IN THE COMMON PLEAS COURT

MERCER COUNTY, OHIO

MARY JO BRAUN, et al.,)

Plaintiffs,)

vs.) Case No. 98-CIV-101

JOHN M. SPECA, D.O., COPY

Defendant.

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Deposition of JOHN M. SPECA, D.O., witness herein, called by the Plaintiffs for cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before me, the undersigned, Joyce C. Bowers, Notary Public in and for the State of Ohio, at the Mercer County Central Services Building, 220 West Livingston Street, Celina, Ohio, on the 6th day of April, 1999, at approximately 9:40 a.m.

JOYCE BOWERS
PROFESSIONAL COURT REPORTERS
4300 WILLIAM AVENUE
CELINA, OHIO 45822
(419) 586-8548

APPEARANCES:

FOR THE PLAINTIFFS:

Donna Taylor-Kolis, Esq.
1370 Ontario Street
Cleveland, Ohio 44113-1701

FOR THE DEFENDANT:

Warren M. Enders, Esq.
Reminger & Reminger
Courthouse Square
505 South High Street
Columbus, Ohio 43215

I N D E X :

JOHN M. SPECA, D.O.,

of lawful age, having been first duly cautioned and sworn, as hereinafter certified, was examined and testified as follows:

CROSS-EXAMINATION

BY MS. KOLIS:

Q. Dr. Speca, by way of introduction, as you know, my name is Donna Kolis, and I've been retained to represent Mary Jo and Tom Braun in a lawsuit which we have filed against you. My purpose today is to perhaps come to understand what happened during Mary Jo's surgery and go over with you some of the notes which you made in the chart, in addition to which I would like to discuss with you in some detail the examination and evaluations which you performed of Mary Jo Braun prior to the surgery.

Let me ask you first for the record, have you had the opportunity prior to today to give a deposition?

A. I'd like to say one thing. You pronounce my name Speca.

Q. I'm sorry.

A. That's okay.

Q. It's Speca, like short e, Speca?

A. Yeah.

Q. Okay.

A. Yes, I've given depositions before.

Q. Okay. Given that you have had that opportunity,

I'm certain that you're familiar with the rules, but just for purposes of the record, I'd like to establish some of the ground rules.

As you are probably aware, you are required to answer each and every question verbally. Are you aware of that requirement?

A, Yes.

Q. All right. If I ask a question and you answer it, I'm going to presume that you have understood the content of the question. Do you also understand that?

A. Yes.

Q. Accordingly, I would indicate to you that if at any time I ask a question that you do not understand, either because I use a word that you are unfamiliar with, which is highly unlikely, but if that were the occasion or the phrasing of the question leaves you wondering what information I'm seeking, I would appreciate you indicating that you don't understand the question. Can I secure that agreement from you?

A. Yes.

Q. All right. Additionally, although it's not usual, or at least in the depositions that I take, your counsel may at some point interpose an objection to a question. You're instructed by myself not to answer the question until your attorney and I have worked out our

respective differences as to the question. Can I secure your agreement on that as well?

A. Yes.

Q. Thank you. Dr. Speca, this morning I have been handed what your attorney represents to be your updated CV. I'd like to just briefly go through your background for the record. Why don't you tell us about your education beginning with college that led you to your profession as a physician?

A. I attended Loyola University of Chicago from September of 1971 to May or June of 1975.

Q. Uh-huh.

A. I went to Loyola University Stritch School of Medicine from 1975 and graduated in June of 1979. I did one year of internal medicine internship at Christ Hospital in Oak Lawn, Illinois. I did five years of orthopedic residency at the Medical College of Ohio in Toledo from 1980 to 1985.

Q. Okay. Fair enough. As part of your training at the Medical College of Ohio, Doctor, did you learn the technique of arthroscopic surgery?

A. Yes.

Q. Okay. And I take it, based upon information contained in your CV, that at your first opportunity to take the boards in orthopedic surgery, you did so?

A. There was a lot of confusion when I graduated from residency as to when we were eligible to take the boards

because they changed the requirements. So I actually missed at least the first time and possibly the second when I was eligible to take them. I just didn't know that those were the times available.

Q. Okay. You probably gave an articulate answer. What was the confusion when you graduated about your ability to apply for and take the board?

A. They changed when we could take them. Once upon a time, you took the boards two years after you finished your residency, both oral and written on the same day.

Q. Okay.

A. And when I graduated, they weren't sure if I would, if I had to wait two years, if I chose to wait two years or take them in a year; and it was hard to know exactly when I was eligible to take the boards at that point, and I think I missed the first offering of the boards.

Q. Okay. But then you took them as soon as you were able to schedule them?

A. Yes.

Q. Is that a better way to say it?

A. That's probably the best way.

Q. And you successfully passed that examination?

A. I passed the examination on the second time that I took it.

Q. Okay. You took part one of the exam -- you took

both parts, but you only passed part one the first time, and then you took part two a second time a year later? Am I reading this correctly or incorrectly? And it could be the reader not the preparer.

A. My apologies how this is written. I took the boards once in 1988, and I failed them that time.

Q. Okay.

A. I then came back in 1989, took the boards, the written boards, both of those, passed that. Then part two is the oral examination, and I passed that the first time that I took it, and that's when I became board certified.

Q. Okay. I think that now that's pretty clear. Subsequent to graduating from your -- I call it graduating, but completing your orthopedic residency program, where did you begin the practice of medicine?

A. My first year in practice was in Kankakee, Illinois, which actually is close to Bourbonnais where that train crash was, like, a couple of weeks ago.

Q. And so you were there for about a year; is that right?

A. Yes.

Q. All right. And then did you come here to Celina?

A. No, I went to Galesburg, Illinois, where I practiced for seven and a half years.

Q. Okay.
A. Let me see.
Q. Can you tell I'm not awake yet this morning? Is that St. Marys Sports Medicine?
A. That St. Marys Sports Medicine, the confusion is, there was a St. Marys Medical Center in Galesburg, Illinois, and there's a St. Marys Hospital -- well, there's a hospital in St. Marys, Ohio, and the name is actually Joint Township District Memorial Hospital.
Q. All right. So you were at St. Marys Medical Center in Galesburg, Illinois, from September of '86 through sometime in 1994?
A. Yeah, and to make matters worse, there was a St. Marys Hospital in Kankakee, Illinois, too.
Q. Okay.
A. Okay.
Q. All right. In 1994, is that when you came to this area?
A. In May of '94, yes.
Q. Okay. Let me ask you briefly, the practice that you were involved in from '86 to 1994, were you in a private practice?
A. I had one partner, who I was full partners with, and we had other associates while I was there too.
Q. Okay. And what was the nature of that

orthopedic practice?

A. It was a general orthopedic practice.

Q. Okay. What kinds -- I never know how to ask this question -- when you say it was a general orthopedic practice, what kinds of medical services were you providing specifically during that time period?

A. It's pretty much what I do now. You see people who have fractures and sprains and strains. You see people with knee injuries, shoulder injuries, and just about anything may walk into your office, and then you have to determine what types of things you care for and what types of things you send on.

Q. All right. So you hold yourself out at that time and at present as a general orthopedist; is that an accurate statement?

A. Yes.

Q. Okay. Do you consider, based upon your experience, that you are a specialist in any one area of orthopedic surgery?

A. No.

Q. Okay. You came to Celina in about 1994. What kind of practice did you go into at that time?

A. A general orthopedic practice.

Okay. Were you in a practice with partners?

No, I was not.

Q. Okay. You opened your own practice?
A. Yes.
Q. Okay. When you came here, at what hospitals did you seek privileges?
A. When I moved here, I only sought privileges at Mercer County Joint Township Community Hospital, which everybody calls Coldwater Hospital for short.
Q. Okay. Any other hospitals or that's it?
A. I had no intention of going to another hospital and practice by myself at that time.
Q. Okay. Fair enough. And is that still the same today?
A. No. I subsequently have taken on an associate, and I now go to Joint Township District Memorial Hospital, which everyone calls St. Marys Hospital.
Q. Okay.
A. Or Joint Township, and so now we attend both hospitals.
Q. When did that become your situation? Was it after Mrs. Braun's surgery?
A. Yes, this occurred in May of '98.
Q. All right. In May of 1998 is when you brought on an associate and then expanded your practice. Correct?
A. Correct.
Q. All right. Now, I'm doing this strictly from

memory. It's my understanding, roughly, based on the interrogatory answers that were prepared by your attorney, that prior to Mrs. Braun's surgery, you had done about 150 arthroscopic knee surgeries. Am I stating that correctly?

A. Here in Ohio that I had records of. I have done knee arthroscopies prior to that in both practices, but I had no accurate record of how many I had performed.

Q. All right. So that the record is clear, the interrogatory answers that you submitted to me confine themselves solely to verifiable numbers of procedures that you've done since you came to Ohio; is that right?

A. I've kept records, yes.

Q. Okay. And that prior to that you had indeed engaged in the practice of arthroscopic knee surgery, but you didn't have records and didn't want to venture a guess?

A. Correct.

Q. Okay. Fair enough. Doctor, other than the instant matter, have you been sued for professional negligence?

MR. ENDERS: Objection. Can we have a continuing objection on any questions to prior lawsuits?

MS. KOLIS: Fair enough.

MR. ENDERS: All right.

A. Yes.

Q. Okay. Can you recall for me how many other

occasions you have been sued for medical negligence?
A. I think seven others.
Q. Okay. Let me ask this because I don't necessarily want to discuss all of your other actions. In any other instance where you were sued for professional negligence, did it involve an issue of arthroscopic surgery of any sort?
A. One that was dismissed did, but that's, that's the only one involving arthroscopy.
Q. Okay. So once again -- and I do this a lot. I repeat for the record because I don't have anyone taking notes for me today.
You're indicating that there was another action filed against you involving arthroscopic surgery, but that matter was dismissed?
A. Can I --
Q. Any time you need to confer with counsel, that's fine.
(An off-the-record conversation was had between the witness and counsel.)
A. Okay. Yeah the one that was dismissed, and then I had one other case where I did an arthroscopy as part of a procedure, but that wasn't a part of the reason I was sued.
Q. Okay. In the second matter which you're discussing, you were sued for a procedure. Arthroscopy was a

part of it, but they weren't criticizing the arthroscopy portion; that's what you've told me. Correct?

