IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

TRAVIS CATES, et al.,

Plaintiffs,

-vs-

JUDGE J. McMANAMON
CASE NO. 167835

CLEVELAND METROPOLITAN GENERAL HOSPITAL, et al.,

Defendants.

Doc. 297

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Deposition of MARY-BLAIR MATEJCZYK, M.D., taken as if upon cross-examination before Aneta I. Fine, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the MetroHealth System, 3395 Scranton Road, Cleveland, Ohio, at 2:00 p.m. on Tuesday, October 3, 1989, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiffs in this cause.

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On behalf of the Defendant,
MetroHealth System.

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

CROSS-EXAMINATION OF MARY-BLAIR MATEJCZYK, M.D.

BY MR. KAMPINSKI:

Q. Doctor, would you state your full name, please?

A. Mary-Blair Matejczyk.

Q. And why don't you spell your last name.

A. M A T E J C Z Y K.

Q. Where do you live, Doctor?

A. At 15433 Brewster, B R E W S T E R, Road, East Cleveland, 44112.

Q. I'm going to ask you a number of questions this afternoon. If you don't understand any of them, please tell me. I will be happy to rephrase any question you don't understand.. When you respond to my questions you have to do so verbally. She can't take down a nod of your head, all right?

A. All right.

Q. Your CV's coming so I will wait till it gets here to ask you background information, okay? I

will back up to do that when it gets here.
A. Okay.
Q. Briefly, though, Doctor, we're here at Metro, and what is your affiliation with Metro Hospital?
A. I'm employed here as a staff physician in the orthopedics department.
Q. All right. So you are actually paid by Metro?
A. I receive part of my salary from Metro.
Q. And is that for purposes of training residents?
A. Partly it is.
Q. And what would the other part be, to take care of staff patients?
A. That's part of the salary, too. There's no specific breakdown or apportionment.
Q. I see. You are also a member of University Orthopedics, correct?
A. That's correct.
Q. You are an employee?
A. That's correct.
Q. As well as a shareholder?
A. I personally am not a shareholder.
Q. All right. You said that as though someone you are related to is?
A. Most of the people in the group are.

Q. Okay. You are just an employee?
A. I have equal status with everyone but I happen personally to have chosen not to own stock in the corporation.
Q. I see. When you see a patient, do you bill them through University Orthopedic Associates or does Metro bill them or how does that work?
A. Any patient that I see as a private patient is billed through the University Orthopedic group.
Q. I see. And anyone who would walk in the door who you'd see as a staff patient would be billed through Metro?
A. That's correct, with no particular billing coming from me or my services.
Q. All right, And then somehow you would then charge back to the hospital for your services?
A. No, we really don't do that for staff patients.
Q. You are on a salary then?
A. We don't get any specific reimbursement for staff patients.
Q. All right. Are you then on a salary from Metro?
A. Yes, I do receive a salary from Metro.
Q. And that's you personally as opposed to University Orthopedics?
It's somewhat complex.

Q. Okay. Why don't you explain it to me?
A. But I could get a check from Cleveland Metropolitan General Hospital.
Q. Does University Orthopedics also receive compensation for the work you do for staff patients?
A. I don't believe so,
Q. All right, Do you know if there is a contract between University Orthopedics and Metro?
A. I don't know specifically if there is.
Q. Was Travis Cates a patient that was a staff patient or was he someone you billed through University Orthopedics?
A. No, he was billed through University Orthopedics as a private patient of mine,
Q. Okay. How long had he been a patient of yours, Doctor?
A. Several years.
Q. All right, Doctor. I think I have gotten your office records. I think. I am not sure. Do you have your office records?
MR. SEIBEL: They're back in the Doctor's office.
Q. Why don't you get them so we can refer to them?
A. Should I get them now?

Q. Please.

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

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Q. Doctor, is that your entire office chart on Mr. Cates?

A. Yes, it is.

Q. All right.

MR. KAMPINSKI: Why don't you mark that.

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(Thereupon, Plaintiff's Exhibit 1 was mark'd for purposes of identification.)

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Q. Doctor, we'll come back to your record in a minute, but I have just been given your CV. Where did you go to -- okay. Did you go straight to medical school after college?

A. Yes, I did.

Q. What did you do before college, Doctor?

A. I went to high school.

Q. All right. Straight from high school to college?

A. That's correct.

Q. And how old are you?
A. 40.
Q. Doctor, at one point I requested your records. Are you aware of that?
A. Was it quite some time ago?
Q. Yes. And what I received, Doctor, was one, two, three, four, five, six, seven, eight pieces of paper.

MR. SEIBEL: I think for the record at this point we ought to note that Mr. Kampinski requested the Doctor's record in connection with an action for discovery which is no longer active. And I don't think, Mr. Kampinski, that you made a request for the Doctor's chart in this case, yet.

MR. KAMPINSKI: Mr. Seibel, I sent the Doctor a letter before there was any case filed including discovery asking for all of Mr. Cates' records, so I don't understand what you're saying.

MR. SEIBEL: You want it read back?

MR. KAMPINSKI: I guess I'd like an answer *to* my question.

Q. Do you know why I was only sent eight pieces of

paper when I asked for Mr. Cates' record and sent up an authorization signed by Mr. Cates asking for his chart?

MR. SEIBEL: Only if you know, Doctor.

A. I really at this point don't have any recollection of correspondence or letters.

Q. Doctor, when a patient is seen by you for a visit how do you chart what occurs in that visit?

A. Generally I dictate an office note either at the time of the visit or later that day and it is subsequently transcribed and filed.

Q. Could you, and I'm going to -- well, this portion of your record which apparently consists of those transcriptions, right? These few sheets of paper there?

A. That's correct.

Q. Is that what you're talking about?

A. That's correct.

Q. Could you tell me where the transcription is for the visit of December 30, 1987?

A. I don't believe that there's a transcription.

Q. Why not?

A. At this time I really don't know. Occasionally

the secretaries don't transcribe, papers get misfiled.

Q. Was anything removed from this chart before my coming here today?

A. I don't believe, I just found this chart actually and hadn't looked at it for at least since the lawsuit was filed.

Q. My question was was anything removed from it, Doctor?

A. Nothing was removed,

Q. When you say you just found it since the lawsuit was filed, where was it?

A. When a lawsuit is filed my practice is to take the original chart and file it in the bottom of a filing cabinet which contains some other debris, and remove it from the regular chart, and I just hadn't remembered where it was.

Q. On the front of your chart there's a new patient registration, and just below that I guess there is an information sheet, and the date is August 31 of '81. Would that be when Mr. Cates first came to you?

A. I believe so, yes.

Q. Okay. And --

A. This is an updated copy of this, same form.

Q. Okay. So this one's saying August 31 of '81 is when he would first come to you?
A. That's correct.
Q. As a patient. And you had just begun working on the staff at University -- at Metro August of 1981?
A. That's correct.
Q. So he was one of your first patients?
A. That's correct.
Q. How is it that he was -- that you saw him as opposed to anybody else at University Orthopedics or on the staff at Cleveland Metro?
A. He was referred to me by a rheumatologist here on the staff.
Q. Who was that?
A. Dr. Stan Ballou, B A L L O U.
Q. And the reason he was referred was what?
A. He had an abscess involving his arm.
Q. And you first saw him then when, September of 1981? You can look at your original and I will try to follow along on these copies.
A. There's a note before that probably because that says -- I really don't see an original note here.
Q. Are these your original records that are in this

file, Doctor, or are these copies?
A. These appear to be original records.
Q. Okay. All right. So there would have been --
A. These --
Q. I'm sorry?
A. I think this might have been yours.
Q. No. I don't think so. I think that's your original, Doctor.
A. This is a letter so the original would have been sent.
Q. Okay,
A. Okay.
Q. Are you saying that there is or that there are parts of your record missing?
A. Are you referring specifically to 1981?
Q. Yes. I mean you seem to indicate in response to my question that you thought that there were or that there was a previous visit that wasn't reflected here?
A. It appears that way because the registration sheet is dated August 31.
Q. All right. So where would that be?
A. I don't see a note from that date unless that was possibly as a hospital consult instead of an outpatient visit.

Q. What did you treat Mr. Cates for through, let's say, middle of 1987? Was there any one problem that you were seeing him for?
A. Could you be more specific about that?
Q. Well, he's got rheumatoid arthritis, right?
A. That's right,
Q. And I mean were you treating him for any problem related to that?
A. His rheumatoid arthritis was being managed by his rheumatologist, Dr. Ballou,
Q. Okay.
A. And I would see him episodically really in conjunction with Dr. Ballou when Dr. Ballou felt there was a problem that I could help with.
Q. Is Dr. Ballou on the staff here also?
A. Yes, he is.
Q. There's a reference in the medical record to a Dr. Ballou who is a resident. Is that the same Dr. Ballou or is there a different Dr. Ballou?
A. There's only one Dr. Ballou that I know and he's also been a staff rheumatologist.
Q. He is not a resident?
A. Since I have known him.
Q. He is not a resident?
A. He is not a resident.

Q. During the hospitalization of November of 1987 were you involved in the care of Mr. Cates?
A. Yes, I was.
Q. And how were you involved?
A. Specifically?
Q. Specifically.
A. Do you have a specific question?
Q. Yes. What did you do?
A. He was my patient.
Q. Oh. And what was he in for?
A. He was in for a breakdown in the area of his old total knee replacement incision.
Q. Who did the total knee replacement?
A. I did.
Q. When did you do it?
A. I need to look to tell you the exact date.
Q. Sure.
A. That was done April 25.
Q. Of?
A. 1984.
Q. Had he had problems with -- was it both knees or the right or which?
A. No. He only had a right total knee replacement.
Q. When you say a breakdown of it, what do you mean by a breakdown?

A. Well, when we did the total knee we do it through the anterior approach and he had a scar on the front of his knee.
Q. Okay.
A. And then several years later he developed a local problem with that scar,
Q. What kind of problem?
A. There was apparently a scab or something that formed over the front of it that the rheumatologists were looking at and it seemed to come and go, and then one day, I believe it was in November, when he was admitted he presented acutely with swelling and warmth and redness and drainage from that local area.
Q. Okay. We're talking now about the admission of November 13, 1987?
A. That's correct.
Q. All right. There's no office record of yours pertaining to that admission, Is there a reason for that?
A. As I was reviewing these notes I see a message from Dr. Wilbur who was one of my partners probably on call that day.
Q. Yes.
A. That he had been admitted, so it would not have

been -- I didn't see him in an office visit that day.

