Generally, what we do is place a bulky dresging with cotton reinforced by plaster splints, but not a circumferential cast at this point.

Q It's not the type of cast you see a man or woman walking down the street with a broken leg?

A No.

Q All right.

A Robert-Jones dressing, that's the bulky cotton dressing. I notice there is a little bit in the note about posterior and side splints. The idea is that you have a dressing spacious enough to accommodate swelling and not be constricting, but yet one that immobilizes to a certain degree to protect the repair.

Q Okay. In your professional opinion, then, after the surgery was done, again, you're the only signatory on the sheet again.

A I think --

Q Excuse me. I'm sorry. I'm on the wrong one.

No, I'm correct. 6-30 we're on. This was dictated on 6-30, and typed on 6-30. You indicated, however, that the surgery was over at 7:30 p.m. and still it was dictated on June 30th and typed on June 30th?

A Our medical records department has a continuous 24-hour transcription service.

Q All right. And then on the operative reports, I see your signature. There is a line for Mark Figgie's signature. However, he never signed the report. But am I, again, correct to assume that after reading the report and after being in the operative room at the time of the surgery, that you agree that this is what transpired in the operating room?

A Yes.

Q And that you have agreed that this was what happened?

MR. McILHARGIE: In general terms.

A In general, that's true.

Q Fine. All right. Now, we're back to the nurse's notes on June 30th, 8:00 p.m., and Laurie Smith is now in the recovery room?

A Let me catch up with you.

Q There are no page numbers, This is only by dates and time, I attempted to start numbering pages and decided to give that up.

MR. McILHARGIE: Sometimes the hospital records go through it for you. It's really nice.

Q 6-30, 8:00 p.m.

A Okay,

Q All right. Now, we're looking for signs, again, to see just how the patient is recovering.

MS. OETTINGER: Let's take a five minute break.

(Recess taken,)

BY MS. OETTINGER:

Q All right. Now, we're looking for signs to see how Laurie is recovering from the surgery on June 30th. And what do the nurse's notes say as to what her skin looks like at this time?

A Color pink, skin cool and dry.

Q Okay, Further on, however, what does it say about her right toes?

A Right toes pale, slightly dusky, with fair capillary refill.

Q What does that mean, ':capillary refill"?

A It means when you applied pressure, generally

over the nail, you notice a blanching.

Q Yes.

A When you release the pressure, the pink color comes back.

Q And you tested by doing that with the nail, the toenail, for example?

A The toenail or you can test it on the skin,, If you can press your skin, it turns white and gradually the color comes back.

Q And good capillary refill will take how long in time?

A This is a test I, personally, don't place a great deal of precision in. It's commonly done, commonly reported, but I think that normally would be somewhere around one to two seconds. When the test is done, there is no one there with a stopwatch checking.

Q Of course.

A It's a subjective sort of test,

Q What do the nurse's notes indicate as to her movement of her toes or foot?

A They indicate that she had no movement or sensation.

Q Does the fact that the toes were slightly dusky indicate a problem right away?

A Not necessarily. Anyone that's had a prolonged extremity operation, complicated extremity operation, oftentimes in the recovery room will have some coolness, some subjective differences in color.

Q Now, you indicated that this surgery was four and a half hours long, And I don't know that I asked you how long the surgery on June 28th was. Was it as long as two and a half hours or was it shorter?

A No. Much shorter and much less complicated.

Q How long would you say that surgery was?

MR. McILHARGIE: 6-28 surgery?

MS. OETTINGER: Yes, 6-28 surgery,

A From the time that the tourniquet was inflated, until the time that the patient left the room, from ten to 11, 11:30, so an hour to an hour and a half.

Q Okay. Would a dusky color, any kind of discoloration, somehow indicate that there were big problems up ahead?

A I think in general, a color change in the skin indicates a potential problem, but not necessarily an existing problem or a definite

problem,

Q Okay. What about the drainage, was there any drainage or what kind of drainage was there?

A You're referring to the drainage? Hemovacs with scant drainage. Hemovac in complicated surgery, where there is expected to be postoperative bleeding, any tube or tubes are placed in the wound and evacuated through a little box called a hemovac, There is nothing to be concerned with scant bloody drainage,

Q Was she feverish at the time?

A We're back to there?

Q Back to there again.

MR. McILHARGIE: 6-30.

A No. Okay. I want 6-30, you know, 1 think the temperature in the recovery room must be recorded on a different place than this.

Q I don't see it in the notes at that point.

A I think it further --

Q There is a break in the graphics?

A I think there is a further sheet for the recovery room. That's a matter of finding it.

Q I have it here,

A Recovery room. Okay.

Q Temperature, there is nothing recorded until

9:30, when she's 38.5.

A Okay,

Q Okay.

A I would say that's a usual temperature for an immediate post-op patient,

Q What about her complaint of pain, was there any complaint of pain at this point? Look at the second line in the notes.

A Oh, I skipped over that, pain at the operated site,

Q If I'm not mistaken, the surgery on the 28th, she did not complain of any pain, is that correct?

A These are very different surgeries,

Q I understand,

A Well, on the 28th, 11:15 a.m., the patient complained of pain, anesthesiologist called.

Q And what was she given for the pain?

A According to this note, Demerol, 25 milligrams IV on the order of the anesthesiologist,

Q Are you looking on the 28th or the 30th?

A The 28th.

Q On the 30th, what kind of medication was she given for pain?

A Medicine indicated with morphine, six milligrams

IV.

Q At any time up to the time that we're discussing now, 6:38 a.m., was she given any antibiotics at all?

A Yes. She, with her open fracture, was started on antibiotics virtually as soon as she was admitted,

Q And is she still receiving them as of 6-30, meaning June 30th?

A Yes. I believe they were continued completely throughout this whole course. She was receiving the antibiotics for two purposes. First, the open fracture. And second, we routinely use prophylactic antibiotics for extensive knee surgery,

Q Okay.

A And that should be reflected in orders in the medication records,

Q Do you happen to know what kind of antibiotic she was receiving at this time?

A On 6-28, she was started on a medication called Ancef.

MR. McILHARGIE: Doctor, can you spell it for us?

A A-n-c-e-f.

Q And later, was she continued on Ancef through June 30th?

A Yes.

Q And how long was she on Ancef or was it supplemented by another antibiotic?

A Not until later on in the course.

Q But she was receiving --

A She was receiving,

Q -- she was receiving Ancef from June 28th, until the period of time we have not established, right?

A Right. Until the infection complication came out and treatment with antibiotics was changed at that point, but that's in the future, yet.

Q Okay. NOW, we're still on June 30th, but it's getting late in the evening, 9:30 p.m., what are her signs now in her right leg? What is her skin, what is that like to the touch?

A According to this nurse's notes, the right toes were pale, slightly cool, fair capillary refill, not really changed, apparently, from the previous note that she had recorded.

Q Is that a good indication, that toes are pale and cool?

A I'm not sure you can define it as good, bad or

indifferent.

Q Would it be better if they were warm and pink?

A It would be better if they were warm and pink, but it depends, also, on the whole condition of the patient. And the fact that, again, she had a long tourniquet and a long operation.

Q Okay, What about the movement in and the sensation in her right toes, has that returned, yet?

A No, that has not returned.

Q And both her right leg and her left leg are immobilized at this time, is that correct?

A Yes.

Q Now, we're on ten o'clock on that same evening?

A Okay.

Q Again, what are the signs that are apparent at this time?

A Let me interject here that between 9:30 and ten was the time of the transfer back to the floor took place,

Q I see that.

A And I think that I'd like to state that I know this nurse well. And I believe she would not have transferred the patient from the recovery room without being satisfied with her condition.

Q And this nurse is J. K-u-s-s-m-a-u-1, is that correct?

A Yes.

Q How long has she been with Cleveland Metro General Hospital?

