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

IN THE COURT OF COMMON PLEAS

Martha Green,)
Plaintiff,) Doc. 399
vs.) Case No.
Hillcrest Hospital,) 133,825
et al.,)
Defendants.)

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Deposition of MELVIN SHAFRON, M.D., a witness herein, called *by* the Plaintiff **for** examination under the statute, and taken before Luanne Protz, a Notary Public within and for the State of Ohio, pursuant to the agreement of counsel, and pursuant to the further stipulations of counsel herein contained, on Tuesday, the 12th day of July, 1989 at 5:00 P.M., at the offices of Melvin Shafron, 26900 Cedar Road, City of Beachwood, County of Cuyahoga and the State of Ohio.

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APPEARANCES:

On behalf of the Plaintiff:

Gaines & Stern, by

John Scharon, Esq.

On behalf of the Defendants

Drs. Zelch and Heller, and

Chagrin Valley Radiology:

Reminger & Reminger, by

Marc Groedel, Esq.

On behalf of the Defendant

Sidney Stone, M.D.:

Weston, Hurd, Fallon

& Sullivan, by

John Jeffers, Esq.

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P R O C E E D I N G S

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MELVIN SHAFRON, M.D., being of lawful age. having been first duly sworn according to law, deposes and says as follows:

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(At this time Plaintiff's Exhibits 1, 2, 3 and 4 were marked for identification purposes.)

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EXAMINATION OF MELVIN SHAFRON, M.D.

Y MR. SCHARON:

Dr. Shafron, we are here on this Martha Green matter. You have been named as an expert for the Defendants in the case, or at least the Defendant, Dr.

We have besn favored with two reports from you, a report dated March 17, 1988, nd a report dated March 7, 1989.

I have also had a chance to look at our file, and we have marked your CV, two letters from Marc Groedel to you, and also our handwritten notes.

Other than the binders of medical records that you have next to you, is that your complete file in the matter?

A As far as I know, yes.

Q You don't have any notes that *you* made contemporaneous with reviewing the records in the case?

A I may have. If they are not in my folder, I've tossed them out. Obviously, when I go through records, I use a legal pad.

Q All right.

A Sometimes I keep them; sometime I throw them out.

Q They are not in that file; so, you think you threw them out?

A Probably.

Q I expect you would have tried to incorporate all of those notes into your reports.

A Sure.

Q Was your first involvement in this case following Marc's letter of January 21, 1988, introducing himself to you as representing the interests of Dr.

James Zelch and Dr. James Heller?

A I am sure of that.

Q All right. There is a handwritten note at the top of that, that says, "Discussed 1/27/88."

A Uh-huh.

Q Does that correspond with the discussion that *you* had *by* telephone?

A Probably, sure.

Q Are there any notes or memoranda of that phone conversation with Marc?

A I doubt it. I doubt it.

Q Do you remember anything about that conversation?

A No. I may have just called him and said that I looked at the records, or something like that; but I don't recall.

Q Do you know when you actually got them?

A No.

Q Page three of that letter indicates that enclosed with the letter are records from Hillcrest Hospital, Cleveland Metro General.

A And, indeed, they may have come with

the records.

Q Okay.

A Yes.

Q Also it says that there was a summary of the above-noted hospital records. Do you have that?

A In my records, no.

Q A summary?

MR. GROEDEL: It may be in there.

THE WITNESS: A discharge summary? I am not sure what you mean.

MR. GROEDEL: Let me see if it is in here.

John, what it is, is a summary prepared by my office which I usually put in the black binders. Those records have been in my office. It is quite possible that: I just pulled the summary out, and it is in my file. I will provide you with a copy.

MR. SCHARON: Fine.

BY MR. SCHARON:

Q Marc asked you to advise him, please, if you needed to see any of the X-rays. Have you seen the X-rays?

A No.

Q You are a neurosurgeon?

A Correct.

Q How do you define the practice of neurosurgery?

A A neurosurgeon is a doctor who deals with the diagnosis and treatment, surgically sometimes and medically other times, of a variety of disorders which can affect the brain, the skull, the bony spine, the spinal cord, the peripheral nerves.

Q What did you consider your assignment in this case to be?

A To render an opinion about what this patient's problems were, and what they are now.

Q Did you understand that you were to comment about whether the standards of care were met at Hillcrest Hospital?

A I am not sure I was asked to say

that, to be honest with you.

Q Is that your intention?

A I don't know,

Q Do you understand that to be your task in this case?

A I have no idea. I really don't.

Q Well --

MR. GROEDEL: Well, to clarify it, my letter to Dr. Shafron just asked for opinions on what is known as the proximate cause issue.

MR. SCHARON: Okay.

MR. GROEDEL: I can tell you that, on direct examination, I am not going to ask him any questions on the issue of standard of care.

MR. SCHARON: All right. That is all I am getting at.

BY MR. SCHARON:

Q This isn't a trick question.

A All right.

Q What I am trying to find out here is what we can expect you to be testifying to. Frankly, that wasn't clear to me from reading the reports.

A Okay.

Q So, you are not anticipating rendering any opinions about whether the radiologic studies at Hillcrest Hospital were appropriately read, for instance.

A I don't think so.

Q Okay.

A I don't believe so.

Q You haven't been asked to do that and haven't done it yet?

A No.

Q You don't plan on doing it in the future?

A I don't know what Mr. Groedel is going to ask me to do three months down the road; I really don't.

Q Similarly, as regards the orthopedic care at Hillcrest Hospital, you were not asked to render opinions about whether ths orthopedic care met acceptable standards?

A To the best of my knowledge, I was not; that is right.

Q Your CV indicates that you are on the staff at Hillcrest Hospital.

A Indeed, I am.

Q Do you know Dr. Stone?

A Yes, sure.

Q Do you know why he has, apparently, left the practice of orthopedic surgery?

MR. JEFFERS: Objection.

THE WITNESS: I haven't the

A No.

? Do you know Dr. James Zelch?

A Yes.

Q Have *you* worked with him?

A Yes.

? For how long have you had a professional relationship with Drs. Stone and Zelch?

A I don't think I ever had a professional relationship. I know who Dr. Stone is. I used to work at Euclid General where he was more active,

Q All right.

A Then, he was at Hillcrest. I don't think he was ever a very active practitioner in orthopsdics at Hillcrest, but

would see him in the hall and say hello to him. I know who he is, obviously.

Dr. Zelch is a radiologist. So, I knew Dr. Zelch from the time he came to Hillcrest, and I don't know what year that was. I think he left two or three years ago.

Q All right.

A But I certainly knew him at the time he was there.

Q Would you have worked with him?

A If I had --

Q Would you have consulted with him?

A If I had a patient who had problems, if he were going to be performing an examination on one of my patients, I would, obviously, look at the X-rays with him after they were done and discuss them with him, Among the things I usually do, if I have a patient who needs a special diagnostic study, if he were the one who was going to --

MR. JEFFERS: Let me insert an objection, because I find this to be irrelevant as to what he

would have done as a neurosurgeon with a radiologist.

THE WITNESS: I would talk to the radiologist and tell him what my problems are, and what I am interested in, and if he were to perform a myelogram or any other test for me, I would consult with him. I did that all the time with any other doctor who was going to be doing studies on my patients.

