THE STATE OF OHIO,)
) SS:
COUNTY OF CUYAHOGA.)

IN THE COURT OF COMMON PLEAS

FRANCES SMITH, Administratrix of the Estate of Rlvester Smith, Sr., Deceased,

Plaintiff

vs.

Saint Luke's Hospital, et al.,

Defendants.

Doc. 421

Case No. 100877

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Deposition of CURTIS We SMITH, MD, a Defendant herein, taken by the Plaintiff as if upon cross-examination before Lorraine J. Box, a Registered Professional Reporter and Notary Public within and for the State of Ohio, at the office of Charles Kampinski, Esq., 1530 Standard Building, Cleveland, Ohio, on Monday, the 25th day of August, 1986, commencing at 2:25 p.m., by agreement of counsel.

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APPEARANCES:

Charles Kampinski, Esq.,
On behalf of the Plaintiff.

Reminger & Reminger, by:
Mark Groedel, Esq.,
On behalf of the Defendants Timothy L. Stephens, Jr., MD and Curtis W. Smith, MD.

Arter & Hadden, by:
Rita A. Bartnik, Esq.,
On behalf of the Defendants St. Luke's Hospital, J. E. Edmonson, LPT and K. Fedeshen, LPT.

Jacobson, Maynard, Tuschman & Kalur, by:
Stephen J. Charms, Esq.,
On behalf of Defendant S. J. Lee, MD.

ALSO PRESENT:

Timothy L. Stephens, Jr., MD

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STIPULATIONS

It is stipulated by and between counsel for the respective parties that this deposition may be taken in stenotypy by Lorraine J. Box; that her stenotype notes may be subsequently transcribed in the absence of the witness; and that all requirements of the Ohio Rules of Civil Procedure with regard to notice of time and place of taking this deposition are waived.

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CURTIS W. SMITH, MD,

the Defendant herein, called by the Plaintiff for the purpose of cross-examination as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposes and says as follows:

CROSS-EXAMINATION

BY MR. KAMPINSKI:

Q. Would you state your full name, please?

A. Curtis West Smith.

Q. We've met before, Dr. Smith, you've been through this. I'll forego some of the preliminaries. You're board eligible, I take it, but not board certified?

A. That's correct.

Q. Have you taken the test?

A. Yes, I have.

Q. You did not pass it?

A. I took the test this spring; I'm awaiting the results.

Q. Okay. This is first time you took it?

A. No, it isn't.

Q. How many times have you taken it before?

A. This is my second time.

Q. First time you didn't pass it?

A. I passed part of it.

Q. Do you take it in parts?

A. Well, it changes at various times, but at the time I took it you could take the written and the oral part, and I passed the oral part and I haven't passed the written part.

Q. You took them both?

A. Yeah.

Q. You don't have to take the one you passed again or do you?

A. You have to take them all over again, according to the rules at the time I took it. They have changed.

Q. What do you have to do now? How have they changed?

A. This year I could still take them both. It doesn't require passing of both to go on to the next step. People who graduated who finished their residency last year can take only the written part. At the time that I took it there was at least a two-year wait before you could take it. That was no longer in force. You could take it as soon as you finish your residency. It's been a flux in terms of when you can take it. At the time previous people took it I believe you had to wait a

year and it was changed to two years for various reasons.

Q. When do you get your results on the testing?

A. End of September.

Q. Just briefly to remind me, when did you graduate from medical school, sir?

A. 1977.

Q. That was where?

A. Case Western Reserve University.

Q. And residency in internship was where?

A. University Hospitals.

Q. Until when?

A. '77 to '82.

Q. Okay. And then you commenced with?

A. Dr. Stephens.

Q. Okay.

A. Associates in Orthopedics.

Q. Have you been there ever since?

A. That's correct.

Q. Would you indicate, please, what your -- where you have your privileges, what hospitals?

A. At St. Luke's Hospital, Huron Road Hospital, St. Vincent's Charity Hospital, Suburban Hospital, and Mt. Sinai Hospital.

Q. How many of these did you have in 1984?

A. All except Mt. Sinai.

Q. Have you ever had any other patients die after a hip replacement procedure, sir?

MR. GROEDEL: Objection. Go ahead.

Q. Die in the hospital.

A. I think when I was a resident I had -- its either -- yeah, I believe it was when I was a resident.

Q. Since you've been a doctor?

A. I was a doctor then.

Q. Since you've been in charge and responsible for the treatment of the care as opposed to having a primary physician over you as a resident?

A. I don't recall.

Q. Was that a patient that you operated on?

A. It was a patient that I was the primary resident on. I don't recall whether I was the first or second assistant on the case.

MR. CHARMS: Dr. Smith, could you keep your voice up? I'm having a little trouble hearing you.

THE WITNESS: Surely.

Q. (BY MR. KAMPINSKI) Is that a risk you

tell patients?

A. Of death?

Q. Yes.

A. Certainly.

Q. What procedure do you use for total hip replacement, Doctor?

A. Depends on the condition that the patient has and the patient's age.

Q. What procedure did you use with Mr. Smith?

A. It's called a bipolar prosthesis.

Q. Bipolar meaning what?

A. Two poles.

Q. Where would the two poles be?

A. The one pole is considered the replacement of the femoral head, which is a metallic ball, a second pole is a non-cemented semispherical acetabular hip socket.

Q. And whose equipment would you use? Did you have any preference for any --

A. I used that that was currently being used at St. Luke's Hospital.

Q. Which was what?

A. This was a -- I believe at that time -- I can look at the chart and tell you.

Q. Sure, go ahead. Feel free to look at the

chart any time I have a question of you that you need to look at it. Just so you indicate for me what you're looking at when you find the answer.

A. Sure. It's a DuPue.

Q. What kind? Does it give additional --

A. Left bipolar endoprosthetic replacement, it's called. At that point we were using a tri-lock, I believe.

Q. Tri-lock meaning what?

A. The fit into the femoral canal, into the lower man --

Q. What kind of cement did you use?

A. At this point, at this case we used methyl methacrylate, bone cement.

Q. Has that changed, the type of cement being used with the hip replacement?

MR. GROEDEL: Objection.

A. I'm sure there are always revisions in the cement that's used, but I don't know whether we've made changes. We use whatever is the current state of the art.

Q. You mean you don't know what's used in it?

A. I know methyl methacrylate is still used as a bone cement.

Q. Is it used at St. Luke's?

A. I would have to check.

Q. When is the last time you did a hip replacement?

A. That I cemented?

Q. Yes.

A. I can't recall.

Q. Why is that? You don't cement anymore?

A. For most of the ones I do, we do what's called a poros-endo, so cementing is something that's not done on every occasion.

Q. Has there been a movement away from using cement because of the difficulties in revisions?

A. Certainly.

Q. Okay. And has the hardware changed also to accommodate that change?

A. The hardware is designed specifically with the particular instrumentation that you use.

Q. What hardware are you using now mostly?

A. Again, you're dependent on the hospital. At St. Luke's, a number of pieces of hardware are still available. Some of the DuPue hardware is still there, I believe Halmedica has equipment still there, so the choices you make really depend on what you decide to use in a particular case.

Q. Has there been a change in policy at St.

Luke's in terms of the use of cement or can you if you wanted to still use it?

A. Surely, you can still use it.

Q. Okay. Why was it decided to use cement with respect to Mr. Smith?

A. The decision was made at the time of the operation. The decision was made because in the process of preparing his femoral canal for the femoral stem of the prosthesis, there was a small crack in the femoral neck. In order to stabilize the femur, it was elected to use cement.

Q. In other words, you weren't planning to use it before you got in there?

A. No, I hadn't. But that decision is made at the time of surgery.

Q. Well, don't you have to do preparatory work in terms of the size of the hardware that you're going to use? Don't you have to do a template --

A. Sure, but that's a guide. The ability to use a size up or a size down can be made on the spot.

Q. Do you have any records, notes, anything that reflects what it was that you decided you were going to use before you got in there? Would the

x-rays tell us that?