A That, I don't know exactly, specifically, but she is a fairly well-known recovery room nurse.

Q You say you know her fairly well. How long have you known her?

A I've known her since I've been working at Cleveland Metro, which is 1971.

Q But the fact is this: That was mistaken, that there was something wrong with Laurie Smith?

MR. McILHARGIE: Object.

MS. OETTINGER: Why the objection?

MR. McILHARGIE: You assume it's something -- you haven't established it.

A I think it's as definite as she can be at this point. She's still in the point there may be something clearly wrong and there may not.

Q Right. All right. Ten o'clock, what again are her signs?

Let me ask you this: Is it common for the nurses to make make notes so frequently? I

notice a note here, nine o'clock, at 9:30 and now again at ten. Why is it so often that they're making notes on Laurie?

A At Cleveland Metro Hospital, you notice it's somewhat different from other hospitals, where that the nurse's and physician notes are intermingled, chronologically, And it's the common practice there for their routine care of postoperative patients to make frequent notations during the first couple of hours.

Q All right. What are the signs now on the right leg at ten o'clock on June 30th?

A The notes state that the color is pale, the toes are cool, no edema, complaints of pain, no movement with complaint of tingling and a one to two second capillary refill.

Q Okay. What does a tingling indicate?

A There is still some more in these.

Q Yes, there is?

A The Neurovascular status of the left leg is also noted to be pale and cool.

Q I see here left leg has knee immobilizer and it's indicating that there is a moderate amount of yellow serous drainage.

Is that for the left leg again or the

right leg?

A The left leg, that's the one with the open fracture.

Q I understand there is still some draining on the left leg and they do make a note to that?

A Let me just add something to what I was talking about, the treatment of the open fracture. The wound is left open so it drains for several days before the draining decreases and it's closed.

Q That was on the left leg that the wound was left open, is that correct?

A Right.

Q On the right leg?

A No, the wounds were closed.

Q Again, there is another notation about the status of the left leg. What again does it say?

A Can you --

Q Right at the very bottom of the page.

A I see, "left,"

Q Is that left or right?

A I just pointed that out, neurovascular statistics of the left leg states that the toes were pale and cool, as well. And I think that when I was saying before about pale and cool toes in and of themselves do not mean that

something bad is happening at that moment.

Q Okay. Vital signs-, what is her temperature at that time?

A 38.6 and return from the recovery room.

Q Is that an alarming temperature or is it fairly normal for post-op?

A For this period, post-op, it's normal,

Q We're now on July lst, at midnight. And we have a notation here about Doppler popliteal pulses, does that indicate that they use that machine that you told me about to see what the pulse would be like?

A Yes.

Q And what is, "Doppler," referred to?

A It means it was possible to detect the pulse,

Q You could detect the pulse?

A With this machine,

Q Is Doppler named after someone, because sometimes I see it capitalized.

MR, McINTYRE: A doctor?

A No, it's refers to physics, the Doppler effect.

Q Sure, the Doppler effect, that's what 1 thought, I knew I heard the word before.

Is there sensation and movement in the left leg and foot at this time -- or foot, I

should say, the left foot?

A The left foot has not specifically been mentioned in this note.

Q But in the previous note, was there movement, is there any mention of movement and sensation in the left leg?

A There is, Movement in the left leg was good,

Q And right leg, how was it?

A One second capillary. And on the right leg, no pain with movement in the right leg.

Q How was the capillary refill at this point, twelve o'clock on July lst?

A Capillary refill nil with no popliteal pulse.

Q And no pedal pulse, What would that indicate?

A That would indicate that that extremity was not receiving adequate distal blood flow.

Q There is a small note here that looks like, "Ten x-ray for arteriogram"?

A "To x-ray for arteriogram,"

Q That's at 12:45. Who made that notation?

A I can't read the signature, but I believe the title says, "LPN."

Q That's what it looks like, "LPN."

It looks as if that was in a different handwriting where it says, "two x-rays for

arteriogram"?

A Yes, it does.

Q Who do you think made that notation?

A It has to have been one of the nursing personnel.

Q A doctor did not make this notation?

A No.

Q Does a nursing personnel order an arteriogram?

A No. These are not orders.

Q I understand. Have you been called at any time since 7:30 on June 30th, until midnight --

A No.

Q -- July 1st, you have not been notified of any of this, any of these signs --

A No.

Q -- in her right leg?

Who is the doctor on service or on call at that period of time?

A The doctor on call was Dr. Haller.

Q So how many hours have elapsed before an arteriogram is ordered?

A From beginning what time?

Q From the time the surgery is over?

A Five, four and a half, four and one half.

Q And again, the notations give all these

different signs. And what does all this indicate, the fact there is persistent pallor in the right foot, there is no sensation, there is no movement, her toes are cold, there is no pedal pulses, but there seems to be a popliteal pulse, is that correct?

A According to this notation, yes.

Q What would all this indicate to you, in your professional opinion?

A Well, I hypothesize the patient is beginning to get into vascular difficulty over the period -- from the time she left the operating room until she was definitively examined by the house physician at midnight.

Q And arteriogram is now ordered, where do they do these arteriograms?

A In a special suite on the ground floor of the hospital.

Q It's not in the regular operating room then?

A For this particular study, no. But you can do arteriograms in the operating room.

Q Okay. And this was designated an emergency arteriogram, was it not?

A Correct.

Q What is this here, arterior lesion possibly at

trifurcation, is that the word?

A Yes.

Q What does that mean exactly?

A What he's saying is he found that there was a pulse in the popliteal space. And the vessel goes down and it splits into three. And a commonplace for that vessel to be occluded is at the place where it splits into three parts.

Q And the popliteal space is where, behind the knee, in the back of the leg?

A Immediately behind the knee.

Q Okay. Who is called in to do the vascular surgery on -- excuse me, Let me back up. The arteriogram revealed what?

A It revealed a cutoff at the popliteal vessel.

Q Total cutoff?

A I have not recently reviewed the arteriogram, but I believe it revealed a complete cutoff somewhere along the course.

Q Well, is the term used, the popliteal artery was occluded, is that the term used?

A Yes. But occlusion can be either total or partial. And I believe, according to the radiologist's report or the vascular surgery resident, there was some distal filling, That

is different people interpretating different studies.

Q There seems to be a conflict whether there was distal filling or whether it was occluded.

Were you informed at this point now of Laurie Smith's condition?

A Yes. As soon as I was notified by Dr. Haller there was a problem, I went to the hospital.

Q About what time was that, do you recall?

A I was called shortly after midnight,

Q Okay, And when did you arrive at the hospital?

A It takes me 20 minutes to get there from my house,

Q And at that time, how did you find Laurie, where was she, in what condition?

A She was in the angiography suite. She was having her x-rays done, so things were proceeding from there. The vascular surgery resident had been -- had evaluated her and things were in motion.

Q And was a vascular surgeon called in?

A The first person called was the general surgeon who -- general surgery resident who covers the vascular surgery service at that hospital.

Q Who was that?

A I don't know these people as well. David Jacobs.

Q Okay. And that's the signatory on the bottom of this page, 7-12:30 a.m.

A Yes.

Q Okay.

A And he immediately called his attending physician, who was the chief of general surgery at Metro.

Q Who was that?

A And that person came right in.

Q Who was that?

A Dr. Imbembo.

Q Dr. Imbembo, is he still in Cleveland?

A Yes.

Q Is Dr. Jacobs still in Cleveland?

A I don't know that.

Q Okay. There are two notes here that seem to be conflicting. One says, "Arteriogram showed a tapering cutoff of the popliteal artery just distal to the geniculate branches --"

A Geniculate.

Q Excuse me for my pronunciation. "-- was slow, but eventually filling."

That would indicate to me then, that there

was some filling of that artery, is that correct?