A. Correct.

Q. Did that litigation end by way of settlement or verdict in favor of the plaintiff?

A. That's still pending.

Q. That is still pending. Is that the action that is also pending in this county?

A. That's pending here, yes.

Q. Okay. If my research is correct, and it isn't always, in addition to this particular action, there is only one other pending suit against you in Ohio at present?

A. Correct.

Q. Okay. Fair statement. All right. We'll move along.

Doctor, have you had an opportunity in your career at any time to serve as an expert witness on behalf of a physician or a plaintiff in a medical negligence case?

A. Not in a medical negligence case.

Q. Okay. I would gather because you are a general orthopedist that you have been called upon from time to time to testify in automobile-accident cases and things of that nature, traumatic-injury claims?

A. I have.

Q. Okay. All right. In preparation for today's

deposition or at any time since I filed this action against you, have you done a review of the literature to refresh your memory or expertise on the issues that are involved in this case?

A. No.

Q. Okay. If I were to ask you, Doctor, as a colleague -- which I am not but assume hypothetically that I was your colleague -- for literature to read or review as to the removal of loose bodies or embedded loose bodies, what would you recommend to me, if anything?

A. Whenever I prepare for a case where I feel that I need outside help, I usually go to a number of sources; and then when I read those sources, I may choose what I feel best fits the need for that particular patient. And the source may not be the same one in each and every time.

Q. So -- excuse me. Were you done with your answer?

A. Yes.

Q. So I gather from the answer you gave me today that there is not a source that you are aware of that you would consider definitive or authoritative on the subject matter of the removal of loose bodies in the knee?

A. That's correct.

Q. Okay. All right. Doctor, in anticipation of today's questions, can you tell me what medical records you

have reviewed?

A. I've only reviewed my office's medical records.

Q. Okay. So you've reviewed your own office notes, I'd assume?

A. Yes, and then Mr. Enders had a summary of the various medical records that was prepared by his office to give me a background on some of the other things that have been occurring, but I've only reviewed my office notes.

Q. When you say he prepared summaries, are you discussing or indicating to me that you have seen summaries of Mrs. Braun's care subsequent to the surgery?

A. Yes.

Q. So that you are aware of her current medical condition through those summaries?

A. Yes.

Q. Okay. Did you bring your office chart with you, today?

A. Yes.

Q. Okay. Why don't you probably slide it towards you because we'll probably ask you some questions about it.

A. (The witness complied.)

Q. Okay. Prior to initiating this lawsuit, I think -- I'm saying, because I don't have it in front of me -- I requested that you provide to me your entire office chart. Do you recall receiving such a request?

A. I get various requests from other places, and I probably read it and answered; and I can't remember specifically that that occurred but probably did.

Q. Do all requests for medical records in your office practice come across your desk before they're released?

A. Not all.

Q. Okay. What kinds wouldn't come across your desk?

A. Oh, probably ones from other physicians who patients may have sought as a second opinion.

Q. Sure.

A. Or if workman's comp would happen to request. It's the ones that come from attorneys regarding lawsuits that come across my desk.

Q. Okay. When I sent the request, you wouldn't necessarily have known it was regarding a lawsuit; is that a fair statement?

A. There are times when I just end up finding a note in the chart that an attorney has requested records, and I don't oftentimes see that note until after I get the -- is it a summons when that comes to my office and serves me with the suit?

Q. All right. Contained within your office chart, Doctor, in addition to your physical examination notes and

what I call referral letters that you sent to Dr. Dobbins, do you have the operative summary?

A. Yes.

Q. The operative pathology?

A. Yes.

Q. Okay. As well as diagnostic study reports both of the MRI and the X ray that were taken prior to the surgery?

A. Yes.

Q. Okay. Good. Then I think we have a place to work from. You have not reviewed her entire hospital chart?

A. No.

Q. From the time she was admitted through the surgery?

A. No.

Q. Your office chart, it wouldn't contain then the progress notes which you wrote while she was in the hospital?

A. That's correct, it would not.

Q. Does it contain the discharge summary which you prepared when she was released from the hospital?

A. Yes.

Q. Okay. We're going to go through all this, but let me ask you this. Are you aware that Dr. Dobbins wrote a discharge summary as well as yourself in this matter?

A. Dr. Dobbins always writes discharge summaries on

his own patients.

Q. Okay. For me that was a little unusual, but that's just something that Dr. Dobbins personally does even if he is not the primary attending?

A. Yes.

Q. Okay. Have you actually seen the discharge summary that was written by Dr. Dobbins?

A. I have not.

Q. Okay. Dr. Dobbins, if I understand this correctly, and I was confused because there were two different initials, but the same Dr. Dobbins that referred Mary Jo to you as a patient was the Dr. Dobbins who was the anesthesiologist at the surgery that was performed on May 13th?

A. The one and only.

Q. Okay. I just wanted to make sure, okay, because is there another Dr. Dobbins in town, or am I just misreading initials?

A. No, Dr. Dobbins is a family practitioner who has privileges to perform anesthesia. He is a medical anesthetist. He's not an anesthesiologist, and he will tell you that.

Q. Okay. Fair enough. Before we get into your treatment notes, let me ask you the following questions.

Based upon your training and experience as an

orthopedic surgeon and one who, by his own testimony, has dealt with knee surgeries, what problems do you expect that loose bodies will cause in the knee?

A. They can cause locking. They can cause arthritic degeneration because it will cause wear on the bones. They may grow larger.

Q. Do they cause effusion?

A. Yes.

Q. Okay. What problem would an embedded loose body cause in a knee?

A. There it wouldn't be able to move, and it would cause an abrasive area of wear if it's in the right position.

Q. Okay. Is it fair for me to conclude based upon my review of your records, and we'll get into your own testimony about it, that prior to performing the surgery on Mary Jo Braun, that you did not suspect that she had either loose bodies or an embedded loose body?

A. That's right.

Q. Okay. And, therefore, since you didn't suspect that she had it, you did not secure a consent from either Mrs. Braun or her husband to perform surgery for those conditions?

A. Not specifically. I think the consent form will say if any other conditions present themselves that we can treat those, and it's not unusual to find other presenting

problems when you perform a knee arthroscopy that we proceed to care for while we're at that same sitting.

Q. Doctor, do you draft the consent forms for the hospital or is it a standard consent form?

A. It's a standard consent form.

Q. From the best of your recollection or notes, if you have some to support it, when you discussed the surgery with the Brauns, did you advise them that you felt that there was any other condition existing other than potentially a torn meniscus that would account for the symptoms that Mrs. Braun had prior to the surgery?

A. Well, I know that when I looked at my records, that just by seeing the X rays, she had some degenerative changes in the X ray, so that would tell me that there would be some problems with the knee from that point of view. But to say that there was a loose body in there, a torn meniscus and a loose body can act the same, and I don't remember saying that there was a loose body within the knee prior to surgery.

Q. Uh-huh. Okay. Let me ask you, and this is a deplorable copy but it is the one that I received from records deposition service, I believe. Can you identify what this very gray document is?

A. This is the consent form that they use in Coldwater for surgery.

Q. Okay. Did you, as a surgeon with privileges at the hospital, have the ability to review documents and make needed changes if you felt that any form was inadequate?

THE WITNESS: Would you just reread that question for me, please?

(WHEREUPON, the last question was read back.)

Q. Did you, as a surgeon with privileges at the hospital, have the ability to review documents and make needed changes if you felt that any form was inadequate?

A. That's probably true.

MS. KOLIS: Okay. Let me, we're going to mark this Plaintiff's Exhibit A. Actually we're going to cheat. We are going to mark the CV Plaintiff's Exhibit A.

Q. Doctor, did you identify this as the signed consent form for the procedure which you performed upon Mrs. Braun?

A. Yes.

Q. Okay. Consent form for the surgery of May 14th? I'm saying that because for some reason, my brain just went blank. Was the surgery on May 14th, Doctor, or 15th?

A. I have it as May 15th.

Q. It is May 15, 1997.

(WHEREUPON, Plaintiff's Exhibit Nos. 1 and 2

were marked for identification.)

Q. Doctor, we've marked Plaintiff's Exhibit 2, the informed consent form which your attorney has a copy of. The procedure which is listed is arthroscopy, right knee, partial meniscectomy -- if I can say that right this morning. The authorization indicates that yourself and any such assistants as you select were to perform the procedure. Would you agree with that?

A. Yes.

Q. All right. Now, I'm cuing in on perhaps what you indicated as an extension of the procedure, and I will read it:

"I understand that during the course of the procedure, my physician may find some previously unknown condition that requires an extension of the procedure or a modification. I authorize the physician and his assistants to undertake such extended or modified procedures as they may judge desirable if I am unable at such time to grant such permission." Is that what you're referring to?

A. Yes.

Q. Okay. Let me ask you two questions regarding this informed consent form, or, I guess that's what they call it, consent to surgery.

As you sit here today, is it your testimony and will it be your testimony at the trial of this lawsuit,

should we not resolve this matter, that the removal of the embedded loose body was a necessary procedure at the time that you performed the arthroscopy?

A. Yes.

Q. Why was this a necessary procedure at that time?

A. Because I was in the knee. I was looking for reasons that she could have problems with her knee giving out, and it was in an area that was adjacent to degeneration on the posterior condyle c-o-n-d-y-1-e of the medial side of the femur, and I thought that this may have been contributing to the degeneration going on there.

Q. Doctor, did you conclude during this surgical procedure that this embedded fragment which you found -- and I'm calling it fragment now. We'll define it later -- was the cause of the knee problems that she's presented to you in your office?

A. I thought it may have been one of the causes that she presented within the office.

Q. You had met Mrs. Braun's husband. Correct?

A. Yes.

Q. During the surgery, is there a reason that you did not attempt to contact him to explain that you were about to undertake a procedure that greatly increased the risk of the operation?

MR. ENDERS: Well, let me just object to the

assumption of the question. I'm not sure he's agreed to that yet.

MS. KOLIS: Let me back it out, and make sure I go back to the question.