Q. Okay. As a matter of fact, the last note you have got -- well, the only note you have got in '87 is of July 6, correct?

A. That's correct.

Q. Why was he admitted and what was done for him in November of 1987, Doctor?

A. He was admitted with an acute problem with his knee. I believe that he came to see the rheumatologist on that day, was sent down immediately to orthopedic clinic where I wasn't, I am not sure where I was that particular day.

Q. Okay.

A. And admitted to the hospital. I received a call from my partner, Dr. Wilbur, and that day went up and saw him and evaluated the situation.

Q. And what was the situation?

A. Well, the initial impression was that his prosthesis was infected, however, what I determined when I evaluated him that night was that the problem appeared to be entirely superficial.

Q. Superficial?

A. As opposed to involving the knee joint.

Q. And I assume you charted that somewhere?
A. I don't believe that I specifically did.
Q. You're doing this then by recollection?
A. Yes.
Q. If it would have involved the entire joint would you have removed the prosthesis?
A. Yes. If we had obtained pus on aspirating the joint, on the day of admission, which we didn't,
Q. When you say we, you are talking about you, aren't you?
A. Me or whoever aspirated the joint.
Q. Well, who did?
A. I really don't recall.
Q. Well, take a loolc at the chart enough to --
A. I don't really remember that it says who specifically aspirated it.
Q. Does it say what --
A. It probably was the resident in orthopedics clinic or it could have been rheumatology,
Q. Who was that?
A. Here, I do have it. That was one of our orthopedic residents, Dr. Meyer.
Q. And what are you looking at, Doctor, progress notes?
A. No. I'm looking at the admission, history and

physical on November 13.

Q. All right. But you say that evening -- well, all right. Are you referring to what was aspirated on the admission?

A. That's correct,

Q. Okay. Why don't you read that for me?

A. Right knee aspirate under sterile conditions, gram stain, no organisms, few WBC, WBC 11, 89 percent polys, 1 percent B's.

Q. And that was Dr. Meyer?

A. That was Dr. Meyer.

Q. Why don't you continue, What was his assessment and plan?

A. As he wrote it, Infected right total knee arthroplasty, which is not correct and not specific. Has been admitted, will obtain x-rays. Follow CBC and ESR. ID consult. Cardiology consult. Antibiotics, 1 believe, he means per ID consult.

Q. Well, where does it indicate that there was no pus when he aspirated it?

A. His little side note down to the left indicates that the cell count was 216 which is very, very low, certainly not pus.

Q. Pus is something you see, isn't it?

A. You see and there are certain laboratory characteristics as well.
Q. So this is a comment on the laboratory value?
A. This 216, yes.
Q. So does that tell me that there was no pus when he aspirated it?
A. That's correct.
Q. Doctor, if you would turn to the progress notes, please,. of November 13 and 14. You have got a yellow mark through them also, don't you? Do you see the infectious disease note down there?
A. Yes, I do.
Q. And who was the infectious disease person?
A. I really can't say with certainty whose signature that is.
Q. Well, you were the attending physician, weren't you?
A. That's correct.
Q. And are you the one to call for the consult?
A. Personally?
Q. Or someone on your behalf?
A. The orthopedic service did. I personally didn't call the infectious disease consult.
Q. Well, you were in charge of the orthopedic service as related to this man, weren't you?

A. That's correct.
Q. *So* he would have been called on your behalf then?
A. That's correct.
Q. Who was he?
A. I believe this is an infectious disease fellow who sees, generally they see all the patients and write the notes. I can give you two possibilities but **I** can't identify that signature with certainty.
Q. Who were the possibilities?
A. The first possibility is a woman, Dr. Roberta Bender, and the other one is Blinkhorn so you can see where the signatures might be a little bit difficult to decipher.
Q. Did you read this note?
A. When?
Q. At the time it was written?
A. I don't recall that.
Q. Have you read it since then?
A. Yes, I have.
Q. Can you read it for me, please?
A. You want me to read the entire note?
Q. Yes.

MR. SEIBEE: *Go* ahead.

A. Okay. Asked to see this 53-year-old -- shall I read the abbreviations or translate?
Q. You can translate it.
A. White male with long standing RA.
Q. What is that?
A. Rheumatoid arthritis. Sorry. Who presented to the, this could be ortho or could be arthritis clinic, with complaint of superficial ulceration over the right knee times two weeks. No definite history of probable trauma. Has been doing or caring for this wound with dressing changes only. It's difficult to read this writing, no antibiotics taken. No healing noted something this time period. And on the a.m. of admission noticed increased right knee swelling. Called rheumatology M.D., and I'm sure that's Dr. Ballou but it doesn't look like it in the writing, who suggested ortho clinic appointment. Right knee found to have appreciable effusion.
Q. What does that mean?
A. An effusion is fluid accumulation within the joint.
Q. *Go* ahead.
A. Superficial right knee ulcer with something

purely on drainage.

Q. How about obvious purulent drainage?

A, Yes.

Q. What is purulent drainage, pus?

A. Purulent drainage means pus.

Q. I just thought you told me there was no pus?

A. I was making the distinction between inside the joint cavity versus superficial to the joint cavity.

Q. Well, how do organisms present themselves? How do you determine whether there is an organism inside the joint cavity as opposed to superficially outside of the joint cavity?

A. You insert a needle into the joint cavity which is the aspiration that's referred to, you examine that fluid with a gram stain, you might do some laboratory analysis such as a cell count, and finally you culture that fluid.

Q. Was that done?

A. Yes, it was.

Q. Why don't you turn to the lab values if you would, Doctor? Can you tell me which ones were taken of the knee joint and which ones were taken of the surface? Can you determine that?

A. I haven't examined this particular copy of the

records so I am not sure but I will try.
Q. Okay.
A. These pages aren't numbered. Do we know that they're in the same order?
Q. I'm sorry?
A. My pages of the lab results aren't numbered so they may not coincide with yours.
Q. You can just tell me which one you are looking at and I will find it.
A. Okay. I'm looking at a report dated 11-13.
Q. Okay.
A. Time, 1309, joint --
Q. Give me some reference up here so that I can follow along with you.

MR. SEIBEL: Looks like it's page 2. Inpatient Cumulative Summary Report.

A. It's confusing the way these are filed because preliminary reports go in and then it had replacement --
Q. Okay. This is labeled Permanent Patient Record, right?

MR. SEIBEL: I am not sure we're on the right page, Chuck.

MR. KAMPINSKI: I think we are. November 13, '87, time, 1747, right?

MR. SEIBEL: Mine looks different than yours. Turn the next page.

MR. KAMPINSKI: Oh, I'm sorry, that's page one, You're right. Page two, all right.

Q. Okay. *Go* ahead.

A. On the 11-13, time, 1309, specimen, joint knee there's a result for glucose and a result for total protein. And that has to be from fluid as opposed to a swab.

Q. All right. Now, would that correlate, Doctor, to -- is there a number of that particular specimen that we can see what was grown as **far** as a culture?

A. **I** don't think that would be the same number. Are you referring to some identification numbers?

Q. Now, is 1309 the time, is that the time it was taken or the time that it was examined or which? Do you know?

A. 1 believe that's the time that it was examined in the lab or clocked into the lab because some tests aren't available immediately as they're checked into the lab. But this lab, body fluids, pathology, would be a different lab than

the lab that would process the specimen for microbiology.

Q. I see. So that in terms of the organisms, we're looking at the wrong page here, right?

A. We were just starting to look at the chemistries or the fluid analysis of that aspirate specimen.

Q. Does that help you in terms of knowing what the organism is that's infecting the knee?

A. Well, if you just, if you just finish this little section,

Q. Okay.

A. The white count of that knee joint fluid is listed as 216 which is extremely low and totally inconsistent with an infectious process within the joint,

Q. I see.

A. And the culture as we'll see later that were taken from the superficial draining area, you wouldn't be able to get a cell count on it because it wouldn't be a volume of fluid.

Q. I am not sure I understood what you just said.

A. If you take a culture of a wound by a swab --

Q. Okay.

A. -- and then all you get is the tiny drop of the material on the swab --

Q. Okay.
A. -- as opposed to taking fluid out of the inside of the knee and then you have a syringe and a certain volume of fluid that you can work with, and then you would divide it up and say well, what do we need to get on this specimen.
Q. And the distinction you are making is what?
A. The exact location of where the specimen came from.
Q. I see.
A. Whether it came from the superficial hole in the skin which can be contaminated with skin organisms versus whether it was a deep aspiration obtained by a sterile technique.
Q. All right. So what you're saying is that this particular page and this particular test is, in fact, the aspirate that was taken out of the knee and it shows very few white blood cells?
A. That's correct.
Q. Okay. Why don't you take me through this particular test which apparently indicated to you that it was not into the knee joint. I mean is this the only one?
A. No. I think that the subsequent documentation is, two things, one is the gram stain on that

fluid which I believe was noted by infectious disease who customarily does the gram stain themselves without going through the lab, and then also the subsequent culture of that fluid.

Q. All right, Why don't you find those for me?

A. So we need to find these, May I point out something else?

Q. Sure.

A. Here is the distinction we were talking about. This is just the chronologic log of specimens received, and this one is labeled right knee aspirate.

Q. I need to know what we're dealing with here in terms of page so I appreciate that we're not on the same numbering sequence here but give me a moment so I can find that.

A. Okay.

MR. SEIBEL: I think that's it, Chuck.

MR. KAMPINSKI: Yes.

Q. This is, let's see, page one of what. December lst, '87 is the date, and the time is 1726 in the left-hand corner?

A. That's correct.

Q. Go ahead.

A. I was pointing out the distinction between the two knee specimens here and the labeling. One is body site, knee aspirate, the other one body site, right knee which is a more general kind of term. Specimen received in the first case was syringe, in the second case was a swab.

Q. Okay. The numbers over to the left right next to the time, would those be the numbers of the specimens then? Do you know?

A. I believe that they would but I don't -- I never really paid much attention to those before.

Q. All right. Well, if we --

A. But we can keep track of them anyway.

Q. All right. Go ahead.

A. I found something else. I'll stop you here while it's on top. We were talking about the gram stain.

Q. All right.

A. And the report of that is few white cells seen, no organisms seen. So again, that mitigates against an infection deep within the knee.

