#649

1 IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

2

3 - - -

NABILLA BASTAWROS,
4 et al.,

5 Plaintiffs, :

6 vs. : CASE NO. 291775

7 CHARLES C. SHIN, M.D., : (Judge Calabrese)
et al.,

8

Defendants.

9 - - -

10

11 Deposition of ANDREW M. ROTH, M.D., a witness
12 herein, taken by the defendants as upon
13 cross-examination pursuant to the Ohio Rules of Civil
14 Procedure and pursuant to agreement as to the time
15 and place, and stipulations hereinafter set forth, at
16 the offices of Freiberg Orthopaedic Group, 3120
17 Burnet Avenue, Suite 101, Cincinnati, Ohio, at 1:10
18 p.m., on Thursday, April 22, 1999, before Kelly
19 Green, professional court reporter and notary public
20 within and for the State of Ohio.

21 - - -

22

23 Cin-Tel Corporation
813 Broadway
24 Cincinnati, Ohio 45202
(513) 621-7723

1 APPEARANCES:

2

On behalf of the Plaintiffs:

3

CLAUDIA R. EHLUND, ESQ.
4 Lowe, Eklund, Wakefield, Co., L.P.A.
Tower City Center
5 610 Skylight Office Tower
1660 West Second Street
6 Cleveland, Ohio 44113-1454
(216) 781-2600

7

8 On behalf of the Defendants:

9 DENNIS FOGARTY, ESQ.
Weston, Hurd, Fallon, Paisley & Howley
10 2500 Terminal Tower
Cleveland, Ohio 44113
11 (216) 241-6602

12

\- - -

13

14

15

16

17

18

19

20

21

22

23

24

1 S T I P U L A T I O N S

2 It is stipulated by and between counsel

3 for the respective parties that the deposition of

4 ANDREW M. ROTH, M.D., a witness herein, may be taken

5 at this time and by the defendants as upon

6 cross-examination, pursuant to the Ohio Rules of

7 Civil Procedure and pursuant to agreement as to the

8 time and place; that the deposition may be taken in

9 stenotypy by the notary public/court reporter and

10 transcribed by her out of the presence of the

11 witness; and that examination and signature to the

12 transcribed deposition is requested.

13

14

15

16

17

18

19

20

21

22

23

24

1 I N D E X

2

3 Witness — Page

4 ANDREW M. ROTH, M.D.

5 By Mr. Fogarty — 5

6

7 E X H I B I T S

8

9 Defendant's Exhibit No. A — 35

10 Defendant's Exhibit No. B — 42

11

12

13

14

15

16

17

18

19

20

21

22

23

24

1 ANDREW M. ROTH, M.D.,
2 a witness herein, having been duly sworn, was
3 examined and testified as follows:
4 CROSS-EXAMINATION
5 BY MR. FOGARTY
6 Q. Dr. Roth, my name is Dennis Fogarty. I
7 represent Dr. Shin in a lawsuit that was filed in the
8 Cuyahoga County Court of Common Pleas by Nabilla
9 Bastawros; and we're here today to take your
10 deposition. I understand that this deposition has
11 been set up by agreement of all parties.
12 MR. FOGARTY: Claudia, we have a waiver of
13 notice and so forth?
14 MS. EKLUND: Yes, we do.
15 BY MR. FOGARTY:
16 Q. Doctor, I assume you've had your
17 deposition taken before?
18 A. Yes.
19 Q. How many times have you been in this kind
20 of setting, a deposition?
21 A. A deposition, many, many, many times.
22 Q. Over 100?
23 A. Maybe not that many, but 55 to 100.
24 Q. So I don't have to give you the ground

1 rules about verbal answers and so forth?

2 A. Yes. I understand it completely.

3 Q. And if you don't understand a question I

4 ask you, you will tell me --

5 A. Yes.

6 Q. -- rather than give me an answer?

7 A. That's correct.

8 Q. Let's start-off with some background.

9 Your full name is Dr. Andrew M. Roth?

10 A. Yes.

11 Q. And we are conducting this deposition at

12 your business address?

13 A. Correct.

14 Q. What is that address?

15 A. 2120 Burnet Avenue; Cincinnati, Ohio.

16 Q. And can you give me your date of birth,

17 sir?

18 A. November 7, 1948.

19 Q. You said that you have given a deposition

20 many, many times; and I'd like to know the context in

21 which -- the various context in which you have given

22 deposition testimony. First of all, let's talk about

23 this context. You have been retained in this case as

24 an expert **by** Ms. Eklund to testify --

1 A. Yes.
2 Q. -- on behalf of Ms. Bastawros, correct?
3 A. Yes.
4 Q. How many times, let's say -- and let's
5 start keeping with the deposition context. How many
6 times have you given deposition testimony as an
7 expert retained by a party to a lawsuit in your
8 career?
9 A. In terms of lawsuit like this or any
10 lawsuit?
11 MS. EKLUND: I guess a deposition as a
12 treater or --
13 Q. Okay. That's fair. I did say retained as
14 an expert, but let's just say -- let's back it up and
15 say have you testified with respect to a lawsuit?
16 A. Yes.
17 Q. And how many occasions has that occurred?
18 A. Probably close to 100.
19 Q. Do you distinguish between your testimony
20 wherein you're retained as an expert versus
21 testifying as a treating physician? Do you
22 understand the distinction?
23 A. I understand the distinction, but a
24 deposition is a deposition.

1 Q. In this case, you are not testifying as a
2 treating physician?
3 A. That is correct.
4 Q. You never provided any medical treatment
5 to Ms. Bastawros; is that correct?
6 A. That's correct.
7 Q. You have been retained as an expert to
8 offer your opinions regarding **Ms.** Bastawros'
9 claims against Dr. Shin, correct?
10 A. Yes.
11 Q. How many times have you testified in that
12 context?
13 A. About five times.
14 Q. Would this be the sixth?
15 A. Give or take one or two.
16 Q. In all those prior occasions, were they
17 medical malpractice cases that you were retained to
18 testify in?
19 A. Yes.
20 Q. Have you ever been retained to give an
21 independent medical evaluation of a patient who's
22 involved in an personal injury action? Do you
23 understand what I mean by that?
24 A. I've been retained to do an evaluation,

1 but I do not believe I was deposed on that
2 evaluation.
3 Q. I see. Okay. So of the hundred or so
4 depositions that we talked about that involved
5 litigation, only about five of them involved
6 occasions where you were retained as an expert to
7 testify against --
8 A. That is correct.
9 Q. -- another doctor?
10 A. That's correct.
11 Q. Do you have any recollection of those
12 other cases and the attorneys with whom you worked?
13 A. Yes.
14 Q. Do you remember the names of the attorneys
15 who retained you in those other cases?
16 A. Maybe a few, but not offhand. Not well.
17 I don't remember the names of the attorneys well.
18 Q. Can you give me any names?
19 A. I can give you the name of the firms.
20 Q. Okay. Go ahead.
21 A. Law firm of Nurenberg Plevin, Cleveland;
22 law firm of Maynard Jacobson, et. al., out of Toledo.
23 Q. Toledo? Okay.
24 A. A couple other -- a few others that I just

1 can't remember the names of the firms offhand.

2 Q. Do you remember the name of the attorney

3 from Nurenberg Plevin?

4 A. No.

5 Q. Do you remember the name of the attorney

6 from Jacobson Maynard in Toledo?

7 A. No. That was several years ago.

8 Q. Getting back to the original question that

9 sparked all this, the five occasions in which you

10 testified as a retained expert in a medical

11 malpractice case, in each of those five cases, were

12 you testifying on behalf of the plaintiff or the

13 defendant?

14 A. Both.

15 Q. So when you testified for Jacobson

16 Maynard, can I conclude you testified in defense of a

17 doctor?

18 A. That is correct.

19 Q. And of those five prior occasions, how

20 many were for the doctor and how many were on behalf

21 of the plaintiff?

22 A. It's probably 25 percent for the defendant

23 and the remainder for plaintiff.

24 Q. Okay.

1 A. If that much.

2 Q. The other occasions that you've testified
3 that did not involve medical malpractice cases, which
4 appears to be the bulk of the occasions you have
5 testified, you were testifying as a treating
6 physician; is that correct?

7 A. That's correct.

8 Q. And am I correct then that you would have
9 been testifying on behalf of the plaintiff in that
10 pending litigation most often?

11 A. Most often, the deposition was requested
12 in regards to my activities as treating the patient
13 and his or her outcome.

14 Q. I see. Do you remember the names of any
15 of the attorneys who you testified -- or, who
16 facilitated your testimony in those cases?

17 A. No, not a one.

18 Q. Now, distinguishing between testifying and
19 then perhaps providing a report, evaluating the
20 condition of a patient or a medical malpractice claim
21 on behalf of an attorney, can you estimate for me the
22 number of times you've been asked to do that, prepare
23 a report relative to a pending litigation?

24 A. Yes. Perhaps 20 to 30 over the past 3 or

1 4 years.

2 Q. Let's do it this way. I assume, I could

3 be wrong, that each time that you testify in a

4 deposition, you have also prepared a report in that

5 case. Am I wrong about that?

6 A. That would be correct.

7 Q. So you have prepared a report at least as

8 many times as you have testified in pending

9 litigation?

10 A. Actually more reports than testimony.

11 Q. So when you said 20 to 30, does that mean

12 20 to 30 times you've been involved preparing a

13 report for one side or another in a pending

14 litigation but you didn't testify?

15 A. Let me rephrase that. If not preparing a

16 report, then reviewing charts and discussing it with

17 the attorneys as to what my findings were -- rather,

18 what my opinions would be.

19 Q. And have you done that on behalf of the

20 plaintiff?

21 A. Both.

22 Q. What percentage? Can you break it down?

23 A. At least one-third for the defendant and

24 two-thirds for the plaintiff.

1 Q. That's fair. Any other lawyers or law
2 firms in Cleveland that you can remember?
3 A. Andrew Krems, who has broken away from
4 Nurenberg Plevin.
5 Q. Oh, you're aware of that?
6 A. Well, that happened about a year or two
7 ago.
8 Q. Was he the attorney at Nurenberg Plevin
9 that you were retained by?
10 A. No.
11 Q. So in addition to Andrew Krems, there's
12 another attorney at Nurenberg that you worked for?
13 A. Correct.
14 Q. And you recently worked for Mr. Krems in
15 his new association with Mr. Alkire?
16 A. It started with Nurenberg Plevin and
17 continued. I'm just not good at these...
18 Q. I understand. How about John Irwin?
19 A. Yes. John Irwin.
20 Q. You have been asked to prepare a report
21 for a client of John Irwin's?
22 A. Yes.
23 Q. That's recent?
24 A. Yes.

1 (Off-the-record discussion.)
2 BY MR. FOGARTY:
3 Q. Have you been retained -- obviously, we've
4 established that -- to render your opinions in
5 medical malpractice cases, correct?
6 A. Yes.
7 Q. And for that, you charge a fee?
8 A. That is correct.
9 Q. This is a more narrow context I want to
10 talk about, just the medical malpractice cases. In
11 this case, you were retained by Ms. Eklund to render
12 an opinion about the care and treatment of Dr. Shin,
13 correct?
14 A. Yes.
15 Q. And for that, you have charged Ms.
16 Eklund's firm a fee?
17 A. Yes.
18 Q. Can you tell me do you have established
19 set fees for your evaluation of a medical malpractice
20 claim?
21 A. Yes.
22 Q. What are those? Can you describe the fees
23 to me?
24 A. The fees include an initial retainer

1 between 1,000 -- 1,500 applied against an hourly fee
2 of $400 to review charts, x-rays, other reports, to
3 prepare reports, and have phone calls or attorney
4 meetings. In addition, the fee for deposition would
5 be $600 per hour and a fee of $3,000 dollars per day
6 for testimony to trial.
7 Q. In other words, the discovery deposition
a like we're doing today,. you will charge -- actually
9 you're charging me $600 an hour, correct?
10 A. That is correct.
11 Q. Three thousand dollars a day to testify in
12 trial, correct?
13 A. Correct,
14 Q. How many times have you had to testify at
15 trial in your career?
16 A. Once.
17 Q. When was that?
18 A. About three years ago -- three to four
19 years ago.
20 Q. What kind of case was that?
21 A. I represent -- I was retained by Jacobson
22 Maynard in defense of an osteopathic physician who
23 was sued in relation to the patient developing a
24 herniated disk.