A If you go on, "Eventually filling of the popliteal artery and tibular trunk in the distal calf." That implies that some blood is getting through to that area. And I think that is entirely consistent with the course of time between the surgery and then the time that there was nothing there, so I think what that implies to me -- and I hesitate to play vascular surgeon in interpretating this, but I think that implies a gradual diminution of flow over time, rather than a sudden cutoff.

Q But on the other hand, we have another note right after that that says, "acute arterial occlusion"?

A That's the same person's note.

Q I know. Why does he seem to be -- to my mind, there seems to be a discrepancy to the way this artery was cutoff or the blood supply was cutoff?

A I think it's simply semantics. "Chronic," refers to a condition that existed over weeks, months, years. And "acute," refers to a condition more in the hour time period.

Q Okay, A sudden condition?

A A sudden condition. So I --

Q It's indicated at this point then by Dr. Jacobs that a popliteal exploration is in order, And do you order a bypass or do you order surgery at this time?

A Do I order surgery?

Q Yes. Do you say, "Yes, we will take this patient into surgery at this time:'?

A It seems like a strange question to me. We have --

Q Who decides?

A We have a problem we recognize, we have a problem, we call in the vascular consultation people.

Q Okay,

A We communicate with them and there is no disagreement here that this patient needs to go to surgery.

Q Okay, So who makes the ultimate decision to take her into the operating room for surgery?

A I suppose the people that do the surgery, the vascular surgeons,

Q Now, do you go into the operating room at this time?

A The orthopedic service was there for part of this vascular procedure.

Q For part of it. And you represent the orthopedic service at this time?

A And the resident.

Q Okay. The actual person doing the surgery, however, is whom?

A Well, I really hesitate to speak for the general surgery service, but according to the operative record, we have Dr. Jacobs, Figgie and Haller, which are our residents and myself and Dr. Imbembo as the supervisors.

Q Okay. And who actually performed the surgery, Dr. Jacobs?

A Dr. Jacobs and Dr. Imbembo.

Q And you stood by?

A With this sort of surgery, it's not a one-person show.

Q I understand.

A It's back and forth.

Q You did not actually scrub at this time?

A No.

Q Were you supervising at this time?

A No.

Q You were simply observing?

A Present.

Q Present for observing?

A I was very interested in what was happening at this point.

Q And this surgery actually took place approximately 2:30 a.m., is that correct?

A I can tell exactly from the anesthesia record. Okay. It looks like things started at 3:00 a.m.

Q At 3:00 a.m. That's approximately seven and a half hours after the surgery of 6-30, June 30th was completed?

A That's correct.

Q Was there any indication up until the arteriogram that there was any kind of problem to her circulatory system in that right leg?

A Can you be more specific?

Q Yes. Was there any indication on June 28th, on June 29th, on June 30th, that there was any problem in the circulatory system in the right leg?

A Preoperatory, no.

Q Okay. Now, there is a posteromedial incision made and what do you discover --

MR. McILHARGIE: Are we on the 7-81 surgery?

A No. We're talking about July 1st at three o'clock.

MR. McILHARGIE: I'm going to object. She already indicated she didn't perform the surgery.

Q She was the visitant doctor, Her name is the only name -- the only signatory on the operative.

MR. McILHARGIE: She's neither the surgeon operating nor did she supervise.

A This is a procedure problem in my hospital. I am, myself, very compulsive about keeping my chart work, signing things, very much up to date.

Q I understand,

A Other services are not so compulsive about signing things. And there is a problem that exists with having charts signed by the appropriate people over time, Part of the other problems have been that this chart may have been out of medical record for a period of time. And therefore --

Q I understand all that.

A -- had not had the opportunity to be signed by

anyone else.

Q I understand all that. The fact of the matter is, that Dr. Mary Matejczyk and Dr. Imbembo and Dr, Jacobs' names are all on the operative reports. The fact is that Dr. Matejczyk was the supervisory doctor --

MR. McILHARGIE: I'm going ,to object to that, That is a misstatement, She was not the supervisory doctor.

Q -- of Laurie Smith at the time of her admittance to the hospital.

MR. McILHARGIE: That's not true. You have not established that. That is not true. Not during that surgery.

MS. OETTINGER: You're talking about the surgery July lst?

MR. McILHARGIE: That's right.

A Until the points of time when we consult and transfer the patients cared for in the vascular service, I was the attending physician. From the point they make an incision, they're in charge.

Q All right. Then you are a doctor who can interpret these notes, is that not correct? And

didn't we already establish that when you signed these surgical notes, that you have read them and that you basically agree with what's in them and that's what your signature indicates?

A I said in general terms, I read and agreed --

Q Fine.

A -- that the record reflects what happens,

Q Fine. That's all I want to know. In general terms, you agree this is what happened. All right,

When the incision was made, what was found?

A I'm a little reluctant to interpret the findings of someone else or some other surgeon.

Q Didn't we already establish the fact you signed this report and you did read it and you did, in general, agree with what was in the report?

MR. McILHARGIE: I'm going to object to that. It's argumentative. She's acknowledged she agrees, in general, what has occurred, She doesn't imply by that statement that she understands, specifically, what a vascular surgeon means when he makes a particular notation in the chart. She's not a vascular

surgeon. You're taking her out of her field of expertise and experience.

MS. OETTINGER: She is a doctor. She was present in the operating room. She signed the report.

WR. McILHARGIE: Fine.

MS. OETTINGER: She already acknowledged the report. She reads the report, she signs it, she agrees with it generally.

MR. McILHARGIE: I'm not going to argue, She's not a vascular surgeon.

MS. OETTINGER: I understand. But she was in the operating room when this mistake was carried out.

MR. McILHARGIE: I'm going to object and move to strike. You can ask her what she's aware of.

MS. OETTINGER: She was in the operating room when the Ovicryl suture was put around the artery, which cutoff the blood flow on the leg.

MR. McILHARGIE: Is that a question?

MS. OETTINGER: No, it is not a

question. I am simply still talking to you, Mr. McIlhargie. Ovicryl suture was removed. So I don't suppose Laurie Smith was born with an Ovicryl suture -- was born with Ovicryl sutures around her popliteal artery. It had to get in there when the right leg was opened up for surgery on June 30th.

MR. McILHARGIE: I'm going to object, because there is no indication that the Ovicryl surgery was around the popliteal artery.

MS. OETTINGER: It says, "teather."

MR. McILHARGIE: Let's go back to questions and answers.

A The incision was made. And what was --

MR. McILHARGIE: Let Gail ask you specific questions. Let her direct your attention to what she wants to know about, because she has a right to make these inquiries.

A Right. Let me mention, at this point, I was not scrubbed. I was not -- you said, "scrubbed." I was not in a direct supervisory capacity of

anyone --

Q I understand thpt.

A Okay,

Q I am totally aware --

A -- when the incision was made. To go on to describe the exposure, which was different than the exposure that was used to repair the knee problem.

Q In what way was it different?

A It was in a different spot.

Q Where was it?

A It's, I believe, a long, very long knee incision toward the back of the knee.

MR, McILHARGIE: Let the record reflect the doctor indicated on the inner aspect of the knee, an incision twice the length of the one she previously indicated as being necessary for the original knee surgery performed by her.

A And far more posterior. That is a vascular surgery approach to the popliteal artery.

Q I understand.

A Okay. Then they open the artery and they pass a catheter,

Q Where did they open the artery, at what point?

A I can't tell from their note specifically what point in the artery.

Q Okay. Go on.

A Okay. Then they passed the catheter. They found problems passing the catheter distally and then noted a suture. At this point, I was there and saw what happened. There was no suture around an artery, through an artery or in any way intimately connected with the artery.