Q. And that was also from what date, November 13?

A. November 13.

Q. Okay.

A. You can see it's confusing when they continue.

Q. Okay. And that also has a five digit number, 11197 by it if we go back and maybe this is the same thing. No. I'm looking now at page two of the document that's November 18, 1987 with a time of 1719, okay. I find a reference to that particular number, that is, 11197 that you were just showing me. Do you see that?

A. Let me catch up with you.

MR. ZELLERS: Number 18?

MR. KAMPINSKI: Yes, That's the date on the page.

A. I haven't found it yet.

Q. Okay.

A. This one is November 17. It's the same information but it's not exactly the same page. November 18, 1719.

Q. All right.

A. Okay. What was the question?

Q. I'm just trying to get a handle on these numbers to see if, in fact, these numbers correlate to a particular slide or a particular test, all right. It's got the 11197 which you had just referred to a moment ago, All right. Correct?

A. That's correct. We're talking about the same test.

Q. All right. And it's just reported on a different lab slip read out on a given day?
A. That's correct.
Q. All right. So I assume from looking at this that a lot of different cultures were done of his right knee, correct, not just on one day but on a number of days?
A. No. That's really not correct because the way that this lab reporting system works, it looks like many, many cultures were done, but --
Q. Were they all done the first day?
A. Well, I think the ones that were done the first day, and I would really need to sort out the numbers like you're doing, were the swab of the wound, and the aspiration. And I believe that there were some done subsequently during the treatment,
Q. The swabs showed heavy growth of staphylococcus aureus, did it not?
A. I believe if you go back to that same page, the one where it says right knee drainage, which is really just someone else filling out the slip and using different language, shows heavy growth staph aureus.
Q. What does that mean, right knee drainage?

A. That is the swab specimen as it's indicated a little further down.
Q. Okay. How was he treated for the staph?
A. I think I haven't really completely answered your question about the results from the aspirate.
Q. Okay. *Go* ahead.
A. If you can find the lab sheet dated November 20, '87 time, 1720.
Q. Okay.
A. Toward the end.
Q. I have got it.
A. This is the final report on the knee aspirate from the syringe just to confirm that we're looking at the same specimen.
Q. Okay.
A. Finally, no growth five days, and then just below that is the gram stain of that aspirate with few white cells, no organisms seen.
Q. So after five days there was no growth in the aspirate that they took out of the knee joint?
A. That's correct,
Q. Okay. What is a mannitol plate? Is that just something they put a specimen on?
A. I believe that's just another culture medium

that they would plate a specimen on.
Q. And what are flares? What are flares?
A. Flares refers to the nose.
Q. To the what?
A. Nose.
Q. Nose. Why would you take a culture of the nose?
A. As is indicated in the infectious disease note, they are checking this person, Mr. Cates, to see whether he is a chronic staph carrier, that is, there's certain people in the population that have these organisms present in and around their body at all times,
Q. And by checking the nose they could tell that?
A. That's correct, that's one of the characteristic locations.
Q. Well, if you have a staph infection in one part of your body, can it be in another part of your body? Is that how these infections work?
A. I really don't understand your question. I'm sorry.
Q. Well, if someone develops a staph infection in their knee can there be staph cells in other portions of their body such as their nose or ear?
A. Yes, there can be.

Q. All right.
A. Most people actually do have staph on their skin. If you cultured your own hand right now you would probably grow it.
Q. Is that what happened when they cultured the nose, they got heavy growth staph aureus from the flares?
A. That's correct.
Q. Is that just normal?
A. It's not a normal condition but it is a condition that's found in the population and it means that those people generally are more susceptible to serious staph infections as opposed to just carrying it around on your skin and having it cause you no problems.
Q. You found some in the right ear', too?
A. Yes. He had had a chronic infection of his right ear.
Q. Is a foreign body a good medium for staph to seed in?
A. I am not sure I understand your question. Body is not the medium that it grows in,
Q. Foreign body. I asked if it was a good medium for an infection such as staph to seed in?
A. You wouldn't say that medium is the correct

word, but yes, it's a location that staph could seed in.

Q. And recur?

A. Yes, it could recur.

Q. What is your background in infectious disease?

A. I am not an expert in infectious disease but I'm familiar with treating orthopedic infections.

Q. Okay. And I assume one of the things you are concerned with when you have somebody that has an infection that also has a prosthesis is that the organism would, in fact, seed in the foreign body, the prosthesis?

A. That's correct.

Q. What is the appropriate length of time that an individual with a staph infection should receive antibiotics for?

A. I don't think that there's really a specific answer to that. It would depend on the location of the infection, the seriousness of the infection, the clinical manifestations. As we said, staph can be present as a contaminant virtually anywhere and certainly it can be deleterious to treat those types of infections.

Q. How long did Mr. Cates receive antibiotics for?

A. I believe that he received Vancomycin for a

total time of 14 days.

Q. And who was the person that stopped the treatment of antibiotics for Mr. Cates? Was that you?

A. No, Generally that's done on the recommendation of the infectious disease consulting service.

Q. How was it done here?

A. It was done by the infectious disease consulting service.

Q. Who?

MR. SEIBEL: *Go* ahead, loolc at the chart, Doctor.

A. I am not sure exactly. I see a notation in the order sheet dated 11-27.

Q. By whom?

A. By the -- whoever this B person is from the ID service indicating that vancomycin, 500 I.V. Q6 approved through 11-29-87.

Q. Does that mean you stop it then or --

A. That's how I would interpret that, yes.

Q. You were the attending physician. Whose orders was it that stopped it? Was it yours or was it the infectious disease fellow?

A. The way that we work in conjunction with the infectious disease service is to communicate

with them but let them really call all the shots for specific choice of antibiotic and duration.

Q. Okay. So that was their decision then?

A, That's correct, but based on clinical findings that we would note as well, namely that the wound was healing.

Q. What kind of staph aureus was this? Was it in the methicillin resistant MRSA?

A. That's correct,

Q. What does that mean, Doctor?

A. That means that it is a particular brand **of** the staph organism that is not killed by the drugs that would kill the routine garden variety staph.

Q. So does that make it more difficult to treat?

A. Yes, it does.

Q. Is it your opinion, Doctor, that a two week course of I.V. antibiotics is an appropriate treatment for methicillin resistant staph aureus? Is that your opinion?

MR. SEIBEL: I will object to the Doctor rendering opinions that may be outside her area of expertise but if you can go ahead and answer, Doctor.

A. If you would ask if that were my opinion in this

specific case in dealing with a superficial wound problem that was healing well, yes, I would say that would be perfectly adequate. But this was not done with the idea that we were converting him from a staph carrier to a nonstaph carrier. That's an impossible condition to treat.

Q. Would you believe that he was, was a staph carrier?

A. I think there's ample evidence in this chart and previously that he is,

Q. How do you then try to prevent a recurrence of this happening specifically with it becoming worse in terms of its manifestations?

A. There's no easy answer to that. I don't think that there's a specific or that there was a specific drug regimen at that time that would prevent a recurrence of an infection in this gentleman, especially given that he had had this chronic infection problem with his ear, various other problems with ulcers on his feet, et cetera, so I think that the best answer is careful monitoring of them and having him come back at the first sign of anything that's new or different for him.

Q. What evidence is there that he had staph infections of his ear previously, Doctor?
A. He had the -- do you have the previous volumes of his hospital. record?
MR. KAMPINSKI: Do you have that?
MR. SEIBEL: We only brought from November '87 on.
Q. Have you reviewed them?
A. Yes, I have.
Q. And when did he have a previous staph infection?
A. I believe he had those sorts of infection going back as far as probably '82. Now, he also had the abscess in the arm that I treated him for in '81.
Q. Did that grow staph?
A. I believe it did. I don't remember the specific microbiology details.
Q. Okay. Any time after the '84 one did it show evidence of staph infection?
A. To be really sure I would have to review those records again.
Q. Which records?
A. But I believe so. The records from his prior hospital records before this date.
Q. Well, there was the '84 hospitalization when you

did the total knee, right?
A. That's correct.
Q. What other hospitalizations were there?
A. I believe that this hospitalization is volume four and prior to that there are obviously three previous volumes with various admissions.
Q. My question is which hospitalization did he have between this one in '84 and '87? Did he have any?
A. I don't recall.
Q. When you say chronic staph carrier, that to me as a layman means he's got it all the time?
A. That's correct.
Q. Is that what you meant to say?
A. He has the organism present and obtainable by culture but not causing any clinical infections all the time.
Q. By suturing the wound on the 14th day -- you did that by the way, did you not?
A. I believe one of the residents did that.
Q. At your direction?
A. Yes, that's correct.
Q. And what was the reason you did that, Doctor?
A. We wanted to get rid of that one little local source that was right over the knee prosthesis

and get that skin to heal up and close.

Q. Is that the standard of care for an infected prosthetic knee?

A. This patient did not have an infected prosthetic knee.

Q. Does the record -- did your residents diagnose it as an infected prosthetic knee?

A. That is what is written in the initial impression by Dr. Meyers, junior resident. That's not the correct diagnosis.

Q. If it were an infected prosthetic knee would it have been appropriate to suture the wound?

A. As I said, this wasn't an infected prosthetic knee, and the answer is no, it wouldn't have been treated this way at all. If it were an infected prosthetic knee it would have been opened and drained immediately as soon as it was diagnosed.

Q. Was Mr. Cates discharged on any regimen of antibiotics?

A. I don't believe he was.

Q. Whose decision was that?

A. I believe that that was infectious disease in conjunction with our service.

Q. When did you next see him?

MR. **SEIBEL:** After when?

Q. He was discharged. He was discharged December 2, right?

A. **I** don't see a date on the discharge order but I think it was December 2,

Q. When did you next see him?

A. As **I** recall, I saw him probably twice before I brought him back for formal excision of that area and surgery and I don't really recall the specific dates.

Q. That was on -- well, when you did the surgery was December 22, is that correct?

A. That's correct.

Q. And what was the reason for doing surgery, Doctor?

A. He continued to have breakdown in this area.

Q. And what does that mean, breakdown?

A. It means that along his old incision line there was a small area that just wouldn't heal back together again, and as we subsequently determined the reason, was fairly unusual, the pathology report from the excised specimen showed the presence of a rheumatoid nodule within that scar tissue. And again, **I** would point out that this is superficial external to

the prosthetic knee joint.