1 Q. And that was in Toledo?
2 A. In Freemont, Ohio.
3 Q. And you were retained by Jacobson Maynard
4 to testify then?
5 A. That's correct.
6 Q. When we say Jacobson Maynard, we know that
7 that actually means you were retained by the PIE
8 Insurance Company; is that correct?
9 A. I was retained by Jacobson Maynard.
10 Q. Do you have any knowledge or understanding
11 about the former relationship between Jacobson
12 Maynard and the PIE Insurance Company?
13 A. Yes.
14 Q. What's your understanding?
15 A. That Jacobson Maynard was a law firm with
16 multiple offices who essentially exclusively provided
17 services for the PIE Insurance Company, to the best
18 of my understanding.
19 Q. Have either you or your practice group
20 ever been insured by PIE?
21 A. Yes.
22 Q. Over what period of time were you insured
23 by PIE, if you know?
24 A. Approximately between 10 and 15 years.

1 Q. From when to when?

2 A. Sometime in the eighties until...

3 Q. Until they went down the tubes?

4 A. 1997.

5 Q. Have you ever been represented by the

6 Jacobson Maynard law firm yourself?

7 A. Yes.

8 Q. In defense of a medical malpractice claim?

9 A. Yes.

10 Q. How many times has that occurred or how

11 many cases have you been sued in?

12 A. About five.

13 Q. Are any still pending?

14 A. No.

15 Q. When was the last one resolved either by

16 way of trial or settlement?

17 A. Last one was about three years ago and was

18 withdrawn.

19 Q. Okay.

20 A. In fact, all of them were withdrawn.

21 Q. So you were not directly impacted by the

22 liquidation of the PIE Insurance Company in any way

23 other than the fact that you had to go get new

24 insurance?

1 A. Correct.
2 Q. Lucky you. Were you aware that Dr. Shin
3 in this case is a former PIE insured?
4 A. No. I did not know that until last night
5 in reading one of the depositions.
6 Q. Which deposition lead you to that
7 discovery?
8 A. One done about two or three years ago, and
9 I noticed that the -- you were not the attorney, and
10 the attorney's law firm was typed on the deposition
11 under his name, and I went, "Oh."
12 Q. Doctor, a little bit about your
13 background. Can you just give me your educational
14 history beginning with undergraduate, or do you have
15 a CV?
16 A. Yes, I do.
17 Q. Do you have a CV that I can take a copy
18 of?
19 A. Yes, I do.
20 Q. I don't want to spend a lot of time.
21 According to your CV, you obtained a BS from
22 Northwestern in 1970?
23 A. Yes.
24 Q. Then you graduated from the University of

1 Kentucky Medical School in 1974?
2 A. Yes.
3 Q. Internship at University of Pittsburgh,
4 '74 to '75?
5 A. Yes.
6 Q. I see you had a fellowship in California
7 from '75 to '76, and then you did your residency at
8 University of Cincinnati in '76 to '80. Is that
9 unusual to take a fellowship before your residency?
10 A. It's very uncommon, but this fellowship at
11 Rancho Los Amigos is a very special type of place.
12 The hospital and the whole center is a very unique
13 medical center, and I took that in the year between
14 doing the internship and my residency.
15 It's not uncommon though for residency
16 programs to build in a year of research into the
17 program where the resident spends a year or two in
18 regular training and literally is a year in research
19 and then goes back and finishes the residency.
20 So a lot of programs have a built-in year
21 of research. This **was** just a separate program that I
22 had...
23 Q. I see. I just thought that was unusual.
24 I haven't seen that too often. You are board

1 certified in orthopedic surgery?
2 A. Yes.
3 Q. Are you licensed to practice medicine in
4 the state of Ohio?
5 A. Yes, I am.
6 Q. Any other states?
7 A. State of California.
8 Q. Is that California license still in good
9 standing?
10 A. Yes.
11 Q. Have you ever had your licenses suspended
12 or revoked in either state?
13 A. No.
14 Q. Do you hold any teaching positions?
15 A. I did.
16 Q. I see that you did. How about currently?
17 A. No.
18 Q. I'm sorry? You said --
19 A. 1 apologize. Yes. At the Jewish Hospital
20 where I do my practice, I am an instructor with the
21 Department of Internal Medicine as a preceptor and
22 instructor for the medical residents. As they go
23 through their training, they spend time in my office
24 to learn orthopedic management.

1 Q. Is that the University of Cincinnati
2 sponsored?
3 A. No. That's -- the hospital has its own
4 program, the residency program.
5 Q. And you are currently engaged in the
6 clinical practice of medicine?
7 A. Yes.
8 Q. And how much of your professional time do
9 you spend in the critical -- clinical practice of
10 medicine?
11 A. About 98 percent.
12 Q. And you are an orthopedic surgeon?
13 A. Yes.
14 Q. This case, as you know, involves a left
15 total knee arthrosplasty, correct?
16 A. Yes.
17 Q. Is that a surgery that you have performed
18 yourself?
19 A. Yes.
20 Q. About how many times in your career have
21 you performed similar types of surgeries?
22 A. Probably hundreds.
23 Q. Hundreds?
24 A. (Witness shakes head up and down.)

1 Q. Do you specialize in any peculiar part of
2 the body, orthopedic wise?
3 A. In a sense, yes, I have special interests
4 in certain areas.
5 Q. What are those?
6 A. Total joint replacements known as adult
7 reconstruction and spinal surgery.
a Q. You say total joint. Is that any joint?
9 A. To be more specific, total knees and total
10 hips.
11 Q. How about shoulders?
12 A. No.
13 Q. About how many surgeries do you perform a
14 month?
15 A. Between 20 and 30.
16 Q. What hospitals do you have privileges in?
17 A. I work in Cincinnati and the suburban
18 areas at the Jewish Hospital of Cincinnati, Bethesda
19 Hospitals, Franciscan Hospital in Mount Airy, and
20 also Franciscan Hospital in Western Hills, Mercy
21 Anderson Hospital, and that's the bulk of the
22 hospitals.
23 Q. Are you married?
24 A. Yes.

1 Q. Children?
2 A. Yes.
3 Q. How many?
4 A. Four.
5 Q. You were contacted by Ms. Eklund to
6 perform an evaluation in this case, correct?
7 A. Of the records, yes.
8 Q. And when were you first contacted by
9 someone from Ms. Eklund's office?
10 A. Approximately November 1998.
11 Q. The materials you have in front of you are
12 materials that Ms. Eklund's office provided to you;
13 is that correct?
14 A. That's correct.
15 Q. I see things, piles of paper in front of
16 you, and I just -- why don't you give me an
17 opportunity to take a peek at what you have, and then
18 I'll ask you a couple of questions about it.
19 (A brief break was taken to review
20 documents.)
21 BY MR. FOGARTY:
22 Q. Doctor, I'm looking at a letter dated
23 November 30, 1998, authored by Claudia Eklund. Is
24 this the first piece of correspondence you received

1 from Ms. Eklund's office regarding this case?
2 A. Yes.
3 Q. Prior to receiving this letter, I assume
4 you spoke to somebody from her office?
5 A. Yes.
6 Q. Do you have notes that reflect the first
7 contact, whether verbal or written?
8 A. Yes.
9 Q. What are you looking at there?
10 A. A green memo sheet in which a nurse in
11 Akron called on 1/12/98 regarding referral to Ms.
12 Eklund over this case.
13 Q. A nurse in Akron?
14 A. That's correct,
15 Q. A nurse in Akron contacted your office for
16 this case?
17 A. That's correct.
18 Q. Do you know the name of the nurse?
19 A. Diane Volinchak.
20 Q. Do you know whether that individual has
21 some kind of relationship to Ms. Eklund's office?
22 A. I have no idea.
23 Q. That's your office's first contact
24 regarding Nabilla Bastawros?

1 A. Yes, but it was only regarding cases.
2 Q. What does it say?
3 A. Call regarding reviewing cases for her;
4 and when I called, she gave me Ms. Eklund's name.
5 Q. Have you ever spoken to that person
6 before?
7 A. The nurse in Akron?
8 Q. Yes.
9 A. No, not that I recall.
10 Q. What else is written on that green memo
11 sheet?
12 A. Phone numbers and just the name of this
13 patient in question, and that was it.
14 Q. At some point, Doctor, I would like to get
15 copies of that, your notes, and every other piece of
16 paper that you have here that is not a medical
17 record. Can I do that?
18 A. Sure.
19 Q. At my expense, obviously. And can I
20 request that or do I need to subpoena that from you?
21 MS. EKLUND: You can request it. You can
22 have it.
23 MR. FOGARTY: Can I send the doctor a
24 letter to that effect, or how do you want to

1 handle it?

2 MS. EKLUND: He'll send it.

3 THE WITNESS: You can send a letter or

4 it's in the deposition. That's fine.

5 MS. EKLUND: You'll get it.

6 BY MR. FOGARTY:

7 Q. After you received that note, you

8 contacted this nurse and were given Ms. Eklund's name

9 and phone number; is that how it worked?

10 A. I think I said certainly I would be

11 interested, and then I received it in the mail.

12 Q. And then you received this letter?

13 A. Yes.

14 Q. The letter dated November 30th?

15 A. That's correct.

16 Q. You didn't talk to Ms. Eklund prior to

17 receiving this letter?

18 A. I don't think so.

19 Q. It looks as though you were provided, per

20 this letter, a number of documents including medical

21 records relating to Nabilla Bastawros and a report

22 written by Dr. Allen Wild.

23 A. Yes.

24 Q. And also the check enclosing the retainer

1 was provided. Is that the $1,500 you talked about?
2 A. Yes,
3 Q. The letter asks that you call Ms. Eklund
4 after you have an opportunity to review the records.
5 Do you have notes or records that indicate that you
6 did that, that you called Ms. Eklund after reviewing
7 what she provided you with in her November 30th, '98,
8 letter?
9 A. Just that I made a phone call in December
10 for 15 minutes.
11 Q. All right. The notes that you're looking
12 at are what?
13 A. Notes that I made after reviewing those
14 initial papers that were sent to me in November.
15 Q. If I can take it in chronological order,
16 can you give me the notes that you took after
17 reviewing the materials you were provided in the
18 November 30th letter?
19 A. Yes.
20 Q. Are these notes that you took while you
21 were reviewing as well as notes indicating how much
22 time you spent?
23 A. That is correct.
24 Q. Does this say, Personality conflict

1 between patient and P.T. therapist? Is that what the
2 note says?
3 A. That is my assessment of reading the
4 chart.
5 Q. All right. In December, you called Ms.
6 Eklund for what reason?
7 A. She asked me to call after I reviewed the
8 notes -- I mean the charts.
9 Q. Do you remember what you discussed?
10 A. The patient and the treatment.
11 Q. Had you formulated any opinions at that
12 point?
13 A. Let's say they were information in terms
14 of what I had read.
15 Q. Because on December 28th, I have another
16 letter from Ms. Eklund dated December 28th in which
17 she provides you some additional information
18 including a report by Dr. Lance Yarus, a copy of the
19 deposition of Dr. Christine Eckhauser, and the
20 deposition of plaintiff Nabilla Bastawros.
21 Was this material forwarded to you at your
22 request; in other words, did you ask Claudia to send
23 you additional materials?
24 A. No. I believe she sent that in the course

1 of her professional activities.