This suture was in soft tissues maybe one and a half to two inches, maybe more, maybe less, in the soft tissues adjacent to the arteries, kind of changing its course, so that it was teathered. That's what teathered means. Teather does not mean sutured or around it.

Q Will you explain again what, "teathered," means please? It's my understanding that the artery tented. Did the artery tent?

A Tent?

Q Yes. In other words, it bent like?

A I think that that picture is a little bit too much of an acute angle, but that's the idea. Where something -- if the artery is coming down like that, and you have damage to some structures over here --

Q Okay.

A -- a lot of damage,. say you want to suture this problem here, you would put a suture like that. And this part of the suture is in the soft tissue, which is around the artery. And I believe at this point what's happened is it's over from its regular course.

Q So there is a partial tenting. My tenting was a little too acute; is that what you're suggesting?

A Right,

Q That is what you call, "teathering," that is, it was teathered?

A That was what the person who dictated this note called it. Teathering is not really the medical term.

Q I didn't think it was, What would you call it then?

MR. McILHARGIE: General English language term.

A Term, there is no official medical term for teathering.

Q Well, how would you describe it then, you said that the incision was not -- the suturings, the suture is -- in layman's language -- is a piece

of material used to sew. Like a thread used to sew torn segments, tendons and all the rest. And this piece of thread was not around the artery?

A No.

Q But this piece of thread was around other tissues?

A If I can give you an analogy, if I took your jacket and pulled on your sleeve without touching you or your skin, I could pull you across the room by your jacket without physically touching your skin.

Q Okay.

A And that's the situation with this suture, holding on to soft tissues, but not holding on to the artery itself.

Q And by this suture not touching the artery, it was able to block the flow of blood through the artery?

A I think that it contributed to a gradual decrease in the flow through the artery, which occurred with time. And I believe that it's only one of the -- one of a number of possibilities to explain why the vascular injury occurred.

Q That the suture was one of several possibilities as to why the vascular injury occurred; is that what you just said?

A Yes. If you look in the operative note from here on, okay, so they find this suture --

Q Let me backup,

MR. McILHARGIE: Let her finish her answer,

Q You said the catheter could not be passed any further than ten centimeters distally, which means there was an obstruction there, correct?

A Obstruction that that catheter couldn't negotiate,

Q Let me ask you, how big is an artery in relation to this pen, for example?

A The popliteal artery in a normal size person at this level is a little bit bigger than that pen.

Q About the size of this pen, about the size of my finger?

A Probably not that big,

Q How many centimeters around would you say that would be?

A In diameter?

Q Yes.

A I would say it's a centimeter or a centimeter

and a half in diameter,

Q Okay. Is it something that a doctor -- senior resident and a doctor allowed into the operating room would recognize right away?

A Of course.

Q Okay. And a doctor would, in recognizing it, would agree and would recognize the fact that it's a very important part of the anatomy of the individual?

A Any orthopedic surgeon, even at the most basic level, of course.

Q And you're suggesting -- what is the suture made out of?

A Synthetic material called polygalatic acid.

Q And does it dissolve in the body?

A Eventually dissolves in the body.

Q And how big around would the suture be?

A You mean the diameter of the thread?

Q Yes.

A Like this particular: size?

Q Like hair?

A Larger than hair.

Q Like a thread that I sew a button on?

MR. McILHARGIE: Fishing line?

A No. Support yarn, like a piece of carpet thread

is, heavy thread, thread that you would use to sew buttons on, heavy thread.

Q About that size?

A About that size.

Q And that particular suture was used to repair the torn ligament in the vicinity of the popliteal artery, correct?

A The position of the posterolateral, which is not in the general vicinity of the popliteal artery.

Q If it is not in the general vicinity of the popliteal artery, where is it?

A Lateral to it.

Q And you're suggesting that that piece of suture, which is the size of a piece of thread that you sew a button on, would push this pulsating artery, which is the size of this pen, in such a way that would stop the flow of blood?

MR. McILHARGIE: Objection to the form of the question. Go ahead.

A Depending on where it were sutured into, it could alter the course of the artery.

Q Alter the course of the artery. Stop the flow, however?

MR. McILHARGIE: Objection. She never said it stopped the flow of blood.

MS. OETTINGER: I know she never said that.

MR. McILHARGIE: You're assuming that within your question.

A I believe that this, in and of itself, would not be sufficient to stop the flow of blood in that artery,

Q Was the flow of blood stopped during the period of time after the surgery on June 30th at 7:30 p.m., to July 1st at 2:30 a.m., was there indication from the arteriogram and also from outward signs in the patient that the flow of blood was stopped to that lower right leg?

A I think the only definitive answer to that is that at the time the arteriogram was severe compromise to the flow. All the rest of the documentation is subjective and vague and 1 have no way of knowing when the insult occurred.

I am fairly certain that it did not occur immediately following the completion of the surgery, because when you have a complete shut off of an artery, it's no mystery, You see the foot is totally white, it's not cool, it's cold and it's a fairly obvious thing,

Routinely, at the completion of any

orthopedic surgery, you check to make sure that the toes refill after the dressing is put on, so as far as the degree of blockage and the time course that it occurred over, I have no way of knowing. Nobody does.

Q What would you suggest, then, happened all of a sudden to cause the blood flow to diminish and then to decrease to a point where no blood was getting to the lower part of the right leg?

You're not suggesting that anybody went into that leg in a surgical procedure to do anything to that, are you?

MR, McILHARGIE: Object to the question. It's multiple. It's a paragraph, I ask you to rephrase it. It's just in fairness to the doctor.

Q You suggested just now that there was not a complete shut-off of the artery after the surgery, that sometime during the recovery of the patient, during those hours from 7:30 on the 30th of June to July 1st, that this surgery -- that something occurred within the right leg that caused a decrease in the flow of blood and then in effect almost caused total shut-off of blood flow on the leg.

Do you have any professional opinion as to what occurred?

A I can't give you a precise answer of what happened, but what I think happened was that at the time of the initial injury, the lining of the blood vessel had some damage. And this is something called intimal damage, which the vascular surgeon can tell you about.

In and of itself, that problem doesn't always go along to develop into a complete shut down. That's factor No. 1. Factor No. 2, during the surgery, we used a tourniquet to completely shut down the flow, which was a necessary part of the procedure.

And following the time when he let the tourniquet down, the flow through the area may be sluggish, the blood may be hypercoagulable and factors might later relate to circular problems, And it doesn't happen frequently, but it's a potential problem in any tourniquet situation,

Q Can you --

MR. McILHARGIE She hasn't finished her answer about the tourniquet.

Q So a tourniquet is a factor?

A Intimal damage, it could be the tourniquet.

Q Would you would you spell it?

A I-n-t-i-m-a-l. The intimal is the lining of the artery.

Q Okay. Go on. That was another factor, perhaps?

MR. McILHARGIE: Or is it just up until the time of the vascular surgery?

A I'm getting confused now.

Q Let me backup.

A You asked me, basically, to explain what happened to cause the arterial compromise that was noticed at midnight and, obviously, was complete. There was no question in anyone's mind at midnight.

Up until midnight, I don't know. But I think that she has a number of factors that could have all contributed to the loss of flow in that blood vessel. And up until this point, I would list the initial injuring as causing damage to the lining the artery, which initially was not detectable by any means.

Essentially, the surgery required a tourniquet, postoperatively patients go through all sorts of metabolic changes, which may alter their flow status, hemadynamically can lower the

pain of blood pressure, those sorts of factors.

And I think that's what we're dealing with in addition to this teathering effect of the suture that caused the compromise. If you go further on in the record -- okay. Here we find the teathering, the artery returns to its normal course and then the catheter could be passed,

Q Right.

A At this point, there is no reason to believe that we shouldn't have completely reestablished totally normal circulation. But then this operative report goes along to describe how much difficulty the vascular surgeons had in reestablishing flow from this point on.