BY MR. SCHARON:

Q How much expert work do you do on medical malpractice cases?

A I probably see at least three or four a year, I guess, at least.

Q Okay,

A At least.

Q Over what period of time has that been true?

A Ten years; I don't know exactly.

Q All right.

A Maybe more, maybe less; I don't know.

Q In addition to medical malpractice

cases, are you also involved in medical/ legal reviews?

A I certainly am. Yes, I see at least one patient a week for that.

Q One patient --

A A week.

Q A week?

A Yes.

Q Is that pretty much throughout the year?

A As an average, yes. Maybe one week I would go without seeing anybody, and maybe see two patients the following week.

Q Would that have also been true over the period of ten years?

A Yes, I suppose, sure, sure; ten years, maybe less. I don't know.

Q Do you have any feeling about the percentage of time that you spend on medical/legal issues, whether it be mal-practice or otherwise, in any given time period that you want to choose?

A It is a small amount of my practice.

Q Can you give me a percentage?

A Five percent.

Q The rest of your time is spent --

A Seeing patients and operating; seeing patients here in the office, seeing patients at the hospital, and operating.

Q On the medical malpractice cases that you have worked on, have you ever worked on the plaintiff's side?

A Indeed, *yes.*

Q How many times?

A I think at least two in the past year.

Q All right. Two of the three or four times in the past year, then, you have worked on medical malpractice cases for the plaintiff?

A No. I would say in the past year and a half, **or** half a dozen cases.

MR. JEFFERS: What?

THE **WITNESS:** Two for the plaintiff in, perhaps, the last half dozen cases that I have seen, or eight cases, something like that.

BY MR. SCHARON:

Q All right.

A Maybe ten, I don't know. I really

don't count or keep track.

Q Are there any other plaintiff's cases?

A I am not sure what you mean.

Q Have you been an expert for the plaintiff in any malpractice cases, other than those two that you have mentioned out of the last half dozen that you have worked on?

A Yes, yes, yes.

Q How many in addition to those two?

A Several, maybe two or three more.

Q Have you ever been involved in a medical/legal case involving a lumbo-sacral facet dislocation?

A I had never seen one before, not like this. I had never seen one like this before.

Q That is neither in your practice nor in consultation?

A That is correct.

Q Or in a medical/legal setting?

A Correct.

Q Would you agree that lumbosacral facet dislocation is the appropriate term

to apply to what Martha Green sustained?

A I believe that is appropriate.

Q All right.

A Locked facets, bilaterally locked facets, sure.

Q Some of the literature, I guess, talks about a pure dislocation. Is that a term that you are familiar with?

A You can have a dislocation with locked facets, You can have a dislocation without locked facets. The fact that you say "dislocation" doesn't necessarily mean that you have locked facets-

Q Right.

A So that you would have to qualify what you say, With locked facets, there is no question that you would have a dislocation. Conversely, with a dislocation, you may or may not have locked facets.

Q Okay.

A So, they don't mean one and the same thing.

Q She had locked facets?

A As far as I know, yes.

Q Do I understand accurately, or, may-

be, am I paraphrasing your opinion in the case that, even if Martha Green had been operated on, had her dislocation reduced and had her lumbosacral spine fused in the immediate posttraumatic period, that her outcome would not have been significantly different than what you saw or what *you* found in this patient?

A Oh, she had no neurological deficit. I would assume, as with every patient I have ever seen who has had an accident of any kind, there's back pain. In other words, I think she would have back pain regardless *of* how soon or how late this were done, if the reduction could have been performed. In all honestly, I don't know whether or not the reduction could have been performed at all under any circumstances.

Q All right.

A It certainly couldn't have been done on day one, two, or three, or four, but on day ten or 12, I don't know if it would have been technically feasible to do. I don't know.

Q So that I understand what we might expect you to testify to, you don't expect to testify that it wouldn't have been technically feasible to do that surgery.

A I haven't the vaguest idea whether it could have been.

Q Okay.

A I don't know.

Q Are you saying that the severity of her back pain would have been the same?

A I am not --

Q Whether she had had that early surgery or not?

A I am not sure how severe her back pain is. I can't tell. She has some every day. She says it gets worse with activity, as I noted, It gets worse when she is on her hands and knees. She may have no pain without much activity. So, she has pain. The pain varies in intensity, and I can't say whether or not she would have had pain or not had pain had the reduction been able to be done. I don't know.

MR. JEFFERS: If what?

THE WITNESS: If the reduction had been able to be accomplished; in other words, I don't know whether she would have pain. I am just saying, in my own experience with patients like her whom I have seen, the pain never quits. So, you know, had she been able to have had a reduction of the dislocation and locked facets accomplished, I don't know whether the pain would have been any different,

BY MR. SCHARON:

Q Okay.

A Pain is -- now, that is something that you can't measure in a patient.

Q If the reduction and fusion had been able to have been accomplished in -- I refer to it as the immediate posttraumatic period. Let's Just put a general time limit on it, and let's say four to six weeks after the trauma. Given that time frame, do you think that she would have had the same postural deformity that she has now?

A I didn't notice any. So, I really can't comment on it.

Q As far as you know, she doesn't: have any postural deformity?

A I didn't notice any. I didn't notice it when I examined her. Therefore, I would not comment about it. I really can't tell.

Q How about any gait problems; did you note any of those?

A She had no gait problems when I examined her.

Q From reviewing the records, you are aware that she had her first attempt at reduction and fusion of this dislocation at Metro General in August of 1986.

A Correct, sir.

Q She went to nonunion.

A She had a nonunion fusion, yes.

Q Now, in that attempt at reduction and fusion, they were not able to reduce the dislocation, and they attempted a fusion, in situ.

A Sure.

Q All right. Do you have any opinion

as to whether the inability to reduce the dislocation made it necessary or resulted in the nonunion?

A Oh, I have no idea. Fusions do fail.

Q All right.

A No matter where they are done or how they are done, they can fail, and I can't tell you why the fusion did not take. I don't know.

Q Would *you* agree that, having to attempt to fuse this patient in the dislocated state; that is, with the facets displaced, and dislocated and locked, it would have increased the amount of stress on the fusion components?

A I can't answer that. I don't know.

Q Are you saying, Doctor, that -- strike that. Let me start that over.

Are you rendering any opinion about whether conservative management of this lumbosacral facet dislocation was appropriate?

MR. JEFFERS: Would you read that back?

THE WITNESS: I don't under-

stand your question.

BY MR. SCHARON:

Q Yes. Let me try and put it a different way.

We know the lumbosacral facet dislocation was not diagnosed at Hillcrest, correct?

A Well, I don't know. There are some allusion5 to the fact that one of the people taking care of her noticed it, but I can't answer that.

? Well, she didn't have surgery at Hillcrest Hospital.

A Yes.

Q She was in the hospital for about five or six weeks.

A At Hillcrest?

Q At Hillcrest.

A Okay, yes.

Q Do you know what the standards of care call for in the treatment of a diagnosed lumbosacral facet dislocation in that posttraumatic period?

MR. JEFFERS: Object.