2 Q. Was her forwarding those materials to you

3 based on your discussions that you had after

4 reviewing the materials you first saw on November

5 30th of '98? Do you understand what I mean?

6 A. I understand your question. It was

7 forwarded because I agreed to review the charts and

8 provide an opinion, and she -- I -- on depositions, I

9 shouldn't make assumptions. You'd have to ask her

10 why she sent it to me, but I would guess to complete

11 whatever records I had.

12 Q. Do you know why she didn't send these

13 materials to you -- Yarus' report, Eckhauser's

14 deposition, and Bastawros' deposition -- why she

15 didn't send that to you on November 30th?

16 A. No, I do not know why.

17 Q. The next letter I have is dated April 19,

18 of 1999. Do you have any other letters in between

19 December of '98 and April of '99 from Claudia?

20 A. No, I don't believe so, unless there's a

21 separate letter that came with the mailing of the

22 x-rays' but I don't have anything else that...

23 Q. Yes, that's -- Okay. I see. On November

24 30th of 1998, Claudia indicates she's enclosing Dr.

1 Shin's deposition and the following x-ray folder
2 which is being sent Fed-Ex under separate cover. Do
3 you have a copy of that -- of a letter that enclosed
4 these x-rays and the deposition of Dr. Shin?
5 A. I don't know. You have everything that 1
6 have. It may be mixed into some of those.
7 Q. I assume it would have been dated shortly
8 after November 30th of.'98?
9 A. There may not have even been a letter in
10 it, but I don't recall specifically.
11 Q. All right. So the only letters I have are
12 the November 30th letter, this December 28th letter,
13 and then a letter dated April 19th enclosing the
14 deposition of Brendon Patterson. And that, to your
15 knowledge, is all the correspondence you received
16 from Claudia's office?
17 A. Yes.
18 Q. Any letter notifying you about this
19 deposition, or was that by phone or how did that
20 work?
21 A. I believe it was by phone through my
22 secretary.
23 Q. Okay. And that's --
24 A. And there may have been a letter regarding

1 that, but... I believe we have the letter some place
2 in my stack of loose papers that just tell me where
3 I'm going to be on a certain day. It would have
4 nothing more than the agreement of this date's
5 deposition.
6 Q. And that would have been recently
7 received?
8 A. Probably within the last six weeks.
9 Q. Is there any other letters that might be
10 somewhere else in filing?
11 A. Well, that would be the one.
12 Q. And there's no other letters anywhere
13 else?
14 A. Correct.
15 Q. Can I get a copy of that letter?
16 A. If I find it, absolutely.
17 Q. Is it possible I could get it before we
18 leave today or no?
19 A. No, I don't believe it's here.
20 Q. Where else would it be?
21 A. In a stack of papers on my desk at home
22 with just other papers.
23 Q. I didn't notice that. I should have
24 noticed this before. Claudia was corresponding with

1 you at home, correct? This isn't your business
2 address, correct?
3 A. I think we corresponded through both, but
4 if I get a paper -- this is not related to my work
5 through this professional group, so those papers I do
6 not store here because it's not part of the practice.
7 Q. Getting back to this nurse who called you
8 before November of -- November 30th of 1998, is she
9 affiliated -- that nurse -- do you know her or who
10 her affiliations are?
11 A. I have a note here that says she is an
12 independent reviewer, and I guess she got the name
13 from Mr. Jeff Maloon who is an attorney in Columbus.
14 Q. Do you know Jeff Maloon?
15 A. Only by telephone and correspondence.
16 Q. Have you ever been retained by Mr. Maloon?
17 A. Yes.
18 Q. To do what?
19 A. Medical malpractice review.
20 Q. How many medical malpractice reviews have
21 you done for him?
22 A. One.
23 Q. When was that?
24 A. It's presently in progress.

1 Q. It's in litigation?
2 A. Yes, it is.
3 Q. Do you know where it's filed?
4 A. Columbus, I believe.
5 Q. Franklin County?
6 A. I suppose.
7 Q. Do you know the name of the patient?
8 A. I have it, but I don't -- I can't recall.
9 Q. Do you advertise in any publication or
10 pamphlet or materials that are likely to be
11 circulated to lawyers or law firms?
12 A. No.
13 Q. Do you subscribe to any publications that
14 are related to the legal profession?
15 A. No.
16 Q. Then I want to look and list for the
17 record the materials that you have relative to this
18 patient and the materials that you reviewed in
19 preparation for your report. Okay?
20 As far as I can tell, you were provided
21 Grace Hospital records relative to Nabilla Bastawros
22 from 7/13/93, that admission; and then 8/23/93 to
23 8/27/93 from Southwest General Hospital; and 3/14/94
24 from Grace Hospital; then 8/11/94, an admission from

1 Metro Health Medical Center; December 13, '94, Metro
2 Health Medical Center; February 6, '96, Metro Health
3 Medical Center; February 28, '96, Metro Health
4 Medical Center.
5 You were provided a report by Dr. Allen
6 Wild; a report by Dr. Lance Yarus; a deposition
7 transcript of Christine Eckhauser; a deposition
8 transcript of Nabilla Bastawros; a deposition
9 transcript of Dr. Shin; and a deposition transcript
10 of Dr. Brendon Patterson.
11 A. That is correct.
12 Q. I see you also have --
13 MS. EKLUND: I don't think you mentioned
14 the x-ray films.
15 MR. FOGARTY: No, 1 didn't. I'm sorry.
16 BY MR. FOGARTY:
17 Q. And x-ray films. I don't have a list.
18 That's kind of why I was asking about the letter. I
19 don't have a list of the x-rays you were provided,
20 and I guess we'll get to those a little later, but it
21 looks as though you were provided x-rays from Grace
22 Hospital. Go ahead and tell me what x-rays were
23 provided.
24 A. Maybe there's a letter in here. The

1 x-rays provided are as follows: Grace Hospital,
2 7/13/93. All of these x-rays, by the way, are of the
3 left knee. Grace Hospital, 3/14/94; Southwest
4 General Hospital, 8/23/93 and 8/27/93.
5 Q. Okay.
6 A. Should I continue?
7 Q. Yes, please.
8 A. Metro Health system -- or, Medical Center,
9 8/11/94, also, 12/13/94, also, 2/6/96, and 2/28/96.
10 Q. Okay. I misspoke earlier. The records
11 that you were provided were not those that I listed
12 off to you. I listed off to you basically the x-rays
13 you were provided, and then you just listed them back
14 to me.
15 The records you were provided, I assume --
16 are those in a folder indicating records of Nabilla
17 Bastawros from -- and on the front of the record
18 folder, it says, Claudia Eklund, attorney for Nabilla
19 Bastawros?
20 A. That's correct.
21 Q. Can I mark this folder somewhere?
22 A. If you wish.
23 (Deposition Exhibit A was marked for
24 identification.)

1 Q. I marked a folder Exhibit A. If you
2 would, take a peek at that.
3 A. Yes.
4 Q. Is that a binder containing all the
5 medical records you were provided relative to Nabilla
6 Bastawros?
7 A. Yes.
8 Q. I'm excluding the two reports you were
9 provided by Wild and Yarus. I'm not considering
10 those records.
11 A. That plus copies which are duplicate
12 copies of the x-ray reports that are enclosed in this
13 binder are also included with each of the set of
14 x-rays individually separated as we just enumerated.
15 Q. Let me just ask you since you have that in
16 front you, do you believe you've been provided Dr.
17 Shin's complete medical chart relative to his
18 treatment of Ms. Bastawros?
19 A. It appears to be.
20 Q. How about the postoperative Metro Health
21 Medical Center physical therapy records after the
22 first Dr. Shin surgery from September of 1993 until
23 January of 1994? Were you provided those records?
24 A. Yes, I was.

1 Q. Then were you provided the Metro Health
2 medical records from -- I believe it is October of
3 1994 through February of 1996?
4 A. Yes, but actually August '94 to February
5 '96.
6 Q. Including the revision surgery?
7 A. That is correct.
8 Q. The report of Dr. Wild dated April of
9 1997, did you review that prior to drafting your
10 report dated December 23rd of '98?
11 A. Yes.
12 Q. Did you review a later report prepared by
13 Dr. Wild dated -- well, did you review any other
14 reports from Dr. Wild?
15 A. Yes.
16 Q. You did? What other reports did you
17 review from Dr. Wild?
18 A. Ms. Eklund has a copy of a second report
19 that he did sometime earlier this calendar year.
20 Q. Dated February 2nd of '99?
21 A. That sounds correct.
22 Q. When is the first time you saw that?
23 A. I think about a month ago.
24 Q. I don't see it here.

1 A. Neither do I.

2 Q. Why is that?

3 A. I don't know.

4 Q. I don't see the letter enclosing it

5 either.

6 A. Neither do I.

7 Q. Is it somewhere in your office?

8 A. No. It's probably somewhere in my house.

9 Q. Can you look in all the places that you're

10 aware of where letters from Claudia might be?

11 A. Yes.

12 Q. And if you can, locate them and include

13 them as copies in the requests that I will send you,

14 if you don't mind.

15 A. I do not mind, and I will be happy to do

16 that.

17 Q. Do you remember what Claudia's letter

18 enclosing that report said?

19 A. As I recall, it was a very short letter

20 that said, Here is a secondary report from Dr. Wild

21 for you to review.

22 MS. EKLUND: That's a copy of the letter I

23 sent if you want to read it. (Indicating.)

24 MR. FOGARTY: Can I take it in case he

1 doesn't find it?

2 MS. EKLUND: How about if I copy it for

3 you?

4 MR. FOGARTY: That's fine.

5 BY MR. FOGARTY:

6 Q. So you reviewed both of Dr. Wild's reports

7 before today, correct?

8 A. That's correct.

9 Q. And you also -- you're aware that Dr.

10 Patterson was deposed recently because you were

11 provided his deposition transcript; is that correct?

12 A. That's correct.

13 Q. When were you provided that?

14 A. It came yesterday.

15 Q. Did you have time to review it before

16 today?

17 A. Yes.

18 Q. And did you and Claudia meet and discuss

19 this deposition prior to it occurring?

20 A. Yes.

21 Q. And that happened today?

22 A. That's correct.

23 Q. Did you discuss with Claudia Dr.

24 Patterson's testimony?

1 A. Yes.
2 Q. And did you discuss with Claudia Dr.
3 Wild's second report?
4 A. Yes.
5 Q. What's the substance of your discussions?
6 Can you summarize them for me concerning Dr.
7 Patterson's testimony?
a MS. EKLUND: I'll show an objection.
9 A. I really can't summarize it ?if you want
10 to ask individual questions... But it's a very
11 involved case and we discussed the entire case.
12 Q. Okay.
13 A. And I think it's not fair to say summarize
14 it because it's too many thoughts.
15 Q. Did you discuss with Claudia whether Dr.
16 Patterson's testimony was consistent with the
17 conclusions you came to in your report?
18 A. Yes.
19 Q. And can you summarize that conversation
20 for me? Is that specific enough?
21 A. Certainly. Dr. Patterson's deposition, if
22 I may review it while we talk, discussed his opinion
23 as to why he operated and what he found on his
24 evaluation before and at the time of his revision

1 surgery. And I certainly agreed that the revision
2 was necessary because of the malalignment of the --
3 Q. Tibial platform?
4 A. -- tibial component, right, and the fact
5 that -- the fact that he felt that there was a
6 mechanical block related to the malposition and that
7 physical therapy would not overcome that, and that's
8 taken from his deposition on page 27.
9 And I agreed that he felt there is an
10 ability for the need to tolerate some degree of
11 malalignment, which I interpret as a small degree of
12 malalignment, as he says, before you reach a level in
13 which there's a mechanical block, which I interpret
14 that to mean there's only so much one can tolerate.
15 And once there's a greater degree of
16 malalignment, then a mechanical block develops, and
17 it leads to the problems as he relates he felt the
18 patient had, which was corrected with his revision
19 surgery.
20 Q. This mechanical block that you're speaking
21 of, can that lead to pain?
22 A. Yes.
23 Q. And decreased range of motion?
24 A. Yes.