Q That's right.

A Which had nothing to do with this suture problem approximately. Now, all these problems that they have suggest that indeed there was something else going on besides the problem with the suture.

Q Okay. Let's back up. First of all, what exactly do they mean when they say, "teathered laterally"?

A I think I should just draw a picture.

MR. McILHARGIE: Why don't we

use something we can attach to her deposition?

A Okay. Draw a picture of the knee. Fibular, tibia and lateral side of the knee and medial side. Okay. The artery is coming down, And to me, teathering laterally means that instead of going straight down --

Q It's not the femur, this is happening, it's the tibia?

A It's behind. Okay. The thing runs down the back of the leg.

Q I understand.

A But as you get near the level of the knee --

Q Okay.

A -- the artery is pulled off course now. The area of that, she had damaged from the knee ligament injury is --

MR. McILHARGIE: Doctor, do it with a blue felt tip pen so we can let the record show it. Yes.

Q The area from the trauma is now being drawn in with blue felt tip pen?

A It's the lateral side. So of this whole area.

MR. McILHARGIE: Labeled, "damage."

Q That was damaged by the accident, by the initial accident. Okay.

A And then in order to repair that damage, which tissue was severely traumatized in order to reapproximate these tissues so the lateral side of the knee has some stability, one of the sutures is -- and this is one of many other, sutures that was in that area.

Q I understand.

A Apparently, let's see, do you have a red pen? I can draw a suture. Okay. I'm not sure.

MR. McILHARGIE: Let the record reflect the red felt tip marker is being used to identify the suture.

A The position out here of the suture is really not accurate, but just for purposes of illustration, but managed to pull the artery by tugging on the adjacent soft tissues.

MS. OETTINGER: Let the record also reflect the doctor drew arrows showing the direction the artery was being drawn by the suture, as opposed to the suture.

BY MS. OETTINGER:

Q You used an example before, taking my jacket

without touching me and pulling me across the room, right?

A Yes.

Q In doing that, I'm going to take my partner's shirt and attempt to pull him. In doing that, this is the soft tissue and his arm is the artery. I am pulling on his arm and making his arm indent here.

A Well, soft tissues around the artery here are not analagous to arms around.

Q No, but you used that analogy.

MR. McILHARGIE: We agree the analogy is improper. The soft tissue didn't go all the way around the artery.

Q What you're suggesting is the suture got around the soft tissue of the artery?

A Not around, in.

Q In the soft tissue of the artery?

A Next to the soft tissue.

Q And you pull that like a piece of thread. And do you knot it?

A Yes.

Q You tied it or you knot it, you tied it tight around the soft tissue?

A The purpose is to bring together the tissue

that's damage.

Q You tie it tight to bring it together, the tissue. In doing that, the artery was pulled, instead of going straight down the leg, was pulled off course, is that correct?

A That's correct.

Q You also indicated that-that alone would not cause a stoppage of blood flow, is that correct?

A I don't believe that that alone would stop blood flow.

Q Then you said there are other kind of things that could affect the blood flow and you indicated it could have been intimal damage in the vessel, the artery itself, due to the accident, is that correct?

A That is correct.

Q Knowing the extent of the injury to the soft tissue that you saw when you first examined Laurie Smith when she first came into the hospital and afterward and during surgery of June 28th, and knowing the amount --

A Referring to the examination of the knee under anesthesia?

Q Yes. I'm referring to all the different times you saw Laurie Smith and all the damage and all

the injury that occurred to that left leg, wouldn't it -- right leg. Excuse me. Wouldn't it behoove you to do an arteriogram to determine if there was any kind of damage to the artery?

A There was nothing in any of those examinations that would indicate an arteriogram. If you did an arteriogram on every person with a severe knee injury, you'd be doing it on everyone. And that's just not part of any routine.

Q Didn't you indicate previously that this was a very extensive injury, one that is not ordinarily seen and that's why there were several doctors in the operating room?

A No, I did not,

Q You said it was an unusual kind of surgery that was so much damage and it's not often that you have that kind of --

MR. McILHARGIE: I object to that. She said it was interesting and unusual because it was to a different side of the knee injured, as to the extent of the knee being damaged. The fact that made it an injury is the side of the injury, not the extent of the injury.

Q Would an arteriogram show up intimal damage?

A I think that question would be better put to an arteriologist or vascular surgeon, but it's my understanding that it may not anyway.

Q Okay. You seem to be quite knowledgeable. However, when you were going through this other explanation, first, of a vascular problem --

MR. McILHARGIE: Vascular signs and symptoms, the ones she talked about earlier as to surgery, I think, is a grand difference.

Q NOW, it says here, "The pulse did not return to the popliteal artery once this suture was removed"?

A Are you reading from the operative note?

Q Yes, I am. Why is that -- why didn't the pulse return? Let me rephrase that.

When the pulse did not return, did that indicate that the blood flow was not going through the artery?

A Can you point out, specifically, where you're reading, what you're interpretating?

Q "The pulse did not return in the popliteal artery." First sentence.

A Yes. That indicates that flow was not reestablished.

Q Flow was not reestablished.

And why would that not occur? Why would that not be reestablished once that suture was taken away?

MR. McILHARGIE: I'm going to object.

A Why did not flow not come back?

Q Why did flow not come back to the artery once the suture was removed from the surrounding tissue?

A I don't know.

Q And after that they had to do an arteriograph, is that correct?

A I wasn't involved in doing the arteriograph.

Q Were you involved in that in any way?

A No.

Q You were observing -- were you observing at that point?

A I don't think that at this point I was actively observing. You know, we just were -- just letting them get on about their business.

Q Did you leave the operating room at that point?

A Yes.

Q At what point did you leave the operating room, exactly, once the problem was observed?

MR. McILHARGIE: I'm going to object to the assumption. What problem are we talking about?

MS. OETTINGER: There is obviously a problem of blood flow on the leg and the artery. That's the problem I'm referring to.

A Okay. When we were in the operating room, it was for the purpose of seeing where, in fact, the surgery that we had performed had contributed to the arterial compromise. And I think when we noticed the problem with the suture and saw that it was rectified, then from the orthopedic point of view, that was it, you know. I would have no business doing the vascular surgery or helping them or anything like that.

We were also there from the point of view of trying to insure that the repair we had done would not become disrupted and to contribute to further damage, but that is not really an active role.

Q Okay. So after seeing this suture, this Ovicryl suture, and after seeing that it was removed, you left the operating room, is that correct?

A To the best of my knowledge, yes.

Q During the surgery on July 1st -- on June 30th, excuse me, were Ovicryl sutures used?

A Yes.

Q This report was the date June 30, '83. The date of the surgery, however, that does not seem to be accurate, does it?

A You're correct about that.

Q Actually, the surgery was July 1st, wasn't it?

A Right. Early in the morning of July 1st.

Q When was it dictated?

A The date on here is 7-10-83.

Q Who dictated it?

A This was dictated by, I believe, Dr. Jacobs or possibly Dr. Imbembo. I don't have any way of knowing for certain.

Q And when was it typed?

A Typed on the 11th.

Q And who are the signatories on the third page of the operator report?

A Myself, Dr. Imbembo and Dr. Jacobs.

Q Who were the signatories who actually signed it?

A I actually sign it. And the other: people have not yet signed.

Q Why did you sign it if you were not the surgeon

in attendance?

A I signed it as the visitant meaning, that I had some involvement with the case.

Q Okay. You also suggested that one of the reasons why the blood flow would have stopped to the lower right leg was because of the tourniquet that was placed on her leg during surgery. Would you explain that further, please?

A What specifically is the question?

Q You stated that the tourniquet shut-off the flow of blood to the leg and that perhaps affected the flow to the leg. How did that happen?

A The following application of a tourniquet and its release, there are all sorts of metabolic changes in the extremity that can contribute to decrease in blood flow.