Q. Were there samples sent to the lab again, Doctor?

A. Yes, I believe that there were.

Q. And what did they look like?

MR. ZELLERS: This is from December 22?

MR. ICAMPINSKI: That's right,

Q. Did they look pretty good?

MR. SEIBEL: It wouldn't be in here.

Q. That's in your office notes I think, Doctor. Clinic Copy, right? How did they look, pretty good?

A. Let's see. We're looking at 12-22, time, 1555, date in lab, location with a swab of that, which had broken down again showed moderate growth, staph aureus.

Q. What is thio confirms?

A. Thio.

Q. Yes.

A. I believe that that's just a different culture medium that they process the specimen in in addition to the routine culture medium.

Q. By the way, when do you get these results back?

Do you get them right away?
A. That is pretty variable. The absolute minimum time that you would get a positive culture report back is in the range of 24 to 48 hours. If the lab doesn't find anything right away, it may not be for 5 or 7 days, and these papers may get shuffled around to various locations. Generally they go back to the clinic.
Q. I assume if you're interested you can just pick up the phone and call, though?
A. Yes, that's correct.
Q. Did you do that in this case?
A. No, I didn't because at the time of surgery the wound was clean and healthy looking and there was no evidence that there was a reason to be concerned.
Q. Well, did the lab results give you a reason to be concerned, Doctor?
A. Well, according to the -- according to my written note on this sheet.
Q. Let's deal with the written results, sir. Did they give you any reason to be concerned, ma'am?
A. I think in conjunction with the clinical appearance of the wound and the fact that he was doing well, the wound looked well, no, I wasn't

concerned.

Q. When I read here, Moderate Growth Staph Aureus Thio Confirms, how did you treat that?

A. That wasn't treated at all.

Q. Why not?

A. Because clinically the wound was doing fine and healing and we know that this man has a chronic staph carrier state and it's not necessary to treat every positive culture.

Q. Then why did you take the culture?

A, Routine, Culture of the specimen that we obtain from surgery.

Q. You have got a written note on there. When did you write that, Doctor?

A. The date, 12-30-87.

Q. I asked when you wrote it?

A. To the best of my recollection, that's when.

Q. And why don't you read it for me.

A. It says, translating the abbreviations --

Q. Is all the writing on there yours, the circling up above where it's got your name circled? I mean did you circle that?

A. I don't think that I would have circled my name. I have a feeling that this report went to the outpatient clinic.

Q. You have a feeling?
A. Well, I'm telling you that to the best of my knowledge the reason that my name is circled is that it went to the outpatient clinic where there are many people working, and someone put my name around it and then sorted it into a mail pile.
Q. Below that's a checkmark. Did you make that checkmark?
A. That's my checkmark.
Q. Why did you make a checkmark?
A. It's my habit to make a checkmark when I have noted something and dealt with it.
Q. If we look at the other clinic copy for November 13, there's no checkmark or is there?
A. In place of that this write-in chart which is my writing.
Q. You have got chart written on the other one?
A. It just indicates to my secretary that that goes into the chart.
Q. The checkmark was for what again?
A. I believe it's just my indication that I have dealt with this, sort of an internal note to myself.
Q. All right. How did you deal with it?

A. Discuss the situation with ID, if wound, it looks to me if wound fine, path report, rheumatoid nodule, exclamation point, wound check excellent.
Q. Why don't you read it from the beginning, 12-30-87. What does that say?
A. No RX.
Q. What does that mean?
A. Treatment. AB, antibiotic,
Q. Per ID?
A. Per ID if wound fine.
Q. Who is the ID?
A. I don't know who that person would be, per ID.
Q. Well, did you call him or her?
A. Oh, this indicates that I called them.
Q. Who did you call?
A. You know, I don't have a specific recollection, We work closely with infectious disease on many, many cases and I have told you the two possibilities of the names starting with B. So one or the other of those people.
Q. Would it have been the one you called on December 30, '87?
A. It most likely would have been -- it had to be the same person that was involved with him in

the hospital.
Q. Okay. So that person told you that there was no treatment necessary?
A. Well, this is sort of a discussion we would have about a patient, and it says if wound fine, and apparently at that point I didn't know if the wound was fine or not,
Q. Why didn't you know?
A. Because I hadn't seen him back yet.
Q. Didn't you see him on December 30?
A. I am not really sure. I suppose I must have because wound check excellent.
MR. SEIBEL: 12-30.
A. But this could have come in the morning or it could have come before he came.
Q. When did it come?
A. You know, I am not sure that I can actually tell you when it came. The wound -- the translation of my written notes here is that the decision was made if the wound is fine, clinically he is doing well, we'll not recommend any further antibiotics. Also if you look at the sensitivity patterns of this organism, there is no oral antibiotic that you could use anyway.
Q. Well, how about an I.V. antibiotic? Did that

ever occur to you, Doctor?
A. No. At this point there was no clinical indication to do that.
Q. But you don't even remember when you saw him or what it looked like. How do you know?
A. I do remember that the wound was doing well.
Q. Was it?
A. Yes. I guess if it weren't doing well he would have been admitted immediately.
Q. Either that or you would have been a bozo for not admitting him, right?
MR. SEIBEL: I'm sorry, can I have that read back, please?
A. I am not a bozo, Mr. Kampinski.
Q. Well, how did this man do after his wound looked fine on December 30, 1987? Did he do pretty good?
A. I have no knowledge of how he did until he came into the hospital on January 3, I believe it was.
Q. How did he look then? Did he look pretty good then?
A. I didn't see him on January 3rd.
Q. Did you see him at all afterwards?
A. Can you ask me specifically?

Q. When did you see him next, ma'am?
A. According to the record it's January 5th, '89, and according to my recollection I was called to see him in the intensive care unit when he was very sick.
Q. Gee, what was wrong with him?
A. Well, how detailed do you want me to be?
Q. As detailed as necessary to answer the question,
A. He, according to the records and what I was told and what I recall, presented basically septic with a history of acute onset of confusion, disorientation, high fever, provisional diagnosis of meningitis, I believe.
Q. And what was the organism?
A. That was also staph aureus. I am not certain if it was exactly the same sensitivity pattern as previous organism,
Q. You referred a moment ago, Doctor, to the pathology report, right?
A. That's correct.
Q. Indicating that there was a rheumatoid nodule formation?
A. That's correct.
Q. You see under persistent symptoms, physical and

x-ray findings up above where it says right knee wound, rheumatoid, presumably rheumatoid arthritis, rule out vasculitis?

A. That's correct,

Q. Is that what you had sent the sample for, to rule out vasculitis?

A. Yes. This typed notation here would have been a reflection of what would have been written on the request that went with the pathology specimen, and in my mind at that time I'm wondering why this wound was being so indolent. Chronic vasculitis associated with his rheumatoid disease was in my mind as a possibility.

Q. No active acute vasculitis was seen, correct?

A. Correct.

Q. So what was causing the problem,. as far as you were concerned, Doctor?

A. As far as I was concerned this explained the whole scenario in that he developed a rheumatoid nodule within the scar from his previous knee surgery, and the nodule not being of normal skin tissue didn't heal or broke down, subsequently became infected with his chronic staph. I'm sorry,. I lost my train of thought.

- - - -

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

- - - -

A. Okay. Let me carry on from there. The staph had been treated, the nodule had been excised and I had every expectation that that problem was healing and doing well.

Q. You were wrong, weren't you?

A. No, I really don't think that I was wrong.

Q. Where did the infection that he suffered from on December -- on January 2, 1988 come from, Doctor?

A. I have no way of knowing nor does any expert where this came from. This could have come from any number of sources around his body. He had some ulcers on his skin elsewhere, there was an ulcer on his back, I recall seeing when we had -- when he was readmitted to the hospital, he had this chronic cartilage infection of his ear which would intermittently break down and become infected. It could have come from the knee, it could have come from foot ulcers which he was chronically and intermittently afflicted with over the years.

Q. *So* you don't know?
A. Not with certainty, I don't know.
Q. How about with probability?
A. I don't know with probability either,
Q. What is the reason that you called infectious disease on December 30, 1987?
A. Most likely in response to their lab report.
Q. I mean to tell them the results or --
A. Well, being somewhat surprised that it's positive, maybe not surprised, but just to continue communication with them.
Q. I don't understand. I mean was it to convey Christmas greetings or what do you mean, continued communications?
A. Well, as I explained about how we work with the infectious disease service --
Q. Yes?
A. We work very closely with them, we confer back and forth about what is going on, what our recommendations might be as far as surgery, nonsurgery, dressing changes, what we think the wound is doing.
Q. C1inica11y?
A. Clinically.
Q. Yes?

A. And they, and in an ongoing dialogue, confer back with us to help make decisions about antibiotic choices.

Q. All right, So that you defer to them in terms of both the type of antibiotic as well as the duration, correct?

A. Well, I would say we confer with them, but we -- obviously they have the most up-to-date state of the art knowledge, and are in a better position to make the ultimate decision, but it's done in conjunction, really.

Q. Well, if infectious disease would have wanted to continue antibiotic treatment of Mr. Cates, I assume you would not have objected to that, you would have deferred to them in terms of their wisdom?

A. Most likely, yes.

Q. And I assume, assuming that you made this phone call December 30, 1987, if ID, whoever ID is, would have indicated he needs to be on antibiotics immediately, you would have complied with that also?

A. 1 think that's correct. I think we also need to look at the possible choices of antibiotics. If it were a simple matter of calling up a drug

store and saying get some Keflex and take it for a few days, that might influence your decision one way versus does this guy need I.V. antibiotics if clinically nothing serious is going on.

Q. If Mr. Cates and his families' recollection is that it didn't look very good clinically they'd be mistaken, wouldn't they, according to you?

A. Could you repeat that, please?

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

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A. Well, I think if their assessment was that if it didn't look good clinically at that point they would have done something about it, namely called Dr. Ballou or called me. Generally his pattern or habit was to get in touch with Dr. Ballou if anything was different or unusual.

Q. Apparently came to see you on December 30?

A. For a routine follow-up.

Q. Does it say that? I mean where does it reflect that December 30th, the day before New Year's years would be a routine follow-up?