1 Q. Stiffness?

2 A. Yes.

3 Q. Is that a complete answer to my question
4 when I asked you to summarize your conversation with
5 Claudia about Dr. Patterson's deposition and whether
6 his testimony was consistent with your opinions in
7 his December 23rd report?

8 A. Yes.

9 Q. I have one copy of your report, and I
10 neglected to make a copy of it, but I want to make it
11 "B." I see you have a copy of it over there, Doctor,
12 but I'm going to just show you...

13 (Deposition Exhibit B was marked for
14 identification.)

15 Dr. Roth, I'm going to hand you my copy of
16 a report I marked as Exhibit B. And again, that's
17 the report that you prepared at Claudia's request
18 which details your opinions about the quality of the
19 care Nabilla Bastawros received from Dr. Shin; is
20 that correct?

21 A, That is correct.

22 Q. Doctor, you have your own copy there.
23 Have you prepared any other reports for Claudia in
24 this case, any other written correspondence to her

1 from you?
2 A. No, I have not.
3 Q. Does this report that I marked as Exhibit
4 B, a copy of which you have in front of you,
5 represent a complete summary of your opinions in this
6 case?
7 MS. EKLUND: I just want to show an
8 objection to that because the report is meant to
9 put you on notice of the areas that he will
10 express opinions. No letter can reasonably
11 contain all of the opinions a witness might have
12 in this kind of a case, so...
13 A. In answer to your question, no, this is
14 not a complete opinion.
15 Q. There are matters that you intend to
16 testify about that are not contained in this report?
17 A. That is correct.
18 Q. Let me summarize what's in this report,
19 and then we'll talk about what's not in the report.
20 Incidentally, up on your x-ray screen over there, are
21 those x-rays relating to Nabilla Bastawros?
22 A. Yes.
23 Q. Can you describe what you have up there?
24 A. These are x-rays of her knee taken before

1 and after the initial surgery.

2 Q. Which ones are before?

3 A. There's one that shows the knee prior to

4 surgery dated 7/13/93 and two that were taken on the

5 day of surgery immediately postoperatively dated, I

6 believe, 8/27/93.

7 Q. That is the day of Dr. Shin's arthroplasty

8 surgery?

9 A. Yes. This is dated 8/31/93.

10 Q. Looking at the first x-ray, the

11 preoperative x-ray up there, do you agree that Ms.

12 Bastawros' knee presented a problem sufficiently

13 warranting arthroplasty?

14 A. Yes.

15 Q. Based on that x-ray there?

16 A. Based on I reviewed all of the x-rays that

17 were sent which are sitting here on the table; and as

18 a combined view of that, yes.

19 Q. The report that you prepared -- and we'll

20 use these x-rays -- the postoperative x-rays if we

21 can. The report that you prepared, in my own mind, I

22 summarized basically three reasons you believe the

23 revision surgery was necessary. I want to talk about

24 that. First is the malalignment of the tibial

1 component.

2 MS. EKLUND: I'm sorry. Are you talking

3 about this revision or the initial surgery?

4 MR. FOGARTY: The initial surgery -- three

5 reasons why she needed the revision.

6 BY MR. FOGARTY:

7 Q. And that is that the first arthroplasty

8 performed by Dr. Shin resulted in a malaligned tibial

9 component?

10 A. Yes.

11 Q. And we can see that on the x-ray, correct?

12 A. Yes.

13 Q. Can you describe the malalignment for me

14 using that x-ray if possible?

15 A. Yes. On the front view known as the A.P.

16 view, the tibial component is situated with the --

17 placing the lower leg in a varus position, which in

18 plain English is bowlegged.

19 In addition, on closer inspection, it is

20 not truly centered and overhangs the medial or inner

21 side of the upper tibia by at least six millimeters.

22 Q. You can't see that on the x-ray view that

23 you have there?

24 A. Yes, I do.

1 Q. You can? Okay. Can you point to that for
2 me?
3 A. Right here, pointing towards the medial
4 side of the upper tibia.
5 Q. Okay.
6 A. Now, that was not addressed by anyone
7 else, which is additional as you were questioning in
8 terms of my total opinion.
9 Q. The tibial component overlays the -- go
10 ahead.
11 A. It extends medially beyond the border of
12 the actual bone on the inner side of the patient's
13 knee.
14 Q. Six millimeters?
15 A. As I measure on the x-ray, yes.
16 Q. Now, that is observable on that x-ray that
17 you are referring to, right bottom, correct?
18 A. That is correct.
19 Q. What's the date of that x-ray?
20 A. 8/31/93.
21 Q. And you were provided that x-ray as part
22 of the initial submission by Claudia, correct?
23 A. Correct.
24 Q. All right.

1 A. Plus it shows that the -- as I said
2 before, the leg still has a deformity known as varus
3 deformity, which in lay term is a bowleggedness.
4 **Q.** And that's caused by the arthritis,
5 correct?
6 A. No and yes. Let me explain. What it
7 shows and what is indicates is the patient's
8 deformity is still present.
9 Now, the articulare surfaces, the surface
10 of the bone which is the surface that has the
11 arthritis obviously has been replaced by both the
12 upper and lower components of this set called a total
13 knee.
14 **Q.** Okay.
15 A. ***So*** the arthritis surfaces -- arthritic
16 surfaces have been replaced; but if you study the
17 films, the deformity was not corrected.
18 **Q.** Okay.
19 A. Now, on the side view known as a lateral
20 view addressing the tibial component, there is a --
21 as I measured, approximately a ten-degree tilt
22 forward of the metal plate which is the base plate of
23 the tibial component, and it's tilted forward with a
24 -- let's call it a wedge of cement behind it.

1 Q. Why is the wedge of cement there? Do you
2 know or do you suspect what it's doing there?
3 A. Well, more than that -- yes, I know why
4 it's there, but more than that is that there is a
5 stem -- the base plate has a stem that goes down the
6 upper part of the shaft of the tibia.
7 And in preparation of the knee for
8 insertion or implantation of the tibial component,
9 certainly gigs or cutting guides are used to prepare
10 the bones, and we -- one cut is made that goes across
11 the bone from front to back; and once that is made,
12 then the next gig is used to prepare the hole for the
13 stem.
14 Q. Okay.
15 A. And what I see on the x-ray is that the
16 stem of the tibial component appears to be in the
17 upper shaft. I do not see that the hole was prepared
18 perpendicular to the shaft.
19 So in retrospect, the tibial component was
20 inserted as the upper tibia was prepared; and it was
21 prepared allowing a ten-degree tilt so that when it
22 was inserted, the back of the tibial component is
23 lifted up. And of course, the cement that is used to
24 interlock and hold the component in still there

1 instead of being flattened out.

2 And instead of having a one- or

3 two-millimeter layer of cement, we've got this very

4 large wedge of cement in the back of the component.

5 So that tilts the whole component forward.

6 Q. Let me ask you this. Do you think that

7 was intentionally put there to make up for the

8 tilt -- the cement?

9 A. No. I believe that in preparation of the

10 proximal tibia, by looking at these films which are

11 only three days post-op, the hole that was drilled

12 for the tibial component was not as designed by the

13 manufacturer or is done on a routine knee

14 replacement. In other words' it's incorrect.

15 Q. I was asking you why the cement was wedged

16 in like that, and you said you thought you knew.

17 A. Well, yes, because the stem really directs

18 where you put the tibial component.

19 Q. Okay.

20 A. And if you drill a hole sideways and you

21 insert something in it that's long and it's a big

22 thick fat stem, you force it flat because it guides

23 it and prevents it from going down flat.

24 Q. Is the cement wedged in there to make up

1 for the tilt that was created because the stem was
2 not drilled and inserted straight?
3 A. I believe that the template used for
4 drilling -- let me rephrase that. I believe that
5 this was not done on purpose, because reading Dr.
6 Shin's testimony, he says he osteotomized or cut the
7 bone flat and used the templates and drilled the
8 holes.
9 And he intended -- as was asked and
10 answered in his deposition -- for the tibial plate to
11 be flat on the bone, which is this transverse line.
12 Q. Right.
13 A. But having drilled it in this manner, it
14 didn't go in correctly; and so the cement that sits
15 on top -- when a tibia component is inserted, the
16 cement that is put in is a large amount so that you
17 get a good coverage, and you implant the tibial
18 component flat.
19 And the excess cement is pressed out and
20 it's wiped or cleaned away, and the component is held
21 in place until the cement hardens, which is somewhere
22 between 8 to 15 minutes.
23 Q. Referring to Dr. Shin's testimony, did he
24 describe the quality of the bone surface that he had

1 after he flattened out the tibia to get it ready for
2 the component?
3 A. He may have, I don't recall directly.
4 Q. So you don't recall what kind of surface
5 he was working with?
6 A. No. But the appearance of the x-rays
7 looked -- the bone does not appear osteoporotic on
8 these or the other x-rays.
9 Q. Do you believe Dr. Shin knew that he had
10 not drilled the hole straight at the time he was
11 inserting the stem?
12 A. No. I do not believe he realized that
13 this was not done according to the protocol and
14 instructions for inserting or implanting this
15 component.
16 Q. There are several procedures that you use,
17 the gigs and the cutting guides, that will enable you
18 to create or drill the hole straight?
19 A. Correct.
20 Q. And that's what you have to use. You use
21 the gigs and the guides vis-a-vis the bone that you
22 have in front of you to determine whether you've got
23 a straight fix on where to drill, correct?
24 A. If you use them, that's correct.

1 Q. If you use them?
2 A. Yes. Some people have been known to just
3 do it freehand.
4 Q. Just eyeball it?
5 A. That's correct.
6 Q. You don't know what Dr. Shin did in this
7 case?
8 A. I don't know.
9 Q. What was his testimony?
10 A. I do not recall. I believe he said he
11 used the appropriate gigs.
12 Q. Okay. And these gigs are produced by the
13 manufacturer of the component parts, correct?
14 A. Right. Each gig -- set of gigs and
15 instruments is exclusive for that manufacturer's
16 components.
17 Q. Are there circumstances where you think
18 it's -- where you would think it would be okay to
19 eyeball it or just get the feel for it yourself?
20 A. Not me.
21 Q. Have you ever estimated where to drill the
22 hole for the tibial component without using the gigs?
23 A. No.
24 Q. Now, obviously, you want to -- any surgeon

1 wants to strive for perfect alignment -- correct? --
2 of the tibial component?
3 A. That's correct.
4 Q. Perfect alignment is probably impossible
5 to get; would you agree with me?
6 A. If you define perfect as absolutely
7 unattainable, yes; but one can get pretty close to
8 perfect or something that either the doctor or the
9 manufacturer would love to put up on all their
10 literature as this is exactly how it's supposed to
11 be. So within a degree or so, it would be perfect
12 Q. Let me ask you this. What's your comfort
13 level in terms of the degree of malalignment that you
14 would accept as part of the standard of care? If we
15 both agree that some malalignment is inevitable --
16 let's put it that way. You agree with that? Some
17 malalignment is inevitable? Some?
18 A. I disagree with your statement. Some
19 malalignment is possible, not inevitable.
20 Q. Going back to what we said, the perfect
21 alignment is hard to attain?
22 A. Correct.
23 Q. So there must be some acceptable amount of
24 malalignment. When I use malalignment, I'm using the

1 word as it's used in this case. A malalignment might
2 be a judgmental term. There is some degree of
3 variance with perfect alignment that you would agree
4 falls within the standard of care?
5 A. Correct. The manufacturer -- let's expend
6 that the manufacturer does not say there's a perfect
7 alignment. The manufacturer has instruments in order
8 to put in the correct alignment.
9 Q. Right. Okay.
10 A. And if you vary within, let's say, two or
11 three degrees, which is the number I believe you're
12 looking for, then that would be the acceptable
13 variance of alignment. When it goes beyond that, it
14 becomes known as malalignment.
15 Q. Okay.
16 A. Which by definition means it's beyond an
17 acceptable amount of alignment. You would not call
18 something malaligned as being acceptable.
19 Q. I see. I used the term the wrong way.
20 That's what I was striving at. So you would accept
21 two to three degrees of variance? Can I say that
22 word?
23 A. Yes.
24 Q. Okay.