Q Are you on notice of these, are you aware of these when you're performing surgery with tourniquets?

A These changes I'm referring to occur after the tourniquet is removed.

Q Are you aware of them?

A Yes. We use tourniquets in almost every extremity procedure, so we're well aware of

their potential complications.

Q And what do you do to minimize those complications?

A We adhere fairly strictly to the policy of deflating after two hours, as I mentioned before. We take care to insure that the tourniquets in the hospital are operating properly at the proper pressure,

Q Do you have the responsibility for insuring of these things?

A For insuring that the equipment is proper?

Q That it's operating at the proper pressure, for example?

A I, personally, don't directly check or calibrate the machines, but that's part of the OR routine, operating routine maintenance.

Q Are you, personally, involved in making sure that the tourniquet is released after two hours?

A In any case that I'm participating in, yes.

Q Is a tourniquet at times left on for two hours and five minutes?

A Occasionally,

Q Would that do any more damage than if it was left on for one hour and 55 minutes?

A Probably not.

Q Is it done occasionally for the tourniquet to be on for two hours and 15 minutes?

A You're asking me very generally things. Occasionally, yes.

Q What I'm asking you is, what point will damage be done if the tourniquet is left on for two hours and five minutes, two hours and 15 minutes, two hours and 30 minutes?

A I can't give you an intervening time on that. There is. But the factors of times, the tissues involved, the experimental animals involved. And this is work relating specifically to the question that you're asking. But it is generally considered in orthopedic practice to be safe to leave the tourniquet on for two hours.

There are surgeons that say three hours is safe, but it depends on so many factors that it's very difficult to tell you what point muscle damage occurs with the tourniquet in place for certain time.

Q Let's go back to that Ovicryl suture that was around the soft tissue near the popliteal artery.

If that suture, in your professional

opinion, that if that suture had not been placed there, would that artery have just remained in a straight position down the leg without tenting off to one side?

A It's possible that it could have changed position, anyway, due to the position of immobilization and in the cast or subsequent swelling or a number of factors, but I think --

Q Was she in a cast at this time?

A Excuse me. I mean, the bulky dressing of splints.

Q You're suggesting that the bulky dressings in the splints could have changed the artery?

A I think it could have changed the flow through the artery.

Q Why, because they were on too tight?

A It's possible.

Q Well, isn't that up to you to make sure they're not on too tight?

A Occasionally, there is postoperative swelling, which makes initially fine dressings become too tight.

Q And who's responsible for determining whether the dressing is too tight?

A The people looking after the patients

postoperatively, including nurses.

Q How often did you see Laurie after the surgery of June 30th, within that period of time from 7:30 to 2:30 the following morning?

A How many times? I did not see her until I was aware of the problem and she was in the suite, angiography suite, I saw her at that point.

Q Okay.

A So the number of times is irrelevant. I was sort of there and with her with other people from then until the time the vascular surgery could be carried out.

Q At the time of the surgery on June 30th, would you say that that Ovicryl suture was placed in those tissues?

A Yes. The suture was placed at the time of that surgery.

Q On June 30th?

A Yes,

Q And that suture somehow affected this artery and tented it in some way; is that what you're saying?

A Well, according to this record, as you point out, which was dictated a bit later than I would have hoped it would have been, yes.

Q Okay, And the suture you indicated -- I'm just reviewing a little bit for my own identification -- the suture, you indicated, was about the size of thread you sew a button on, is that correct?

A Heavy thread.

Q And the artery itself was about this size?

A Arteries are generally about at this level a centimeter, centimeter and a half,

Q Was this -- excuse me, Was this suture found before the artery trifurcated?

A Yes, Above or about to that level.

Q Was there any other artery to the leg supplying blood at this time?

A "At this time," at which time?

Q At the time the blood flow was decreased and then cutoff altogether, are there any arteries to the leg, to the -- beside the popliteal that trifurcate?

A Some flow was getting there for a period of time.

Q I understand.

A But there is no other aside from the collaterals, which can contribute varying amounts. This is the main arteries.

Q There is no other main arteries to the leg?
A Below the knee, no.
Q Below the knee, that's what I want to know, There is some collateral flow?
A Yes.
Q Was blood getting through at that time?
A I think up to the time the foot was completely white, there was flow getting through from other areas, from the collateral circulation.
Q So it's possible than that this popliteal artery was totally occluded, but there was other flow getting through from collateral circulation; is that what you just said?
A I'm not sure I can answer that precisely.
Q I thought that's what you just said, the blood flow didn't stop altogether and that there is collateral circulation and it was likely that blood flow was getting through?
A But the collateral circulation basically originates from this vessel. I mean, you have to look at an anatomy book and see the pictures of all the different vessels.

MR. McILHARGIE: In fairness, Dr. Matejczyk is telling you what she reads from the notes, being made by

vascular people who come in behind and do assessment,

Q And you have no knowledge as to why the surgical notes were dictated ten days later?

A No, I don't, except I think we run our service rather tightly and, apparently, this service runs, at that time, was running a little sloppily.

Q What are the major problems that would occur to a leg when the blood flow is cutoff?

MR. McILHARGIE: Object to the general nature of the question. Doctor, if you can, answer it,

A Well, in basic terms, the tissue of the leg dies, The tissues include muscle, nerve, skin, bone,

Q And would a vascular surgeon, as well as an orthopedic surgeon, be aware that when blood is cutoff from the leg, the tissues die?

A Yes,

Q Would they be put on notice, on alert, that this would be a definite possibility?

A I don't understand that question.

Q Well, knowing that the blood supply to a leg is cutoff for seven and a half hours, would --

MR. McILHARGIE: I'm going to object. That has not been established.

Q You're making a --

A We don't know it was off for seven and a half hours.

Q There was a diminishment of blood to the leg, is that correct?

A That's correct.

Q There was a diminishment of blood to the leg from approximately the end of surgery on June 30th, 7:30, until the surgery on July 1st at 2:30 in the morning, is that correct?

A And beyond.

Q And beyond. All right, A diminishment of blood, possibility a complete shutting off of blood?

A Yes. Everyone would know this would result in damage to the tissues.

Q Would there be anything a doctor would do to try to insure that the tissues would not be dying at this point?

A The course would be to determine what the cause was and to correct it as soon as possible.

Q Was it corrected as soon as possible?

A Was it corrected as soon as possible? Well, one

would hope that it would have been corrected more promptly than it was,

Q Why wasn't it corrected so promptly?

A I think because there was difficulty with the vascular surgery,

Q Exactly what do you mean by that, once the surgery was begun at 2:30 in the morning, there was difficulty then?

A If you look at how long the vascular procedure lasted, it was clear they were not dealing with a simple vascular problem.

Q How long did the vascular surgery last?

A It's a long time. Starting at three.

Q Three o'clock in the morning?

A 3:00 a.m. and the patient left the operating room somewhere around 12:30 the following afternoon, so --

Q 12:30 p.m.?

A Nine and a half,

Q Nine and a half hours.

A So that tells me and, you know, I was kind of in and out and aware of what was going on, but not there, that they were having some real difficulty getting the leg revascularized, They weren't dealing with a simple problem. They

weren't dealing with a problem as simple as finding a misplaced suture and dealing with that,

Q Are you suggesting that if the suture wasn't misplaced, that the problem would have occurred anyway?

A I don't know,

Q Okay,

A I think it certainly could have,

Q And there was no indication during the surgery, that you were supervising and that you were present at, that there was any problem to the artery at that point, meaning the surgery of June 30th?

A The ligament repair?

Q That's right.

A We did not specifically review, dissect or attempt to assess the popliteal artery at the time of the injury on June 30th.

Q Is that the standard procedure?