A. The x-rays would have been of assistance to put the template up on the x-rays.

Q. But I mean where is it that it says what size component you're going to use before you go in there so that it's ready and available for you?

A. All of the components are available.

Q. Okay. No matter what size you ultimately have to use what is --

A. Right.

Q. -- available is right there in the operating room?

A. Right there in the operating room.

Q. What size did you use with Mr. Smith?

A. 17 and a half millimeters.

Q. Was that what you were planning to use or do you have any recollection?

A. I don't have a recollection.

Q. Do you subscribe to osteotomizing the trochanter or not?

A. In a primary total hip, no.

Q. No?

A. No.

Q. Do trochanteric osteotomies make it easier to do the surgery though?

A. I would suppose it would. Depends on your usage of trochantery osteotomies in the past whether you deem it necessary to create sufficient exposure. Most often with trochantery osteotomies they're used for revision of total procedures.

Q. They are?

A. They are.

Q. You didn't do one here though?

A. This was not a revision.

Q. You didn't osteotomize the trochanter?

A. No, I did not.

Q. Why don't you tell me what you did do during the operation. You can refer to your operative note if you want.

A. Exactly what do you mean? You mean from the time I entered the room?

Q. Sure.

A. Starting from --

Q. Are you reading from your operative note, doctor?

A. This is -- I assume you wanted the entire thing. This is the report of the operation.

Q. What page so I can just follow along with you.

A. 146.

Q. Okay. By the way, this was dictated by whom?

A. Dr. Michael Gill.

Q. Okay. That would have been what, your resident?

A. He was a chief resident on the service at the time.

Q. Okay. Countersigned by -- is that your signature?

A. That's correct.

Q. This is November of 1984?

A. That is correct.

Q. So you had been with Dr. Stephens for approximately what, two years, a little over two years?

A. A little over two years.

Q. Had you done a lot of these surgeries, these hip replacements?

A. Bipolar prostheses?

Q. Sure.

A. Yes, I've done quite a few of them.

Q. How many would you say you've done?

A. I would have to check my records.

Q. One a month? One a week? Just to put us into some type of framework.

A. Certainly at least one a month.

Q. I'm sorry, go ahead.

A. Indicates that the patient was brought to the operating room --

Q. First, before you even get to the procedure, there's a little notation above it that says complications.

A. Surely.

Q. Are those complications during the surgery?

A. Certainly if you consider surgery at the time of the patient's being put to sleep, then yes.

Q. These were surgeries, then put it in the anesthetic --

A. I'm sorry?

Q. These were complications in the anesthetic?

A. Yes.

Q. I'm sorry. Go ahead.

A. "Patient brought to the operating room placed on the operating table in a supine position," which means on his back. "He was induced with general anesthetic. He was intubated, endotrachial tube. He was ventilated through that airway. He was turned to the side lying position," it's called

the decubitus position, "such that the left hip was exposed to the surgical field."

Q. I can read this as well as you can.

A. I don't understand what you want from me, sir.

Q. Well, how many people did you have assisting you?

A. I can tell you the number of residents there. Dr. Gill and Dr. Peters

Q. It says surgeon, Dr. T. Stephens?

A. Sure does.

Q. That I take it is an error?

A. [illegible]

Q. You w[illegible]

A. [illegible]

Q. Y[illegible]

[illegible] that correct?

A. I had met him prior to that, but yes.

Q. When had you met him prior to that?

A. I met him in my office.

Q. And he was referred by the internist?

A. Dr. Edgar Jackson.

Q. Okay. And when you met him in the office, was this procedure discussed what would be done?

A. Yes, it was.

Q. And the purpose of the procedure was to what, alleviate a problem he had with the limp?

A. It was primarily to alleviate his pain.

Q. He was having pain?

A. Right.

Q. It was an elected procedure, was it not? It was something he had lived with for a number of years since he was a teenager, apparently?

A. Well, I assume it was a little bit more than elective because he wouldn't have presented unless he wanted to change significantly his lifestyle.

Q. I assumed that.

A. He gave me that impression. He said he was having pain. The limp is something that he had had since the time of his adolescent injury, but the pain was increasing.

Q. Okay. So it was decided to do something about it at that time?

A. It was decided that he wanted to have something done about it.

Q. So that is elective?

A. Surely.

Q. Okay. It's something he could have lived

with, something --

A. That he chose not to live with.

Q. And you agreed after, I take it, reviewing x-rays that you could do something for him?

A. Correct.

Q. And you took a medical history, I take it?

A. Absolutely.

Q. And you were aware of his hypertension problem?

A. Yes, sir.

Q. You were aware of his other past medical history?

A. I was aware of his hypertension. Dr. Jackson's usual routine when he refers patients, he would give me a call to let me know what the patient's status was, what he thought his problem was, asked me to see him.

Q. As a matter of fact, after it was decided that this would be an appropriate procedure to perform on Mr. Smith, he was put into the hospital for that procedure in October and that was vetoed by Dr. Jackson? I mean, he indicated that it wasn't appropriate at that time because of his hypertension and an upper respiratory infection,

correct?

A. That is correct.

Q. In any of these x-rays that you looked at before, was this crack in the femoral neck noted by you?

A. It was not there.

Q. Okay. So this had to happen when?

A. As I said, during surgery.

Q. So while you were doing surgery, a crack developed in the femoral neck?

A. Yes.

Q. Okay. I apologize if I'm bouncing back and forth, but as I think of these things, I certainly want to give you an opportunity to respond to them. After he went home in October, the decision was made for him to come back I guess November 14th, he actually came back the 12th?

A. Decision was made on discharge that Dr. Jackson would follow him in the office and when he thought appropriate he would call me and we would arrange a readmission.

Q. That was done, I take it?

A. That was done.

Q. He did in fact return to the hospital I think November 12th. Did you see him or his family

upon his return to the hospital?

A. I'm certain that I saw him. I did not see his family.

Q. He knew you were going to do the surgery, not Dr. Stephens?

A. Absolutely.

Q. Okay. Did Dr. Jackson again check him to clear him for the surgery?

A. Prior to his second -- after his second admission?

Q. And before the November 14th surgery.

A. As I stated, he checked him periodically in his office and he checked him in the hospital prior to his surgery, that's correct.

Q. So it was decided that he was in an appropriate physical condition to undergo the surgery?

A. That is correct.

Q. What caused or precipitated the complications regarding maintaining adequate blood pressure and poor intra-operative oxygenation, if you know?

A. I don't know.

Q. This is something that the anesthesiologist had to deal with, I take it?

A. That is correct.

Q. Why is it, sir, that he was sent from that operation to intensive care? Whose decision was it?

A. Anesthesia's decision.

Q. Did you have any input into that decision?

A. My input usually is do -- if they ask me or if they're concerned about the patient's oxygenation, I leave it up to them. If they say, Do you object if we send him to SICU, I would say no.

Q. Have you ever had input to the point where you're the one that indicated you want your patient going to intensive care?

A. Not regarding an operative -- if this is a postoperative decision, that's usually based strictly with anesthesia. I have input into that. If I have some concerns that differ with the anesthesiologist's concern, then I'm sure we would try to come to a decision about whether it would be most appropriate. I'm sure in the case where either of us thought it was appropriate, that's where the patient would go.

Q. Who is the physician in this situation responsible for the patient, you or the

anesthesiologist? Whose position is it?

A. Just as in most situations where delegation and responsibility is given to the parties that are most attuned to taking care of those particular areas as in the postoperative phase of an anesthetic, the anesthesiologist is generally considered to be in charge of the patient.

Q. Who is the attending physician?

A. I am the attending physician.

Q. You have direct primary responsibility for that patient while he's in the hospital, do you not, sir?

A. That is correct.

Q. You can, can you not, sir, give orders with respect to where you want that patient in the hospital, can you not, sir?

A. I can do that at any time.

Q. Okay. So that if you perceive the existence of a problem, whether it be intra-operative or postoperative or preoperative, you can address that problem as the primary physician responsible for that patient; can you not?