Q. Doctor, in point of fact, after the surgery you explained to Mr. Braun that you did not know that there were loose bodies in that knee. Is that an accurate statement?

A. Yes.

Q. All right. That's contained actually at the end of your operative surgery, isn't it?

A. Yes.

Q. And you told him that the reason you couldn't explain the increased risk is you did not know about the foreign bodies. Am I stating this accurately?

A. Yes.

Q. Okay. So you would acknowledge that the procedure that you undertook to remove this embedded, loose body greatly increased the risk of the surgery?

A. At the time that I undertook that procedure, I didn't think it would be so difficult to take it out as it turned out to be. And as a result, I didn't feel any need to look for an outside permission when in other cases, I have simply taken out loose bodies as I proceeded. Because when you're doing a knee arthroscopy, it's common that you find other problems that you treat as you're performing the

procedure.

Q. Okay. I think I understood that answer. So your answer is, the reason that you did not attempt to secure or at least advise Mr. Braun before proceeding to a procedure which had not been explained to the family is that you didn't think it was going to be difficult to remove that embedded body?

A. Correct.

Q. Okay. Fair enough. All right. Let's go to your chart. Based upon your charting, when is the first time you saw Mary Jo Braun and for what reason did you see her?

A. Mary Jo came to my office for the first time on March 17, 1997.

Q. And she was referred to you by Dr. Dobbins; is that a fair statement?

A. Yes.

Q. Okay. When she came to see you in March, what information did you have about the patient before she arrived, if any?

A. Well, she provided me with a history. She filled out small history form regarding her prior health and family history, and she filled out another sheet that we have them fill out with various insurance informations and things like that.

Q. All right. Now, she brought with her at that

first visit her X ray; is that what's reflected in your chart?

A. Yes.

Q. Okay. I'm trying to locate my copy of the X ray report. It will just probably take a minute, I'm hoping.

Okay. Doctor, you reviewed that X ray yourself on the first visit; is that an accurate statement?

A. Yes.

Q. Do you recall that you told the Brauns that you did not see evidence for a fracture on the X ray?

A. My note in the chart says, quote, I think the fractures may represent either old fractures or a fracture of the spur.

Q. And then -- I'm sorry. *Go* ahead.

A. And then I go on, I do not think the amount of fluid in her knee is from being only a four-day-old injury, meaning the fracture, but looks as though she has an acute fracture that is interarticular, and that's unquote.

Q. So that was your own reading of the X ray?

A. Yes.

Q. Okay. And when you say you felt that there was an interarticular fracture, what were you defining?

A. Well, Dr. Kandula had seen a possible fracture, and I don't remember this X ray right now, so I can't tell you exactly what I remember reading other than what I have

written here.

Q. Okay. So you had his X-ray report. You were able to review the film yourself. Right?

A. Yes.

Q. Right. And you've just indicated by your answer that you felt the amount of fluid was inconsistent with a four-day-old injury?

A. Fractures tend to have rather large effusions within the knee.

Q. All right. And did you believe she had a lot of effusion at that time based on your physical examination?

A. My examination says she has minimal effusion.

Q. All right. Fair enough. So she didn't have effusions. What was her primary problem at that time?

A. Well, I didn't say she didn't have an effusion. Okay. At that point she had -- I wanted to make sure she didn't have a fracture because one was suggested, and I wanted to see if she didn't have some injury to her collateral ligament at that time.

Q. All right. What was your plan for this patient at that point?

A. I wanted to get an MRI of her knee.

Q. Okay. Why did you want an MRI?

A. Well, an MRI can show you quite a few things. It can show you if there's a fracture. It can show you if

there's torn cartilages and torn ligaments, but it's not 100 percent accurate.

Q. Okay. Now, the date of that visit one more time was 3/17; is that right?

A. '97, yes.

Q. All right. You didn't at the conclusion of that day's visit order an MRI for Mrs. Braun, did you?

A. I'm not sure. Usually when I say something like that, that's what I want to do, and then you have to go through workman's comp to get approval. So I may have tried to order it, but it may not have been approved.

Q. Do you have any documents indicating that you requested from the Bureau of Workers' Comp approval to do an MRI?

A. On 3/17/97, one of my secretaries wrote, "MRI scheduled for right knee on 3/26/97 at 7:30 a.m." Subsequent to that, there's a note one week later on 3/24/97, "insurance is wondering if MRI is necessary. Insurance is wondering if repeat X ray will do. Says knee is feeling much better. Continue to wear knee brace."

Q. Okay. So that's what I was wondering what happened. So it sounds like you were dealing with bureaucracy in terms of getting the examination scheduled; is that a fair statement?

A. Yes.

Q. And did you then have to subsequently write them an explanation indicating that a repeat X ray would not be of value to further confirm what diagnosis you were going to make? I'm guessing what you would have written to them. I'm not certain.

A. I don't know if I wrote a letter off the top of my head. I'd have to look.

Q. Okay. Go ahead.

A. I don't see a letter at that point clarifying the need. Sometimes simply giving my secretary the information is adequate to get them to change their mind. Sometimes it takes a letter.

Q. Okay. This is all by way of background so it's not that terribly important, but I just wanted to see if I could fashion along what you were thinking.

Obviously you believed that you needed to have an MRI?

A. Yes.

a. Okay. Based upon the X ray -- let me retract it.

The reading of the X ray and the review of the patient clinically by yourself and the review then of the X-ray film, did that leave you not confident that you would know what the cause of her problems were without an MRI?

A. Yes.

Q. Did you suspect a torn meniscus without the MRI?
A. It's not stated that day. I don't remember if I thought so or not. I didn't put it in my notes.
Q. Okay. Well the symptoms that she had on presentation on March 17 -- and we've got a couple hours, so I don't want to rush you -- based upon what's contained in your chart, the history given to you by the patient, the symptoms which she reported to you, what did you think the potential diagnoses were? What were you focusing on?
A. Sometimes you just don't know.
Q. Okay.
A. You know. Okay. You can have people that show up with classic signs that don't have what they should have had on their classic signs, and there are other times when they have no signs suggestive and they turn up with various injuries. So that day the MRI was going to help me to sort out which problems this patient may have had.
Q. Okay. I do appreciate that but my more -- I thought it was a simplistic question, but it might not have been.
What I want to know is, as a physician who's dealt with knees for some time, at that point based upon the presenting history, the complaints, and your physical examination --
A. Yes.

Q. -- and a review of that preliminary X ray that was done at the hospital, what were your -- and I guess, we all use this word -- what were your differential diagnoses?

A. Okay. Looking at my chart and looking at the operative, or, the physical examination --

Q. Uh-huh.

A. -- her physical examination did not support a torn meniscus at that time.

Q. Okay.

A. But we did find that she had some osteoarthritic changes within the knee, but you can have torn meniscal cartilages in the presence of those. The problem of a fracture came up as a potential thing, so that was one of the reasons and I was thinking about a collateral injury -- make that collateral ligament injury -- that may have been a mild foramen since she really didn't have any laxity on stressing the collateral ligaments.

Q. Okay. All right. Mrs. Braun came back to you on March 24th. Am I stating that accurately?

A. Yes.

Q. Okay. And you examined her again?

A. Yes.

Q. Did you find an increase in her symptoms or a change or any new information at the time of that examination?

A. There were changes. She said that she felt better.

Q. Okay.

A. But the examination said that she now had lateral joint-line tenderness that's quite severe; and when I checked it, she flinched with pain, and then I couldn't find that same tenderness. And she had tenderness on the medial side of her knee too.

I performed a McMurray's test which tests for meniscal cartilage, and there was snapping and popping. And at that point, I was concerned that she may have a torn cartilage even though she didn't have too much of an effusion within the knee.

And, again, I thought she may still have some irritation of the degenerative changes in her knee which we could tell with the various spurs that she had on the X ray.

Q. Okay. You were aware, Doctor, that she had had a previous arthroscopic examination of the right knee?

A. Yes.

Q. Okay. Did you consider or believe that the prior arthroscopy was the cause of the degenerative changes?

A. That would be the probable cause.

Q. Okay. In addition to the fact, were you made aware by history that there had been a meniscus repair on the previous arthroscopy? Can we just come up with a short name?

A. There is a difference between a meniscal repair and a meniscal excision.

Q. Did you know at that time what procedure she had had performed?

A. My assumption was that it was a meniscal excision.

Q. Okay. Fair enough. Did you get the records or attempt to get the records of her prior procedure?

A. No.

Q. Okay. Did you think that you needed them in order to formulate a treatment plan for the patient?

A. I don't think it would have mattered.

Q. Okay. Fair enough. You indicate that at that visit there was increased pain -- did you say pain? Lateral?

A. On her physical findings, yes.

Q. Okay. What did that suggest to you?

A. When you have joint-line tenderness, oftentimes you may have a torn cartilage.

Q. Okay. And the medial difficulty with the snapping and popping?

A. That's what a McMurray's test checks for. That with pain is significant to suggest a torn medial meniscus.

Q. Okay. Obviously, just moving forward, as we now know intraoperatively, you did not find a torn meniscus. Correct?

A. Correct.

Q. Okay. What do you believe -- since you had the opportunity to explore the knee, and we now know there was not a meniscus tear -- what do you believe accounted for the snapping and popping that you found during the McMurray's test?

A. Well, she had a degenerative area on the posterior femoral condyle. There could have been irritation of the knee-joint lining that may have been getting caught. There is one picture here of a loose body that was floating free in the lateral compartment, and that may have been the cause of it too.

Q. When you say one loose body, is that the first loose body that you extracted, not the embedded one?

A. Correct.

Q. Okay. Doctor, let me ask you this question right now, and I hope I don't get myself off track. I'm not trying to imply anything sinister. But when I requested your records, I did not receive a copy of the photographs of the knee. And today, one of my questions was going to be to you whether or not you had actually photographed the knee intraoperatively. I'm assuming the answer is yes?