A. Why not?

Q. Well, I don't know. Do you have a scheduling book somewhere that you keep?
A. I think they're probably around somewhere. I don't really know right now.
Q. Who would have them?
A. Who would have it?
Q. Yes.
A. Generally my secretary would have it but we have just moved from the sixth floor down here so I imagine it's in a box somewhere,
Q. Who is your secretary?
A. Ruth Tibbs.
Q. Was she also your secretary in December of 1987?
A. Yes, she was, unless she was on vacation.
Q. What is contained in your secretary's notebooks?
A. Her notebooks, appointment books?
Q. What are we talking about as far as the schedule, what kind of documents are we talking about?
A. In which records, in her regular appointment book?
Q. I don't know, Doctor. They're your records. I'm asking what they are.
A. But which records are you asking about?
Q. If there was a regular appointment for Mr. Cates

on December 30, where would that record be reflected?

A. It should be reflected in an appointment book.

Q. Okay.

A. Or as part of an outpatient chart somewhere on a piece of pink paper. The records could be in a number of places.

Q. Well, if it were part of an outpatient chart somewhere would it be in these records that we have got before us?

A. You would think that it should be but because this man has so many volumes of charts I noticed when I was looking through all of his records there are frequently notes misfiled chronologically out of order. Also when a person has recently been in the hospital an outpatient visit chart if he comes to the clinic occurs on a loose sheet of paper which may or may not get filed subsequently in the records.

Q. Is there anything in the chart that reflects he had a follow-up visit for December 30th?

A, I would really like to wait until I have looked through every piece of medical records --

Q. I thought you had.

A. -- available.

Q. I thought you had.
A. I haven't looked for that specifically.
Q. And you believe your appointment book for December of '87 is where?
A. It's somewhere in this orthopedics department.
Q. Where?
A. As I explained, we just moved so --
Q. Could you ask your secretary while we're here? She might know exactly where it is.
A. I really don't think so.
Q. Well, how do we know unless you ask?
A. Pardon me?
MR. SEIBEL: You want to make a document request, Chuck?
MR. KAMPINSKI: If it's here rather than come back and question the Doctor again. It only took us a year to ask her questions this time. Why don't you just ask. If it's here let's take a look at it.
A. Wait a minute. I just remembered something that I saw here.
Q. Go ahead, turn it around, go through whatever you need to, Doctor.
A. How about this'? This is a note from my secretary to me dated 12-23 which would be the

next day, Called, doing fine, no drainage, make appointment anytime. Thursday he can come. Now, this would be her --

Q. Let's go slow.

A. This would be him calling me, caller, Travis Cates.

Q. On December 23?

A. On December 23.

Q. The day after the surgery?

A. Right.

Q. And?

A. And he was most likely instructed to do that as part of the post-op discharge orders from the ambulatory unit.

Q. Okay.

A. When dress and change, what to do if gauze sticks.

Q. Okay.

A. He has FU, follow-up 10 a.m. Wednesday, 12.

Q. So that was what time he was supposed to come back for follow-up?

A. Apparently, yes.

Q. Did he come back or call any time after December 30th?

A. After December 30th?

Q. Sure. And before January 2nd?
A. I don't think so. At least I have no record that he did or didn't.
Q. And who's writing is this, Doctor?
A. This writing is my secretary. This writing is mine, MB.
Q. MB?
A. Mary-Blair.
Q. Oh, I see, This is a note from you to your --
A. This is to me.
Q. Yes.
A. Okay. From Travis with that information.
Q. Yes.
A. And then this is my response. This is just the way that you customarily deal with these little notes.
Q. Would all your phone messages relating to Travis Cates be in your file or just these?
A. I do make an effort to save and file all phone messages. Sometimes it's not always done but I think my secretary is pretty thorough in clipping these or collecting the little phone messages. I don't really recall that Mr. Cates very frequently called me. As I said before, usually he dealt with Dr. Ballou as his primary

intermediary. I didn't see phone messages through here.

Q. Did you remove the prosthesis?

A. No, I did not remove the prosthesis.

Q. Did anybody?

A. Not to my knowledge.

Q. How was he treated in the hospital in 1988? Were you involved with that treatment at all?

A. Yes, I was.

Q. And what was your involvement?

A. I was urgently called to see him in the intensive care unit and we took him to surgery and opened and drained both knees which had been found to have pus in them.

Q. So I guess the pus got in there between December 30th and January 2nd, right?

A. Apparently so. I am not certain of that, actually.

Q. No? When did it get in there?

A. It may have been in there for an indefinite period of time.

Q. So that the needle aspirate just didn't get into the right place. Is that what you're saying?

A. You mean the original needle aspirate?

Q. Yes.

A. I'm sure that that was in the right place.
Q. All right. Maybe I just didn't understand the answer that you gave me a moment ago. You just said that --
A. Repeat the question.
Q. Yes. You just told me that the pus may have been in there for some extensive period of time?
MR. SEIBEL: She stated indefinite period of time.
Q. I'm sorry?
A. I really don't know but I know that when we took him to surgery on January 5th or I believe it was January 5th, and the knees had been aspirated the day before, there was pus in them.
Q. Well, once again my question is when did that pus get in there?
A. I don't know,
Q. Was it there when you saw him on December 30th?
A. Clinically it was my impression that it wasn't.
Q. You keep saying clinically. I mean are you talking about looking at it?
A. I'm talking about looking at a man that looks his usual state of health,
Q. What did the knee look like?
A. I don't think that the knee gave me any cause

for concern.

Q. What did it look like?

A. It would have had sutures from the excision.

Q. Was there pus coming out of it?

A. No, there wasn't.

MR. KAMPINSKI: All right, Can we have an agreement as to having all her records copied and then the court reporter can give her back her originals and provide copies?

MR. ZELLERS: I need copies,

MR. KAMPINSKI: Is that okay with you?

MR. SEIBEL: Well, I can take the original and make copies for everyone if that's what you'd like to do.

MR. KAMPINSKI: I meant the court reporter make copies. I have tried to get them through you guys and, you know, I have had a lot of trouble with that.

MR. SEIBEL: I have no objection to the court reporter taking the original file and making a copy for everyone and returning the original file to me.

MR. KAMPINSKI: Okay, that's fine. You want it as opposed to the Doctor.

MR. SEIBEL: Yes, I'll take it.

MR. ZELLERS: I want a copy, too,

MR. KAMPINSKI: All right. If I could have just a moment I think I will be able to finish up fairly quickly.

1 don't have any more questions.

Mr. Zellers.

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CROSS-EXAMINATION OF MARY-BLAIR MATEJCZYK, M.D.

BY MR. ZELLERS:

Q. I have got just a couple, Doctor. I'm Mike Zellers and I represent Metro General Hospital which is now MetroHealth Medical Center.

A. That's correct.

Q. Do you have any criticisms of any of the physicians or residents at Metro General. Hospital as it relates to this case and the treatment of Mr. Cates?

A. Can you be specific?

Q. Sure.

A. That's a pretty broad question.

Q. There were orthopedic residents who were working with you I guess in conjunction with Mr. Cates, is that correct?

A. That's correct.

Q. And those orthopedic residents 1 would assume were working under your direction and control?
A. That's correct.
Q. Do you have any criticisms of any of the orthopedic residents in this case?
A. **Well,** I think my one minor criticism is the admitting diagnosis put down by Dr. Meyers of the, whatever it was, infected prosthetic knee.
Q. You don't believe that ultimately turned out to be correct, is that true?
A. That's true.

MR. KAMPINSKI: Objection.

Ultimately it was, in fact, correct.
Q. In terms of that specific admission, you don't agree with it, is that right, that admitting diagnosis put down by Dr. Meyer?
A. I think admitting diagnosis is a provisional diagnosis but when I examined Mr. Cates on November 13th in my opinion he was incorrect or perhaps simply vague in the way that he wrote the words in the chart.
Q. So as of November 13, as of that same day you had examined the patient and made your own decision in terms of what the diagnosis was --
A. That's correct.

Q. -- did the diagnosis, provisional diagnosis put down in the chart and the admitting history and physical by Dr. Meyer have any adverse consequences to him in terms of that admission?

MR. SEIBEL: To Mr. Cates?

Q. To Mr. Cates?

A. I really don't think it did.

Q. Because as of the 13th, you had seen him and you were in charge of the patient as of that time?

A. That's correct.

Q. Okay. Other than that, do you have any other criticisms of the orthopedic residents in this case?

A. At this time, not that I can think of.

Q. What does that mean at this time?

A. As I said, that's a pretty broad question and I haven't gone over word by word specifically --

Q. If at some point as you review this case, and if you do develop criticism of the orthopedic residents, can you communicate those to our lawyers? Would you do that?

MR. ZELLERS: And then Rob, will either you or John let me know?

MR. SEIBEL: Sure.

A. Sure.

MR. ICAMPINSKI: Well, can we know, too?

Q. But you'll do that, is that correct?

A. Yes, I will.

MR. KAMPINSKI: Which, let you know or let everybody know?

MR. SEIBEL: E think we're confident if the Doctor will let me or John Jackson know, but if we do get that information we'll deal with it at a later point.

MR. ZELLERS: But I ask you, Bob, if the Doctor has criticism of the orthopedic residents if she has not given me today --

MR. KAMPINSKI: Wait a minute. This is a deposition and if you're asking her a question on deposition that you want her to supplement I think I'm entitled to that information, too, if it gets supplemented.

MR. ZELLERS: You ask whatever questions you want. I'm asking this question now.

MR. SEIBEL: Mike, you are asking me, it's not my deposition.

MR. KAMPINSKI: Whose deposition is it?

MR. SEIBEL: It's the Doctor's deposition. You asked me whether I would give you that information and at this point I told you if the Doctor develops that information I'm sure I will know about it and we'll deal with it in the appropriate kind of way.

MR. ZELLERS: So you are not saying you'll tell me?

MR. SEIBEL: That's right.

Q. Doctor, what possible criticisms do you have of the orthopedic residents in this case at this time?

MR. SEIBEL: She just told you that.