A Yes, it is. When you're repairing knee ligaments and surgery on the knee joint, you try to stay away from the popliteal artery as much as possibile. The only time you would directly visualize it is the rare instance where you

would do a direct posterior approach to the knee, which is rare,

Q When a surgeon is suturing torn tissues, don't they usually -- wouldn't you usually take a retractor and retract the artery to insure it wasn't anywhere in the vicinity of the tissue you're repairing?

A Retractors are commonly used.

Q And it was not used at this time?

A I have no way of knowing whether the moment the suture was placed, whether a retractor was in place or not.

Q Weren't you in the operating room at the time?

A Yes. But you don't remember every detail like that, but I can say, definitely, that you are constantly aware of where the popliteal artery is, You usually have retractors in the vicinity, so that you can see exactly what you're suturing, And I believe that was done in this case, because a suture was not placed in the artery or even very near the artery, as you seem to be suggesting.

Q Well, you suggested the suture was placed around the tissue that surrounded the artery, isn't that near the artery, in the vicinity of the

artery?

A Yes. In the tissue, but -- yes, but it's a definition, how near is near and how close is close?

Q It's not a very large space in that knee?

A No, there isn't.

Q But you cannot tell me from your personal experience in the operating room --

A I believe you --

Q Let me finish the question.

You cannot tell me from your professional experience in the operating room at that time in which you were supervising the senior resident, that a retractor was placed around this artery to push it out of the way, while the suturing was taking place?

A Let me just show you,

Q Could you answer the question, please?

A Tell me the question once more, I don't think I can tell you, unless you understand the anatomy better than you do,

Q I understand the surgery.

A Have you ever been in --

Q I've never been in surgery, but I am an attorney, not a doctor.

From your personal experience being in the operating room on June 30th, being as a supervisory doctor at that time, supervising a senior resident, can you tell me from your personal experience whether a retractor was placed around that artery to insure that it was pushed out of the way while the repair of this tissue was taking place?

MR, McILHARGIE: Objection. Go ahead and answer, if you can.

A I'm concerned about your terminology, because when you're operating in this area, which I will show you in a minute, you do not place retractors around arteries.

Q Okay,

A Specifically, the popliteal artery in this location when you're operating through a lateral incision.

Q Where do you place a retractor?

A Wherever you need it, so you can see clearly wherever you're suturing.

Q How did you protect it?

MR. McILHARGIE: I'm going to object. I think that assumes that it's in the surgical field.

A It's not in the field.

MR. McILHARGIE: It's not in the area she's operating. It isn't in the area where the area she's visualizing might be.

MR. McINTYRE: Isn't it true she first had the obligation of localizing that?

MR. McILHARGIE: We have to have that from Gail, so we have it from one direction here.

BY MS. OETTINGER:

Q You're suggesting that this space that you're operating on is a large space. And looking at anybody's leg and knee area, this is not a very large space.

A Right.

Q Once you've made an incision, there are two incisions in the knee, in the leg, laterally and medially. And once you have entered that area, do you mean to tell me you were not on notice or on alert to guard against any kind of damage to that artery?

MR. McILHARGIE: Objection.

A You are aware of where it is at all times. The

knee is flexed so that it further falls back where it's out of the way, but in no standard or lateral approach to the knee is isolation, identification of the popliteal artery part of the exposure.

Q You did identify and protect the peroneal nerve?

A Yes. Because that is directly in the operative field.

Q Did you identify and protect any other nerves or arteries or veins?

A No, as I said before.

Q There were no veins or arteries in that area of the leg where you were doing the surgery?

MR. McILHARGIE: Objection. That's not what she said. She said it was not necessary to isolate and protect. There are millions of tiny little arteries.

MS. OETTINGER: Of course there are.

MR. McILHARGIE: Why don't you put a new question to her, or if you can have the old one read back to her --

A Can I just show you the area we're talking about? The popliteal artery is back here in

this space, the lateral incision is here.

Q Right.

A And the area of severe damage, the posterolateral torn is right there, so you're away.

Q Isn't it deep within the leg?

A It's deep -- well, it's outside the knee joint, but it's inside from the skin.

Q Show me the knee joint. Isn't that the very front of the leg?

A The knee is the whole thing.

Q Okay. It's outside the knee joint?

A But, you know, here is the area where we're repairing torn tissue.

Q Okay.

A Here is the peroneal nerve running right through the incision. Therefore, you can't miss it. What business would we have to go all the way back here?

MR. McILHARGIE: Let the record reflect the doctor is indicating the area where the incision was made was on the side of the knee, which is what she referred to, the lateral side. The area of the popliteal aretery is the space

immediately behind the knee joint in the small pocket space; is that fair to say, Doctor?

MR, McINTYRE: I would say it's the medial.

MR. McILHARGIE: What she's indicating is that the surgical incision is closer to the front of the knee in the medial incision, is that correct, Doctor?

THE WITNESS: It can be either way.

MR, McILHARGIE: That's lateral?

THE WITNESS: It can be either way. You can get around to see what you need to see.

MR, McILHARGIE: But are there medial or lateral closest to the -- what we call the front of the knee?

THE: WITNESS: Right,

MR. McILHARGIE: Okay. Whereas the popliteal artery runs behind the knee in the pocket or space. Your incision doesn't go to the back of the space?

THE WITNESS: No.

MR, McILHARGIE: It goes only to

the front near the cap.

MS. OETTINGER: It's now five o'clock. And I indicated that I wanted to quit at five o'clock. Before we do so, though, I'd like to just consult with my partner for just a minute.

MR. McILHARGIE: Would you like to continue with a specific date or work out another date?

MS. OETTINGER: I'll be right back and I'll check my calendar, also. Off the record.

(Discussion had off the record.)

(Recess taken.)

BY MS. OETTINGER:

Q Okay. Just a couple quick questions and then we'll go. All right. There was a long explanation as to why the popliteal artery did not have to be retracted and was not even involved in this surgery. However, the fact is, that a suture that was used to repair tissue, somehow got involved with a popliteal artery.

MR. McILHARGIE: I'm going to object. That's not a question, that's a statement.

Q If you'd like to -- this is a question now. That's right. I have to use a preliminary, because I left the room.

How can you then --

MR. McILHARGIE: That's argumentative again.

Q The popliteal artery is-not in the vicinity of the surgery that you were doing?

MR. McILHARGIE: Objection. Argumentative question. Go ahead and answer, if you can.

A I would ask you to define "vicinity."

Q Near enough so that a suture would be involved in doing some kind of damage to the artery?

MR. McILHARGIE: I'm going to object to that, too. There is no evidence of the suture doing actual damage to the artery. What it was, it was in the area of the vicinity of the soft tissue.

A The suture did not do any direct damage to the artery.

Q That the suture -- there was a suture, is that correct?

A Yes.

Q All right. The suture was in the vicinity of

the popliteal artery, is that correct?

A Yes,

Q The suture, by your testimony, was around the soft tissue that surrounded the artery --

MR, McILHARGIE: Objection,

Q -- that was in the soft tissue around the artery?

MR, McILHARGIE: Objection. Not around the artery, adjacent to the artery.

Q Was in the soft tissue, if I'm not mistaken, soft tissue that surrounded the artery?

A Adjacent to the artery,

Q All right, This is just a matter of semantics. This is the artery --

MR, McILHARGIE: We've already drawn a diagram, Let's go back to our diagram here.

A Here is the tissue,

MR. McILHARGIE: We want something that becomes part of the record here.

A I can add to this one, adjacent to the artery.

Q Does it surround the artery, does it go all the way around the artery?

A There is some over here, some in the front,

Q Is there some soft tissue all the way around the artery?

A Not in a circumferential artery as you're saying. I think you're --

Q Is it around the artery?

A I think you're trying to trap me.

Q I'm not.

A There is tissue around the artery, but it's not continuous as a ridged structure, soft tissue is just that.