A. If I'm made aware of the problem.

Q. Okay. Do you have any recollection of having input, sir, into the decision to send Mr.

Smith to intensive care after the November 14th surgery?

A. Not directly.

Q. Okay. You were aware of the fact that he was sent there?

A. Oh, of course.

Q. Okay. You indicated that a crack in the femur occurred. Could you show me where that is set forth in this operative note? Okay, I see it. Page 147.

A. I have about a quarter of the way back.

Q. Okay. What's the calcar portion, what part of the femorale or the femur is that?

A. It refers to an area proximal to the left trochanter and distal to the femoral neck -- femoral head on the inner aspect what we call the medial side.

Q. Did you take x-rays of that during the operation?

A. We took it after we finished, yes, during the operation.

Q. During the operation?

A. If you're considering the operation as the time -- the total time he was in the operating room, yes.

Q. Why don't you find those x-rays, if you would, so you can show me what you're talking about.

A. This is the area of the left trochanter, this bump here. This is the outer portion. This is the hip socket. This is the prosthesis. This is the area of the calcar. It is thickened --

Q. Can we see some type of a fracture there?

A. I can't.

Q. Why not?

A. Why not?

Q. Yes.

A. Probably depended on the projection. It was a very small crack at the time. We were concerned not so much about how large it was, but where it was.

Q. Okay. And that caused you to cement the femur?

A. That's correct.

Q. Cement the -- actually put cement all the way down inside the femur?

A. Down at least to the ends of the prosthesis.

Q. Do you have any postoperative pictures, Doctor?

A. Yes, I do.

Q. On this one that we're looking at, which is I guess dated the 14th, I believe -- it's actually October.

A. It's admission 10-18-84. He probably still had his initial card.

Q. That couldn't be it, could it?

A. No. I'm saying the number you're asking about --

Q. Okay.

A. He probably had his initial template made on that date.

Q. Okay.

A. Postoperatively with surgical --

Q. We can't really see the cement though, can we?

A. Not very clearly, no.

Q. Do you have any others?

A. No, I don't.

Q. That's the only postoperative film that you have?

A. Yes, it is.

Q. Is that the only one that was taken?

A. You mean initially?

Q. Isn't at any time postoperatively?

A. There's another operation that could be

considered postoperative.

Q. Do you have those?

A. Surely.

Q. Let me see.

A. Here it is.

Q. Can you see the cement in there?

A. End of the cement right there. (Indicating)

Q. That's the line for the cement. Is the cement supposed to be poured evenly through the femoral canal?

A. It's injected under pressure as evenly as possibly can be done.

Q. Have you had a lot of experience using cement?

A. Surely.

Q. This is the second operation, Doctor?

A. That is -- no.

Q. A picture during the second operation?

A. This is the socket. This is out of the socket. This is the picture that was taken to confirm he had a dislocation.

Q. How did that happen?

A. I don't know. I wouldn't know how it happened.

Q. Well, was he put under some type of restraints after the operation?

A. He is put in a triangular --

Q. Traction?

A. He's put in what's called an abduction splint.

Q. What's that?

A. I was explaining it to you.

Q. I'm sorry.

A. A triangular device between his legs to keep his legs in a position that's not closed together because this -- any type of hip replacement has an area of weakness and one of the things you want to maintain is that position of abduction. The patient helps maintain that, the nursing staff, the abduction --

Q. He can't get up and walk around with that thing on?

A. With the pillow in between, I've had patients try to get up. It's very difficult to do it.

Q. And I take it nurses are in to watch him to make sure nothing occurs with respect to that particular hip so that the cement can't set and that --

A. Cement's already set.

Q. It is set. It hardens immediately?

A. Hardens within 10 or 15 minutes, depending on the particular cement.

Q. You don't cement the ball into the acetabulum, do you? How is that --

A. There are a number of prosthetic replacements for his particular problem which were elected not to do.

Q. Why not?

A. Because of his age, because of his shape of his acetabular.

Q. How was it set in there then?

A. When you asked me initially about the bipolar component, this sets as a suction fit into the already existing hip socket that is relatively freely mobile in the socket, but with the constraints that it's locked in, so if you can picture a suction fit. But you're still able to twirl the socket. That's what the design of this kind of prosthesis is for.

Q. I assume that's easier to dislocate than a cemented one, or maybe I'm wrong?

A. I think you're wrong. There are a number of -- they are all prone to dislocation, and the

exact figure I would have to look up. It's my impression that the dislocation rate is somewhat higher in this type of prosthesis. The exact numbers, I couldn't quote you at this time.

Q. It would take some type of movement, would it not, to dislocate it to the extent we see it in that picture?

A. Extent doesn't make any difference. If it's dislocated, it's dislocated.

Q. All right. What would, in your opinion, cause that to --

A. The patient could have malpositioned himself even within the -- even within the constraints of his bed. He could have been turned to prevent weakness in this prosthesis. A number of things could have happened. I have no idea of knowing which one of them.

Q. Does he undergo physical therapy after the operation?

A. Yes.

Q. What do --

A. There is a routine protocol for postoperative.

Q. What do they do with respect to the hip, if anything?

A. Well, he is further instructed in the physical theraputic modality that he had been instructed in prior to surgery. He is initially begun on strengthening exercises to the muscles around the hip joint.

Q. What does he do for that?

A. He performs the exercise that he's instructed by the physical therapist.

Q. What exercise would they be?

A. Initially they involve basically isometric tightening of the muscles around the hip joint. Once he becomes a little bit stronger from the effects of a general anesthetic and a major surgery, he's gotten up and his ambulation is assisted. He's shown how to --

Q. That didn't occur here, did it?

A. No, it did not. You asked me what the protocol was.

Q. You've reviewed this record before coming here today, haven't you?

A. Yes, I have.

Q. He did have some physical therapy, didn't he?

A. I didn't review that part of it, no. But I would have to review it.

Q. Why don't you take a minute, take a look at that.

A. Okay. He was seen by physical therapy pre-operatively and given protocol, which is on page 106 in the physical therapy, in their rehabilitation notes. He was seen on 11-15 while the patient was still in the intensive care unit. He would --

Q. They would see him in intensive care?

A. They see him the day after surgery.

Q. I'm sorry?

A. He was seen by the doctor in the intensive care unit. His lower extremity exercises consisted of ankle pump, which are just moving the ankles up and down to try to avoid clots.

Q. Thromboembolic phenomenon.

A. Ankles, circles in both directions.

Q. He was seen by the same licensed physical therapist the -- November 13th, November 15th and November 16th, correct?

A. That's correct.

Q. J. E. Edmonson, and then seen by K. Fedeshen, licensed physical therapist on November 17th, correct?

A. That's correct.

Q. And there is something different that was seen on the 17th and that is the internal rotation, she's got underlined apparently. That's a dislocation?

A. Until proven otherwise.

Q. Well, it was not proven otherwise, it was dislocated?

A. You asked me was it a way to assess that. To get a proper follow-up, proper x-rays. Those were obtained.

Q. Okay. She do anything when she saw him --

A. I did not have conversation with her.

Q. According to the note, can you determine -- or what does it mean when it says unable to position (L) LE to neutral? What does that mean?

A. Unable to position left lower extremity to neutral.

Q. What is neutral?

A. Point the toes straight up in the air.

Q. Would that be because of this dislocation?

A. That could be one of the causes.

Q. So she tried to position him and couldn't?

MS. BARTNIK: I'm going to object.

Q. (BY MR. KAMPINSKI) According to the notes, as best we can determine?

A. As best we can determine.

Q. Then it says patient states he has not been performing AEPs on his own. What are AEPs?

A. Probably something to do with the ankle exercises, but that's physical therapy -- a symbol that I'm not familiar with.

Q. Then we go down a little bit, it's got "Poor diaphragmatic breathing secondary to complaints of abdominal pain." Do you see that notation there?