A. At this time I have no specific criticisms of the orthopedic residents.

Q. What criticisms if any do you have of the nurses in this case?

A. I haven't really thought about it from that point of view but I have no specific criticism of the nurses.

Q. If you develop criticism of the nurses are you going to tell your lawyers about it?

A. Yes, I will.

Q. Okay. What criticisms do you have of the

infectious disease service in this case, if any?
A. I have no specific criticisms of the infectious disease service.
Q. Do you have any general criticisms of the infectious disease service?
A. No, I don't, I'd like to point out I think that we have one of the finest infectious disease services of any hospital in the city.
Q. So in terms of recommendations made in this case relating to treatment of Mr. Cates you have got no criticisms of those recommendations, is that correct?
A. That's correct.
Q. Now, in terms of the lab slips, there were a couple of original lab reports in your office records that I have not seen and are not contained in your chart itself, or at least not the copy of the hospital chart that I have seen?
A. They should be.
Q. Okay. Well, how come -- can you pull those out for me, the green and white slips, the ones, the ones you have got your writing on, one dated December 13th or at least it has December 13th at the top and the other December 30th? They're in your chart, You just looked at them.

A. Your chart. You are getting copies of the chart so you'll have that.
Q. I know. I'd like to ask you some questions about it.
A. Okay.
Q. Can you look at them?
A. The green sheet?
Q. Yes.
A. This is really the only lab report I have in here.
Q. The only -- and I guess what I'm trying to get at is those look like original documents as opposed to copies of lab reports, is that correct?
A. These may be one of a set of original copies. I am not sure exactly how the lab processes this type of report as opposed to those computer printouts that we saw that were continually updated, I don't know.
Q. In terms of your chart you have got two green and white lab reports, is that right, eight and a half by eleven lab reports?
A. Right.
Q. And there's pen markings on each of them, your name is circled on each of them?

A. Right.
Q. And they say Clinic Copy at the top?
A. Right.
Q. And one I guess is dated November 13th of '87?
A. Right. The one that says AFB culture.
Q. Okay. And the other one is dated December 30th of '87?
A. That's correct.
Q. And that's the one that contains the handwriting, your handwriting on it?
A. That's correct.
Q. And it starts at the top with your name circled and then a checkmark and under that it's got chart and then at the bottom it's got wound check excellent?
A. Correct.
Q. Now, do you know how that document is generated? I guess it's generated by the lab?
A. Right.
Q. When it says Clinic Copy, what clinic are they referring to?
A. I think that that means outpatient clinic.
Q. Okay. Are these records kept differently than inpatient clinic records or inpatient records?
A. Well, they all should ultimately get into the

patient's entire medical record, including inpatient and outpatient.

Q. Is there an outpatient clinic chart relating to Mr. Cates?

A. No. That's separate from his ongoing record.

Q. When it says clinic does that refer to orthopedic clinic?

A. Not specifically,

Q. It's just a general clinic of which a part of that is orthopedics?

A. It appears to me that somewhere along the line they have changed the laboratory report generating procedures, and I say that because most of the things that we looked at today look like computer generated kind of updates and things which looks different from this document, and it may simply be the difference in handling between inpatient and outpatient. I am not sure. I thought those all came from the same lab.

Q And when we're talking about document, just so we're straight, we're referring to this December 30th document with your handwriting in the lower right-hand corner. Do you know who else if anyone were to receive a copy of that lab

report?

A. I really don't know. I think the fact that it says copy indicates that there is another set of these that went somewhere. Whether it's to the medical records or --

Q. You don't know, is that correct?

A, I don't know,

Q. Did you look through the chart in this case, I mean the hospital chart?

MR. **SEIBEL:** I believe those copies of those reports are in the outpatient records for this patient.

Q. Did you see them in the outpatient record, Doctor?

A. I looked through almost all of his records and one thing that I did notice, that there are various pieces of paper that are not filed chronologically, so -- I think that it's in there somewhere.

Q. Did you see it when you went through it?

A. I don't recall specifically.

MR. **ZELLERS:** Bob, do you recall seeing it when you went through it?

MR. **SEIBEL:** The copy I have, at least a copy in the group of records that I have

labeled outpatient records of that particular lab report that I was given from the hospital.

MR. ZELLERS: Could you help me find it? I just can't find it.

MR. SEIBEL: Let me see the second page of that.

THE WITNESS: I think they're completely different.

MR. SEIBEL: Okay. Here is one.

MR. ZELLERS: That's not an outpatient, that's an inpatient.

MR. SEIBEL: It's the same report. It's on the same format. That's what is confusing. Actually it says outpatient lab report. And this says outpatient lab report.

MR. SEIBEL: Here it is.

MR. ZELLERS: These are outpatient records?

MR. KAMPINSKI: Can we see that?

MR. SEIBEL: For the record, our nurse/paralegals have taken the copies of the medical records that were given to us by the hospital and organized them in a way that they have removed and separated all the outpatient records for this patient into one volume.

A. Within the original record they're mixed in.
Q. Now, how do we know -- can I see what you're looking at? So your understanding of this would be that one copy or the original would have gone to the outpatient records or whoever keeps, I guess it's got a stamp here that says medical records, and then you would have gotten a copy or the clinic would have gotten a copy so at least there were two generated. Is that your understanding?
A. I think that's an understanding. As we have noted, though, the format of the lab reporting system is confusing.
Q. There are a lot of records in this case. Are you aware of any notes or any records at all relating to a December 30th visit other than, you know, what is contained on these **lab** reports, the lab reports dated December 30th?
A. At this time I am not aware of any.
MR. KAMPINSKI: I'm sorry to interrupt you but let me get something straight. This came out of the hospital record?
MR. SEIBEL: Referred to me by the hospital, yes.

MR. KAMPINSICI: I'm sorry, go ahead.

MR. ZELLERS: You want a copy, Chuck? 1 will be happy to give you that. Why don't we mark that. I have never seen it quite frankly.

MR. SEIBEL: It has a different heading.

MR. KAMPINSKI: That's my point.

MR. ZELLERS: It may well be in there. The record's three feet thick. 1 guess we'll mark, I guess what I'd like to mark is just a copy of what we think is the original lab report dated December 30th, '87 which says Outpatient Lab Report at the top as Defendant CMGH's Exhibit 1.

MR. KAMPINSKI: But it also says Cleveland Metro General Hospital at the top whereas the Doctor's copy says Clinic Copy at the top.

MR. SEIBEL: This might be a multi-part document, has different headings.

MR. KAMPINSKI: I don't disagree.

MR. ZELLERS: We'll mark what is in the Doctor's chart Defendant CMGH's Exhibit 2.

Q. Doctor, in terms of the note that you got on the lab report, that's your only note from December 30th, is that correct, that you're aware of right now?
A. I didn't find any other notes,
Q. But everything on here is your handwriting?
A. With the exception of the circle. I would have no reason to circle my own name.
Q. It looks like you would have called infectious disease?
A. To the best of my knowledge, yes.
Q. All right. And I believe that what you have got written there is no -- is that no treatment antibiotic per infectious disease? What does RX mean?
A. Treatment.
Q. If wound fine. Would you have asked a question of infectious disease? I mean do you recall the conversation at all?
A. We had encountered this situation really quite frequently. In fact, I'm dealing with a patient right now in a similar set of circumstances, so generally when it would happen we would say hey, I got this positive culture in this and this setting in a patient that you know has this and

this organism, what do you think. And then we might say gee, it's easy to treat, let's just do this, it's not going to -- we would talk things over that way. And this situation comes up a lot.

Q. With infections in an orthopedic patient is it ultimately a joint decision in terms of what type of antibiotic and the duration or is this a decision made by infectious disease?

A. Generally speaking it's a decision made by infectious disease in concurrence with the orthopedic department.

Q. Do you have a say in that decision?

A. What do you mean by say? It's kind of a consensus decision if you want to put it that way.

Q. So I guess you have input into the decision?

A. We have input from our clinical knowledge of the patient and their -- from the background of their specific orthopedic problem.

Q. Is the clinical knowledge of the patient important in terms of deciding what type of antibiotic or for how long it should be continued?

A. Yes, it is.

Q. Did anyone from infectious disease see Mr. Cates on December 30th?
A. I really don't have any direct way of knowing that.
Q. From your note can you tell me one way or the other whether someone from infectious disease saw the patient?
A. I don't think that it's likely but it wouldn't be impossible.
Q. So if I understand your note, infectious disease told you that it would be all right not to give antibiotic treatment if the wound was fine or looked fine?
A. Right, and I think the reasoning behind that is that this specimen is from tissue that was widely excised at surgery, so to my way of thinking this positive culture is now gone and removed from his body.
Q. so --
A. This specific circumstance.
Q. So I take it then once you got that advice or that input from infectious disease you then went and you looked at Mr. Cates' wound?
A. Right.
Q. And your observation and your clinical judgment

was that the wound was excellent? Is that your note?

A. That's my note, yes. I'm quite certain that if it weren't excellent he would have been readmitted to the hospital and had an entirely different course.

Q. And you would have done that, right? I mean you would have admitted him if the wound did not look excellent?

A. Yes.

Q. And if the wound didn't look fine would you have checked back with infectious disease to see what should be done?

A. Yes.

Q. But in terms of the specific discussion with the infectious disease person on December 30th, do you remember any more details than you have already given us today?

A. At this time I really don't.

Q. Is it an oversimplification to say that you don't treat just lab values, but you have to treat the overall clinical picture when you're looking at an orthopedic infection?

A. That's really not an oversimplification about any patient with an infection.

Q. So you'd agree with that statement?
A. Little confused with the double negatives but I think I agree with you.
Q. Okay.

MR. ZELLERS: I have got nothing further. Thank you.

MR. KAMPINSKI: Just a few things.

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FURTHER CROSS-EXAMINATION OF MARY-BLAIR MATEJCZYK, M.D.

BY MR. KAMPINSKI:

Q. You don't ignore lab values though either, do you, Doctor?
A. I think that you take them into consideration along with the rest of the picture.
Q. So the answer is you don't ignore them?
A. I really don't like the way that you're saying that.
Q. Can you answer it? Whether you like it or not, can you answer it?
A. Can you define ignore?
Q. Ignore in the context of not doing anything about the fact that somebody's got an infection?
A. You may not do anything about a positive lab value.