A. Are you just asking me if I photographed the knee?

Q. Yeah.

A. The answer is yes, that's pretty much standard.
Q. How many photographs do you have of the knee?
A. There are two sheets with four pictures on each, so eight.
Q. All right. In addition to those four photographs, was it your custom, practice, or protocol of the hospital at the time that you performed this surgery on Mary Jo to actually film the entire arthroscopic procedure?
A. No.
Q. Okay. So these four photographs represent what exists. Right?
A. These are the -- no, these are not the only four photographs. Is that what you're asking?
Q. Yes.
A. No, there's three copies made of the pictures typically. On rare occasion, they may not set the three button and there's only one. So usually the patient gets a copy, the chart gets a copy at the hospital, and my chart gets a copy. If there's only one copy, then I get the copy for my chart because --
Q. Okay.
A. -- it does me more good.
MS. KOLIS: All right. Can we go off the record for one second?
(An off-the-record discussion was had

between counsel and the defendant.)

MS. KOLIS: Okay. Go back on the record.

Q. While we took a very brief recess off the record, Doctor, you have indicated to me that there are four photographs in your file and that you are going to provide them to your counsel who will receive color copies of the same?

A. I told you that we had two sheets with four pictures on each, so we have eight photographs.

Q. Sorry. I misunderstood. So there are eight photographs?

A. Yes.

Q. All right We'll probably come back to those a little later. Okay. All right. So now I lost my track where we were.

I think you had indicated that some of the snapping and popping that you had found on the McMurray's test may have been accounted for by the loose body, which is the first body you removed --

A. Yes.

Q. -- that you found in the knee; am I right?

A. Yes.

Q. Okay. Thanks for giving back my point of reference. All right.

Moving backwards, after your examination on

March 24, what did you think you needed to do with this patient?

A. Well, she felt better in spite of my physical finding, so we tried to send her back to work with some limitations of her work schedule.

Q. Okay. You had her off on rest for maybe two weeks and that might -- or a week, I guess, that is -- and that might have accounted for her feeling somewhat better. Would you agree with that?

A. Yes.

Q. Okay. So you were going to send her back to work to see how she did. Her next visit with you was April 7th, I believe. Your billing suggests that and so do the notes I have. Would you agree with that?

A. Yes.

Q. Okay. I'd like to go through briefly what your physical exam was on April 7th. As I read the referral note that you wrote to Dr. Dobbins it says:

"On examination she has extreme tenderness over the medial meniscus with palpation. She jumped off the table. There is no effusion in her knee." Am I reading this correctly?

A. Yes.

Q. All right. So at that point in time, the medial meniscus has some pain when you palpate it, and you're

indicating that at least on that date you found no effusion in her knee?

A. Right.

Q. Okay. "She had a positive patellar grind test." Doctor, I don't know what a patellar grind test is. That's my fault not yours.

A. You take the patient -- how I do it with them -- lying supine; and then you just take the kneecap, and I push it from proximal and distal and then side to side to grind it down into the knee. And when it's in an extended position, it's not exactly in the articular portion of the knee joint, and *so* then sometimes I'll flex it and get it down into the area and grind it again to see how it does.

Q. Okay. What does that indicate to you if a person has a positive patellar grind test?

A. That they have a source of pain coming from their kneecap.

Q. Okay. Once again, sort of shifting, since you were able to examine the knee intraoperatively, what condition did she have on the kneecap that would have caused that finding?

A. Again, there may have been some degenerative changes on the back of the kneecap. She could have had a piece broken off the back of the kneecap. It may not have been the kneecap but the area that it articulates with that

may be the problem. You may be getting some of the lining in the joint interposed between the two and that may be painful. So it's a test that causes pain, but it doesn't always tell you exactly the reason that they're having it.

Q. All right. I guess I didn't ask the question very articulately.

Based upon your intraoperative examination and findings, do you have an opinion today what caused that patellar grind test to be positive in this patient?

A. It still doesn't answer -- you can have people with a positive patellar grind test, look at the kneecap in surgery and still have it appear normal, yet a year later come back and find out that significant degeneration has gone on. When I saw the patient that day, April -- or, sorry -- May 15, '97, there was nothing on the kneecap that looked like there was any pathology there.

Q. Okay, So that was what I was -- you didn't find any kneecap pathology at the time of your examination?

A. I couldn't see any pathology. Okay. There is sometimes a pathology occurring at a level between the cartilage and the bone, deep to what I can see, *so* I didn't see any pathology.

Q. Okay. Fair enough statement. At that point it's your conclusion, or at least based in your letter to Dr. Dobbins, that she needs some more time off of work; she

shouldn't be working more than five days in a row; and you wanted her to have an MRI. Right?

A. Yes.

Q. Okay. You also indicated she will need a bone scan as well to see if there are any active areas in the compartment of the patella femoral compartment related to arthritic changes. Did you order a bone scan?

A. We probably did not. I don't see the report of one.

Q. Okay.

A. Or maybe we did.

Q. If you'd like to check, that's what I'm asking. I will represent to you that I have been through the charting that you sent me and the records, and I cannot find a bone scan.

A. There is no order, but we did end up getting the MRI, so maybe workers' comp called the secretary and said, if we can get the MRI, do you need a bone scan?

Q. Well, let me ask you separately. I know why you wanted an MRI. We've gone through that. Why would you have additionally wanted a bone scan?

A. Well, sometimes you try to get one if you can't get the other. And the bone scan can tell you if there's something going on in the bone since it's a picture of the function of the bones as opposed to what the bone looks

like. And so it's -- I was trying to see if there was some type of problem going on in the kneecap or in the femur adjacent to the kneecap that may have been producing this pain with the patellar grind test.

Q. You would be looking for arthritis through a bone scan. Correct?

A. Not necessarily. Bone scans have to be looked at with the history involved. And it may represent arthritis, but it could also represent a fracture or other things.

Q. Okay. So that I'm not confused at a later time -- and that happens -- when you were ordering an MRI and contemplating a bone scan -- we'll use that word, contemplating -- were you trying to further define the potential areas of fracture that you saw in the X ray or were you actually looking for something different?

A. If there were fractures, the bone scan would have shown those areas because of the time span that occurred since the time for the fracture, unless the fracture was more than at least two years old and maybe a year and a half or a year. I can't remember exactly if I was still concerned with the fracture that particular day or not. I just knew that there was a problem with the knee that needed further diagnostic testing.

Q. Okay. All right. And so she goes and she has

her MRI?

A. Are you asking me a question?

Q. Yes.

A. Okay. Yes, she did.

Q. Okay. I could just say tell me the whole story but -- all right. I'm sorry. This noise is going to be distracting.

The radiology report I have is dated April 23, 1997. I assume that they directed a copy of the MRI report to your attention?

A. Yes.

Q. All right. Would you have looked at the MRI?

A. Yes.

Q. Okay. You have an ability to look at MRI's and find, I'm going to call them, defects?

A. I don't proclaim myself to be an expert at reading MRI's. This is technology that came out subsequent to my training. And so I usually look at them, read the report, put together what I have learned, and try to come together with if I agree or disagree with what's going on. And I see a lot of knees, so I feel more comfortable looking at a knee MRI than some of the other joints I see.

Q. Is it your recollection that your own visual examination of the MRI ended up being, shall we say, in concert with the reading that was submitted by Dr. Kandula?

A. I don't know if my -- I don't have in my note whether I think, too, that the MRI has a torn meniscus. I'm sure I looked at it and based on her physical findings, her persistent pain, and the findings of the MRI, I felt that that was a reasonable diagnosis.

Q. Okay. After the MRI results were received, you saw Mary Jo again on April 28th and you wrote a referral letter to Dr. Dobbins; is that a fair statement?

A. Yes.

Q. Okay. And in that letter, if I read it accurately, you're stating that the MRI suggests a torn medial meniscus. Right?

A. Yes.

Q. Okay. The second paragraph -- which I don't necessarily want to belabor -- has something. Was there some confusion about something you wrote to the bureau and their interpretation of the diagnosis? I guess that's an easier way to ask that.

A. Apparently there was a code given, 823.8, and I don't know these codes off the top of my head, but apparently that code is for an evulsion fracture of an ankle, which wasn't part of this patient's treatment; and I think that's all that we're talking about there.

Q. Okay. The history that was given at the time is that Mary Jo has had difficulty walking on her leg and did

not have the ability for normal ambulation at that time; am I right? That's in your second paragraph?

A. Yes.

Q. Okay. Doctor, is there any indication that her leg was locking?

A. No.

Q. Okay. Was there ever any indication that her leg was locking prior to the surgery?

A. I asked a question on her form that she filled out when she came in. It said, "Does it lock or limit motion?" And she answered yes. "Can you completely straighten your knee?" And she said no. So that would be some indication of locking.

Q. Okay. The way that you write your -- and I'm going to call it intake form, and that's probably not a good word -- preliminary patient history form, you write, Does it lock or are you limited in motion? Correct? You make it a compound?

A. Yes.

Q. All right. Based upon the sum total --

MR. ENDERS: Let me object and clarify for the record, what he read was, quote, Does it lock or limit movement? quote.

MS. KOLIS: Can I see the document you're looking at?

MR. ENDERS: Sure.

MS. KOLIS: Right. And I don't know the distinction but --

MR. ENDERS: You paraphrased. You may as well have it accurate.

Q. Oh, okay. "Does it lock or limit movement?" You make it a two-part question because lock and limit aren't necessarily the same thing. Am I accurate in that?

A. That's right.

Q. Okay. And as I reviewed the sum total of the referral notes that you sent to Dr. Dobbins, we don't have an episode of her leg locking from the time that she came under your care until the time of surgery. Would you agree with that representation?

A. They're not in my letters to Dr. Dobbins.

Q. Do you have them anywhere in your physical-findings charts that didn't end up in the Dr. Dobbins letters?

A. I just read it. When you say, "Can you completely straighten your knee?" and she said no, that means she has a locked knee.