1 A. As acceptable.
2 Q. And that's your professional opinion?
3 A. That's correct.
4 Q. Anything outside three degrees, let's say,
5 would be a failure of the standard of care?
6 A. It may contribute to failure of standard
7 of care.
8 Q. I don't understand that. In light of what
9 you just said --
10 A. There's more than one thing that indicates
11 a failure to achieve the standard of care.
12 Q. All right.
13 A. It's not one single component, which makes
14 this case or many other cases complex in the nature
15 that you can't just put up one x-ray and say, Uh-oh,
16 that's it. Everything's bad.
17 Q. Let's talk about this case. The failure
18 of the standard of care in this case included a
19 malaligned tibial component --
20 A. That's correct.
21 Q. -- in addition to some other things we're
22 going to get to in a minute.
23 You told me before that you would accept
24 two to three degrees of variance in the alignment of

1 the tibial component which would still be acceptable;
2 and anything more than that, we're getting into
3 trouble. Did I misunderstand you?
4 A. No. That's correct. Anything more than
5 that should raise the suspicion that you are or could
6 get into trouble or, to be more frank about it, that
7 your patient is going to get into trouble.
8 Q. What degree of misalignment do you detect
9 here?
10 A. Well, it's multiple things, but the
11 ten-degree tilt off the transverse cut of the tibia
12 from front to back. We have to look at two things
13 here. There's two views we're looking at: Front and
14 sideways.
15 And on the side view, we see the cut or
16 the osteotomy on the top of the tibial -- the top of
17 the tibia is called the plateau. So the top -- the
18 arthritic surface is removed in a flat surface.
19 And the cut as I can see from the x-ray
20 from front to back actually *is* a very -- of the bone
21 itself is a very good cut. The cut or the osteotomy
22 on the front view reveals that the bowlegged
23 deformity was not corrected, which is all part of the
24 whole package of correcting an arthritic knee.

1 You don't just remove the worn-out
2 surface, but you correct the deformity that has
3 formed as a result of the worn-out surface.
4 Q. Can you show me that on the x-ray there,
5 the deformity --
6 A. What I am pointing to is the thigh bone,
7 or the femur, comes down towards the knee joint, and
8 the end of it has the femoral metal component
9 cemented to it. The top of the tibia -- the
10 component is cemented to the top of the tibia, but
11 the tibial shaft appears to be in varus or
12 bowleggedness as also was noted by Dr. Patterson.
13 The patient presented with history,
14 according to Dr. Shin's notes, of a varus or deformed
15 -- let's call it a bowlegged deformity, which was all
16 part of her package of having pain from her
17 arthritis.
18 So what we see here is, on the front view,
19 that the osteotomy was flat but it didn't correct the
20 angulation. If more had been taken off of the
21 lateral outer half of the top of the tibia, it would
22 have inserted the component in a better position.
23 Now, in addition to the way it was cut,
24 when the -- I would presume when the gig was used for

1 drilling the hole, it wasn't centered directly on
2 this center in the middle of the top of the tibial --
3 the cut surface of the tibia, because you can only
4 implant the component where the hole is.
5 It won't slide left and right, up and
6 down. It's not a loose hole. It's not a very set
7 position, so there's not a lot of play there, just
8 enough for a little bit of cement -- a thin layer of
9 cement; and we can see that it's shifted off the top
10 of the tibia.
11 So on the inner side, it extends six
12 millimeters too far inside; and on the outer side,
13 it's not up to the edge, so it's off center. So you
14 add that together -- and this is just tibial
15 component. You add that together where it's off
16 center, it's still in varus, and then it's tilted
17 anteriorly; and you add all that together, that's
18 malalignment of just the tibial component.
19 Q. All right. The off center -- the
20 six-millimeter off center, the tibial component that
21 you've been describing, was observable to *you* in that
22 x-ray that you were provided by Claudia on November
23 30th, correct?
24 A. That's correct.

1 Q. It is not reflected in your report. In
2 fact, you said before no one has pointed that out to
3 your knowledge to this day?
4 A. That's correct.
5 Q. Why didn't you put it in your report if it
6 was observable in that x-ray you were provided
7 November 30th?
8 A. Because I went back on the purposes of
9 completing the review of the files and charts and all
10 the x-rays to restudy to make sure what we were going
11 to discuss today and...
12 Q. Do you remember when you did that?
13 A. Yes. It was last night.
14 Q. It was when?
15 A. Last night.
16 Q. So the tibial -- the overextension of the
17 tibial component six millimeters was pointed out or
18 discovered by you last night?
19 A. Right.
20 Q. April 21st?
21 A. Correct.
22 Q. After you had been provided Dr.
23 Patterson's deposition transcript?
24 A. Actually before I even read or opened the

1 envelope.

2 Q. After you were provided Dr. Wild's

3 February 1999 report? It took place after that,

4 correct?

5 A. Right.

6 Q. So anyway, getting back to this question,

7 the two- or three-degree comfort zone -- tilt comfort

8 zone that you have anteriorly that we were talking

9 about or what you observe in the left --

10 A. Well, combined, two to three degrees maybe

11 anteriorly, inner/outer.

12 Q. That's acceptable to you, and I just want

13 to stay with that issue for now. I don't want to

14 talk about a whole -- the combination of factors

15 which you believe lead to the failure of this

16 arthroplasty.

17 But that degree of variance from the

18 correct alignment is acceptable to you, no more than

19 three degrees -- correct? -- or is it you can vary it

20 more than three degrees as long as you don't have

21 these other factors as well? Is that what I am

22 saying? That's what I am saying.

23 A. No one thing is that -- let me rephrase

24 that. There's an acceptable range from what you're

1 calling perfect, that acceptable means just that. It
2 appears to be in a good position.
3 Q. Let me tell you why I'm asking that
4 question. I think Dr. Patterson agreed that some
5 degree of malalignment -- and I will use that word
6 the way you defined it in this case.
7 A. I would not use that word --
8 Q. All right. Well, let me use --
9 A. -- because it means exactly that.
10 Q. I know what you're saying.
11 A. It means bad.
12 Q. Have you seen patients with malaligned
13 tibial components with no dysfunction?
14 A. I would say yes.
15 Q. In this case, you have a malaligned tibial
16 component and you have Ms. Bastawros' claim,
17 dysfunction, correct? That's what we have here?
18 A. In part, yes.
19 Q. One of the things you blame on her
20 dysfunction and the failure of the arthroplasty is
23. this malalignment?
22 A. That's one of the components, that's
23 correct.
24 Q. But the malalignment itself, as I think I

1 understand you're saying now, is not the cause of the
2 failure -- in and of itself is not the cause of the
3 failure of the arthroplasty. Is that what you were
4 telling me before in that lengthy --
5 A. Well, you wanted to tone it down to one
6 thing, and I think it's better answered by saying
7 this is one of the components. Now, the malalignment
a that I've seen has never been a tilt like this.
9 Q. You've never seen a tilt that bad?
10 A. I've never seen a tilt at all like that.
11 I've never seen a tilt that most people get it
12 squared and flat. Now, sometimes the cut on the
13 tibia is one or two degrees different, but the
14 component is flat in position.
15 And sometimes there's one or two or three
16 degrees of varus position on the front view; but
17 we're talking about a combination of that tilt, the
18 offset of the tibial tray, and the failure to correct
19 the deformity which changes the entire mechanical
20 axis and activity of the knee joint.
21 Q. Well, that's what I understood your report
22 to say, that the tilt of the component and the varus
23 deformity were the cause of her pain, because -- as I
24 am reading from your report, because these two

1 factors -- you didn't talk about the overextension at
2 that point. You discovered that recently. But those
3 two factors per your report allowed the patella to
4 tract incorrectly which caused her pain?
5 A. Can we assume to say that this is a
6 preliminary report and not a definitive final report
7 dated December '98 that I provided Ms. Eklund?
8 Q. Does that mean that it's wrong?
9 A. No. It means it's a preliminary report.
10 It's not as complete as can be done when one sits
11 down and studies all the details. Not being the
12 treating physician, I didn't have a patient coming to
13 me complaining every day -- every visit, how much it
14 hurts, to say, gee, what's going on with this
15 patient. Let me restudy it. So I have to do this
16 retrospectively.
17 Q. Is it still your opinion that the failure
18 of Dr. Shin to correct the varus deformity and the
19 angulation of the tibial component caused the patella
20 to tract incorrectly causing the pain? Is that your
21 opinion anymore?
22 A. It is my opinion that the implantation of
23 the tibial component in malalignment, that the use of
24 a Femoral component that appears to be too wide for

1 the size of her knee --

2 Q. Doctor, wait a minute. Wait a minute.

3 Let's go back.

4 A. Then I cannot answer the question as you

5 phrase it.

6 Q. Okay. Then that's my fault. Is it today

7 your opinion that the pain Ms. Bastawros complained

8 of which ultimately lead to the revision surgery was

9 caused by the failure of Dr. Shin to correct the

10 varus deformity and the tilt, the malalignment of the

11 tibial component, combining together to create

12 patella maltracking? Is that your opinion today,

13 that that's what the cause of --

14 A. That's part of the opinion.

15 Q. But that's not the total cause?

16 A. That's correct.

17 Q. So then I will conclude that if I wanted

18 to know what your opinion of the failure of the

19 standard of care in this case is, I cannot rely on

20 the report that was provided to me, correct?

21 MS. EKLUND: I'm going to show an

22 objection. If you read the last paragraph of

23 Dr. Roth's opinion, he talks about the improper

24 size, the entire manner of the implant of the

1 prosthesis. I think you are being unfair with
2 what the report contains.
3 BY MR. FOGARTY:
4 Q. Those two factors resulting in patellar
5 maltracking are only part of the reason you believe
6 the arthroplasty ,failed, correct, Doctor?
7 A. They're part of the reason and not
8 exclusive of other reasons.
9 Q. Is it your opinion that the malalignment
10 and the failure to correct the varus deformity
11 resulted in patellar maltracking?
12 A. In part, but actually resulted in the
13 entire prothesis maltracking. So I need to expand it
14 that it's not just patella.
15 Q. All right. Let me talk about patellar
16 maltracking for a minute. In the records that you
17 reviewed, did you find reference to Patterson or
18 anyone else observing patellar maltracking?
19 A. Yes.
20 Q. Who?
21 A. Dr. Thomas in the orthopedic center in
22 Metro Health.
23 Q. Can you find that record?
24 A. Yes. It's a visit dated 8/11/94.