THE WITNESS: I would make

certain presumptions that this is an unstable situation; that is, totally locked facets is an unstable situation. One would make an attempt, probably, to reduce it if you could, and if one could or couldn't, then, if you couldn't, you would have to fuse the patient in the unreduced position with her spondylolisthesis, and if you can reduce it, then, you would fuse her in the reduced position. But, she would probably have to be fused under any circumstances. The mere fact that she has a spondylolisthesis doesn't necessarily portend that a fusion will fail. There are lots of patients with spondylolisthesis for many reasons who have fusions.

BY MR. SCHARON:

Q Oh, I understand that.

A Sometimes the fusions fail, and sometimes they don't fail.

Q At this point, this question was not aimed at --

A I am sorry.

Q -- at the question of failure of the fusion.

A Yes.

Q My question is really whether a person who has a diagnosed lumbosacral facet dislocation needs to have, as you have said, that unstable spine reduced.

A I presume *so.*

Q And fused.

A I have never seen this.

MR. JEFFERS: I will put an objection in here. Before he finished his question, *you* commenced your answer.

THE WITNESS: I am sorry.

MR. JEFFERS: I want an objection between the two.

THE WITNESS: I have never seen this injury before, and I have never, obviously, therefore, treated a patient with an injury like this of the low back, Obviously, if I were going to be involved in something like this,

I would either have to consult a knowledgeable orthopedist who may have seen something like this, or go to the literature. But, I have never personally seen anything like this, nor have I been consulted for purposes of this.

BY MR. SCWARON:

Q Have you gone to the literature in preparing for your testimony in this case?

A No, no, no.

Q What about the lumbosacral facet dislocation makes it, to use your term, unstable? What does unstable mean in this context?

A In order for a total dislocation of locked facets to occur, the restraining ligaments of the facet joint5 have to be destroyed, and the position of the facet joints with relation to each other is totally reversed, and one is lacked over the other, or one is locked under the other, whatever *you* want to call it. One would presume that the patient has a nonstable spine in a situation like that.

Q Ooes instability carry with it the potential, then, for the vertebral elements, one on top of the other, to move?

A Sure.

Q In the area of L-5/S-1, we don't have a spinal cord within the spinal canal, but we do have the nerve roots of the cauda equina.

A Correct.

Q Now, as I understand it, in the cauda equina region, L-5/S-1, you've got relatively more room for the nerve fiber5 than *you* do in some of the upper levels of the vertebral column where you have spinal cord within the column.

A That is a reasonable conclusion or assessment, sure.

Q Well, understanding that you haven't seen this condition before, does it seem reasonable to you that you could get a lumbosacral facet dislocation at L-5/S-1 without producing many, if any, neurological abnormalities?

A Well, it is obvious that it happened

with her, sure, and I have seen spondylolisthesis for many reasons, not necessarily traumatic, in which patients have no neurological deficits, sure. She has no observable neurological deficit, except for what I mentioned in my report.

Q Would you agree that the decision as to whether or not to attempt a reduction and fusion of a patient with an L-5/S-1 facet dislocation in the immediate post-op period --

A You are not saying that right.

Q -- in the immediate posttraumatic period, is one that you make based on instability, irrespective of the presence or absence of neurological abnormalities?

MR. JEFFERS: Objection.

THE WITNESS: When you say "immediate," what are you defining "immediate" as?

BY MR. SCHARON:

Q We talked about it before.

A Four to six weeks?

Q Anytime from the date of the accident or the date of the trauma until four to

six weeks later.

A Well, the decision to operate on a patient depends, for a problem like this, on a number of factors, the most important of which is the patient's overall or general condition.

Q Sure.

A It would have not been prudent to operate early on this patient under any circumstance.

Q I am sorry.

A It would not have been prudent for anybody to consider an operation on the back here under any circumstances in the absence of any significant neurological findings or abnormalities.

Q All right.

A One would assume that this patient had an unstable back, and that something eventually should be done for her.

Q That "something" being an attempted reduction and fusion?

A Yes,

Q Is there a window within which that has to be accomplished?

A In order to do what?

Q In order to achieve reduction.

A Let me profess my ignorance to you.

Q Okay.

A I don't know whether a surgeon could have technically reduced this on day one easier than he could have done it on day ten, or easier than he could have done it on day 30. I just don't know. I really don't know.

MR. JEFFERS: Let me put another objection on the record, not to be totally objectionable for the evening. But, Dr. Shafron is here on behalf of the radiologist, and all I have been hearing recently are questions which are dealing with the particular surgical procedure which would seem to relate to the orthopedic surgeon in this case. He wasn't, as he indicated at the beginning, retained to make comments on that.

So, he's not basically here for you to sit around and ask him

about orthopedic problems, as far as I can tell, in this type of deposition. So, I object to your doing it. To make life simple, I will be quiet if you will accept that I object to all of these questions.

MR. SCHARON: I accept that, sir.

MR. JEFFERS: Okay,

MR. SCHARON: I really think that these questions go to the proximate cause issue which, apparently, he is here to testify about.

BY MR. SCXARON:

Q Putting that aside, I presume that, when you said that it wouldn't have been prudent to operate on the patient immediately after her trauma and admission to the hospital, that has to do with her general physical condition.

MR. JEFFERS: I object. He said: without significant neuro-logical signs.

THE WITNESS: Plus the fact that she was having bleeding.

BY MR. SCHARON:

Q Yes.

A Nobody knew where. She was given both fluid and blood resuscitation in the first three or four or five days, and life is more important than limb, so that the people in charge of her care had to make certain decisions about her.

Q Okay.

A And, they did.

Q If the lumbosacral facet dislocation had been diagnosed in the period when the more important care, the life care, was being rendered, would any precautions have been important to make sure that the unstable spine didn't progress?

MR. JEFFERS: Objection.

THE WITNESS: The only --

MR. GROEDEL: Objection. Go ahead,

THE WITNESS: The only thing that you could have done, if you felt the patient was in an unstable

situation, would be to brace her, if you could.

MR. JEFFERS: It would be what?

THE WITNESS: To brace her.

MR. JEFFERS: Okay.

THE WITNESS: Satisfactory or unsatisfactory as that may be, that would have probably been difficult early on, because she had so much pain and swelling that it might have been difficult to fit her with an appropriate brace,

BY MR. SCHARON:

Q Would you try to avoid getting a person up and walking or off to physical therapy?

A If I thought she were unstable, that would not be a prudent thing to do.

Q From the records at Hillcrest Hospital, it appears that, on discharge from the hospital after five or six weeks, and I don't know the exact date --

A Yes.

Q I will use that term, five or six weeks after her admission; she was

ambulating with the assistance of a walker.

A Uh-huh.

Q You still --

A Uh-huh,

Q Does that indicate that it is possible that she had some weakness of her legs at that point in time?

A No. It doesn't mean a thing.

Q It doesn't mean anything?

A I can't tell *you* why she was walking with a walker.

Q Okay.

A I would have to look at her therapy notes, but I can't tell you why.

Q In reviewing the records, did you see whether or not, during the hospitalization, right up until, say, the last week before she was discharged, she had intermittent complaints of numbness and tingling in her legs --

A Uh-huh.

Q -- to the physical therapist and also to the nurses?

A Uh-huh.