A. Surely.

Q. So he was complaining of abdominal pain?

A. According to the note.

Q. You didn't do any surgery on his abdomen, did you, Doctor?

A. No, I did not.

Q. Okay. Were you aware of the fact that he was in abdominal pain, sir?

A. At this point, no.

Q. This is the 17th, I mean, the date that you performed surgery on him.

A. If you're asking me was the -- this information either relayed to me or was I aware he was having abdominal pain, no, I was not.

Q. Would that have made any difference in

your decision to perform surgery on this man on November 17th?

A. Not considering his immediate past history of having the -- having had a major anesthetic as well as a major operative procedure, having had a history of some abdominal surgery in the past to have gastritis following a major type surgery is not unusual.

Q. Is that what he had, is gastritis, Doctor?

A. That is a supposition.

Q. Whose supposition?

A. That was shared with me by the resident on call that evening. It was confirmed by Dr. Jackson the following morning.

Q. What day are you talking about?

A. I'm -- if this is the initial note of -- this was the night before?

Q. 16th.

A. We'll have to check the note.

Q. Go ahead. Well, before you do, let me finish the one sentence then we'll go back and check it. The next sentence says "LE exercises performed well, then standing held today." Do you know what that means, sir? Lower --

A. Lower extremity exercises performed well.

I guess he wasn't going to try standing.

Q. Okay. I'm sorry. Go ahead and see if you can find that note now.

A. On the 16th of November --

Q. What page, Doctor?

A. That's 119.

Q. I'm sorry?

A. 119.

Q. And I'm sorry, what note is it that you're looking at?

A. The on call note by Dr. Cendo.

Q. Dr. who?

A. That signature is Cendo, C-e-n-d-o.

Q. Who is he?

A. He's another orthopedic resident.

Q. Okay. And what does it say?

A. It says "Patient had coffee ground emesis tonight."

Q. What is that, just so the record is clear?

A. Basically vomitus.

Q. Okay.

A. "Also complains of some abdominal distress. Unable to void. No other complaints."

Q. Um-hmm.

A. "Patient may have gastritis or stress

ulcer," in parenthesis, "status post" --

Q. "Intubation"?

A. Looks like "intubation."

Q. "And ventilation"?

A. "Ventilation. Plan, Tagamet IV/PO."

Q. What's that?

A. Maalox.

Q. What's PO?

A. By mouth.

Q. Maalox by mouth?

A. Maalox by mouth, Foley catheter.

Q. You agreed with that, I take it?

A. I knew of it. I can't recall whether he called me to make me aware of it, but I did not disagree with it, yes.

Q. Well, you were aware, I take it, of the possibility of an ulcer earlier, weren't you, Doctor?

A. I'm not sure what you mean, sir.

Q. Well, let's see. I guess it was 119. Did the patient lose a lot of blood in the first surgery?

A. I would have to check and see.

Q. Okay.

A. His estimated blood loss, according to

the brief note on page 112, is 400 ccs.

Q. 400?

A. 400.

Q. On your operative note, which was dictated by Dr. Gill and which you apparently countersigned, it said 200.

A. The actual measuring of the amount of blood loss is done by weighing napkins, surgical sponges, looking at the surgical field, estimating how much may have gone into suction, how much may have been diluted with irrigation, that sort of thing.

Q. So a 200 cc difference is not a big deal?

A. No.

Q. Was a hemovac put in?

A. I'm sure it must have been. It's usually routine. "Large hemovac drain."

Q. And how long was it in?

A. I'll have to check and see. I don't see it. It's usually removed around 48 hours. I don't see the specific references.

Q. Well, would it be removed if there was continual -- or additional drainage or --

A. Depends on the amount and the quantity of the drainage.

Q. Once there was no more drainage, you'd remove the hemovac?

A. It would depend -- if there were no drainage at all, it still would probably remain in place for at least 24 hours, and it would be left in place up to 72 hours and possibly longer.

Q. Is a doctor's order required to remove it? Is a doctor's order required?

A. It's usually removed by the surgical resident, so --

Q. But you can't tell from the record here whether it was removed or not?

A. I cannot tell from the record.

Q. Can you tell how much drainage there was?

A. In the notes of the primary medical staff that include the residents and the other MD personnel, I don't see a reference. I have not checked the nurses' notes.

Q. Doctor, when you were made aware of this possibility of gastritis or stress ulcer, did you do anything to try to check any other tests that had been taken or other values regarding your patient to determine whether or not -- and I take it this diagnosis or possible diagnosis was made because of the coffee ground emesis?

A. The coffee as opposed to disclosure discomfort.

Q. Other things can cause that as well as gastrointestinal bleed?

A. Coffee ground emesis?

Q. Sure.

A. There are many causes, that's right.

Q. There are tests that you can do to try to figure out which one of the causes it is, aren't there, sir?

A. And the usual postoperative state, since this is a relatively common occurrence, the general practice is to treat this as a stress ulceration. If it persists, other tests are undertaken.

Q. Can blood level in a person assist you in determining whether or not it's a bleeding problem?

A. Surely.

Q. GI bleeding?

A. Surely.

Q. How much would you expect normally hemoglobin to drop postoperatively with a 200 or let's say a 400 cc blood loss in a total hip replacement?

A. The one thing that you have to correctly evaluate when you're determining blood loss is not

how much is lost into the field but how much is lost into the soft tissues, into the muscles and such around, and that can be several units. So the actual amount that you see that is drained through the tube may not reflect the total amount.

Q. Would you normally see the hemoglobin drop after any operation because there is some blood loss?

A. Surely.

Q. Did you replace blood, by the way, after the first operation?

A. I'd have to check.

Q. Okay.

A. Not that I can discern.

Q. If there would have been significant blood loss, would you have ordered any kind of blood replacement, sir?

A. If there had been blood loss sufficient that I thought it would make a difference in the patient's recovery, surely.

Q. So apparently you didn't?

A. From -- as I recall, the lab values that I recall most immediately postop did not indicate that he had had sufficient blood loss. I don't know for a fact, as I said, I did not see a

confirmatory or a reference to the fact that I did not give blood, but on my last review of the chart, I don't recall.

Q. I didn't see that either, so I think you're correct, I don't think there was any blood given.

Did you check on Mr. Smith's hemoglobin levels, Doctor, through his short stay in the hospital here?

A. I'm sure they were checked on as a matter of routine for --

Q. Did you check them, sir?

A. I'm sure I must have or I at least asked the resident about them. Whichever specific, I don't recall.

Q. What did you think of them in relation to whether or not this man was having a GI bleed postoperatively?

A. I did not think he was having a GI bleed.

Q. Otherwise, you certainly wouldn't have had him undergo another surgery on the 7th if he was, would you?

A. That is a question that I've not entertained.

Q. Well, why don't you entertain it for me.

If he was having a GI bleed, sir --

A. Then I would get the appropriate -- if I thought that he was having a GI bleed and there were parameters to indicate such, and then a very unusual loss of hemoglobin or hematocrit, if his condition were such that his blood pressure were exceedingly unstable, then I certainly would have considered it.

Q. What do you consider -- I don't want to paraphrase you, but I don't remember the word you used with respect to the hemoglobin loss. I think you said extensive. What would you consider an extensive drop in the hemoglobin?

A. It is not unusual for any major surgical procedure like this to lose a couple units, several units of blood.

Q. How about five units?

A. As a general rule, unless the hemoglobin goes below 10 or hematocrit below 30. And we at that point consider it most often don't transfuse until the hemoglobin is 9 or the hematocrit is 27.

Q. Would a surgical loss of blood or some loss of blood into the soft tissues, okay, be apparent immediately after surgery one day, two days? How long would it take before you got an

accurate reading as to how much blood is lost from surgery as opposed to from some other reason?