Q. Okay. When you write the following sentence, "Can you completely straighten your knee?" what are you asking the patient if they can do? I know that sounds silly. But are you asking if they can sit in a chair and

lift their leg up straight?
A. If the knee goes all the way straight.
Q. When she's standing or sitting? I mean, tell me what you mean by that question?
A. Simply that. Can her knee go all the way straight, and if she says no, then she has something probably more correctly called blocking, but it's called locking of the knee.
Q. Will a torn meniscus cause the knee to lock?
A. Yes.
Q. Okay. I'll ask you to think this through. The embedded loose body -- we'll call it what you called it -- the embedded loose body that you eventually extracted from Mrs. Braun's knee, is that body represented in any of the radiological studies?
A. No, no.
Q. Okay. That's your answer? That's fine. I just want to make sure that you're comfortable with that. Okay.
You got the MRI results, and based upon the MRI results you determine that she needed arthroscopic evaluation and treatment. Is that probably an accurate statement?
A. Yes.
Q. You scheduled her for the procedure about mid May?
A. Yes.

Q. She had one more visit with you on May 9th, before the surgery? Am I -- I think your chart reflects that? Did you find it?
A. Yes.
Q. Okay. Did you make a clinical note as well as the referral note?
A. You mean in this handwriting?
Q. Right. In your handwritten section, did you --
A. Well, that's what -- it's dated May 5th, and it says for pre-op evaluation, and I don't know, maybe she rescheduled, maybe the nurse just wrote down the wrong day. I can't tell you why that's different.
Q. Do you have a clinical note that says 5/9?
A. Are you asking in handwriting?
Q. Yes, a handwritten note.
A. I do not have a handwritten note for 5/9/97. I have one for 5/5/97.
Q. It's possible the wrong date was written down?
A. Possible.
Q. What does the handwritten note of 5/5 say, the one that says 5/5 in your chart?
A. "For pre-op evaluation for right knee, scope, and partial meniscectomy, labs, etc., today." It's initialed by the nurse.
Q. Okay. All right. The note on 5/9 -- if you

want to return to your referral note -- it says, "Mary Jo comes in today for her history and physical." Would that be a pre-op history and physical?

A. Yes.

Q. Okay. And she's just indicating that she's had increasing pain in her knee since Tuesday. Right?

A. Yes.

Q. Didn't add any information or change your surgical plan?

A. No.

Q. Okay. Okay. Let's talk about your surgery if I can find my yellow notes. Okay.

Now, you've already indicated that you do have photographs, and we might need to refer to those. But let's take a look. Doctor, can you tell me when your surgery began and when it ended?

A. It said that the operation began at 8:20 and then it ended -- this was one continuous operation. Okay? It has my operation starting at 8:20 and ending at 1:35 and then resuming at 10:54 and ending at 15:09.

Q. Do you see why that might be confusing to me?

A. This is -- what happened here is that when Dr. Keighley came in, they tried to draw lines between his doing procedures and my doing procedures, but I never left the O.R., and then I assisted Dr. Keighley with this, unless

I took a bathroom break. I suppose in that length of time, I probably may have stepped out for just a short time while Dr. Keighley was operating.

Q. Okay. This is what I'm trying to determine. Do you have the anesthesia record?

A. No, I do not.

Q. Okay. I'll just take a second and I'll locate mine. I'm going to offer you a suggestion or a suspicion. We'll see if this fits.

How long do you believe that your portion of the operation took before you would have called in Doctor -- it's Keiley (sic) --

A. Keighley.

Q. -- Keighley.

A. I can't even guess.

Q. Okay.

A. I don't know.

MR. ENDERS: Off the record.

(An off-the-record conversation was had between counsel.)

Q. This isn't a question, it's more of a statement. I'm just trying to figure this out. Generally speaking, Doctor, if you had gone in to evaluate a knee that you thought had a meniscus, pursuant to what you told the family, the procedure would have taken 45 minutes perhaps to

an hour. Would you agree with that?
A. Yes.
Q. Okay. And this one went a little longer, of course, because you did some additional things. I don't know if you want me to use that word. You determined there was something you needed to do and that was to remove this embedded body. But you just don't have a specific recollection of how long it took you?
A. No, I don't.
Q. Okay. Would you agree with me that at least by 10:20, Dr. Keighley was in evaluating for Doppler pulses?
A. They probably have that kind of thing recorded in the hospital records.
MS. KOLIS: Okay. I'm going to show you what I'm going to end up marking Plaintiff's Exhibit 3.
(WHEREUPON, Plaintiff's Exhibit No. 3 was marked for identification.)
Q. There's different pieces, parts of paper, but this one appears to be the frequent vital signs record, but probably you can tell me where, in the O.R. maybe?
A. I'm sure this is in the O.R.
Q. Okay. This indicates, and you can look at it. I don't know if your attorney flipped to that page. It says, "Dr. Keighley here" -- this is at 10:20 -- "also unable to palpate or hear pulses." Do you see that note?

A. Yes.
Q. All right. So that would be some indication that your portion of the operation ended about that time. Right?
A. Yes.
Q. Okay. Let me ask you another question since we have this exhibit out. Says, "Decision made per surgeon to open leg." Obviously we're going to open the leg to find out if there had been some interruption that shouldn't have occurred. Would you agree that was the purpose in opening the leg?
A. Yes.
Q. Okay. "Dr. JMS," is that you?
A. Yes.
Q. Dr. Speca, "requests husband not be notified yet. Find cause of bleeding first." Doctor, why didn't you want to just pick up the phone and call Mr. Braun?
A. I wanted to give him some information. I didn't -- I wanted to be able to tell him this is what happened, this is what we found, so that he knew why we were doing what we were doing.

To me, with an artery without there being a pulse, we needed to go ahead, and I just felt that I wanted him to have information so that he wouldn't necessarily be concerned.

Q. Let me see if I understand this correctly. At 10:20 -- and this is the only document I could find that helped me a lot, I suppose, in terms of timing -- Dr. Keighley was there. He couldn't find a pulse either. The decision was made obviously to open the leg. You requested that Mr. Braun not be notified because you wanted to find the cause of the bleeding first.

Was it your intention to wait until you knew exactly why she didn't have a pulse before you called him?

A. Yes, because if there was some, if there was a problem that was relatively minor, I didn't want him to be overly concerned; and if there was a major problem, then give him a better understanding of what was going on.

Q. Okay.

A. Go ahead.

Q. Okay. Fair enough. Although this is dialogue -- you don't know me and I don't really necessarily have a flair for the dramatic in asking these kind of questions -- but in your own mind, given that she had no pulses and you knew what procedures you had just finished doing, was there any risk that Mrs. Braun might not make it at that point in your mind?

A. You mean, might die?

Q. Right.

A. No.

Q. Okay. So you were just concerned that you find the spot of the bleeding -- you're assuming there was bleeding, of course, of a serious nature -- then call him. Right?

A. Yes.

Q. All right. You ended up calling him at 11:50, about an hour and a half later?

A. Yes.

Q. Did you participate in the surgery with Dr. Keighley, or did you merely watch him?

A. Well, I held retractors.

Q. Okay. All right. Did Dr. Dobbins assist you in your first part of this procedure with Mrs. Braun, or was he simply administering the anesthesia?

A. He needs to administer anesthesia, so he can't assist.

Q. Okay. Did you have anyone assisting you in that procedure?

A. Not that I can remember. I don't think so.

Q. I didn't see, I didn't see any --

MR. ELDER: Try to keep your voice up. Now I'm having trouble.

THE WITNESS: All right.

MS. KOLIS: Well, we could go tell them to take a long lunch break.

Q. But I didn't see an indication of an assistant, and that's why I asked you.

A. Right.

Q. Okay. Do you customarily do arthroscopic procedures with no assistance?

A. Depending on what I perceive the nature of the scope to be in a situation like hers, I didn't expect there would be need for an assistant so I had none.

Q. Okay. I accept that answer. Let's turn to the surgery itself.

Doctor, how many different attempts did you make at removing what you have called the embedded loose body?

A. I don't know.

Q. Okay. Well, we're going to go through your "I don't know," but let's follow that up with a couple of preliminary questions.

As I read this -- and understand that I do not read operative reports probably as well as I should, although I'm not a doctor -- you initially had the patient intubated. You fixed her legs in the correct positions, and then you went in with the scope to examine all the surfaces. Am I stating that correctly?

A. Yes.

Q. Okay. You found a normal -- initially it says, "The knee was distended and the suprapatellar pouch was

visualized and was normal." Correct?
A. Yes.
Q. All right. And the retropatellar surface was also normal, and that's talking about the underside of the kneecap; am I right?
A. Yes.
Q. Okay. The medial gutter going around was also normal?
A. Yes.
Q. The medial compartment was visualized, and it appeared normal?
A. Yes.
Q. Says then you establish an anterior medial portal and probed the medial meniscus, and there was no evidence of any tear. Have I gotten -- and I'm doing this in summary fashion. Correct so far?
A. Yes.
Q. Okay. Now, at this point you've just appropriately initiated the procedure, gone in, examined the pertinent structures, and you have found normal findings. Correct?
A. Yes.
Q. At that point did you have a thought as to what might have been causing the problems that Mrs. Braun was presenting to your office with? Did you stop and give pause

since you just found all these normal structures?

A. Well, when you talk about looking in the medial gutter --

Q. Uh-huh.

A. -- the reason you look in the medial gutter is to look for loose bodies.

Q. Okay.

A. Okay. So when you do an arthroscopy of the knee, and whether you're going in to perform ligament surgery or meniscal surgery, you're going to look for loose bodies, and that's what I was in the process of doing routinely.

Q. Sure. And loose bodies can be fragments of bone or cartilage, can't they?

A. And/or cartilage, yes.

Q. And/or cartilage. Correct.

Then you proceeded to the anterior cruciate ligament. At one point I guess you'd had some concern that there might be a ligament instability based on what we talked about, but that was normal, wasn't it?

A. Yes.

Q. Okay. Now, in the lateral compartment which you visualized, you found a loose body sitting. That's the way you describe it?

A. Yes.

Q. Right. But it was wedged between the horn of

the lateral meniscus and the tibia. Right?
A. Yes.
Q. Would that body, as we've discussed, being wedged there have -- and I don't like the word, but I'm going to say -- been the cause that mimicked those positive symptoms that you thought might be meniscal in nature?
A. Yes.
Q. Okay. So you found that, and it says, "I was able to remove this," apparently without much difficulty, if any. I'm adding that. Is that a fair statement?
A. I took it out.
Q. All right. And you had to slightly enlarge the hole to remove the body; am I right?
A. Yes.
Q. Okay. All right. You said, I then saw a remnant of lateral meniscus after the prior arthroscopic partial meniscectomy. What does that mean?
A. That's where he had done the surgery before.
Q. Okay. All right. All right. And then continuing on, you visualize post-laterally. There you saw a large osteochondral fracture fragment. I'm reading this right out of your operative summary.
Doctor, how did you determine it was a osteochondral fracture fragment?
A. Well, chondral means cartilage, and it was

sitting right behind an area on the posterior femoral condyle, and I thought that it was simply a piece that had broken off, rotated, and embedded itself in the capsule there.