Q Were you able to see whether the physicians who were taking care of her were reacting to those complaints'?

MR. JEFFERS: Objection. You are outside the scope of this.

MR. GROEDEL: Yes. Yes, John. Really, he's not going to testify on direct examination about any of those issues. So, I really don't think it is fair for you to inquire in this deposition on those issues.

MR. SCHARON: Are you telling him not to answer?

MR. JEFFERS: You are about to take Dr. Brooks' deposition. So, *you* may inquire then.

MR. GROEDEL: I would rather that you go on to another question. For discovery purposes, you are entitled to inquire into his opinions that he is going to give on direct examination, and on direct examination, he is not going to be talking about these issues. So, in all fairness --

MR. SCHARON: Well, look --

THE WITNESS: I'll answer your question.

MR. SCHARON: Fair or not, what I am really trying to do is get as much information as I can from the doctor. Now, I understand what you are saying.

THE WITNESS: There is no mention of this in any of the progress notes written by --

MR. GROEDEL: Wait, Doctor. There is no question before you at the moment.

THE WITNESS: Oh, okay, okay. I'm sorry. Excuse me. Pardon me, gentlemen.

MR. SCHARON: With your statement on the record that you are not going to ask him any of that business about how she was treated at the hospital, I am comfortable with not going into that, but only based on that, because, obviously, I don't want to get into a situa-

tion where I am going to get ambushed. That is the popular term these days.

MR. GROEDEL: I am not going to ask Dr. Shafron on direct examination any questions that relate to Dr. Stone's conduct.

MR. SCHARON: All right.

MR. GROEDEL: We may tangentially touch upon what happened during that hospitalization.

MR. SCHARON: All right.

MR. GROEDEL: But only as it relates to the opinions expressed in his reports.

BY MR. SCHARON:

Q Well, let's do it this way: What was her neurological condition during the hospitalization and as of the time of discharge?

A I can't tell. I can read to you what the physical therapist says, but nobody examined her neurologically, to the best of my knowledge.

MR. JEFFERS: Pardon?

THE WITNESS: Nobody examined her neurologically, to the best of my knowledge, or if they did, it is not recorded.

There are notes in the narrative notes that on some days, the patient complained of numbness and tingling in her legs, and on other days, she did not. Numbness and tingling in the legs doesn't mean anything if it is not localized. So, I can't tell you, There are days she had none.. There are day5 when she had some.

If I could look at the physical therapy notes in terms of specifics, that might help. There is really no neurological examination, as far as I can tell in the record, except that they do note on 5/24/84 or, excuse me, 5/24/86, that the patient could have progressed to being independent without a device, which I presume is a cane or a walker.

MR. JEFFERS: What date is that, please?

THE WITNESS: It is dated 5/24/86 on the physical therapy notes.

BY MR. SCHARON:

Q It is the outpatient physical therapy note?

A Whether it was outpatient or not --

MR. JEFFERS: She was discharged on the 20th.

THE WITNESS: Yes.

MR. GROEDEL: That's an out-patient note.

BY MR. SCHARON:

Q In your first report of March 17, 1988, you state that you reviewed records of Hillcrest Hospital and Cleveland Metro.

A Uh-huh.

Q "I did not see the patient, and I have not reviewed the X-rays."

A Uh-huh.

Q But, then, in the next sentence you say, "From reviewing the Hillcrest X-rays --"

A It should be the records; that is an error.

Q On the question of what Martha Green's outcome would likely have been, had she had an attempted fusion and reduction of *the* dislocation in that period four to six weeks after her trauma, would you defer in your opinion on that to an orthopedic surgeon who has seen and treated and reduced three patients with lumbosacral facet dislocations?

A I would have to see it.

MR. JEFFERS: Objection. We are back on the same line of questioning.

MR. GROEDEL: I object also. Go ahead.

THE WITNESS: I would have to look at the records and see that. I just have never seen this injury.

BY MR. SCHARON:

Q Okay.

A And, I just don't know how common it *is.* If an orthopedist says that he has

treated three patients, I would sure like to see the cases that he said he did this with. To me, it is an extraordinarily rare injury. I have been in practice for 25 years, and I have never seen one. I have never been involved with one. So, I can't answer your question.

Q So, you wouldn't be willing to state that you would defer to that orthopedist?

A No, not necessarily at all.

MR. SCHARON: Now, just so that I don't waste time, Marc, on the question of radiologic care, you are not asking the doctor to comment one way or the other as to whether Dr. Zelch correctly interpreted CT scans or plain films or any other radiologic studies; am I right?

MR. GROEDEL: Correct, particularly in light of the fact that he hasn't seen the films.

BY MR. SCHARON:

Q I am not asking this to be a wise guy, but in your report, the first report anyway, you talked about -- I am looking

on the first page in that bottom paragraph right in the middle.

A Yes.

Q You indicated that a radiologist at Metro General said that the findings "may be related to previous trauma."

A That is what he said in his report, I am just quoting his report.

Q I understand. In other wards, there is absolutely no way anyone could say with reasonable medical probability that the changes were due to trauma.

MR. SCHARON: I mean, is that something that he is going to testify about? Because it seems to me that he is commenting there on the interpretation of X-rays.

THE WITNESS: Well, the radiologist -- I am sorry, You are asking Mr. Groedel the question.

MR. GROEDEL: I think, in my interpretation of Dr. Shafron's report, and, Doctor, you, of course, should correct me if I am wrong, he was commenting on the fact that;

the radiologist at Metro didn't diagnose a traumatic dislocation.

THE WITNESS: Absolutely, that is correct.

MR. SCXARON: Right.

BY MR. SCHARON:

Q Let me ask you this: If the radiologic studies at Metro General did show a lumbosacral facet dislocation, and the radiologist at Metro General didn't see it, are you saying that that excuses Dr. Zelch?

MR. GROEDEL: Objection.

THE WITNESS: I am not saying that at all.

BY MR. SCHARON:

Q From your review of the records, is it also correct that the Metro General radiologist noted a defect in the pars?

A That's what he said on the CT report. He did not mention locked facets. Sa, I can't answer that. That is all I can say.

Q From reviewing the operative notes in the case, do you know whether she had a pars defect?

MR. JEFFERS: Had a what?

MR. SCHARON: A pars defect.

MR. GROEDEL: You are talking about the Metro record now, right?

MR. SCHARON: The operative report.

MR. JEFFERS: Objection.

THE WITNESS: I have no idea. You would have to ask the operating surgeon, I assume. I don't know.

BY MR. SCHARON:

Q Do you know who diagnosed lumbo-sacral facet dislocation in Martha Green?

A No. I don't know who made the diagnosis first.

Q Or on what basis?

A No. Let me look at the operative note here.

MR. JEFFERS: Was there a question pending?

MR. SCHARON: No. He said no.

THE WITNESS: I don't offhand. I could look through the records.

MR. JEFFERS: You don't have to, Doctor.

MR. GROEDEL: You can look if you want.

MR. JEFFERS: All right. Who cares.

MR. GROEDEL: Look over here.

MR. JEFFERS: Is there a Dr. Smith or Dr. Jones?

THE WITNESS: Well, it was made postoperatively. I don't know; it was not made pre-operatively by the operating surgeon.