A. It's fairly difficult to tell.

Q. You're a doctor.

A. Surely, but it depends on the area where you operate.

Q. How about the hip?

A. The hip can hide sufficient amounts of blood, but it would be reflected whether you were able to appreciate that in the amount of drainage through your drains or on the dressings or some external indication. There still could be large amounts of blood lost into the soft tissues.

Q. Does it trouble you, sir, that the admitting hemoglobin on Mr. Smith was 15 on admission, it dropped to 13.9 postoperatively and to 10.8 over the next two days? Does that concern you at all, or is that perfectly normal?

A. It is not out of the ordinary for this type of procedure.

Q. Does it concern you in conjunction with the existence of a coffee ground emesis and abdominal pain? Does that cause you any concern, sir?

A. It causes me to realize that the

possibility exists, but the usual statement, the usual postoperative things that we see, it is not out of the ordinary.

Q. Well, when you were considering whether or not Mr. Smith was an appropriate candidate for surgery on November 17, 1984, did you order any additional tests to try to rule this out to ensure that he was not in fact having a GI bleed prior to performing surgery on the man?

A. No, I did not.

Q. Why not?

A. The nature of the procedure that was anticipated for Mr. Smith is a closed procedure and is performed as soon as possible after the dislocation is appreciated. Since there is no anticipated further blood loss through the surgical procedure, the choice was made to get an anesthetic clearance for this man, and if anesthesia thought it was appropriate, move on to the proviso that no open procedure would be done, that we would go ahead.

Q. Sir, you were aware with the fact this man had a heart problem, weren't you?

A. I was aware he had arrhythmia as well as hypertension.

Q. And certainly that's something you take into account with respect to making a decision whether or not to perform surgery, don't you agree?

A. That's correct.

Q. What happens to somebody who has prior heart problems when they have a significant blood loss -- and let's assume that they have some type of bleed, internal bleed. What happens to the heart? Does the heart have to work harder in that type of situation?

A. If you're assuming some things that may in fact not be true, then the amount of blood loss, if it's significantly below a level that the body has been classicly taught to function above, then that would be a concern. As I stated, in the postoperative period of time, a blood loss from a normal level of hemoglobin and hematocrit, which is 15, which is true in his case, even down to 10, would not be a level where we would consider --

Q. Does the heart have to work harder, is the question.

A. The heart works somewhat harder, sure.

Q. Did you order any tests to see what the blood level was right before surgery?

A. I don't recall.

Q. Well, did any doctor order any additional tests, for example, on the morning of surgery? Did Dr. Jackson order his blood level to be monitored once a day? Why don't you take a look, sir. Page 120.

MR. CHARMS: That is in the order strip?

MR. KAMPINSKI: Progress notes.

Q. (BY MR. KAMPINSKI) There's a note by Dr. Jackson, isn't there?

A. Yes, there is.

Q. 11-17, can you read that?

A. Surely.

Q. Why is it that Dr. Jackson was there the morning of the surgery, do you recall?

A. I'm sure he was seeing his patient postoperatively.

Q. Did you discuss having surgery with him postoperatively, after the 14th?

A. Correct.

Q. Did you discuss having the surgery of the 17th with him?

A. I don't recall.

Q. Well, you didn't, did you, Doctor, because as noted the 17th, his note of the 17th

reflects that he had no idea that Mr. Smith was undergoing surgery, does it?

A. If you'd like me to finish my statement.

Q. Yeah.

A. At the time of this note, Dr. Jackson, I assume from the sequence of things here, probably came by earlier than I, and I don't recall specifically, but I in fact believe I did talk with Dr. Jackson on the day of surgery to apprise him of the fact that we were going to have to go back. That is not in the chart, but it's my recollection that that is true.

Q. Um-hmm. And did he then go back and check him to see if he was suitable for surgery?

A. Not according to the notes.

Q. Well, according to the notes, November 17, 1984 note by Dr. Jackson, it reflects directly to the contrary, doesn't it? It says nasal gastric tube to be apparently something if vomit again. Do you see that at the bottom?

A. "Nasal gastric tube if vomit again."

Q. What's the next thing say?

A. "Follow hematocrit twice a day."

Q. What does that mean?

A. Follow hematocrit twice a day.

Q. What does that mean in his desire to have this man checked?

A. That he was interested in having his blood drawn twice a day.

Q. Why is that?

A. You'll have to ask Dr. Jackson.

Q. I'm asking you. You were the primary physician. Weren't you interested in having it checked twice a day?

A. If the concern is that this man were losing blood other than the areas that were suspected, if you were losing it more rapidly than suspected, then to monitor a blood loss more than usual is customary.

Q. Dr. Jackson wanted it monitored?

A. If Dr. Jackson wanted it monitored, he did not discuss that fact with me.

Q. You made no orders to have it monitored twice a day, did you, sir?

A. No, I did not.

Q. And it's your testimony that you think you might have been aware of the dropping hemoglobin or you're just not sure right now?

A. I would have to say that I'm not sure.

Q. You apparently were told by somebody that

the hip had been dislocated; is that correct?

A. That is correct.

Q. And you made the decision that surgery should be undertaken again; is that correct?

A. That is correct.

Q. Did you get a consent form signed?

A. Apparently not.

Q. Why not?

A. We've looked through the chart and shown that there wasn't one.

Q. Why not?

A. It is not my usual responsibility to do that. Usually the residents do that. The residents were in the room and in discussing this with them, I was not aware that it wasn't done. The fact that it was not would not really have precluded our not doing the reduction.

Q. You would have done it without a consent --

A. If he had disagreed, we would not have, but the man verbally agreed to having a reduction performed.

Q. Do you remember that?

A. Of course I do.

MR. GROEDEL: I'm sorry, I didn't hear your response.

THE WITNESS: Yes.

MR. KAMPINSKI: He said of course he does.

Q. (BY MR. KAMPINSKI) Did you talk to the family about it?

A. I did not talk with the family.

Q. Why not?

A. My only contact with this patient had been with himself, never with the family. The family was never -- did not come to the office with him initially and I did not actually ever speak with them prior to the surgery. I spoke with the patient.

Q. Speak with them after he died?

A. I did not speak with them that night. The wife called me on one occasion.

Q. What did you talk about with her?

A. She asked me had any -- I don't recall the specifics, but my impression is that she was asking me the circumstances surrounding the death.

Q. What did you tell her?

A. I told her what was available on the chart, that he apparently died of a myocardial infarction.

Q. Did you tell her that he went to

intensive care after the surgery?

A. I don't recall specifically.

Q. You put that on the chart --

MS. BARTNIK: Objection.

Q. -- didn't you?

A. That he went to --

Q. Intensive care after the surgery of November 17th.

A. And that was also correct.

Q. He did. He went to intensive care after the November 17th surgery?

A. That was also corrected on my copy of the summary, that that was -- in dictating, are you speaking of the expiration summary?

Q. Sure.

A. In my dictating it, I must have dictated the incorrect word.

Q. Did you tell her that he went to intensive care?

A. I don't recall telling her where he went.

Q. Did you order him to go to intensive care after the surgery.

A. I was not on call that night.

Q. Well, you were the one that did the surgery?

A. And he --

Q. Excuse me. My question is after the surgery, right then and there, did you order him to go to intensive care?

A. No, I did not.

Q. Why not?

A. That decision is made in most circumstances by the anesthesiologist. The patient tolerated his procedure well, the patient, according to the anesthesiologist, was stable, he was sent to the recovery room as is a common practice.

Q. Was it a difficult procedure, sir?

A. To reduce the hip?

Q. Yes.

MS. BARTNIK: Objection. Go ahead.

A. No more than usual.

Q. Well, I mean there's some adjectives used by you and the resident that I just wondered if this was unusually difficult. I don't want to paraphrase, I want to use the exact words that you used. "Note that a large amount of force was necessary to reduce this hip." Is that -- why would you say that as opposed to the hip was reduced? What is it that had to be done that

caused you to put "large amount of force used"?