Q. Okay. Given the suggestive arthritic changes that were found on the X ray and perhaps the MRI suggested some, did it cross your mind that this perhaps was a spur?

A. It was right adjacent to where this other thing was, so I thought that it was probably a fracture fragment.

Q. Okay.

A. And it seemed about the same size.

Q. Okay. At this point you find this body. Now, this one isn't floating loose. Right?

A. Right.

Q. Okay. It is -- well, at the point that you find it, do you know it's embedded, per se? It says, "It's embedded within the posterior capsule." How did you know it wasn't simply wedged?

A. It probably looked embedded, or I probably tried to probe it with things and found that it didn't move.

Q. Okay. To a reasonable degree of medical probability, what problem medically was this embedded fracture fragment -- and I'll concede your definition of it because that's what you thought it was -- what physical problems was it causing this patient?

A. It may have been some of the source of what she was having.

Q. Was it likely to have been the source of the problem she was having?

A. I don't know. It was a loose body in the knee, and it was adjacent to an area that looked about the same size; and loose bodies are commonly attached within the knee, and so to me, the fact that it was embedded here with the time that had elapsed from her injury to her date of surgery didn't seem to jive that it was there and scarred in.

Q. Okay. All right. Now, this one didn't come out so easy, did it?

A. No, it didn't.

Q. Let me ask you, because I missed it, and I missed it because it wasn't in there. When you took the first loose body out, how did you extract that?

A. I grabbed it with grasping forceps and pulled it in through the portal, which needed to be enlarged, and took it out.

Q. So if I can use my analogy, it was like a tooth that had no nerve roots left. You just touched it and you could pull it out. You didn't have to do any kind of dissection to make that body move out. Am I stating that fairly?

A. It's reasonable.

Q. Okay. You could have told me a different way, but I didn't see it. It just appeared there were no problems with it. All right.

At this point you see this through your scope -- I'm obviously assuming that's the only way you would have seen it. And it said that you made a portal in the post-lateral after finding the correct position with a spinal needle, and then tried to pry this piece out, pry this piece of bone out with blunt dissection and with the graspers.

You needed to make an additional opening to do what? Did you make an additional opening at that point?

A. Yes, I'm just trying to find the area that you were reading.

Q. I'm sorry. I'm right at the top, fourth line down on page 2 -- well, it says continued page 3.

A. Okay. Yeah, I had to make another portal.

Q. Okay. You needed to make that portal to do what? To put the scope in?

A. So that you could pass an instrument through posteriorly in order to do whatever you could to get this piece out.

Q. Oh, because the other portal you had, you couldn't have removed it from that direction?

A. Well, we talk about triangulation with arthroscopy.

Q. Right. So you just needed a different approach to make a better triangulation for your scope and instrumentation?

A. You have to look from one direction and operate, more often than not, from someplace else.

Q. Right. Okay. All right. So at this point you try to remove this piece with blunt dissection and with the graspers is what it says?

A. Yes.

Q. Okay. And if I understood you correctly -- and I'm just walking myself through the surgery -- the prior piece was not embedded. Correct?

A. Right.

Q. And you only had to use graspers to take it out?

A. Right.

Q. Now, you've added blunt dissection to attempt to get this foreign body -- I call it a foreign body. I'm sorry -- this osteochondral fracture fragment, you're adding a blunt dissection. Right?

A. Yes.

Q. And when you say blunt dissection, what were you using to extract this?

A. I was just using the probe, which has a little right angle, blunt hook on it, to try and pry it away from the wall of the joint.

Q. Okay. Now, at that point it says, "This was not budge it." I think that it should have been, this would not budge it, perhaps?

A. Yeah, it's typographical errors.

Q. Sure and those happen all the time. Did it occur to you at this point to abandon your efforts to remove this fragment since you didn't know if it was even causing any physical problems?

A. Let's just say I wasn't real happy that that particular portion of the surgery didn't get it moving at that point, and I felt that in order to take it out, I was going to have to do things that would be a little riskier, and I would have to be as careful as I possibly could to get it out.

Q. Okay. I appreciate that, but my question is, did it cross your mind that since you were not certain as to whether or not what you are calling an osteochondral fracture fragment that was embedded was even causing a physical problem, that maybe you should abandon it since it wouldn't freely come out?

A. No, because if this was part of the problem and I closed the knee up and she still had problems, then I didn't do the operation to make her better.

Q. All right. At this point then you indicate, "I needed do so something to elevate it off the capsule,"

meaning elevate the fragment off the capsule?
A. Yes.
Q. Okay. "I did not want to use the shaver if at all possible." Doctor, I realize that you had the benefit, of course, of writing this operative summary subsequent to all the events.
A. That's right.
Q. Is that what's going through your mind as you were thinking this through? You did not want to use the shaver?
A. That's right.
Q. Okay. Can you articulate medically why you wouldn't have wanted to use the shaver to remove this body?
A. I just thought that if I had something that I could sort of shell this thing out, that that might be a reasonable way to take it out because the shaver sucks tissues into it, and so I was just trying to be as careful as I could and shell it out with these other instruments first and leave the shaver as a last resort.
Q. Well, when you say it sucks all these tissues, are you talking about it was a technically difficult maneuver if you use the shaver or if there was any increased danger to the patient?
A. Well, that's just how the shaver works. It sucks tissues into it, and then the blade rotates and it cuts

them off. And so being in the back part of the knee, I wanted to be able to have more control over the situation.

Q. All right. So you then attempted -- now, of course, her knee is still flexed. Right?

A. Yes.

Q. Got her in the same position you had her in originally. Your second attempt was, as I'm reading it, "I used a small knife that was a hooked blade, feeling that I could put it behind the component and keep it close to the edge and not have it out of my sight so that I could free up the lateral edge. This was not able to free it up enough to grasp it."

When you're saying it was not able to free it up enough, you're talking once again about the fragment?

A. Yes.

Q. All right. So that's your second attempt?

A. Yes.

Q. All right. At that point did it occur to you -- once again, my question is -- that maybe you should abandon this attempt to dislodge this embedded fragment?

A. Well, at this point I had already been working on it, and it wasn't as embedded anymore; and I didn't want this thing flip-flopping around in there and end up working itself loose, creating a problem. My feeling was that this was from the posterior condyle and needed to come out because

it was right where I saw this defect in the bone.

Q. Doctor, let me ask you this question. If you had loosened it up somewhat but to go on to the next step would require, once again, increasing the risk of injuring, as ultimately happened, the structures behind the knee, the artery, the vein, and the nerve, couldn't you just have allowed it to work itself free naturally at some point in the future and have gone back in and simply removed it at that point?

A. I don't think that's helping the patient. If you leave something that you think is going to work itself free --

Q. Uh-huh.

A. -- and then take them back to the operating room because you didn't take it out when you were right there working on it, I don't think that helps the patient. And so it's -- I'm working this thing free, concerned about where I'm working and trying to make this patient better the whole time.

Q. Well, I guess, let me see if we'll look at it this way together.

Initially, when you tried to pry the piece of bone out with blunt dissection and graspers, it didn't budge. It was completely still embedded in the capsule?

A. Right.

Q. That's what you said. But once you went on to step two and then loosened it some, I guess what you're saying is that your course was set. You were going to go and continue until you got it out. Is that what you're telling me?

A. Yes.

Q. Okay. All right. I think that what happens next is, that didn't work and so the third attempt is, you put a curved blade in that you could skive. I'm not familiar with the use of that word.

A. Skiving to me means you're just trying to slide along the structure, and I was pointing the structure anteriorly and pointing the blade anteriorly towards the structure so it wouldn't go posteriorly where the vessels were and the nerve.

Q. Okay. ". . . so that I could skive along the posterior aspect of the bone and keep it pointed toward the tibia. We were able to do this." That was also why I asked you if you had an assistant. You said we.

A. Well, there's a scrub nurse next to me. She's --

Q. Okay. You're just referring to your scrub nurse, and what is she doing for you?

A. Well, maybe she's holding the leg. I don't know, you know, that's --

Q. Can you discern from the records, as you've reviewed them, who your scrub nurse was for this procedure?
A. It would be recorded on the hospital's chart who was there.
Q. Okay.
A. And let me see.
Q. See if you can find it because I obviously can't read the writing.
A. My operative note does not mention who the scrub nurse was. It's recorded in the hospital's records though.
Q. All right. We'll see if I can take five minutes later and go through some of them and perhaps get you to tell me who it was.
Anyway, "We were able to do this; it slipped but went towards the tibia and not posteriorly." What slipped? The knife?
A. The knife.
Q. Doctor, do you believe that it is at the third attempt where you actually injured the artery, vein, and nerve?
A. No, it was because this thing didn't go towards the artery, vein, and nerve. It went away from it.
Q. When do you think you injured those structures?
A. I think it happened when I passed the shaver in.
Q. Okay. I think the last answer was he indicated

that he believed that the structures were injured when he used the shaver. Did I state that correctly, Doctor?

A. Yes.

Q. Okay. All right. So you complete the third attempt with the knife, the curved blade -- excuse me -- and that didn't work. So now we have a fourth attempt, and if I'm reading this, it says, "At this point I used basket forceps to try and cut around the edge of this fragment by cap one jaw exposed . . ." Should that be by keeping one jaw exposed?

A. Yes.

Q. Okay. ". . . and the other deep and tried to get it freed, but this was unable to do it either." So you're using, I think, they're basket forceps just like a little contraption with a basket on the end, and you try to clamp around it and pull it?