1 Q. Let me get caught up with you. Are these
2 the --
3 A. Metro Health.
4 Q. -- Metro Health outpatient records?
5 A. That's correct. The department of
6 orthopedic visit.
7 Q. Okay.
8 A. And this was under his assessments, slash
9 plan. "A," slash, "P" is how he wrote this.
10 Q. Probable patellar maltracking.
11 A. That's correct.
12 Q. That is what you're referring to?
13 A. And that is where that thought entered my
14 review of all the records.
15 Q. Did you review any of the other records
16 that showed adequate patella tracking prior to the
17 revision? Did you review any records that revealed
18 that?
19 A. There was no other significant records in
20 terms of patella tracking by itself, and that was --
21 well, nevermind.
22 Q. How about a faculty note from Metro Health
23 dated December 13, '94, indicating good patellar
24 tracking? Do you have that record, December 13th of

1 '94. Do you see the record I am referring to?
2 A. I have a record here.
3 Q. Good patellar tracking?
4 A. Which line?
5 Q. Pretty much the same line where it said...
6 Down here (indicating).
7 A. Yes. I do see it. And that's by --
8 illegible signature.
9 Q. Yeah.
10 A. But it also says below it, Tibial tray off
11 anatomic axis.
12 Q. You looked at one record that said
13 probable patellar maltracking and concluded that she
14 had patellar maltracking --
15 A. No.
16 Q. -- but paid no attention to the record
17 that says good patellar tracking?
18 MS. EKLUND: Objection.
19 A. No. Sir, I did not look at one record and
20 conclude.
21 Q. Okay.
22 A. That's a sentence that attaches one thing
23 with a conclusion. Let's rephrase it. I looked at
24 the entire record.

1 Q. Okay.

2 A. Part of my conclusion at the time of this
3 initial expert report to Ms. Eklund was about patella
4 tracking. Like anything else, when one reviews
5 things a second or third time, you glean much more
6 information and you gain more knowledge of what was
7 done and how the patient responded and how the
8 physicians treated the conditions. So other factors
9 become evident that weren't necessarily seen with the
10 initial review.

11 Q. With respect to the patella maltracking,
12 what factors have now become relevant that weren't
13 relevant before regarding your opinion in that
14 regard? In other words, I just showed you that
15 record. Does that then change your opinion as to
16 whether there was patellar maltracking in this
17 patient prior to the revising?

18 A. I would say that patellar maltracking is a
19 component, perhaps not the only component and in fact
20 not the major component, in why the pain was
21 persistent.

22 Q. I'm just concerned with your conclusion
23 that patellar maltracking caused pain in your report
24 here. Has that opinion changed today?

1 A. I'm not sure why you're confused when we
2 just described to you that this is a preliminary
3 report. So if you want me to amend the report and
4 say that the patella tracking is not the reason, that
5 would be part **of** the reason why I come to the
6 conclusion that it was one component. But perhaps if
7 stated as the reason, it was misread by others who
8 think that that's the only thing I am talking about.
9 Q. Well, I may have misunderstood, but that's
10 what your report says.
11 A. Okay.
12 Q. What did Dr. Patterson say about patellar
13 maltracking? Do you remember after reviewing his
14 testimony?
15 A. I believe he was not concerned about
16 patellar maltracking. He also said that you can only
17 tell by doing flection and extension views of the
18 knee, which to my recollection and to all the x-rays
19 that I looked at, not a single one was done by Dr.
20 Shin.
21 Q. Did Dr. Patterson observe patella
22 maltracking?
23 A. **I** don't know.
24 Q. Are there any other records that you're

1 aware of that relate to the issue of potential
2 patella maltracking other than the one you showed me?
3 A. Not that I see at this very moment.
4 Q. Just getting back to what your opinions
5 about this case today are, so far, we have covered or
6 gotten to the point -- I guess if the question was
7 asked what did Dr. Shin do wrong, there are three
8 things that I know of right now that you are going to
9 testify that he did wrong.
10 And the first was that the, of course,
11 tibial component -- installation of the tibial
12 component resulted in an unacceptable roughly
13 ten-degree tilt; secondly, that the tibial component
14 has about a six-millimeter overlay?
15 A. Correct.
16 Q. And that there was a failure on the part
17 of Dr. Shin to correct the varus deformity?
18 A. Correct.
19 Q. Further along in your report indicates
20 that the component itself after the initial
21 arthroplasty failed to achieve fixation and that
22 there was some instability.
23 MS. EKLUND: Where are you reading from?
24 Q. The third paragraph down when you are

1 summarizing the revision surgery operative notes.
2 The operative note indicates that the Femoral
3 component was removed quite easily indicating it had
4 not achieved secure fixation into her femur.
5 Failure to achieve secure fixation would
6 result in the failure of the arthroplasty, correct?
7 A. It could. That's correct.
8 Q. And here, you seem to be referring that
9 one of the reasons this arthroplasty failed was
10 because of insecure fixation?
11 A. That was one of the reasons based on my
12 review strictly of an operative report, which
13 obviously did not include any deposition discussion
14 by the operative surgeon.
15 Q. Okay.
16 A. But I did not say -- I do not see the word
17 "instability."
18 Q. Do you think it's important to talk to the
19 surgeon to see what he meant by certain phrases in an
20 operative report before you render an approximate
21 opinion about what the phrase means?
22 A. I think I can give an opinion based on
23 what's provided at the time. An opinion is just
24 that. The opinion is based on -- as it says in the

1 first paragraph and the last paragraph, the opinion
2 is based on those records; and the opinion is based
3 on trying to interpret what they're saying or what
4 they've left out.
5 Q. Well, let's do this.
6 A. And as I was saying, the fact that twenty
7 percent bone ingrowth is not the ideal and that -- as
8 you always refer to perfect versus imperfect, that
9 one hundred percent would be perfect, but it doesn't
10 happen very often. Twenty percent bone ingrowth is
11 not perfect.
12 And if it was your knee, I don't think you
13 would want only twenty percent of the bone to grow
14 into it. But that's all part of interpreting what I
15 read at the time in December.
16 Q. What *you* were reading was subject to
17 different interpretations as to what Dr. Patterson
18 meant, correct?
19 A. That is correct.
20 Q. And you took the one interpretation that
21 would lead you to believe that Dr. Shin did something
22 else wrong in terms of failing to secure fixation to
23 the femur, and that's what you concluded in your
24 report, that's the spin you put on that statement Dr.

1 Patterson made?

2 MS. EKLUND: Objection to that.

3 A. If you want to call it a spin, I don't

4 understand that. That sounds like a political word.

5 But he put in the component and, quoting Dr.

6 Patterson, only twenty percent of the bone grew into

7 the component. Now, that is not necessarily the

8 whole picture and does not reflect the major part of

9 my opinion. If you focus on it, you certainly can.

10 Q. I'm going to focus on this part of the

11 sentence because you put it in your report, and I

12 want to get the reasons why you put this sentence in

13 your report. Your interpretation of Dr. Patterson's

14 phrase quite easily -- you read Dr. Patterson's

15 deposition testimony, right?

16 A. Yes.

17 Q. Dr. Patterson did not mean to say that the

18 femoral component was removed quite easily,

19 indicating it had; he meant to say he had done good

20 with the Gigli saw?

21 MS. EKLUND: Objection to what he meant.

22 MR. FOGARTY: I asked him what he meant,

23 and Dr. Roth read that testimony.

24 MS. EKLUND: Maybe you should say what he

1 said.

2 BY MR. FOGARTY:

3 Q. You read Dr. Patterson's testimony?

4 A. Yes, I did.

5 Q. He did not in any way mean to say that the

6 femoral component had failed to achieve fixation,

7 right?

8 A. As I read it, yes.

9 Q. So you were going on that sentence,

10 correct?

11 MS. EKLUND: Objection.

12 A. I'm not sure what you mean by that. I

13 simply said his report indicated it came out quite

14 easily to her femur. He feels that secure fixation

15 with twenty percent bone ingrowth. I would venture

16 to say there's a lot of neoplaid surgeons who feel

17 that fixation would require more than twenty percent

18 bony growth, perhaps forty percent; but if it felt

19 solid to him, then I will certainly agree that it was

20 in solid.

21 Q. Well, let's get to that. Dr. Patterson

22 testified --

23 A. Or stable.

24 Q. Dr. Patterson testified about the effect

1 of achieving twenty percent bone ingrowth, did he
2 not?
3 A. Yes, he did.
4 Q. And he testified that's more than adequate
5 for an arthroplasty like this?
6 A. In a few words, yes.
7 Q. Do you disagree with that?
8 A. I don't disagree with what he said.
9 Q. What did he say?
10 A. In his opinion, he felt that it's going to
11 be, quote, pretty well fixed. On some people, it
12 might be pretty well fixed; on some people, it may
13 not be. So in this case if he felt it was pretty
14 well fixed, then she was there in the terms of
15 removing it.
16 Q. And you're not going to dispute --
17 A. I'm not going to dispute what he says in
18 terms of that it was pretty well fixed.
19 Q. What do you recall Dr. Wild had to say
20 about twenty percent bone ingrowth?
21 A. Only what he said.
22 Q. I'm sorry?
23 A. I'm not going to quote Dr. Wild because
24 I'm not reviewing his surgical talents.

1 Q. He was reviewing your expert talents and
2 had this to say about that twenty percent issue, and
3 I just want to know what your thought is on that.
4 He said that he's unaware of any standard
5 as to bone ingrowth. He is unaware of any specific
6 adequacy number of ingrowth. Are you aware of a
7 number of inadequacy bone ingrowth?
8 A. I don't think there's a set number.
9 Q. But you thought in this report that twenty
10 percent was insufficient, correct?
11 A. That's correct.
12 Q. Well, you say actually twenty percent
13 ingrowth is inadequate. What do you base that on?
14 A. Experience.
15 Q. What experience lead you to believe what
16 you just said?
17 A. Experience and reading what's in the
18 literature and what the manufacturer tells us about
19 bone ingrowth.
20 Q. Start with what the literature says about
21 bone ingrowth?
22 A. There's a variety of different opinions,
23 but that --
24 Q. What literature says twenty percent bone

1 ingrowth in a knee arthroplasty is inadequate?
2 A. I don't have any quotes for you.
3 Q. What manufacturer literature says twenty
4 percent bone ingrowth in a knee arthroplasty is
5 inadequate?
6 A. The manufacturer implies when sized
7 correctly there's bone ingrowth into the component.
8 And the implication is, as the sales people tell us,
9 that bone grows in; and they show all kinds of
10 articles about how it grows into the metal
11 components.
12 Q. Is there any brochure, seminar booklet, or
13 literature produced by the manufacturer that you are
14 aware of that says twenty percent bone ingrowth is
15 inadequate?
16 MS. EKLUND: Is there a period of time
17 we're concerned with?
18 A. I don't have any booklets that would
19 indicate that it's inadequate.
20 Q. You told me before that you would rely on
21 -- when I asked you what you relied on, you said what
22 the manufacturers state about it.
23 A. No. 1 said in my opinion in the letter,
24 they feel that that's inadequate. That's my opinion

1 as a surgeon, that if I put one in and it's twenty
2 percent ingrowth, I would say that's inadequate. If
3 Dr. Wild feels it's adequate or Patterson or your
4 favorite doctor, that's his opinion, and I think
5 that's perfectly fine. This is my opinion.
6 Q. I asked Dr. Patterson if twenty percent
7 ingrowth would mean a stable fixed prothesis, and he
8 said yes. And you will say no?
9 A. No, I didn't say that. I said that twenty
10 percent ingrowth is indicative of -- that it had not
11 achieved fixation. That is based on reading his
12 operative report. It did not say it was securely
13 fixed.
14 His operative report gave the impression,
15 and I would say that many other people would have the
16 same impression, that he said it came out very easily
17 and only had twenty percent ingrowth. Now, if he
18 corrects himself and if he backs off and says that
19 was adequate --
20 Q. But he didn't say only twenty percent bone
21 ingrowth --
22 A. I'm reading his operative, and that's what
23 his operative report says. Now, I based this opinion
24 in December based on his operative report without