BY MR. SCHARON:

Q You are sure of that?

A He says that the pre-op diagnosis was grade three traumatic spondylolisthesis, L-5/S-1. The post-op diagnosis is dislocated bilateral facets, L-5/S-1.

MR. JEFFERS: What is the date?

THE WITNESS: August 11, 1986, the date of the surgery. So, I can't tell you, So, I don't know when he made the diagnosis. Pre-operatively, he didn't indicate it as such.

BY MR. SCHARON:

Q Pre-operatively, he called it traumatic spondylolisthesis?

A That is correct.

Q Mow can you get traumatic spondylolisthesis without dislocation of the lumbosacral facets and without having fractures?

A That beats me,

Q That is not possible; -is it?

A Not that I know of,

Q From the reports of the radiologist at Metro, there were no fractures of that area?

A As far as I know. That's a question that you should ask an orthopedic surgeon.

Q You talked about her complaint of the onset of bladder incontinence about a month after her discharge from Hillcrest Hospital. That was in, I think, your second report, if I am not mistaken.

A I didn't see her, obviously, until after I had sent: my first report.

MR. JEFFERS: Off the record.

- - -

(At this time a discussion was held off the record.)

- - -

BY MR. SCHARON:

Q Let's see if I can find it.

MR. GROEDEL: The second paragraph.

MR. SCHARON: The second full paragraph, right.

THE WITNESS: Yes.

BY MR. SCHARON:

Q You said that the exact nature and significance of this is difficult to ascertain.

A That is correct.

Q Are you saying that you don't think, or you don't know whether that bladder incontinence was a result of nerve root involvement in the cauda equina?

A I do not know, because, in my own experience, once this begins, it just doesn't go away. In other words, it came and went, and I have no idea of the significance of it.

I will tell you in a71 honesty that I don't know.

Q In other words, in your experience --

A In other words --

Q I don't want to cut you off.

A If she had a bladder problem because of cauda equina compression, I would not expect it to be here one day and gone the next day. I really don't know why she had it.

Q Did she indicate that it came and went in a day?

A She had a .short period of time when it came and went, from the history I got from her.

Q All right.

A She lost urine once or twice a week. She just lost it. Thinks that -- she does not think this happened while she was asleep, and it went on when she was home for a four-month period of time, so that she had some periodic episodes where she would lose urine once or twice a week.

Now, why this happened, I don't know. I honestly didn't ask her whether it hap-

pened with coughing or sneezing, because a lot of women will lose a little urine if they cough or sneeze sometimes. But, I didn't ask her that, and I really can't tell you. I would think it would be unlikely that it was due to cauda equina compression.

Q Why?

A Because, once it happens, it doesn't stop happening.

Q Even after a surgical procedure to relieve that?

A Absolutely correct.

Q To relieve that impingement?

A This is long before. This is before, and it went away.

Q I beg your pardon? Before --

A This happened during the period of time after she left Hillcrest Hospital, and, as far as I know, before she went to Metro.

Q Right. Wasn't urinary incontinence one of her complaints when she arrived at Metro at the end of July of 19863

A I can't recall that specifically.

Q The beginning of August?

A I would have to look.

Q Assume for a minute that it was.

A It was, okay.

Q Okay?

A Sure.

Q Assume that it was after arriving at Metro, and she went: through the diagnostic workup, and she went to surgery for the attempt at reduction and fusion which, as we know, failed.

A Uh-huh.

Q And, after that period, after that surgery, she had no more complaints about bladder incontinence.

A That would even make me feel it's less likely that it was related to cauda equina compression.

Q Why?

A Because the fusion failed. Nothing was really done, and she no longer had incontinence. In other words, I really don't know what the cause of that in-continence was.

Q When her fusion failed --

A Wait one second.

Q Okay.

A I am trying to give an answer to that, trying to be honest. There is a cystometrogram that she had, and I am trying to find this in the report.

No. What she is describing is not incontinence. What she is describing, or what the urologist describes is that she has too much pain to be able to get to the toilet on time. Once she has the feeling that she has to go, she says that her back pain is so bad that she can't control the urge to void. In other words, she just voids.. There, apparently, is no evidence of incontinence from a neurological deficit, as far as I can tell from reading this note.

MR. JEFFERS: Doe5 that have a marker? What page is that, or what date?

THE WITNESS: It is dated 8/13/86.

MR. JEFFERS: '86?

THE WITNESS: That is the report

date.

MR. JEFFERS: What is it? What type of report is it?

THE WITNESS: It is a consultation report, I presume, from a urologist.

MR. JEFFERS: Okay.

BY MR. SCHARON:

Q Did you find the cysto?

A I am trying to find the report. They say one was done.

Q What in the cysto report would tell you whether or not it was likely or unlikely to be an incontinence?

A If the patient had incontinence from a cauda equina compression, there would be an atonic bladder. Let me see if it is in the discharge summary from the hospital. I don't find the report offhand. I don't see it, in all honesty. I would have to go through the chart very carefully to find it.

Q Could we look at your notes of your physical examination?

A Sure.

Q That was done in February of this year?

A Yes.

Q What I would like to do is just have you read those in, because I don't think that the report is word-for-word what is in your notes. Am I right about that?

A Whatever you want.

Q Well --

A I will read my notes.

Q Thanks.

A I saw no evidence of weakness. She was able to step up and down without difficulty. She was able to heel and toe stand without difficulty.

Q Where are we looking now?

A Under "Exam."

Q All right. Well, please start at the beginning *of* your two pages of office notes.

A You want me to go through the history?

Q Yes.

A Okay. Patient has back pain, her primary complaint, which comes and goes.

I asked her how often it comes and goes. She could not say. Then, she said that she had some kind of pain every day which varies in intensity. It can get worse with activity such as getting on her hands and knees, and when she does this, she may experience sudden pain. She also may have sudden pain with activity, and she also may have no pain without much activity.

She also has what she described as a spasm of her muscles, She sees her muscles contract. The muscles in her thigh rip apart against themselves. She gets cramps in h'er calves, or her feet will curl under -- her toes. This may happen four nights a week.

It also may happen occasionally on days with sitting.

MR. JEFFERS: When, pleases?

THE WITNESS: It also may happen during the daytime with sitting. She said that the left side of her low back will tighten up. She said that these complaint5 that she was

describing to me began after her second operation in 1987.

I asked her what medication she was taking, and she told me. She tald me that she was involved in an accident when she was struck by a car and pinned between a car and a van.

BY MR. SCHARON:

Q Do you have a note there about whether she was given something for this?

A "Question Voltaren." I am not sure that that was the medication that she was given, and Vistaril.

Q And to the right of that?

A "Question, is this the right name far this medication." I don't know.

Q Oh, all 'right.

A She told me something. In other words, she told me the name of a medication, and I could not be sure that she was telling me correctly. The only medication I thought that sounded like that was Voltaren, which is a new type of drug.

Q Just above that, it says "never --"

A "-- quinine."

Q "Quinine," what's that about?

A I am a doctor. She had lots of cramps in her calves at night, and quinine is a medication that is used to sometimes treat this. I told her, as I said in my report -- I was very candid. I said: Talk to your doctors about this. I can't treat you, but there are medicines that can be tried which sometimes help cramping at night, because I have lot5 of patients with this.