A. In determining the stability of any joint, you would rather -- if a joint has been dislocated and it goes in very easily, it indicates a certain amount of -- a relative more amount of instability. The fact that it took more to reduce it only attached to the adequacy of the initial procedure. The tougher it is to get in, the more unlikely it is to come out unless some unusual things were done to it. So the fact it was difficult to get in meant that the supporting structures around the hip, those things were, in general, adequate.

Q. Did you check all the lab values that were done after the first operation to determine whether or not there was any problem with Mr. Smith prior to doing the second operation? I'm talking aside from the hemoglobin now. Did you check any other values, sir?

A. I don't recall specifically.

Q. Why don't you take a look and see if any of them caused you any concern.

A. I'm going through the -- the list of available laboratory values postoperatively. There are a number of values that some appear high, some appear low, none of which that on this perusal I

can say that would have altered my thinking.

Q. What is a CPK, sir?

A. It is an enzyme, which is a protein marker, so to speak, muscle function or muscle activity.

Q. Heart muscle?

A. Can be.

Q. Can be. What's the purpose for taking it?

A. If you worried about -- you're taking any instance of a cardiac problem to monitor or try to get some idea of the level of cardiac damage.

Q. Could tell you if there's a heart attack, couldn't it?

A. Can give you a trend, an impression.

Q. Sure. And --

A. The value by itself does not tell you that.

Q. But it gives you something sort of like a warning light, if it's abnormal --

A. Gives you an impression.

Q. You can follow it and you can see if that's what in fact did occur; is that correct?

A. That's correct.

Q. How does it readout when you get the value?

A. The value is usually high.

Q. I mean, what's it called, the MB band?

A. There are a number of what are called fractions.

Q. Fractions?

A. Yeah. And the MB band is certainly one of them. The interpretation of which I'm not expert in.

Q. Well, if it's abnormal, you're an expert at knowing the difference between normal and abnormal?

A. Surely.

Q. Was it normal?

A. The CPK?

Q. Yes. Why don't you indicate the page number for the record.

A. Page 131. And the value was 339.

Q. Why don't you show me where you look at that?

A. I'm on page 131, bottom of 131 --

Q. I have trouble seeing this copy.

A. The bottom quarter of the page in the left-hand column, it says "Serum, November 14th, 1,400 hours, MB."

Q. 139?

A. 131.

MS. BARTNIK: Page 131.

Q. (BY MR. KAMPINSKI) I still don't see where you're looking. Why don't you show me the original.

A. Bottom of the page here.

Q. November 14th, okay.

A. Okay. 1,400 hours, MB.

Q. Then it says what, 2 percent?

A. Says 2 percent shash 1.

Q. Okay. Then what else does it say?

A. It says under the general heading from before, you have -- there is columns under the LDH isoenzyme, it says "Normal CPK, it says 339 high, under the LDH it says 196 high.

Q. Then what does it say, Doctor?

A. It says, number one, "Myocardial fiber injury as might be seen in severe coronary insufficiency. Total CBK elevated as in skeletal muscle injury due to trauma, surgery, seizures, heat stroke."

Q. So if I understand what you just read me correctly, the level for the CPK is high; is that correct?

A. Normal range is given above from zero to

300. This is at 339, mildly --

Q. It says, "Myocardial fiber injury as might be seen in severe coronary insufficiency"?

A. That's what it says.

Q. Of course you ordered follow-up on that, didn't you, to make sure that hadn't occurred, right?

A. I did not personally, no.

Q. Why not? You were aware of this, weren't you? You checked out the return of the lab values when --

A. When CPK comes back as 339 following a major surgical procedure, then that is certainly not out of the range of an elevation due to the surgery itself.

Q. Did you follow it up, sir, to make sure that it was due to surgery as opposed to -- it says, "Myocardial fiber injury as might be seen in severe coronary insufficiency" in a man you knew had high blood pressure, hypertension and other heart problems? Did you follow it up, sir?

A. If you're asking me did I order a repeat level, I did not.

Q. Why not? Because you felt this was okay?

A. Because I felt it was consistent with the

current state of this man being a postoperative from a major surgical procedure.

Q. You ordered an EKG though, right?

A. The specific orders for any postoperative total hip are not specifically ordered by me; they may be done in consultation with me or the attending internist and/or the residents in training.

Q. You as the treating primary care physician did it in conjunction with all these other people. You ordered an EKG, right?

A. I have no idea whether it was done or not.

Q. What do you mean whether it was done? I asked you whether it was ordered. I assumed if you ordered it it would have been done.

A. I don't recall if I ordered it.

Q. Why don't you take a look.

A. No specific EKG was ordered. This man was in the surgical intensive care unit where routine and constant electromyographic monitoring is done at all time, so he was in a setting where a specific EKG need not necessarily have to have been ordered.

Q. Okay. After the second surgery, certainly you ordered one after he was taken to the

Q. What's that?

A. "And cardiac monitor."

Q. And cardiac monitoring?

A. Cardiac monitoring.

Q. Then what does it say?

A. "A Fib," atrial fibrillation, "with uncontrolled ventricular" -- looks like "STE and frequent." I don't --

Q. "And frequent multifocal PVCs noted"?

A. "Frequent," if that's an F, yes, "multifocal PVCs noted. Dr. Lee aware, L, left dorsalis pedis palpable at three plus left knee immobilizer with five pounds, traction in place. Has sensation at level of sixth rib just below nipple line."

Q. Okay. What did you do, leave, Doctor? That was 5:25. What did you do, leave? Go home? What did you do?

A. I don't recall at what time I went home. This certainly does not have to be a chronology of things as they happened. I may have been in the recovery room early on. The operating --

Q. Early on, the very first thing it says, second line, "Complains of shortness of breath." I assume you were aware of that, weren't you?

A. I don't recall.

Q. What do you recall? You recall very clearly about his saying let's have the operation. What do you recall about him after the operation in the recovery room?

A. The things that I tell you.

Q. Tell me.

A. I've told you that I recalled going to the recovery room with the patient, the patient leaving the operating room, having had no difficulty with the anesthetic. When I left him, he seemed to be stable, and at that time I left. At what time this note was written --

Q. Says 5:25.

A. What time did this procedure end? Why don't we look that up.

Q. Why don't you do that?

MR. CHARMS: Page 154.

A. Says we left the room -- the operating room at 5:25 p.m.

Q. About the same time you left the recovery room.

A. As I stated, the note as it's written, even though the time of entry of the note is 5:25, the recovery room and the operating room are just

maybe 50 feet from each other, so that certainly would account for that, but the time this actual note was written, I have no idea. I have my recollection that at my time of leaving the operating room, the recovery room, that the patient was doing fine, was in no distress.

Q. So you called back what, about an hour, two hours later to make sure that was true?

A. Dr. Stephens was aware that he was on call --

Q. You didn't call back?

A. I did not call back.

Q. What did you do that night?

A. I would only speculate.

Q. Do you have any recollection of that?

A. Not specifically, no.

Q. What's the next thing you heard about Mr. Smith?

A. Dr. Stephens gave me a call.

Q. What time?

A. I don't recall. It was either that night or the next morning. I don't recall specifically if it was the next morning or it was -- it was very early. I don't recall the exact time frame.

Q. If it was that night, would you recall?

Would you go on down to the hospital if it was that evening?

A. If he called me after the events, I don't know. It would have had to have been that time.

Q. What time?

A. I would have had to have been in the situation to really make the judgment at that point. If he had told me that the family had already been aprized, that they had been aprized by he and Dr. Jackson, if everything in terms of the needs at the hospital had been done including getting the proper papers and everything in order, and the family was no longer there, they usually aren't, then I would not have gone down.

Q. Doctor, if you had been aprized of what was happening to your patient, Alvester Smith, let's say between the 5:25 and 7:15 entry, okay -- and in fairness to you, I obviously have to go by the chart. I don't know what time she wrote it. She's got 5:25. Looking at page 155, on the back is 156, she's got a 5:40 entry, right? Almost missed a page. So that's 15 minutes when things are now being directed to Dr. Lee between the time of your ending surgery and your no longer being mentioned, correct?