Q. Doctor, if you would refer back to the progress notes, please,, for November 14th. We stopped reading that infectious disease note.
A. Right.
Q. Okay. We stopped at I think right knee found to have appreciable?
A. Effusion.
Q. Effusion and superficial right knee ulcer with, what is that, obvious purulent --
A. I think we decided it was obvious.
Q. Purulent drainage?
A. Right.
Q. And what does the next sentence say?
A. This is very small writing. It's difficult to read.
Q. Admitted to the orth service?
A. Okay.
Q. For probable septic right knee, paren, (prosthetic knee)?
A. Correct.
Q. That's not your resident writing that, right? That's the infectious disease person?
A. Infectious disease person.
Q. So he or she was wrong also then, right?
A. Well, either that or they're just simply

repeating or recapping or reiterating information that they got from somewhere else.

Q. Sure. Well, if you go to the next page, Doctor.

A. I think if you're asking me to continue the note, the aspirate --

Q. Read the whole thing. I asked you to do that before. Go ahead.

A. Knee aspirate fluid clearly or cloudy, bloody, probably drainage with 614. I'm not sure exactly what that number means. It might be the cell count although it's different than the number we have talked about on the lab. TP3 gram. Here we go. 216 white cells. Probably this is polys, 6 percent. This is the differential, lymphocytes, 84, which again, is not typical of infection. Monos, 10. Gram stain of the fluid with polys -- I can't make out that word. No identifiable bacteria noted.

Q. Now, this is November 14th at 10 a.m. he is writing this note, right?

MR. SEIBEL: He or she.

MR. KAMPINSKI: Right.

Q. Whoever the ID is?

A. That is the date and time on it, but I think

that this is not a note that was contemporaneous with the time they saw him.

Q. When was it written?

A. I think it may well have been written on the 14th but if you look --

Q. The next note is November 14th at 3:30?

A. That's correct, but if you look back in the orders I believe that they ordered antibiotics, infectious disease ordered the antibiotics at November 13th at 8:30 p.m. so they were seeing him, treating him and then just writing the summary of the next day.

Q. All right. The point, though, I guess that I'm trying to make is he already had the lab results, correct, when he wrote this note whether it was the 13th or the 14th?

A. That's correct. At least these preliminary lab results would have been available within a few hours.

Q. When did you get the results of the tests done on November 22nd, I'm sorry, December 22nd? When did you get it?

A. Are you talking about the culture?

Q. Yes.

A. I really don't know but a culture takes several

days whereas the examinations of the gram stain, the results are available virtually within a few minutes.

Q. Well, I thought the last, sentence was no identifiable bacteria noted. Isn't that what you said?

A. On the gram stain which is a different test than the culture --

Q. Go ahead.

A. Continuing on to the next page. Swab of right knee, pustule arrow, positive staph.

Q. I'm sorry?

A. Arrow positive staph.

Q. Well, how did they get that information?

A. I believe that that is a gram stain of the swab, although I am not certain from the way it's written.

Q. As opposed to a culture?

A. As opposed to a culture. I can't be sure from the way that this is written. Exam something for nontoxic appearance, meaning that he didn't look sick.

Q. Let me stop you again just so I'm operating on the same sensors you are. The December 22nd one is a culture as opposed to gram stain?

A That's correct.
Q Okay. *Go* ahead. I'm sorry.
A Oh, exam significant for nontoxic appearance.
Q Meaning he wasn't septic?
A Meaning he wasn't sick.
Q Septic?
A Correct.
Q *Go* ahead.
A Probably pleasant, cooperative white male. Severe rheumatoid changes involving hands, ankles, feet, elbows.
Q Why don't we skip down. Why don't we skip down to -- is that assess? Do you see that, the middle of the page?
A Okay.
Q That's the assessment?
A There's a lot of other information in here about a buttocks abscess, no cellulitis, bilateral effusions, very little pain, no arrythmia, warmth.
Q Assess?
A Assess.
Q Uh-huh.
A Probable septic, prosthetic right knee with superficial furuncle over patella, and I have

pointed out the reasons that I disagree with that wording.

Q. Sure.

A. Severe RA. On steroids. Probable mitral regurg. murmur with, I think that's history of rheumatic fever.

Q. And --

A. Continue?

Q. Yes, sure. What is the next one?

A. Suggest patient started. on Nafcillin I.V., two grams I.V., Q4 last p.m.

Culture for staph carrier. Right ear culture, may need biopsy of this nonhealing ulcer.

Number four, Will require repeat aspirate of the, looks like right ear. It's an illegible word. Local care to, it looks like buttocks abscess. Will check cultures.

Q. This Dr. Meyer, is he still at the hospital?

A. He's a resident in the orthopedic program. He is not at this hospital.

Q. Where is he at?

A. Right now? He's either at University or at the Veteran's Hospital.

Q. On November 17th there's a note by Dr. Meyer.

If you would turn to it, please. Do you see that where it says ortho?

A. At the bottom of the page?

Q. Yes. What does the third line say after *O,* what does O mean?

A. I think it means objective.

Q. Okay. It's part of the --

A. Right.

Q. *Go* ahead. What is it?

A. It says, Right knee, wound center with less purulent drainage, decreased swelling and arrythmia,

Q. *So* there was still purulent drainage on the 17th? I mean less but still some?

A. I think that's a vague and subjective description. There were times through here where there was no drainage, serious drainage, various descriptions by various people.

Q. Sure. That all gets into what you were referring to before as the clinical picture, right?

A. No. I think it's different than the clinical picture in that it's words that may not have a specific and precise definition to each person that's using them.

Q. Well, let's go to what the nurse saw. How about November 17th at 5:30? You want to turn the page? You got this under, let's see, oh, what does it say there?

A. Tell me again where you are looking.

Q. Sure. November 17th. Do you have that, that O? What does that say?

A. O, quoting from the nurses' note, Right knee, dressing. Right knee dressing changed for small thick yellow drainage, Wound, yellow tissue. Normal saline wet to dry. NSWD applied.

Q. That was Nurse Nagy, right? How about if we go to November 18th at 3:30? What did she see under *O?*

A. Scant amount, thick yellow drainage. I think if you're going to read every nurses' note that says one thing you should read every nurses' note that says another thing, too.

Q. One of the wonderful things about the law is my client gets an attorney, you get an attorney, and I get to ask you questions and some day he will, too. November 19th ortho note for Dr. Meyer. Do you see that, Doctor?

Yes, Subjective, I feel better today than any other day since I have been here.

Q. How about *O?*
A. AVSS.
Q. What is that?
A. Afebrile, vital signs stable.
Q. How about the wound?
A. Wound decreased, drainage decreased, swelling.
Q. So there was still some drainage then?
A. As you would expect. It's an open wound.
Q. Before he was discharged, Doctor, on the 30th of, I'm sorry, on the first of December you see the nurses' notes from M. Schrem, RN at 1:30 p.m.
A. Okay.
Q. Do you see that, ma'am?
A. It looks like Schrem, S C H R E M.
Q. Why don't you read that note?
A. Problem, quoting from the nurses' note, Impaired skin integrity. Subjective, quote from the patient, Bad news, it started draining. Objective, Wound closed with suture intact, no drainage, S slash.
Q. On old dressing?
A. Without drainage on old dressing this a.m.
Q. *Go* ahead.
A. This p.m. after patient ambulating, wound

drained small amount, clear sanguinous drainage. Dr. Meyer notified. Wound culture sent. Patient complains of arthritis pain this a.m., medicated times one with Percodan one tab, Vistaril, 25 milligrams. Afebrile. Assessment, wound drain small clear sang, means bloody drainage.

Q. Could you show me the results of that culture, Doctor?

A. Not real quickly but I would assume that they're in here somewhere.

Q. Well, why don't you point it out to me.

A. Have you seen them in yours before we go churning through the lab reports again?

Q. I haven't.

A. Maybe if I start from the back. Okay. I have this 12-1. That was sent to the lab, 1628, and then I have, here we go, final ID, organism one, one colony, coagulation, negative staph which was a contaminant most likely.

Q. I beg your pardon. I don't understand what you just said. This is the December -- which volume is this in?

MR. SEIBEL: This is the next admission, Chuck.

Q. That's the --

MR. SEIBEL: 13.

A. It looks like it was filed in the subsequent volume.

Q. Okay. Fine. So what we have got -- by the way, is this an aspirate or a swab or can't you tell?

A. Swab.

Q. Swab.

A. This was of the small amount of drainage.

Q. It says plates yield one colony coagulase, negative staph. What does that mean, one colony, coagulase?

A. That's not the original infecting organism and most likely an insignificant culture.

Q. What is one colony coagulase? Is that an organism?

A. Well, one colony, and again, I am not an infectious disease expert, but I believe when they plate it out on the round plate, a truly positive culture will have many, many colonies. During the laboratory process it's possible that one germ fell on that one plate or a germ got onto the swab and produced one colony of a nonpathogenic organism, so it's an insignificant

Q. What about thio yields enterobacteria?
A. The fact that it's not on the plate indicates that it's not a true positive culture.
Q. What does the word enterobacteria mean?
A. That's just another type of germ. It comes from the bowels. So basically that culture was negative.
Q. Resistant to Ampicillin and to Cefazolia. What does that mean?
A. Preliminary organism -- I think that's referring to this. It looks like the sensitivities were run through -- these are the various antibiotics.
Q. Doctor, on December 22nd why didn't you do an aspirate of the knee or did you?
A. No, 1 didn't do it because I had no clinical reason to suspect that the knee was involved in -- was probably thinking that it wasn't worth taking a risk of introducing a needle into the knee joint again. There was really no --
Q. You were doing surgery, weren't you, on this --
A. Sure. We were in the operating room.
Q. Say that again. You didn't want to introduce a needle into the joint. Is that what you just said?