Q You don't feel that this cramping pain is any sign of a neurological problem?

A No.

Q Is cramping pain sometimes a sign of a neurological problem?

A Not necessarily at all. I see a lot of patients postoperatively, and it is not a sign of a neurological problem.

Q Never?

A Well, nothing is "never,"

Q Right. Sometimes it is?

MR. JEFFERS: Object, object.

THE WITNESS: What I am saying is: In my own experience, it isn't; but if you ask me: Is it 100 percent, I will tell you that nothing in medicine is 100 percent. I just don't think that that cramping is a sign of nerve compression. I see a lot of patients with night cramps.

BY MR. SCHARON:

Q Okay.

A That is all. Should I go on?

Q Yes.

A She told me that, after the accident, she had a greet deal of back pain following her discharge from the hospital. She couldn't walk because her legs bothered her, She had a tingling or pinching feeling in the lower abdomen and groin, and experienced it for a long time. She thinks this may have gone away after the second operation.

She told ma that she saw Dr. Stone and presumably told the doctor something

about this urinary difficulty which she had some time after her discharge from the hospital, presumably within a month *or* so. She said that she would lose urine once or twice a week. She just lost it. It did not happen while she was asleep. She was home for a four-month period of time.

She said that her body was becoming deformed. Her hips were in the middle of her back, and everything was swollen. These ere her words.

Q Uh-huh.

A She said that she was hospitalized for four months the first time, but I am not sure that that is correct. That is what she told me.

She also told me that she was in a car accident in September of 1985, also an accident in February of 1986. She told me about her other surgery. She had a hysterectomy in October of 1988.

Q She gave you some details about those two automobile accidents?

A She told me, regarding the one in September of 1985, she was making a turn,

and a van was backing up and hit her at an angle. She had X-rays taken at Suburban Hospital of, presumably, the low back. She said she saw no doctor afterwards.

Q You have a note there, something about "hard to believe."

A Yes.

Q Why?

A Well, I am not naive. I can't believe that she wasn't involved in a lawsuit about his.

Q About what?

A About that first accident.

Q How do you know she was?

A I just find it hard to believe, and that's a comment I made, because I see tons of patients who are touched by other cars who run to hospitals or are seen by doctors for years. So, I just made a comment that it was a little hard to believe.

Q Do you think she is one of those patients?

A I just made a comment about it. I didn't say anything else. You brought it

UP-

Q I am trying to explore why you made the comment about her.

A I have no idea.

Q Well, is she a hard-to-believe person?

A I just wrote that her comment about what happened to her was a little bit hard to believe when she said that she had a problem with her low back and never saw a doctor afterwards. That's all I said.

Q Do you know whether she made a claim for that automobile accident?

A I never asked, and I haven't the vaguest idea.

Q Is it your experience that people who don't make claim5 don't run to the doctor'?

A They may or may not. She was also involved in an accident in February of 1986 when her car' was struck on the driver's side by another car. She said that she struck her head and neck, and her head hit the window; that she again went to Suburban Hospital and had X-rays of her head and neck; and she never saw an M.D.

afterwards. She said that she has many medications at home.

Q All right.

A She stated with specific questioning, obviously, that she has no leg pain whatsoever. She had a hysterectomy in October of 1988 for fibroids. She told me that she was divorced, was married, and the mother of two children ages 17 and 11.

I asked her where they took her bone grafts from. She said from the pelvis, which is really the iliac crest, in the first operation, and from the left fibula in the second operation.

Then, I examined the patient.

Q You started to tell us about the exam. I see "no weakness."

A Uh-huh.

Q Go ahead.

A "Steps up and down without difficulty. Heel and toe stands without difficulty. Good pulses in her legs, and both calves were equal in circumference."

Q Was the patient undressed for this exam?

A Well, undressed enough so that I could do the examination appropriately. I didn't have her nude.

Q Well, I mean, were you able to see the contours of her posture and her spine'?

A Let me just tell you something. I didn't note anything, and if I did, I can't make any comment about it, because I did not make a note of it.

Q All I am trying to find out is whether you were in a position *to* see it.

A I was in a position to *see* it.

Q All right.

A If I have a female patient with a problem with the low back, I ask them to take off all of their clothes other than their undergarments, their bra and panties.

I tested her for pin sensation. There were at times scattered areas, I thought, and it was not reproducible. There were scattered areas of altered pin sensation on the anterior thighs, the medial calf, and the lateral calf, and I just couldn't be sure.

I repeated it, but I just couldn't be sure, but I mentioned it.

I tested her reflexes in the lower extremities. I noted that the ankle jerks or the Achille's reflexes were decreased when compared to the others. There are no pathological reflexes.

I performed the straight-leg raising test, and I said that there was no sciatic pain or back pain with the straight-leg raising maneuver. I felt that she had no striking focal findings.

Q Then, what is the last note?

A "Again review records."

Q In the first sentence of your report of March 7, 1989, you say, "I saw this very nice lady in my office,"

A Uh-huh.

Q On page two you say that it is hard to believe that she didn't see any doctor after this automobile accident.

A So?

Q Did you come to any conclusion about whether or not she was a credible person?

A No.

Q Okay.

A I reported what I felt. I reported what I saw objectively.

Q Well, you also reported subjectively that you found it hard to believe that somebody had an automobile accident --

A That *is* correct. That *is* correct,

Q So, you weren't being totally objective, right?

A Well, I try to be objective in my report. I mean, I found it a little hard to believe personally.

Q Having not seen the X-rays, is it correct that you are not in a position to say whether the degree of her spondylolisthesis advanced between the time she was discharged from Hillcrest and the time she got to Metro?

A I can't say. I can't say.

Q So, that is correct; you are not in a position to say?

A I would have to look at it.

Q Have you had any discussions about this case with anyone other than Mr. Groedel?

A Not to the best of my knowledge.

Q Have you talked to Dr. Stone or Dr. Zelch about it?

No, sir.

Are you planning to do anything else on this case, other than respond to questions?

MR. GROEDEL: Objection. Go ahead.

THE WITNESS: I don't know what else *you* want **me** to do.

BY MR. SCHARON:

Q I mean, are you planning to do any literature review or review any further records or review **X-rays?**

A I don't know whether there are any further X-rays to review or records to review. I don't know whether Mr. Groedel wants me to --

Q I am asking subjectively what *you* have in mind to do now.

A I have nothing in mind to do.

Q Very good.

MR. GROEDEL: Just go home, right?

MR. JEFFERS: Go home and have dinner.

THE WITNESS: Or meet my wife somewhere,

BY MR. SCHARON:

Q In your report, in the last sentence of paragraph two, and this is the report of March 7 --

A Uh-huh.

MR. JEFFERS: The last sentence of what?

MR. SCHARON: Paragraph two.

MR. JEFFERS: What page?

MR. SCHARON: One.

MR. JEFFERS: Thank you.

THE WITNESS: Yes.

BY MR. SCHARON:

Q "She related a variety of complaints, including the fact that her body was 'becoming deformed in that her hips were in the middle *of* her back,"'

A That is what she told me. Those are her words, sir.

Q What was the variety of complaints that you were referring to?