A. That's apparently correct.

Q. And she was putting entries in -- when I say she, I guess it was more than one nurse -- almost every five minutes, right? 5:40, 5:45, 5:50, 5:55, 5:57, 6:00, 6:05, 6:15, 6:30, 6:45, 7:00, 7:30, 7:45, 8:00, 8:15, 8:45. The nurse is charting almost every five minutes on this?

A. The charts are labeled as such, yes.

Q. To your knowledge, did anybody try to contact you before I guess 10:40, when a call was put into your answering service?

A. I have no idea when anyone tried to contact me.

Q. You were not contactable, apparently?

A. That is correct.

Q. Had you been contacted, sir, about your patient's condition, let's say at 6:00 -- and you can take a minute to read the notes up until 6:00.

"Atrial fibrillation is uncontrolled, frequent multifocal PVCs noted, multifocal and coupling noted on monitor." Would you have had your patient moved to intensive care?

MR. GROEDEL: Objection. Go ahead.

A. Depends on the level of monitoring available at that time.

Q. You're familiar with the hospital.

A. This was a Saturday afternoon. Depends how many patients were in the intensive care unit, how many nurses were available here, how much monitoring was anticipated to be needed. That can be determined by the person who is evaluating the patient, not by reading the chart.

Q. Why weren't you there evaluating the patient?

A. If you'd like me to repeat again, I was -- when I left the patient, the patient was stable, the --

Q. Okay. I heard you the first time. If you had been told this, would you have gone back and evaluated him again? Would it have mattered if you were told?

A. If the circumstances of the patient's uncontrollability -- if you notice the first several notes here only refer to medications, they don't refer to the patient's condition. If Dr. Lee's assessment, if my assessment, if the resident's assessment, if the people in charge had been concerned to the point that more monitoring was necessary, then I'm sure those decisions would have been made, but they would have had to have

been made at the setting.

Q. Then I'll ask you again. If you had been told of these conditions, would you have gone back to the setting so that you could make the decision?

MR. GROEDEL: At what point we talking?

Q. Any point in this chart, Doctor, if you had been told of this person's condition, would you have gone back and monitored his condition?

MR. GROEDEL: Objection. Go ahead.

Q. Sure. Personally you, the doctor.

A. I would have talked with the anesthesiologist and depending on my concern, if I were there, I would have illicited him, or if I thought the appropriate care was being given through the anesthesiologist, as this was something that's being controlled, then I wouldn't have -- I don't think I would have been able to offer anything that was appreciably different than what was there. I would have been willing to listen to his expertise since that is the area, the time frame in which we're dealing.

Q. Do you agree with Dr. Stephens' recommendation when he returned the call to apparently your answering service since he was on

duty that night to have Mr. Smith transferred to intensive care? Do you agree with that?

A. Given the set of -- I have no idea what set of circumstances he was made aware of.

Q. Well, assuming he was made aware of the set of circumstances that existed that are set forth in the record, do you agree with his referral?

A. That's not always the circumstance --

Q. Assume that that's what he was told.

MR. GROEDEL: Objection. Go ahead.

A. If those circumstances were as described in the chart and I would have had no objection, I probably would have recommended it as well.

Q. Can you tell me why in the world it wasn't recommended by somebody who was there who you left this man in charge of --

MR. CHARMS: Objection.

Q. -- either your resident or this Dr. Lee or whoever?

MR. CHARMS: Objection.

A. I have no idea.

Q. Should he have been, in your opinion?

A. That is a decision that's made at the time --

Q. In your opinion, sir.

A. I cannot make that opinion without having the additional on-hand information of evaluating the patient.

Q. Okay. Dr. Lee still work at the hospital?

A. Yes.

MS. BARTNIK: Objection.

Q. He still provides anesthesia to patients that you operate on?

A. Yes, he does.

Q. You leave patients in his care when you leave, right?

A. Yes, I do.

Q. Dr. Jackson still refer patients to you?

A. Yes, he does.

Q. Have you ever discussed this case with him afterwards?

A. No, I haven't.

Q. You haven't?

A. Only in the vaguest of generalities.

Q. What does that mean?

A. It's an unfortunate thing that this happened to such a young man. It's a major surgery. The specifics of which I can't remember, but I can recall at least mentioning his name and the set of circumstances surrounding it.

Q. Just so I clearly understand it, it was your decision, was it not, to clear this man for surgery on November 17, 1984, correct?

A. It is at my request that the anesthesiologist cleared this man for surgery.

Q. Was it Dr. Lee who cleared him?

A. Yes, sir.

Q. And based upon Dr. Lee's intimate familiarity with this patient and all the tests that he was able to review that were in the chart, you relied upon Dr. Lee's clearing, correct?

A. I relied on Dr. Lee's judgment to clear the patient before he cleared the patient for surgery.

Q. Could you show me the anesthesia note clearing this patient for surgery?

A. I don't see such a note.

Q. Take your time. I don't want you to miss it. Are you saying it's not there?

MR. GROEDEL: It's in there.

MR. KAMPINSKI: Maybe you can help us. I don't know where it is either.

MR. GROEDEL: Page 152.

Q. (BY MR. KAMPINSKI) Is this a clearance, page 152?

A. My discussion with Dr. Lee did not involve written exchange. The fact I had not seen this document until I'm looking at it now. But he in fact verbally cleared him for me or else we wouldn't have gotten him into the operating room.

Q. Okay.

Q. He wrote down some lab ASA status, did he not? Dr. Lee did?

A. ASA physical status?

Q. Yes.

A. Yes.

Q. Are those accurate? That whole box there where it says laboratory investigations, it says HB. What's HB?

A. That stands for hemoglobin.

Q. What's it say there?

A. 15.8.

Q. And was that the fact on November 17th, sir?

A. November 17th was 10.8 and 33.4.

Q. Do you have the actual lab slips? Are they in there, in the chart? Can you find them for me?

A. Blood gases, probably only exist in the printout.

Q. That printout, computer printout, would that have been available on the 17th in the chart?

A. You can always call the lab.

Q. Apparently he never called, did he?

MR. CHARMS: Objection.

MR. GROEDEL: Objection.

A. I have no idea, sir.

Q. What date is the value that he put down as the hemoglobin value on Alvester Smith prior to his approving your performing surgery on this man on November 17th?

A. He put down November 12th.

Q. That was before the first surgery?

A. That is correct.

Q. That was 15.8?

A. 15.8 and 48.9.

Q. And the fact of the matter is that it was 10 point --

A. 10.8, 33.4.

Q. On November 17th?

A. That's correct.

Q. Wouldn't that be important for an anesthesiologist to know in terms of his approving a man for surgery?

MR. GROEDEL: Objection.

MR. CHARMS: Objection.

A. Any lab value of that nature would be relevant but would not change the nature of what had to be done.

Q. You don't know that, Doctor.

A. For a closed procedure, it would not.

Q. And for a person with prior heart problems, it just doesn't matter, right?

MR. GROEDEL: Objection.

Q. Just doesn't matter; is that your testimony?

MR. GROEDEL: Objection.

A. That's yours.

Q. I think that's what you just said. Does it matter or does it not matter?

A. No, sir. I said it does for consideration, but for the type of procedure --

Q. How can it be a consideration if you put down 15.8?

A. That's not my writing.

Q. I know.

A. I have no idea when he wrote the note, at what time.

Q. But it's wrong, isn't it?

MR. CHARMS: Note a continuing

objection to the entire line of questioning.

Q. (BY MR. KAMPINSKI) It's wrong, isn't it?

A. The entry values for the hematocrit and hemoglobin do not reflect that day's value.

Q. Let me see the original chart. I think I'll be able to finish up fairly quickly, Doctor.

Doctor, in your experience, aren't there separate sheets for the different tests, the blood value tests?