A. No, basket is sort of a misnomer, I suppose. All it is is just a couple of jaws that can grab something.

Q. Okay. Is there --

A. A basket forceps. They have basket meniscal cutters, too, and all these things are is that they have some sort of a loop with a sharp edge around -- these are cutters now. I'm not talking about the forceps.

Q. Okay.

A. The basket cutters have a sharp edge, and you

put it under and the top part comes down through it, and it bites it, sort of like you bite things with your teeth. And *so* they just are called basket forceps. And all it is is we have some that close flat and some that close with like an indentation so that you can sort of grab around it. So I don't know which one I was using here but --

Q. Okay. All right. So that didn't work. So you went into your fifth attempt, the way I separate this out. It says, "I then tried to pass the shaver from the posterior medial portal and I looked in the posterior portal first. I did not find any tears present." Why were you looking for tears?

A. Well, we did have a diagnosis of a torn medial meniscus, and sometimes they're very peripherally located; and so I was looking at the medial meniscus to see if it was torn back out of sight where I couldn't see it from the front of the knee.

Q. You weren't fully assured from your first examination that you had sufficiently eliminated that torn meniscus?

A. This is part of my routine arthroscopy where I go through all these parts and look for all these things.

Q. All right. At that point you made an incision, passed in the probe ". . . and I could see the probe under the synovia moving around. I then passed in the shaver, and

the shaver was under the synovium." Are you -- and when you're saying it's under the synovium, what portion are you referring to? In other words tell me where this is located at that point in time in layman's terms.

A. We're in the back *of* the knee.

Q. Okay. "I turned it on so that it would break through the synovium, but it did not." What did that tell you, if anything, that the shaver couldn't break through the synovium at that point?

A. Well, all I knew is that I couldn't put it in. It's not as easy to place an instrument in the back portion of the knee, and so it means -- so it wouldn't go through. I needed to find another way to get it into the back of the knee.

Q. Okay. How many times, Doctor, in your career, have you had to remove a fragment embedded in the posterior portion of the knee?

A. It's not uncommon to find a fragment that's attached to the posterior portion of the knee, and you have to get back there and sort of loosen it up before you can take it out. Embedded like this, I found one other one and -- I found one other one.

Q. When you found -- did you know about those prior to surgery, the other ones that you're referring to?

A. No.

Q. So you have had, were those before or after Mrs. Braun?
A. That one was after.
Q. So you found one after and one before?
A. No, I found Mrs. Braun's, and I found the one after.
Q. Oh.
A. And I do find other fragments back there that are attached to the synovial lining and not freely floating that I have to remove. I can't tell you how many I've found like that. But embedded like this one, I've only found one other.
Q. Okay. All right. As we're going on, this did not work because you couldn't break through the synovium. So attempt number three was that you made a second portal on the lateral side so you could visualize it. Correct?
A. Yes.
Q. And then it says, "I used the shaver again to try to go around the fragment of bone to excise it. It essentially became morselized . . ." Do you mean it was crumbling?
A. Yes.
Q. Okay. ". . . through the multiple attempts. It was at this time that I noticed there was some bleeding from the muscle posteriorly in the knee."

I guess I'm just a little bit confused, and you can clear it up for me. At that point when you say it was essentially morselized, okay, what did you do to complete the removal of this fragment?

A. Just put the shaver in and it just continually bit it piece by piece until it came out in tiny morsels. That's what we're talking about.

Q. Okay. All right. So you actually removed the entire fragment?

A. Yes.

Q. Okay. And then it was at the point that you removed the entire fragment that you saw bleeding?

A. No, because I noticed the bleeding, and I had to put the tourniquet up in order to finish this bone removal process. And then after I completed that, I had let the tourniquet down so that I could find what was bleeding and try to coagulate it.

Q. Okay. So see if I understand the sequence of events. You've got the shaver in there, it's morselizing out the bone; and you say, "It was at this point in time that I noticed there was some bleeding from the muscle. I put the tourniquet up," meaning you were raising the level that would stop the bleeding? Is that what you're talking about?

A. Yes.

Q. Okay.

A. The tourniquet was not on up to this usually. I usually do knee arthroscopy without the tourniquet.
Q. Okay. That's where I'm confused. You had to put it up actually? When you say put it up, you meant really put it up?
A. Turn it on.
Q. Turn it on?
A. Yes.
Q. Is what you meant because of the bleeding. Okay. What did you think was bleeding?
A. Could have been muscle.
Q. You just didn't know; am I right?
A. No, I didn't know what was bleeding at this point.
Q. How long did it take you to put up the tourniquet, best guess?
A. I don't know what you mean by that.
Q. Well, you're saying you had to put it on. What did you have to do physically?
A. I told the nurse to turn on the tourniquet, and she turned it on; and it's up in just a couple of seconds.
Q. All right. So you already have it placed in case you need it?
A. Yes.
Q. Okay. Fair enough. That's really what my

question was.

You finish your procedure, you take the tourniquet down, and it says you did not find any active bleeders. Is that saying -- what would you expect to be bleeding at that point, if anything?

A. I was looking for things that were bleeding. I didn't know that an artery was cut at this point. All I knew is that there was some bleeding posteriorly. I wanted to coagulate it so she wouldn't have a knee full of blood after surgery which can cause problems with knee stiffness and sort of help prevent that.

Q. All right. So you take the tourniquet down. Now she's still under, correct --

A. Yes.

Q. -- at this point? And then you evaluate over the foot and ankle for pulses. Right?

A. Yes.

Q. Now, is that because you were concerned that you had entered the space of the artery?

A. Well, I was working posteriorly in the knee with sharp instruments. And I knew that if there was bleeding, we had to determine, you know, if there was a chance that you had injured the artery. And so I felt for the pulses, and I didn't feel any pulses.

Q. How long did it take you to get Dr. Keighley

there?

A. I don't know. That may be in the notes where they contacted him, and then he came in.

Q. All right. And he likewise could find no pulse?

A. Correct.

Q. And at that point a decision was made to open the leg to explore it for injury. Correct?

A. Correct.

Q. Okay. I'm not going to go through Dr. Keighley's surgery. Tell me in your own words, based upon the surgery itself, surgery, meaning his repair surgery and your subsequent fasciotomies as well as her postoperative course in the hospital, what intraoperative injuries Mary Jo Braun sustained.

A. She had injuries to the popliteal artery, the popliteal vein, and the posterior tibial nerve.

Q. Okay. Would you agree that the artery and vein were in fact lacerated?

A. Yes.

Q. Okay. The nerve, if I'm reading your discharge -- well, not discharge, your operative note -- you went in and observed the nerve. Correct?

A. Yes.

Q. And you're describing it. You describe it as follows. You said, "I put on my operating loops at this

time, and it appears as though there were an abrasion at the site of the nerve. The nerve appeared to be 90 to 95 percent intact."

Based upon her subsequent postoperative course, do you think that that assessment on your part that there was only a small interruption in the nerve is accurate?

A. I don't know. Nerves are funny things. Sometimes there can be a large injury and people seem to function normally, and sometimes the smallest thing can give them significant problems. So I'll stand by what I said here.

Q. Okay. Fair enough. Did you have any conversation with Dr. Keighley after the surgery as to how it was you were able to get through the synovium and injure all three structures?

A. Right after this particular operation, I wasn't sure where this happened, and I'm not a hundred percent sure where it happened even now. One area may be more likely than the next, but I don't know how exactly with a hundred percent certainty this happened, or maybe I should say when it happened.

If I had any discussion with Dr. Keighley, I don't remember it; and like I said, I remember trying to have to sort this out for a while, so I'm not sure.

Q. All right. Suffice it to say, however, you're

fairly certain you didn't injure those three structures at the back of the knee when you initially took out the free body, the first one?

A. No.

Q. Okay.

A. This was injured working in the back.

Q. Fine. Did you and Dr. Dobbins have some conversation after the procedure about what happened intraoperatively?

A. He was there. He saw what happened intraoperatively, and I don't remember any specific discussions regarding it.

Q. So you didn't have a conversation with him. First of all, let me ask you a question. Did Dr. Dobbins at any time during the surgery -- he wasn't there as a surgeon. Let's start with that. Correct?

A. That's right.

Q. Did he suggest to you, however, intraoperatively that he felt that you should not proceed to attempt to remove that embedded body?

A. I don't have any recollection of that.

Q. Okay. And you've already indicated much earlier in the deposition that you've never been able or you just haven't seen a copy of Dr. Dobbin's discharge summary; is that right?

A. I don't remember.
Q. It's not in your office chart?
A. I said earlier in the deposition that I don't remember seeing anything.
Q. Okay. After the surgery you -- well, just to play this out -- Dr. Keighley is not a vascular surgeon, is he?
A. No.
Q. You called him in because you yourself were not capable of doing an artery bypass?
A. Yes.
Q. A repair; is that right?
A. That's right.
Q. Had you worked with Dr. Keighley at any time prior to May 15 regarding the repair of any other structures behind the knee in a surgery that you performed?
A. No.
Q. Okay. After he did his repair, you did fasciotomies. Correct?
A. Yes.
Q. Was the purpose of that to prevent compartment syndrome or help drain the blood?
A. To prevent compartment syndrome.
Q. Okay. And that wasn't totally successful. Correct?

A. She ended up developing some problems in her room that needed to have the sutures removed.

Q. Okay. And, Doctor, the last time that you saw this patient was at an office visit on June 12; is that right, June 12, 1997?

A. Professionally that's the last time I saw her.

Q. Okay. You've seen her in the -- this isn't a real big community. Right?

A. I just saw her Saturday for the first time since June 12, and she was out at a flea market where I was.

Q. Okay. Great. You indicated that you had been able to look at summaries of Mary Jo's current medical condition and treatment provided by your attorney; is that accurate?

A. Well, we discussed them. I saw parts of them.

Q. Oh, okay. Was there anything in her current physical condition that surprised you based upon what you knew about the intraoperative injury that occurred in May of 1997?

A. You're asking me about her condition from her intraoperative injury or anything about her condition since the injury in 1997?

Q. Well, I'm assuming, I'm assuming that the records that I submitted to your attorney summarize the care and treatment that she's needed due to the intraoperative

injuries.