A It is just mentioned there.

Q Anything other than being deformed and having her hips in the middle of her back?

A And the pain.

Q "And everything swollen"; that is another one of your notes.

A That is what she said.

Q There is nothing else that is not noted?

A No, sir.

Q "Weakness in the legs was tested with heel and toe walking."

A Uh-huh, indeed.

Q Any other tests?

A No. That's the best to use, which is a functional test, sure.

Q Have you reached any conclusions about whether the degree of pain that she complains of subjectively is disabling?

A I could not. Even in retrospect thinking about her, I can't say.

MR. SCHARON: I don't have any other questions for you.

MR. JEFFERS: I have just a

C E R T I F I C A T E

The State of Ohio,)

County of Cuyahoya.) SS:

I, Luanne Protz, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, MELVIN SHAFRON, M.D. was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the case aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

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

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

IN **WITNESS** WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, this 28 day of July **A.D.**, 1989.

Luanne Protz

Luanne Protz, Notary Public

In and for the State of Ohio

My commission expires 4/9/93

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Julius Wolkin, M.D. *(retired)*
Melvin Shafron, M.D.
Benedicl J. Colombi, **M.D.**

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CURRICULUM VITAE

Melvin Shafron, M.D.

EDUCATION:

B.S. Adelbert College, Western Reserve University 1952
Phi Beta Kappa, Omicron Delta Kappa
Delta Sigmo Rho Honorary Societies

M.D. Harvard Medical School 1956

INTERNSHIP:

University Hospitals, Ann Arbor, Michigan 1956-1957

RESIDENCY:

General Surgery: Cleveland Veterans Administration Hospital 1959-1960

Neurological Surgery: University Hospitals *of* Cleveland 1960-1964

MILITARY SERVICE:
United States Navy - Active Duty 1957-1959

PRESENT ACADEMIC APPOINTMENT:
Associate Clinical Professor, Neurosurgery
School of Medicine, Case Western Reserve University

SOCIETIES:
AMA, OSMA, Cleveland Academy *of* Medicine,
Ohio State Neurosurgical Society,
Northeast Ohio Neurosurgical Society,
American Association of Neurological Surgeons,
Neurosurgical Society of America,
American College of Surgeons,
Cleveland Surgical Society,
Certified by American Board of Neurosurgery 1966

HOSPITAL APPOINTMENTS AND OTHER ACTIVITIES:
Mt. Sinai Medical Center,
Visiting Surgeon (neurosurgery)
Director, Division *of* Neurosurgery
Member *of* Medical Council
Past Member of Executive Committee
Past Treasurer, Medical Staff

Hillcrest Hospital,
Active Staff, Past Chief of Staff
Past Member, Board of Trustees,
Past Chairman of Medical Council

PLAINTIFF'S EXHIBIT 1 7/12/89

(continues next page)

CURRICULUM VITAE
Melvin Shafron, M.D.

Hillcrest Hospital (continued)
Past Member of the following Committees:
Tissue
Utilization
Peer Review
Quality Assurance (Chairman)
Credentials & Intensive Care
Director, Division of Neurosurgery

Suburban Hospital
Active Staff
Past President of Medical Staff

Cuyahoga County Medical Society
Past Member of Health Insurance Review, Legislative, Ethics, & Peer Review Committees
Past Member of the Board of Directors (two terms-six years),
Past Member of Executive Committee of Board of Trustees, (two years), Vice President

TEACHING ACTIVITIES:
Monthly Tutorials - 3rd Year Clerks
CWRU School of Medicine
Educational Activities - Departnient Surgery, Mt. Sinai
Weekly Activities - (Meetings)
Division Neurosurgery
CWRU

SOCIETY ACTIVITIES:
Northeast Ohio Neurosurgical Society
Past President and Secretary

American College of Surgeons,
Ohio Chapter, Member of Credentials Committee

Neurosurgical Society of America
Past Member and Chairman of Long Range Planning,
Nominating, and Membership Committees,
Current Member of Executive Committee,
President 1988-1989

CURRICULUM VITAE
Melvin Shafron, M.D.

LECTURES/PUBLICATIONS:

Guest Participant in 8th Annual Neurophysiology Conference sponsored by Department of Neurology, Washington University School of Medicine, St. Louis, Missouri, April, 1963

Ascending Spinal Pathways of Centre Median Nucleus in Cat.
An experimental Method for the Study of Pain
Melvin Shafron and William F. Collins, J. of Neurosurgery, Vol. XXI, no. 10, Pages 874-879, 1964

Exhibit on Experience with the Treatment of Hydrocephalus with Ventriculo-Jugular Shunt at University Hospital
Annual Meeting, Harvey Cushing Society, April, 1965

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Melvin Shafron and Stephen Weiner, Radiology, Vol. 85, No. 5, Pages 921-926, Nov. 1965

Aneurysm of Vein of Galen in Infancy, Javier Verdura and Melvin Shafron
Surgery, Vol. 65, No. 3, pages 494-498, 1969

Treatment of Carotid Artery Aneurysms by Carotid Ligation,
Annual Meeting, Neurosurgical Society of America, 1973

Unusual Vascular Complications of Trauma, Annual Meeting,
Neurosurgical Society of America, 1973

M.R.I. evaluation of Pituitary Tumors, Annual Meeting,
Neurosurgical Society of America, 1984

Management of Extensive and Difficult Cranial Defects,
Bahman Guyuron, Melvin Shafron, arid Benedict Colombi,
J. of Neurosurgery, Vol. 69, No. 2, pages 210-213, August, 1988

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MARC W. GROEDEL
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ROBERT D. VILSACK

OF COUNSEL:
LEWIS J. RINGLER

GEORGE M. GREETHAM (1888-1958)
EDWIN C. REMINGER (1895-1977)

discussed 1/27/88

January 21, 1988

Melvin Shafron, M.D.
26900 Cedar Road
Beachwood, Ohio 44122

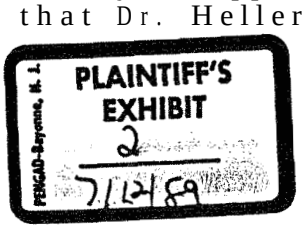
Martha Green vs. Hillcrest Hospital, et al
Our File No.: 360-02-12566-87
Cuyahoga County Common Pleas Case No. 133825

Dear Dr. Shafron:

I represent the interests of Dr. James Zelch, a radiologist, and Dr. James Heller, a general surgeon, in a medical malpractice action that has been brought against these two individuals and others by Ms. Martha Green. I am in need of expert consultation in this matter and would like to know whether or not you would be willing to serve as an expert consultant on behalf of my two clients.

The salient facts may be summarized as follows. The patient, Martha Green, is a 30 year old female who was pinned between two cars in a parking lot on February 15, 1986, and brought to the Hillcrest Hospital Emergency Room by ambulance. Her chief complaint was pain in her lower back and pelvis along with paresthesia of both feet and along the back of the left leg. Her abdomen also showed moderate lower abdominal tenderness along with ecchymosis over the lower abdomen. Lacerations of the lower extremities were repaired and the patient received five units of blood over the first 48 hours of her hospitalization.