1 having -- without having his deposition. And in his
2 operative report, it gives the -- it implies as I
3 stated that it was not adequately fixed.
4 Now, if Dr. Patterson says it was
5 adequately fixed, he was there. If he had to take it
6 off with saws and gigli saws or purrets (phonetic),
7 that's fine. Do I think twenty percent ingrowth is
8 adequate? No.
9 Do I think it was securely fixed, based on
10 his operative report? No. Based on his deposition
11 of only last week or two weeks ago, that's a
12 different story, but that's not what he dictated in
13 December -- or, in February of '96.
14 Q. Is there any record, document, x-ray,
15 anything having to do with this patient which would
16 lead you to believe that the arthroplasty that Shin
17 put in was unstable or failed to achieve fixation to
18 the femur?
19 A. Other than my interpretation of Dr.
20 Patterson's operative note.
21 Q. Which was a misinterpretation of the note.
22 MS. EKLUND: In fairness, Dennis, you're
23 not being fair with the witness because Dr.
24 Patterson says it is debatable whether twenty

1 percent is adequate or not, and you're not --
2 MR. FOGARTY: All I am trying to do -- Dr.
3 Roth read the transcript. All I am trying to do
4 is find out whether in Dr. Roth's opinion there
5 was fixation to the femur or not.
6 MS. EKLUND: He said he wouldn't dispute
7 that.
8 MR. FOGARTY: He did dispute it in the
9 letter. I am already finding out that I can't
10 rely on this letter as to what his opinions are.
11 I am trying to find --
12 MS. EKLUND: That's unfair.
13 MR. FOGARTY: I want to find out what the
14 opinions are and what they are not.
15 BY MR. FOGARTY:
16 Q. You would agree with me that when you are
17 going to prepare a report that implicates the quality
18 of the care one doctor gave a patient, you want to be
19 accurate; you agree with that, right? In other
20 words' you certainly wouldn't want anybody rendering
21 opinions about your care and treatment without having
22 the facts?
23 A. I would not want anyone to make an opinion
24 in testimony without having as much of the facts as

1 A. Yes, sir.
2 Q. That would be a big issue; that would be
3 something that you would put in there, right?
4 A. Are you doubting that I just said yes?
5 Q. So why would I think Dr. Patterson
6 wouldn't put it in there if you would?
7 A. I thought he did as **I** interpreted it.
8 Q. Dr. Wild was of the opinion that her --
9 Ms. Bastawros' symptoms might have been related to
10 some difficulty she had in her physical therapy
11 regime. Although he did note, as you suggested, that
12 the placement of the tibial component wasn't ideal,
13 he did say that it's very likely in his opinion that
14 her failure to adhere to the physical therapy regime
15 might have resulted in her symptoms.
16 You don't agree with that, I understand?
17 A. That's correct.
18 Q. But you do agree that physical therapy is
19 a normal part of the postoperative management of a
20 patient after the arthroplasty?
21 A. Yes.
22 Q. You prescribe it to all your patients?
23 A. That's correct,
24 Q. It's necessary for muscle strength?

1 possible; but if someone wants to have an opinion
2 based on what they read, they can have an opinion.
3 Now, in specifics regarding what Dr. Peterson said...
4 MS. EKLUND: Page 36 at the top.
5 A. You asked the question, Mr. Fogarty, to
6 Dr. Patterson: Did you mean to say that because you
7 carefully employed the osteotomes and the gigli saw
8 and had done it correctly, at that point, you were
9 able to remove the femur easily, or were you saying
10 that the femur was easily removed because there was
11 something wrong with the initial prosthesis?
12 So having asked him that question, to
13 clarify what he said, he answered the question, but I
14 will point out that in his operative report, he did
15 not say that it was adequately fixed. It's just not
16 there.
17 Q. It's not there that it's inadequately
18 fixed?
19 A. He did say that it came out easily.
20 That's open to interpretation.
21 Q. Have you done revision surgery?
22 A. Yes.
23 Q. Would you note in your operative report a
24 failure of the prosthesis to achieve fixation?

1 A. Yes, sir.
2 Q. That would be a big issue; that would be
3 something that you would put in there, right?
4 A. Are you doubting that I just said yes?
5 Q. So why would I think Dr. Patterson
6 wouldn't put it in there if you would?
7 A. I thought he did as I interpreted it.
8 Q. Dr. Wild was of the opinion that her --
9 Ms. Bastawros' symptoms might have been related to
10 some difficulty she had in her physical therapy
11 regime. Although he did note, as you suggested, that
12 the placement of the tibial component wasn't ideal,
13 he did say that it's very likely in his opinion that
14 her failure to adhere to the physical therapy regime
15 might have resulted in her symptoms.
16 You don't agree with that, I understand?
17 A. That's correct.
18 Q. But you do agree that physical therapy is
19 a normal part of the postoperative management of a
20 patient after the arthroplasty?
21 A. Yes.
22 Q. You prescribe it to all your patients?
23 A. That's correct.
24 Q. It's necessary for muscle strength?

1 A. Correct.
2 Q. And muscle strength will improve the range
3 of motion, correct?
4 A. No, but it's all part of the package.
5 Q. Your much maligned report indicates --
6 MS. EKLUND: Maligned by whom?
7 MR. FOGARTY: By Dr. Roth.
8 BY MR. FOGARTY:
9 Q. Your report indicates that she was
10 compliant with her physical therapy after you
11 reviewed the records?
12 A. That is correct.
13 Q. I reviewed some of your notes, and I
14 noticed a note that I asked you early on in this case
15 or this deposition about personality conflicts
16 between Ms. Bastawros and her physical therapy
17 person.
18 How would you characterize Ms. Bastawros's
19 physical therapy after her surgery with Dr. Shin?
20 A. That's a broad question.
21 Q. Yes.
22 MS. EKLUND: In terms of what?
23 A. It has multiple layers on that question.
24 MS. EKLUND: Let him clarify.

1 Q. Do you believe Ms. Bastawros was
2 sufficiently compliant with her physical therapy
3 regimen postoperatively?
4 A. Yes.
5 Q. You must have noted in your review of the
6 physical therapy records that there were
7 cancellations, there were no-shows, and then in fact
8 in January of 1994, she was discharged from Metro;
9 and the reason given, in the records anyway, was for
10 noncompliance with her home exercise program?
11 A. That's what was recorded, yes.
12 Q. In light of all that, why do you believe
13 that Ms. Bastawros was definitely compliant with the
14 physical therapy?
15 A. Ms. Bastawros attended physical therapy as
16 an outpatient 28 times totally compliant between
17 October and December in spite of her constant
18 complaints of pain and swelling.
19 She did not miss one visit until December
20 21st; went back; and then called once to cancel; went
21 back for two more visits; and then did not go because
22 she -- well, she did not go for two appointments.
23 Then after that, they had told her not to come back.
24 Now, she saw Doctor -- in the interim, she

1 saw Dr. Shin, went back for another visit, and went
2 back; and it hurt her so bad, she didn't want to go
3 back. At the same time, they said she was not making
4 any progress -- lack of progress.
5 They canceled her for lack of progress was
6 the first thing and what they felt was noncompliance
7 with the physical therapy home exercise program; not
8 noncompliance for showing up for physical therapy.
9 We have to see that this is a woman who
10 does not drive, could not drive, that is, had to rely
11 on transportation from others, that made 28
12 consecutive visits over two months. Now, that is
13 very, very compliant.
14 Q. How do the records reflect her compliance
15 with her home exercise program?
16 A. Each visit she complained of a lot of pain
17 and swelling and that she was not doing the home
18 exercises, and on several visits, and I don't have
19 them marked, that she was having too much pain to do
20 the exercises. So the therapist noted that, and I
21 would assume that that's got to be communicated
22 somehow to the doctor, but --
23 Q. Do you know whether it was?
24 A. I don't have any direct knowledge of that.

1 Q. Have you ever met Ms. Bastawros?
2 A. No, I have not. However, your question as
3 to whether she was compliant or not in attending
4 physical therapy, based on the fact she has gone to
5 28 visits over two months, she attended therapy quite
6 consistently, that's -- I mean, that's -- of all of
7 her scheduled visits, she missed less than ten
8 percent.
9 Since I treat a great number of patients
10 with joints and other orthopaedic problems, this is
11 exemplary. And to try to criticize her for not
12 showing up to one or two visits is absurd and unfair
13 to the patient.
14 Q. How about failure to do home exercises?
15 Do you believe that is sufficiently compliant?
16 A. I think I addressed that in the letter
17 that you don't care for. But in the face of the
18 pain, she could not tolerate the exercises. Now --
19 Q. Is that from the records?
20 A. It's based on my opinion of reviewing the
21 records, her comment to the doctor each visit, her
22 comment each visit to physical therapy about how much
23 pain she was having, how much swelling, also
24 understanding that she does go to therapy every time.

1 Patients who are noncompliant just don't show up
2 It's as simple as that. They just don't show up
3 Q. Do you know anything about Ms. Bastawros's
4 other -- or her basic -- her other health conditions,
5 any other health problems she suffers from or --
6 A. I believe she has high blood pressure,
7 which is not a major condition.
8 Q. And she's somewhat overweight. Are you
9 aware of that?
10 A. Yes, but not more than the many other
11 patients with similar conditions.
12 Q. Does that play any role in the
13 postoperative progress of a patient, the type of
14 shape they're in?
15 A. No, not necessarily. It can and can't.
16 It depends. If they have serious heart disease,
17 certainly, or weight does not play a major role.
18 Q. Her weight does not play a major role
19 in...
20 A. Her compliance.
21 Q. In compliance with PT and recovery time?
22 A. After she had the revision surgery, she
23 weighed the same and did beautifully, so I don't
24 think the weight had anything to do with that.

1 Q. You indicated that muscle weakness that
2 might be caused by noncompliance with physical
3 therapy does not cause leg pain, but maltracking of
4 the patella due to malalignment of the implanted
5 prothesis does.
6 Is it your contention that her compliance
7 or noncompliance with physical therapy played no role
8 in the failure of this prothesis?
9 A. The failure of the prothesis is the fact
10 that it was put in as we discussed before, and she
11 did not put the prothesis in. She had it in her --
12 Q. That was a bad question. She had
13 complaints of pain immediately after this surgery; am
14 I right? Don't the records reflect that?
15 A. Of course.
16 Q. Under these circumstances, the
17 circumstances that you've described in terms of what
18 was wrong with this surgery, when would you expect a
19 patient to immediately -- when would you expect them
20 to notice pain caused by these factors? Would that
21 be something that would be immediate?
22 A. I think you misinterpreted. Her pain
23 never went away. It's not like she got better and
24 all of a sudden she got worse again. She indicates

1 in her deposition that the pain never went away, and
2 she was significantly impaired in terms of her knee
3 as well as her daily activity with pain.
4 Q. Do you know what kind of condition she was
5 in prior to the initial arthroplasty?
6 A. Only what has been on the notes, and it
7 sounds like an average condition. She was walking.
8 Prior to her initial surgery, she was able to climb
9 steps; she was able to drive her car; she was able to
10 go shopping.
11 Q. She was able to drive a car prior to the
12 surgery? Is that reflected in your records
13 somewhere?
14 A. You didn't ask me what is reflected in my
15 records. It's reflected in her deposition.
16 Q. I'm sorry.
17 A. And you or someone else took her
18 deposition, so I will have you read that one over,
19 but those are things she could do before her surgery.
20 These are things she stated she could not do until
21 revised.
22 Q. Would you expect the pain to be noticeable
23 upon weight baring or would this patient be in pain
24 and bedridden?

1 MS. EKLUND: Are you talking about
2 immediately post-op?
3 MR. FOGARTY: Yes.
4 A. The first week.
5 Q. Other than incisional pain --
6 A. Yes. As time progressed, she didn't, and
7 that is part of the issue here.
8 Q. Let me see what I have covered and what I
9 haven't. Failure of the arthroplasty was caused in
10 this case by the faulty installation, let's say, of
11 the tibial component insofar as there was a
12 malalignment that we've talked about of about ten
13 percent -- about a ten-degree tilt, and there is also
14 about a six-millimeter medial extension of the
15 component, and there's a failure on the part of Dr.
16 Shin to correct the varus deformity?
17 A. Correct.
18 Q. What else? What else caused the failure
19 of this arthroplasty or what else caused her symptoms
20 necessitating the revision?
21 A. You're asking my opinion?
22 Q. Yes.
23 A. And this is based on interpretation of
24 information gathered.