A. It depends on the hospital. If this -- if this was at the time of the changeover to the computer systems being on each of the nursing stations floor, then there may have been only printouts available, may have been written reports that were written down by the secretary or whatever. But the official report, the one that comes to the chart at that point may have already converted to a computer printout system, and these come once a day, couple times a day, depending how often if needed and if available on the CRT on the floor.

Q. Okay. But the separate individual lab slips --

A. I can't attest to that.

Q. They wouldn't be here?

A. If they were still being used at that

3

time, then they would have been in there.

Q. You just don't know?

A. I don't know what was being used.

Q. Why would they still use the blood gas slips if they had switched --

A. Different department.

Q. In other words, respiratory is different than the regular lab?

A. Sure. The regular lab is in pathology, as a matter of fact.

Q. In pathology?

A. In most places. I assume it's that way at St. Luke's too.

Q. You say it's no big deal in terms of just being able to pick up the house phone there, calling the lab and seeing what a value is?

A. It's available.

Q. Okay. How do you know what time these tests get done and get put into the chart?

A. Depends what time you request them. If you request them as a staff procedure, it can be done right away. If you request it as an early morning value, it can be done by 10:00. It depends on the nature of your request.

Q. Can you tell, Doctor, when the hemoglobin

values were requested and when they were put in the chart? Is there any way you can determine that? Wait. Maybe we can tell. What page was that? Do you recall? That one we were looking at?

A. 150 something. I don't remember.

MR. CHARMS: Are you talking about the pre-anesthesia thing, Chuck?

MR. KAMPINSKI: No. The lab values that the doctor was looking at. 127.

Q. (BY MR. KAMPINSKI) Okay. 127. Doctor, I'm going to ask you to look at page 127, if you would, sir. And that is the computer printout apparently that lists the hemoglobin values for the various points in time that Mr. Smith was in the hospital; is that correct?

A. That is correct.

Q. Could you indicate, please, the time and date on the bottom of that computer readout?

A. That particular readout is November 21, 1984.

Q. Four days after Mr. Smith died.

A. There is a preliminary sheet, a pink sheet that comes out daily. As the values accumulate, those temporary sheets are weeded out and a final cumulative sheet is put in at some

point, you know, in the distant future, so it's hard to say exactly what time those values were there.

Q. Okay.

A. This is a summary sheet only.

Q. Okay. What day would -- and up on top it's got discharge, November 19, 1984. I mean, that's not right, is it?

A. The --

Q. He died.

A. Well, you know, by the time the computer system was made aware of it, it may have been November 19th.

Q. You may not know the answer to this, and I apologize if you don't. I don't. Just tell me though, do you know when these hemoglobin tests would have actually hit the chart?

A. No, I don't.

Q. Okay. For example, the one for November 14th and 15th?

A. Well, if you notice there are routine postoperative orders for I believe the first and the third day after surgery that would have put this on the third day after the initial surgery, so the fact --

Q. Could you look at page 126 for me, Doctor? I'm probably just reading this wrong. What's the date at the bottom down there? Is that the 16th?

A. November 16th.

Q. Is that what that date says?

A. November 16th.

Q. Okay. Now, you keep making distinctions, sir, between this being a closed procedure and other procedures which would be open?

A. Right.

Q. That's important to you, I take it?

A. Surely, among other considerations.

Q. And is it important because it makes a difference in analyzing the patient for his suitability for surgery, the fact that it's closed as opposed to open?

A. For the type of surgery, yes.

Q. He still has to undergo an anesthetic; does he not?

A. That anesthetic can vary. The length of the anesthetic can vary. Any number of considerations.

Q. What was it here? What was the anesthetic?

A. The anesthetic was a spinal.

Q. What was his anesthetic when you did the open procedure?

A. General.

Q. So that makes a difference then too in terms of doing surgery?

A. It makes a difference in terms of the anticipated length of surgery. In terms of choosing the anesthetic, that is not something that I do. The anesthesiologist chooses the specific anesthetic. If he had chosen to do a general anesthetic, then since that is his area of expertise, I would probably have gone along with him.

Q. The ultimate decision, whether Mr. Smith was suitable or not suitable, I take it, rests with you. You can reject or accept an anesthesiologist's decision, but you don't have to, I take it? Would that be fair?

A. That's fair.

Q. Okay. So that if you didn't feel that Mr. Smith, based upon all the appropriate testing, was not a suitable candidate for surgery, that was your decision then, correct?

A. In conjunction with the other parameters available.

Q. Sure. I mean, you would consult whoever you felt appropriate to consult, whether that be Dr. Jackson, Dr. Lee. Additional testing, that was your decision, was it not?

A. Yes, it was.

Q. All right, Doctor. I was provided with a set of records here. Why don't you take a moment, look at them, just make sure they're accurate. Those I've been told are your office records pertaining to Mr. Smith. Just take a moment to look at them, make sure that's correct.

A. Yes, this is a copy of the office records.

(Smith Exhibit No. 1 was marked for identification)

Q. (BY MR. KAMPINSKI) Handing you what's been marked as Smith Deposition Exhibit 1, I'll just ask you if you can identify that, please, for the record.

A. I identified it as my office record.

Q. Okay. Was Dr. Lee -- he was not the anesthesiologist who did the first operation, was he?

A. I would have to check the record. Anesthesiologist of record is Dr. Trusso.

Q. Okay. What I'd like you to do, if you

would, please, Doctor, is read your writing. I assume this is yours, in your office record.

A. Entry of 10-12-84. "Injury to left hip at age 13. Refused surgery. Pain times three months. Limp afterwards. Now said pain times three months again. Examination gross limp, l-i-m-p. No flexion contracture. Adduction contracture. Underneath that 15 degrees under abduction, 10 degrees under adduction. Next line, painful IR, ER," meaning internal rotation, external rotation. "Leg length inequality -- 1 inch shorter on left. X-rays. Diagnosis, remote fracture, left hip -- painful. Recommendation, arthroplasty."

Q. Okay. Is that all of it? Your billing, Doctor, for the services that you did, that does not include the hardware, does it, that would have been charged by the hospital?

A. By the hospital.

Q. That's just for your services?

A. Correct.

Q. Was there an original order for blood? Did you anticipate giving blood to Mr. Smith?

A. There was an order on admission to type and cross match for two units of packed red blood

cells.

Q. All right. That would just be --

A. Routine.

Q. -- in case you needed it?

A. Yes, this would be in case we needed it, yes.

MR. KAMPINSKI: All right. Why don't we take about a five minute break then I think I'll be in a position to just finish up with you.

(Short recess taken)

That's all the questions I have, Doctor. Some of the other attorneys may or may not have questions for you.

MR. CHARMS: Doctor, I have no questions for you at this time, but I'm going to reserve my right if something comes up. Thank you.

MS. BARTNIK: I have no questions at this time either. Thank you, Doctor.

MR. KAMPINSKI: You've got a right to read your testimony or you have a right to waive your signature. Your attorney will advise you.

MR. GROEDEL: We'll take a look at it.

(Adjourned at 4:21 p.m.)

I have read the foregoing transcript from page 1 to page 81 and note the following corrections:

PAGE:	LINE:	CORRECTION:	REASON:

_____
CURTIS W. SMITH, MD

Subscribed and sworn to before me this day of , 1986.

_____
Notary Public

My Commission Expires:

THE STATE OF OHIO,)
) SS: CERTIFICATE
COUNTY OF CUYAHOGA.)

I, Lorraine J. Box, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that CURTIS W. SMITH was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above set forth was reduced to writing by me by means of Stenotypy and was subsequently transcribed into typewriting by means of computer aided transcription under my direction; that said deposition was taken at the time and place aforesaid by agreement of counsel; that the reading and signing of the deposition by the witness were expressly waived; and that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I hereunto set my hand and seal of office at Cleveland, Ohio, this 30th day of September, 1986.

Lorraine J. Box, RPR, Notary Public
Within and for the State of Ohio
540 Terminal Tower
Cleveland, Ohio 44113
My Commission Expires: June 20, 1987.

LAWYER'S NOTES

Page	Line	