Q There is tissue around the artery that is just --

MR. McILHARGIE: I'm going to object. She's answered it three times it's not circumferential. She said it doesn't go all the way around the artery, that the suture does not go around the tissue, all the way around the artery. She made that clear several times.

Q Let me ask you a question, if the tissue does not go all the way around the artery, on what section of the artery is there no soft tissue?

A There is less in the front and the back than on the sides.

Q Okay. But you would approach the artery from

the side, is that correct? You showed me on the incision from the medial and lateral side of the leg.

MR. McILHARGIE: Objection. There is no testimony she approached the artery.

Q But you opened the leg on the medial and lateral side?

A Right.

Q This is the sides of the leg?

A Right.

Q If and artery has a side?

A Okay.

Q And it doesn't because it's round.

A Okay.

Q You're approaching it, you're coming into the leg from the side?

A From the side, right.

Q And you're coming into the leg from the other side. Now, you just suggested that there is less soft tissue on the anterior portion of the artery, is that correct, in the posterior portion of the leg?

A Yes.

Q Okay. From the --

A From the back. I guess what I'm trying to clarify is that there is not a solid ring of tissue around, nothing more than that.

Q Okay. I understand what you're saying, but there is soft tissue on all sides of the artery?

MR. McILHARGIE: Objection. She just said there was not a solid ring of tissue around the artery.

MS, OETTINGER: I didn't say, "A solid ring."

A Yes. Because it is all covered with skin, soft tissue. The artery doesn't hang out.

Q There is no place where the artery is not covered with some kind of soft tissue, And you have entered the leg from a side position?

A Correct.

MR. McINTYRE: Want to quit it there?

MS. OETTINGER: All right. Just one more question -- well, we'll take this up at a later time.

MR. McINTYRE: When do you want to schedule it?

MS. OETTINGER: I'm free tomorrow.

MR. McILHARGIE: Let's consult our calendars tomorrow morning. I'll be in my office about nine. I'll have a deposition going forward at ten.

Somewhere around nine o'clock, we can look at our mutual calendars and see what we can do and look at Mary's calendar as well. Okay. Try to complete it in the next couple of weeks.

- - - - -

(A document was marked for identification as Matejczyk Deposition Exhibit No. 1.)

- - - - -

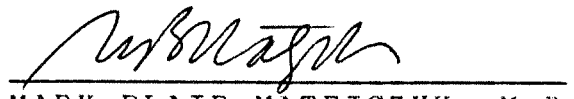
have.

MR. ZELLERS: I don't have any,

MR. SEIBEL: I assume you are having this written up.

MR. KAMPINSKI: You assume correctly.

MR. SEIBEL: We'll sign it.



MARY-BLAIR MATEJCZYK, M.D.

LAWYER'S NOTES

PAGE	LINE	
6	2	could → do
32	2	flares → Nares
"	3	" "
85	19	arrythmia → erythema
87	12	" "
89	6	punctuation misplaced: should read wound, decreased drainage, decreased swelling.
90	19	should read: one colony, coagulase negative staph which (no coma after coagulase)
		reason: all typographical errors

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

I, Nancy L. Brezo, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, Mary Blair Matejczyk, was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; and that the testimony then given by her was by me reduced to stenotypy in the presence of said witness, afterwards transcribed upon a typewriter, and that the foregoing is a true and correct transcript of the testimony so given by her as aforesaid.

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 8th day of May, 1985.

Nancy L. Brezo

My Commission expires April 27, 1988

Nancy L. Brezo, Notary Public within and for the State of Ohio

Cleveland Metropolitan General/Highland View Hospital

LIS CENTER/ DEPARTMENT OF PATHOLOGY WARD ORTH 05:42 12/30/87 PAGE 1

O U T P A T I E N T L A B O R A T O R Y R E P O R T

CATES,TRAVIS 524533 ORTH ORTH 53 MW MATEJCZYK MARY

DATE	TIME	TEST NAME	RESULT	NORMAL-RANGE	UNITS
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		DATE IN LAB	12/22		
		TIME IN LAB	15:55		
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		BODY SITE	RIGHT KNEE		
		SPECIMEN RCVD	SWAB		
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		TETRACYCLINE	SENS		
		ERYTHROMYCIN	RESISTANT		
		CLINDAMYCIN	SENS		
12/22	1537	MISC. PYOGEN CULT			
		DATE IN LAB	12/22		
		TIME IN LAB	15:37		
		PT. LOCATION	ORTH		
		BODY SITE	RIGHT KNEE		
		SPECIMEN RCVD	SWAB		
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		ERYTHROMYCIN	RESISTANT		
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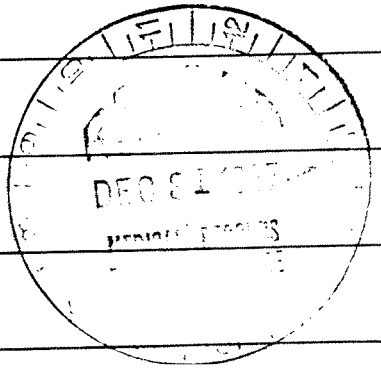

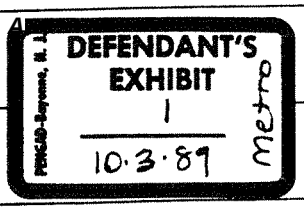

LIS CENTER, DEPARTMENT OF PATHOLOGY WARD ORTH 05:42 12/30/87 PAGE 1

OUTPATIENT LABORATORY REPORT

CATES,TRAVIS 524533 ORTH ORTH 53 MW MATEJCZYK MARY

DATE	TIME	TEST NAME	RESULT	NORMAL-RANGE	UNITS
12/22	1555	MISC. PYOGEN CULT			
		DATE IN LAB	12/22		
		TIME IN LAB	15:55		
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		ERYTHROMYCIN	RESISTANT		
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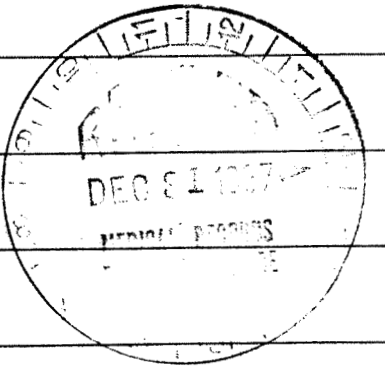

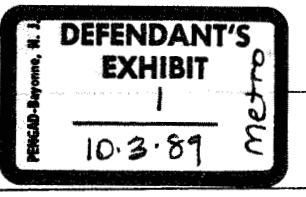

30 Wednesday
December 1987

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10 Ortho Clinic
Travis Cates
David Hemmiger

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TELECOPIER 2161453.2364

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TELECOPIER 614/221-0479

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TELECOPIER 216/696-2645
TELEX 98 5384

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SUITE 4100
DALLAS TEXAS 75201
214/761 2100
TELECOPIER 214/741 7139

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WASHINGTON D C 20006
202/775 7100
TELECOPIER 2021857 0172
TELEX 6502156242 MCI

PLEASE RESPOND TO

Cleveland

December 27, 1989

Charles Kampinski, Esq.
1530 Standard Building
Cleveland, OH 44113

Re: Travis Cates, et al. v. Cleveland Metropoiitan General Hospital
Case No. 167835

Dear Mr. Kampinski:

This will confirm the depositions of Drs. Bender-Persaud and Blinkhorn scheduled for Thursday, January 4, 1990, commencing at 10:00 a.m. and 11:30 a.m., respectively. The depositions will be held in the Legal Office at MetroHealth Medical Center, 3395 Scranton Road, East Building, Room E-102.

Sincerely,

Michael C. Zellers/kk

Michael C. Zellers

MCZ/kk/1305

cc: Robert C. Seibel, Esq.