1 Q. Okay.
2 A. Some of which was after the initial report
3 was written. Dr. Patterson replaced the femoral
4 component as well. I mean, if it was securely fixed
5 and one revises a total knee, you don't always revise
6 both aspects.
7 Q. Incidentally, I don't mean to interrupt
8 you, but you were good enough to bring the
9 components.
10 A. These are trial components and have
11 nothing --
12 Q. The femoral component would be what you
13 have right there?
14 A. Let's look at that from many different
15 ways. He did not remove the patella component. He
16 removed the femoral component.
17 Q. Did he say why?
18 A. No.
19 Q. But he removed the femoral component. He
20 removed it by -- after having gotten all of this
21 information, I obtained some literature from the
22 manufacturers. Dupuy.
23 A. Dupuy, D-U-P-U-Y.
24 Q. The literature has the measurements of the

1 components. The component that was put in -- the
2 femoral component that was put in initially is four
3 millimeters wide.
4 A. Okay.
5 a. Now, that's going from inside to outside
6 looking straight on. What size is that one, by the
7 way?
8 A. I don't know. The femoral component that
9 was placed in by Dr. Patterson was only 65
10 millimeters wide, a nine-millimeter difference.
11 MS. EKLUND: 64, I think.
12 A. No. Medial to lateral, 65, according to
13 the dimensions of the medial to lateral. 64 refers
14 to its anterior/posterior dimensions. I'm talking a
15 different dimension which was not addressed in my
16 letter.
17 And at the end of a thigh bone -- and I
18 will use this skeleton as a demonstration which won't
19 come across on a written deposition, but there's a
20 certain width to a knee from left to right.
21 I've already discussed the fact that the
22 tibial tray is offset. What does that mean? You've
23 got the component which is metal and plastic rubbing
24 on the inner tissues of the thigh everytime you bend

1 your knee from the inside out.

2 Now, if you had tight pants on, it would

3 rub your skin from the outside and irritate you.

4 This is rubbing on the inside. The femoral component

5 that was initially put in was nine millimeters wider

6 than was replaced.

7 Now, I wasn't at the surgery, so this has

8 to be an opinion based on what I read. But nine

9 millimeters wider, if -- when we're -- when a surgeon

10 is at the -- in the operating room looking directly

11 on the end of the femur, part of what the decision

12 making has to be is the size of the component; and if

13 it's too wide, it's going to rub on the soft

14 tissues. So that is also part of the --

15 Q. What soft tissues are left there after --

16 A. All this -- the inner -- not hard tissues;

17 soft tissues.

18 Q. Okay.

19 A. The capsule, the muscles, the skin, the

20 inside of the layer. So all those things can cause

21 an irritation to the knee. Irritation makes it swell

22 all the time. Swelling makes it painful all the

23 time.

24 Q. All right.

1 A. So you asked what other things are going
2 on. Other things contributed.
3 Q. You would actually be able to see that
4 irritation on the soft tissues once you opened up the
5 knee; isn't that correct? You would actually be able
6 to see that the component had been rubbing against
7 them?
8 A. Not necessarily see anything. It doesn't
9 show up like when you rub your eye and turns red.
10 But part of the training in putting in a component is
11 to size it correctly.
12 Q. What about the synovial tissue? Would you
13 see irritation in the synovial tissue with an
14 oversized component?
15 A. You could. You may not see it; it just
16 may be constantly swollen and tender. It's already
17 indicated that there was a great deal of swelling in
18 the knee all the time and that fluid was taken out.
19 Q. What did Dr. Patterson observe?
20 A. A lot of fluid in the knee joint.
21 Q. He did? Okay. Did he observe any
22 synovitis or anything like that?
23 A. He did not dictate that. I don't know if
24 he observed it and didn't dictate it.

1 Q. Where did you get the dimensions of the
2 femoral component that Dr. Shin used?
3 A. From the manufacturer's specifications
4 based on what he implanted, because we have the code
5 number of the implanted components.
6 Q. Where did you find out the code number for
7 it?
8 A. It's on the chart.
9 Q. So in addition to the errors in the tibial
10 component and the failure to correct the varus
11 deformity, an inappropriately-sized femoral component
12 was used by Dr. Shin?
13 A. Correct.
14 Q. Which of these factors, by the way, do you
15 suspect was the cause of her pain?
16 A. All of them.
17 Q. All of them? Not one individually?
18 A. No one thing. No one thing, but you put
19 them altogether, and then she had constant pain and
20 swelling.
21 Q. Have you ever seen an oversized -- have
22 you ever treated a patient or revised an arthroplasty
23 with an oversized femoral component?
24 A. No, I have not.

1 Q. Never run across that?
2 A. I've not run across it.
3 Q. How about the medial overhang that we were
4 talking about with the tibial component? Have you
5 ever seen that before?
6 A. I've probably seen x-rays of patients with
7 that before. Whether I've seen a patient with that,
8 no.
9 Q. What role would the varus deformity have
10 in the creation of the pain?
11 A. Significant role in that the anatomic axis
12 was not restored to what would allow everything to
13 smooth the track.
14 Q. It would affect her gait?
15 A. Yes. She would still be bowlegged.
16 Q. And that would --
17 A. Puts more pressure on the inside of the
18 knee.
19 Q. Where the medial overlay is; is that
20 correct?
21 A. I think that's correct.
22 Q. Did you ever investigate any alternative
23 -- or, in your review, did you ever see or notice
24 anything that might make you suspect an alternative

1 cause for her pain other than what we talked about?
2 A. Right. I just reviewed the fact that the
3 doctors at Metro Health did what appears to be a very
4 complete workup to determine if there's other
5 factors, specifically infection, and were able to
6 prove that that did not exist.
7 Q. Is there anything else with respect to the
8 arthroplasty performed by Dr. Shin that you believe
9 failed to meet the standard of care?
10 A. Yes.
11 Q. What else?
12 A. His failure to recognize that five, six
13 months, seven months after her surgery where one
14 would expect a patient to be relatively pain free and
15 very mobile and doing better than she had
16 preoperatively -- his failure to recognize that she
17 wasn't doing well and to suggest that, in his notes
18 anyway, that revision surgery is necessary or that
19 something else is going on, that that needed to be
20 corrected as opposed to just do more exercises which
21 had already proven to fail to help her.
22 Q. What did Dr. Shin do?
23 A. Has aspirated the knee.
24 Q. Is that something you would do, you would

1 try at least?

2 A. It might be, may not be the first thing.

3 There's bone scan; there's blood tests to be done

4 before you just stick a needle in someone's total

5 knee, which was done by the way by Metro Health, you

6 know, and reassessment as to what the films show.

7 Q. Have you ever had to revise your own

8 arthroplasty?

9 A. No, sir.

10 Q. So the failure to recognize the failure of

11 his arthroplasty?

12 A. That is correct.

13 Q. And to discuss the potential need for

14 revision?

15 A. Right.

16 Q. Which he did not do as far as can you tell

17 from the records?

18 A. From the records, it does not indicate

19 that.

20 Q. Anything else?

21 A. No, sir.

22 MR. FOGARTY: That's all I have, Doctor.

23 But before we go off the record, I want to

24 discuss or just confirm what I've asked for from

1 you.

2 I won't need -- I guess I will. I would
3 need copies of the manufacturers's pamphlets
4 that you have, the letters -- I don't want to
5 take this out of order, but maybe I can stack up
6 for you what I need. How do you have this
7 organized?

8 THE WITNESS: It's here. That's how I
9 have it organized.

10 MS. EKLUND: Is there a copy service
11 somewhere? I hate to ask your office to do
12 this.

13 MR. FOGARTY: Feel free to --

14 MS. EKLUND: If you can send it out to a
15 copy center, whichever you have.

16 MR. FOGARTY: And I will reimburse you for
17 it.

18 THE WITNESS: Do you want copies of all of
19 the protocol books -- some of them are actually
20 Ms. Eklund's -- or just the implant dimensions?

21 MR. FOGARTY: Which ones are yours and
22 which ones are Claudia's?

23 THE WITNESS: It's not a big deal.
24 Actually, the manufacturer's rep would be happy

1 to supply you with some.

2 MR. FOGARTY: I have some, but I just want

3 to have everything you relied on in a nice pile.

4 THE WITNESS: Everything that I looked at

5 was -- I looked at everything. The main thing

6 is the --

7 MR. FOGARTY: Were you going to take these

8 back with you?

9 MS. EKLUND: I was, yeah. How about if I

10 copy these for you?

11 MR. FOGARTY: Is there anything in the

12 x-rays?

13 THE WITNESS: I think they're a19 in the

14 chart.

15 MS. EKLUND: Actually, I'm going to

16 probably take those back with me so I'll have

17 them. So they will be in my office if you want

18 them.

19 MR. FOGARTY: Okay. If I could take a

20 look at that pile you have there.

21 THE WITNESS: You have a copy of this, and

22 you have a copy of his --

23 MR. FOGARTY: Yeah. Like I said, I just

24 want to copy everything or have everything you

1 have in a nice pile. Are those your CVs?
2 THE WITNESS: Yes.
3 MR. FOGARTY: How about your notes there?
4 THE WITNESS: Okay.
5 MR. FOGARTY: So right here -- this -- and
6 Claudia, you were going to send me copies of any
7 of the letters he might not have?
8 MS. EKLUND: Yes.
9 MR. FOGARTY: Doctor, these are the
10 materials I would ask to be copied. You can
11 feel free to use the copy service of your
12 choice, and I will reimburse you for any
13 expenses you incur. And spare no expense, you
14 can get the top of the line.
15 MS. EKLUND: Deluxe color copies.
16 MR. FOGARTY: You can have somebody pick
17 it up. Incidentally, Dr. Yarus' report was
18 reviewed by you, correct?
19 THE WITNESS: Yes.
20 MR. FOGARTY: That's all I have.
21 MS. EKLUND: I just want to put one thing
22 on the record; and that is, Dr. Roth, your
23 report does indicate that it was inappropriately
24 too large, that is, the prosthesis, in the last

1 paragraph. So you were misstating that you
2 hadn't mentioned that when you in fact had.
3 THE WITNESS: Oh, yes.
4 (DEPOSITION CONCLUDED AT 3:20 P.M.)
5
6 ______________________________
7 ANDREW M. ROTH, M.D.
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24

1 C E R T I F I C A T E

2 STATE OF OHIO

3 : SS

4 COUNTY OF HAMILTON:

5 I, Kelly Green, the undersigned, a duly

6 qualified and commissioned notary public within and

7 for the State of Ohio, do hereby certify that before

8 the giving of his aforesaid deposition, the said

9 ANDREW M. ROTH, M.D. was by me first duly sworn to

10 depose the truth, the whole truth, and nothing but

11 the truth; that the foregoing is a deposition given

12 at said time and place by the said ANDREW M. ROTH,

13 M.D.; that said deposition was taken in all respects

14 pursuant to agreement as to the time and place; that

15 said deposition was taken by me in stenotypy and

16 transcribed by computer-aided transcription under my

17 supervision; and that examination and signature to

18 the transcribed deposition is requested.

19 I further certify that I am neither a

20 relative of nor attorney for any of the parties to

21 this cause, nor relative of nor employee of any of

22 their counsel, and have no interest whatsoever in the

23 result of the action.

24

1 IN WITNESS WHEREOF, I hereunto set my hand
2 and official seal of office at Cincinnati, Ohio, this
3 6th day of May, 1999.
4

5
6 My commission expires: Kelly Green
August 8, 1999 Notary Public - State of Ohio
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24