CAT scans of the lumbar spine were taken and interpreted by Dr. Zelch. A spondylolisthesis at the L5-S1 level was found. Dr. Zelch felt that this was a congenital abnormality as opposed to a traumatic injury. It is my understanding that Dr. Heller



managed the patient for her internal injuries, while Dr. Sidney Stone managed the orthopedic aspect. The patient was treated conservatively. At the time of discharge, March 20, 1986, she was able to ambulate with a walker.

Mrs. Green then underwent physical therapy on an out-patient basis at Hillcrest Hospital. Her lower back pain complaints continued and she was eventually able to progress to using a cane. Our notes indicate that she was last seen for physical therapy on April 21.

On August 8, 1986, she was admitted to Cleveland Metropolitan Hospital for further work-up, coming into the care of Dr. R. Geoffrey Wilber. Additional CAT scans were taken which revealed evidence of Grade II spondylolisthesis of L5/S1. A myelogram revealed a complete blockage in the L4-5 area. On August 11, 1986 Dr. Wilber performed an L5 laminectomy with bilateral posterolateral fusion of the L4 to the sacrum. Surgical notes indicate that a rather large cyst was found at the time of the thoracodorsal fascia was opened. The cyst was approximately 8" x 8". Notes also indicate that an attempted reduction was carried out. The L5/S1 facet dislocation could not be reduced. Therefore, the decision was made to do a fusion and the surgery was successfully completed, The remainder of the patient's hospital course was essentially uneventful and August 26, 1986, she was transferred to Highland View Hospital for further rehabilitation. She was discharged on November 4, 1986.

She apparently did well until January of 1987 when intermittent lower back pain and transient intermittent numbness of the right leg reappeared. She was admitted to Cleveland Metropolitan General Hospital on April 3, 1987. On April 6, Dr. Wilber performed a fibular strut graft of the L5-S1. The rest of the hospital course was uneventful and the patient was again transferred to Highland View Hospital on April 20, 1987 for further physical therapy. She remained at Highland View until May 15, 1987. Notes indicate that the patient was told that her pain would be chronic in nature but that it would decrease with time.

Although I have yet to receive any expert report from Plaintiff's counsel, it is anticipated that Plaintiff will allege that Dr. Zelch erred in diagnosing the spondylolisthesis as congenital in nature. I suspect that Plaintiff will argue that Dr. Zelch should have diagnosed a traumatic spondylolisthesis, and had such diagnosis been made, immediate surgery would have transpired with a better result than we have seen thus far. I would

therefore appreciate any comments you might have on this potential issue. Does traumatic spondylolisthesis warrant an immediate surgery? Would Mrs. Green's subsequent surgical course been any different had a traumatic spondylolithesis diagnosis been made at the outset? Would her prognosis have been any different had the surgeries took place in 1987 been accomplished when she was first admitted to Hillcrest Hospital?

Please advise as to whether you will need to view any of the CAT scan and/or x-ray films from either Hillcrest Hospital or Cleveland Metropolitan General Hospital. Also, for your review, I herewith enclose the following documents:

1. Hillcrest Hospital chart for admission of February 15, 1986.

2. Hillcrest physical therapy records (out-patient 4/1/86 to 5/24/86).

3. Cleveland Metropolitan records (admission 8/8/86)

4. Cleveland Metropolitan records (admission 4/3/87)

5. Summary of above-noted hospital records.

6. Report of Dr. R. Geoffrey Wilber, dated November 3, 1987.

Your frank and candid opinions are requested. We will, of course, gladly honor your statement for services rendered. Finally, give me a call after you have had the opportunity to review these materials so that we might discuss your opinions on a preliminary basis. Should you require any additional information or have any comments or questions regarding this matter, please do not hesitate to contact me. I look forward to hearing from you.

Very truly yours,

REMINGER & REMINGER CO., L.P.A.

Marc W. Groedel

MWG: pmh

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March 11, 1988

Melvin Shafron, M.D.
Mt. Sinai Suburban Medical Building
26900 Cedar Road
Beachwood, Ohio 44122

SUBJECT: Martha Green v. Hillcrest Hospital, et al.
Our File Nos.: 360-02-12566-87 and
420-02-12532-87
Cuyahoga County Common Pleas Case No.: 133825

Dear Dr. Shafron:

Enclosed please find a letter from plaintiff's counsel summarizing the opinions of his two expert witnesses, Drs. Glaser and Hartz. At this stage, I will need a report from you summarizing your opinions.

As you may recall from our previous discussion, it was your opinion that the delay in diagnosing her spondylolisthesis as traumatic did not have any impact upon either her immediate course of treatment or her current level of disability. Needless to say, please favor me with your statement for services rendered along with your report.

Very truly yours,
REMINGER & REMINGER CO., L.P.A.

Marc W. Groedel

MWG/jdd
Enclosure

Moon Martha

PLAINTIFF'S EXHIBIT 4 7/14/89

mrs 33

2/21/89 =

C.C. Back: pain in back
comes/goes - how often -
I can't say
few pain of
some kind every day - varies in intensity

gets worse ē activity - worse ē bends/knees
can experience sudden pain ē says have no pain ō
much activity

also "spasm" of muscles - sees muscles contract   cramp in calf
muscle ↑ trying to step stairs apart
foot and under - happens 4 NITES/week
⊕ day ē sitting

⊙ side of low back tightness ō =

began after 2ND op 1987 = doctors at Pentres
VISTARIL   never quinine
⊕ VOLTAREN
? given a name for this

Basically that's

Hillcrest Feb ↑ 1986 = accident - impact now
↓ trauma
hit by car - pinned between it & a VAN -

1ST Hillcrest ~~patients~~ time
much back pain following discharge - couldn't walk
became weaker - leg also hurned - a tingling/pinching
feeling in lower abdomen & groin - experienced it
for a long time - ? went away after 2ND op

saw Dr. Stone - presumably told Dr. Stone about it

~~She~~ urine difficulty - some time after discharge
within a month = her she lost urine 1-2/week
just lost it - ~~thinks~~ it did not happen
while she was asleep; here for 4 months period time

her body was becoming deformed = hips were in the
middle of back - every thing swollen

hosp. 4 months 1ST time

Not busy - any - NOU
Hosp: went home readmitted April following
2 mos

car accident Sept. 1985 =
st. wale a TRAN & a Van Bachi up het
her at an angle = head xray Suburban = low back
no doctor afterwards = } head Suburban

accident Feb. 1986 - drivers side hit
by another car - hit head/neck =
head hit window
Suburban - xray head/neck } never saw M.D. afterwards.
her very neck at home

aptly glands
hysterectomy - Oct. 1988
Hx - nerves Fibroids
married = 2 children 17/11
Husband - divorced

no work now
no work then
She has no leg pain whatsoever

pelvic 1st elevated
tubular (c) 2nd

Ex:

I see no weakness - steps up/down
s difficulty - heel toe stands s difficult
good pulse Both calves 39

Sx: intact to proprioception
& tripping atrophy at times -
scattered & fair - ant thigh, medial calf &
lat. calf

	K-J	A-J	Toes
Reflexes R	++	+20	↓
L	++	+20	↓

SLR - 90/90 s sciatica
a back pain

Comment: no focal findings
exc
big pain recall