A. I really saw no clinical reason to even be worried at that point that the knee joint had pus in it.
Q. So you just did swabs?
A. Of the area around the ulcer that was excised.
Q. And you got moderate growth staph from the swabs, right?
A. Right.
Q. And didn't treat it?
A. That's correct.
MR. SEIBEL: With antibiotics?
A. Okay. With antibiotics, I really did not feel there was a clinical reason to treat that.
Q. The staph that grew out, was it resistant to antibiotics?
A. Are you referring to this report?
Q. Sure. The sensitivities are listed here, Clindamycin, Tetracycline and Vancomycin. Resistant to Cefazolin, Erythromycin, Oxacillin and Penicillin.
Q. Is this the same strain that had been treated when he was in the hospital earlier?
A, I am not really sure.
Q. Why don't you take a look?
A. I assume that it was,

Q. You assume that it was. Well, he was treated with antibiotics for it before, wasn't he?
A. Yes. He has been on antibiotics and then off antibiotics at the time this was taken.
Q. And my point though is whether it was found to exist before he was treated with antibiotics, correct?
A. He was treated with Vancomycin, yes.
Q. And I thought you told me earlier that if it's resistant to methicillin that it's harder to treat, correct?
A. Not necessarily it's harder to treat, it's what I meant to say when we were having that discussion was that it's hard to eradicate totally from the body.
Q. Especially if you don't keep giving antibiotics, isn't it? It makes it even tougher?
A. I think that for methicillin resistant staph you can treat that with antibiotics forever and never get rid of it.
Q. Or you can treat it for -- well, are you saying that a treatment of 14 days is inadequate?
A. No. I'm saying that for the soft tissue infection that he had, 14 days of treatment is adequate.

Q. Do you have any literature that would suggest that a treatment of days as opposed to months and maybe years is appropriate for this strain of staph?

A. In what clinical setting? In a soft tissue isolated local setting?

Q. Okay. Let's use that if that makes you feel good.

A. Well, I don't have any literature at my fingertips concerning that.

Q. Well, are you aware of any?

A. I really don't read the infectious disease literature but I think that it would be generally accepted for soft tissue infection. Two weeks of I.V. antibiotics would be appropriate course of treatment.

Q. Okay. And then when it recurs or when it's found again as a result of cultures that you don't reintroduce antibiotics, any literature even if you call it soft tissue or whatever you want to call it that you don't restart antibiotics, Doctor?

A. I haven't really searched the literature for that specific point.

MR. KAMPINSKI: That's all. I

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.

C E R T I F I C A T E

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

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

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

_____
Aneta I. Fine, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires February 27, 1991

CURRICULUM VITAE

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EDUCATION

M.D. cum laude	Medical College of Pensylvania Philadelphia, Pa. (1975)
B.S. cum laude	(Physics) Allegheny College Meadville, Pa. (1971)

POST GRADUATE TRAINING

Internship	Cleveland Clinic Foundation Cleveland, Ohio (7/75 to 6/76)
Residency	Cleveland Clinic Foundation Cleveland, Ohio (7/76 to 6/80)
Fellowship . Pediatric Orthopaedics	Hospital for Sick Children Toronto, Ontario (7/80 to 6/81)

ACADEMIC APPOINTMENTS

Instructor Orthopaedic Surgery
Case Western Reserve University (8/81 to 8/82)
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Assistant Professor Orthopaedic Surgery
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Cleveland, Ohio 44106

HOSPITAL APPOINTMENTS

University Hospitals Medical Staff (8/81 to present)
Cleveland, Ohio 44106

Cleveland Metropolitan General Hospital (8/81 to present)
Cleveland, Ohio 44109

BOARD CERTIFICATION

American Board of Orthopaedic Surgery, 1982

MEDICAL LICENSE

Ohio (#25-04-6116) (May 1981)

Ontario (#21728) (inactive)

HONORS

A.O.A. North American Traveling Fellowship (1980)

Kappa Delta, American Academy of Orthopaedic Surgeons Orthopaedic Research Award (1979)

SICOT International Orthopaedic Research Award (1978)

William E. bower Fellowship Thesis Prize (1978)
Cleveland Clinic Foundation

Albert E. Klinkicht Research Award
American Orthopaedic Foot Society (1976)

Alpha Omega Alpha Medical. Honor Society (1975)
Medical College of Pennsylvania

Senior Medical Student Surgery Prize (1975)
Medical College of Pennsylvania

Lange Award Outstanding Junior Medical Student (1974)
Medical College of Pennsylvania

Sigma Xi Undergraduate Student Research Award (1970)
Allegheny College

SOCIETY MEMBERSHIPS

American Academy of Orthopaedic Surgeons (1983)

Cleveland Orthopaedic Club (1982)

American Association of University Women (1971)

American Medical Women's Association (1975)

Orthopaedic Research Society (1977)

HOSPITAL COMMITTEES

Orthopaedic Clinic Management Team (1983)

CMGH Subcommittee of the Medical Executive Committee (1981)

CMGH Housestaff Committee (1981)

CMGH Utilization Review Committee (1981)

PROFESSIONAL ACTIVITIES

Arthritis Foundation Speaker's Bureau (1984)

Arthritis Foundation Subcommittee on Business and Industry (1986)

PUBLISHED PAPERS

1. Preliminary Observations on the Weight-Bearing Surfaces of the Human Ankle Joint. Greenwald, A.S., Matejczyk, M.B., Keppler, L.D. Surgical Forum XXVII:505, 1976,

2. Design Development, and Clinical Application of a Total Wrist Replacement. Greenwald, A.S., Matejczyk, M.B., Porritt, D.L. et al. Joint Replacement in the Upper Limb, Institute of Mechanical Engineers, London, 1977.

3. Pathomechanics of the Human Ankle Joint. Greenwald, A.S., Matejczyk, M.B. Bull.. Hosp. Joint Dis. XXXVII, 2:50, 1987.

4. Effect of Gentamicin on Shear and Interface Strengths of Acrylic Bane Cement. Moran, J.M., Greenwald, A.S., and Matejczyk, M.B. Clinic. Orthop. 141:95, 1979.

5. Reversible Cartilage Staining Technique for Defining Articular Surfaces, Black, J.D., Matejczyk, M.B., and Greenwald, A.S. Clin. Orthop. 159:265, 1981.

6. Stability Characteristics of Total Knee Replacements, Greenwald, A.S., Black, J.D., and Matejczyk, M.B. A.A.O.S. Instructional Course Lectures XXX:301, 1981.

~~BOOK~~ CHAPTERS PUBLISHED

I. Knee Joint Mechanics. Greenwald, A.S. and Matejczyk, M.B. Total Knee Replacement, A.A. Savastano, ed. Appletan-Century Crofts, New York, 1980,

2. Management of Fractures in Neuromuscular Disease. Problem Fractures in Children, Thompson, G. and Houton, 6. eds., Butterworths, London, 1983.

3. Biomechanics of Ankle Fractures. Fractures of the Ankle, Yablon, I. ed., Churchill-Livingston, New York, 4983.

4. Biomechanics of the Hip (Chapter 3) and Biomechanics of Total Hip Replacement (Chapter 44) with Greenwald, A.S., The Hip and Its Disorders, M.E. Steinberg, W.B. Saunders, Philadelphia, to be published in 1988.

PUBLISHED ABSTRACTS

1. Clinical Applications and Properties of Acrylic Bone Cement. Greenwald, A.S., Wilde, A.H., Matejczyk, M.B. Trans. of the Orthopaedic Research Society 2:56, 1977.

2" Rotational Characteristics of Non-Hinged Total Knee Replacements. Greenwald, A.S., Matejczyk, M.B., Black, J.D. Trans. of the Orthopaedic Research Society 2:70, 1977.

3. Articular Cartilage Contact Areas of the Ankle. Matejczyk, M.B., Greenwald, A.S., and Wilde, A.H. Trans, of the Orthopaedic Research Society 2:70, 1977.

4. Relation Between Mechanical Strength and Antibiotic Concentration for Palacos R with Gentamicin. Moran, J.M., Matejczyk, M.B., and Greenwald, A.S. Trans. of the Orthopaedic Research Society 3:310, 1978.

5. Pressure Distribution Across the Articular Surfaces of the Ankle Joint. Wynarsky, G.L., Greenwald, A.S., and Matejczyk, M.B. Trans. of the Orthopaedic Research Society 3:90, 1978.

6. Ankle Implant Systems: Laboratory Evaluation and Clinical Correlation, Matejczyk, M.B., Greenwald, A.S., and Black, J.D. Trans. of the Orthopaedic Research Society 4:114, 1979,

a. Effect of Surgical Approach in Surface Replacement of the Canine Hip. Nelson, E.F., Matejczyk, M.B., and Greenwald, A.S. Trans. of the Orthopaedic Research Society 5:177, 1980,

a. Mechanical Characteristics of Patello-Femoral Replacements. Cepulo, A., and Matejczyk, M.B. Trans. of the Orthopaedic Research Society 8:41, 1983.

SCIENTIFIC EXHIBITS

1. Selection of Non-Hinged Total Knee Replacements. Greenwald, A.S., Matejczyk, M.B., Black, J.D., and Wilde, A.H. (A.A.O.S. Annual Meeting, Las Vegas, February, 1977).

2. Ankle Joint Mechanics and Implant Evaluation. Matejczyk, M.B., Greenwald, A.S., Black, J.D., and Wilde, A.H. (A.A.O.S. Annual Meeting, Dallas, February, 1978).

SCIENTIFIC EXHIBITS (cont.)

3. Stability Characteristics of Total Knee Replacements, Black, J.D., Matejczyk, M.B., and Greenwald, A.S. (A.A.O.S. Annual Meeting, Atlanta, February, 1981).

4. Arthritis of the Ankle: Arthrodesis vs. Arthroplasty, Matejczyk, M.B., and Greenwald, A.S. (American Orthopaedic Foot Society Annual Meeting, New Orleans, January, 1982).

5. Mechanics of Patello-Femoral Replacement. Cepulo, A., Matejczyk, M.B., and Greenwald, A.S. (A.A.O.S. Annual Meeting, Anaheim, 1983).

6. Stability Characteristics of Total Knee Replacements. Postak, Matejczyk and Greenwald (A.A.O.S. Annual Meeting, San Francisco, January, 1987).

AUDIO-VISUAL PROGRAMS

1. Properties of Methylmethacrylate and High Density Polyethylene. Greenwald, A.S., Matejczyk, M.B., and Black, J.D. A.A.O.S. Program #715, 1979.

2. Ankel Joint Mechanics and Implant Evaluation. Greenwald, A.S., Matejczyk, M.B., and Black, J.D. A.A.O.S. Program #713, 1979.

3. Knee Joint Mechanics and Implant Evaluation. Greenwald, A.S., Matejczyk, M.B., and Black, J.D. A.A.O.S. Program #730, 1980.

4. Acrylic Bone Cement and the Treatment of Pathologic Fractures. Habermann, E.H., Matejczyk, M.R., and Greenwald, A.S. A.A.O.S. Program #771, 1981.