A. Yes.

Q. So I was asking if there was anything that you saw that surprised you?

A. She was doing more poorly than I would have anticipated her to be doing at this stage of the game.

MS. KOLIS: Okay. Doctor, I don't have any further questions for you. I appreciate the time that you took in being here this morning. I will, however, have your transcript, your testimony transcribed by the court reporter. It's my practice to request that the physician do read their depositions.

MR. ENDERS: You don't have to worry about that because he's instructed to read it.

MS. KOLIS: That's fine. Additionally, however, I will waive the seven-day reading requirement. Most people are too busy to read and return it. However, I would extract from you the promise that it would be no longer than 30. Is that reasonable?

THE WITNESS: Yeah, I'll do everything I can to get it.

MS. KOLIS: Okay. I appreciate it. Thank you.

MR. ENDERS: Thanks.

(WHEREUPON, the deposition was concluded. Signature was reserved.)

STATE OF OHIO:

COUNTY OF MERCER: SS: CERTIFICATE

I, JOYCE C. BOWERS, Registered Professional Reporter and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named JOHN M. SPECA, D.O., was by me first sworn to testify the truth, the whole truth and nothing but the truth; that said testimony was reduced to Stenotype in the presence of said witness and thereafter reduced to typewritten form with the assistance of computer-aided transcription; that the foregoing is a true and correct transcription of his testimony as given on the 6th day of April, 1999.

I FURTHER CERTIFY that I am not a relative or attorney of either party nor in any manner interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Celina, Ohio, on this ____ day of April, 1999.

JOYCE C. BOWERS, RPR
Court Reporter/Notary Public
My commission expires 02/09/00

ERRATA SHEET

Please do not write on the transcript. Any changes in form or substance you desire to make should be entered upon this sheet.

PAGE NO. LINE NO. CORRECTION TO THE TEXT

TO THE COURT REPORTER:

I have read the entire transcript of my deposition taken on the 6th day of April, 1999, or the same has been read to me. I request that the following changes be entered upon the record I have signed my name to this sheet and authorize you to attach the same to the original transcript.

John M. Speca, D.O. Date

JOHN M. SPECA, M.D.
CELINA ORTHOPAEDIC AND
SPORTS MEDICINE CENTER, INC.
950 SOUTH **MAIN** STREET
CELINA, OHIO 45822

"WHERE GOOD SPORTS GET BETTER"

Phone 419-586-5760 Fax 419-586-7179

CURRICULUM VITAE

JOHN M. SPECA

PRESENT POSITION AND ADDRESS

Celina Orthopaedic And Sports Medicine Center, Inc.
950 South Main Street
Celina, Ohio 45822
(419) 586-5760

EDUCATION

Undergraduate School

Loyola University of Chicago
Stritch School of Medicine
Maywood IL
June 1975 - June 1979
Deyree: Doctor of Medicine

Post-graduate Education

Internship - Internal Medicine
Christ Hospttal
Oak Lawn IL
June 1979 - June 1980

Internship - Surgery
Medical College of Ohio
Toledo OH
July 1980 - June 1981

Residency - Orthopaedics
Medical College of Ohio
Toledo OH
July 1981 - June 1985

Passed Part I Examination - American Board of Orthopedic Surgery, 1989

Passed Part II Examination - American Board of Orthopedic Surgery, 1990

Board Certification - American Board of Orthopedic Surgery, July 13, 1990

AWARDS

Intern of the Year Award - 1980 - Christ Hospital, Oak Lawn IL

JOHN M. SPECA, M.D.
CELINA ORTHOPAEDIC AND SPORTS MEDICINE CENTER, INC.
950 SOUTH MAIN STREET
CELINA, OHIO 45822
"WHERE GOOD SPORTS GET BETTER"
Phone 419-586-5760 Fax 419-586-7179

RESEARCH ACTIVITIES AND LECTURE PRESENTATIONS

Minibike and Motorcycle Accidents in Adolescents: A New Epidemic, Journal of the American Medical Association, Volume 232, p. 55, 1975

Accepted for Presentation:

Anterior Spinal Fusion in Pyogenic Infection of the Adult Spine, National Conference for Musculoskeletal Diseases in the Aged, Phoenix, AZ, January 1985

Adolescent Sports Injuries, Hip and Pelvis Injuries in the School Aged Athlete, Sports Medicine Symposium, University of Kentucky, April 1992

Adolescent Sports Injuries, Shoulder and Hip exam workshop, Shoulder Injuries in the Young Athlete, Hip & Pelvis Injuries in the School Aged Athlete. Selected topics in sports medicine. Mexican Association of Sports Medicine, November 25, 1995, Aguascalientes, Mexico, November 26, 1995, Morelia, Mexico

Accepted for Presentation, but not presented:

Revision Hip Arthroplasty: Comparing Prostheses with and without Collars, National Conference for Musculoskeletal Diseases in the Aged II, Scottsdale, AZ, March 1985

PRESENT HOSPITAL AFFILIATIONS

Mercer County Joint Township Community Hospital, Attending Staff, May 1994 to present

Joint Township District Memorial Hospital, St. Marys, Ohio, 1996 to May 1994 to present - active staff

ATTENDING PHYSICIAN

Mercer County Joint Township Community Hospital, Chief of Staff, January 1998 through December 1998.

Mercer County Joint Township Community Hospital, Chief of Surgery, January 1996 through December 1996.

Elk's Crippled Children's Clinic, Henry County Health Department, January 1989 to 1994

St. Mary's Sports Medicine Clinic
September 1986 to 1990

JOHN M. SPECA, M.D.
CELINA ORTHOPAEDIC AND
SPORTS MEDICINE CENTER, INC.
950 SOUTH MAIN STREET
CELINA, OHIO 45822

"WHERE GOOD SPORTS GET BETTER"

Phone 419-586-5760 Fax 419-586-7179

Chief of Surgery, Cottage Hospital and St. Mary's Medical Center, Galesburg, IL
August 1988 to January 1991

Assistant Chief of Staff, Galesburg Cottage Hospital
January 1991 to 1993

Chief of Staff, Galesburg Cottage Hospital
January 1993 to 1994

Board of Directors, Galesburg Cottage Hospital
November 1992 to 1994

Medical Staff, U.S. Ski Jumping Team, 1992 to 1998
U.S. Nordic Combined Team 1998 to present

Great Floridian Triathalon, Volunteer Physician, October 21, 1995

Disney Marathon, Volunteer Physician, January 7, 1996

NCAA Division I & II Indoor Track & Field Championships, Volunteer Physician, 1995, 1996, & 1998

PAST AFFILIATIONS

Galesburg Cottage Hospital, Galesburg, IL
September 1986 to 1994

St. Mary's Medical Center, Galesburg, IL
September 1986 to 1994

Community Memorial Hospital, Monmouth, IL
1988 to 1994

St. Mary's Hospital, Kankakee, IL
July 1985 to September 1986

Riverside Medical Center, Kankakee, IL
July 1985 to September 1986

Iroquois Memorial Hospital, Watseka, IL
July 1985 to September 1986

Mercer County Hospital, Aledo, IL
September 1986 to March 1991

JOHNM. SPECA, M.D.
CELINA ORTHOPAEDIC AND
SPORTS MEDICINE CENTER, INC.
950 SOUTH MAIN STREET
CELINA, OHIO 45822

"WHERE GOOD SPORTS GET BETTER"

Phone 419-586-5760 Fax 419-586-7179

PROFESSIONAL SOCIETY MEMBERSHIPS

American Medical Association
Fellow American Academy of Orthopaedic Surgeons
American College of Sports Medicine
Ohio State Orthopaedic Society
Mercer County Medical Society
Ohio State Medical Society

COMMUNITY SERVICES

Board of Directors - Knox County YMCA - 1991 to 1994

Knox County Needs Assessment Committee for Personal Well-Being
Substance Abuse - 1992

Assistant Pack Master - Cub Scout Pack 209 - 1990 to 1993

Lector and Eucharistic Minister - Immaculate Heart of Mary -
Galesburg, Illinois - 1987 to 1994

Lector and Eucharistic Minister - Immaculate Conception Parish
Celina, Ohio - 1994 to present
I.C. Parish Teacher of Religious Education (Sunday School)
September 1995 to Present

DATE OF BIRTH

September 22, 1953
Chicago Heights, IL

HOME ADDRESS

6844 Lake Acres Drive
Celina., Oh 45822
(419) 586-1323

FAMILY

Wife
Deborah (Debbie - Married 2-1.0-79)
Children
Michael 11-9-79
Matthew 1-7-62
Andrew 1-24-64
Thomas 10-28-85
Kristen 8-16-87

PLAINTIFF'S EXHIBIT
4-6-99
28
NO. 2
PENGAD-Bayonne, N. J.

MERCER COUNTY JOINT TOWNSHIP
COMMUNITY HOSPITAL
COLDWATER, OHIO

CONSENT TO SURGICAL OR MEDICAL PROCEDURE
ADMINISTRATION OF ANESTHESIA
TRANSFUSIONS, BODY MATERIAL

Form 21

Procedure arthroscopy right knee, partial medial meniscectomy

Please CHECK all clauses to which you are giving consent. If you desire additional explanation do not sign this form. You have the right to refuse to consent.

☐ 1. AUTHORIZATION - I authorize Dr. Speed and such assistants as may be selected by him to perform the above procedure.

☐ 2. EXPLANATION - All questions concerning my diagnosis, the nature and purpose of the procedure, possible alternative methods of treatment, what the procedure is expected to accomplish, risks involved, the possible consequences and the possibility of complications have been explained to me by my physician. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

☐ 3. OBSERVERS IN OPERATING ROOM - I consent to the following: the admittance of non-credentialed individuals over 18 years of age who are either medical or nursing students, physician assistants, students in other health care training programs, or equipment representatives, or the significant other or support person for the patient undergoing regional anesthesia for a cesarean section.

☐ 4. RECORDINGS IN OPERATING ROOM - I consent to the following: the taking of visual recordings (including still or motion pictures) by the surgeon during the course of the procedure.

☐ 5. EXTENSION OF PROCEDURE - I understand that during the course of the procedure my physician may find some previously unknown condition that requires an extension of the procedure or a modification of the procedure. I authorize my physician and his assistants to undertake such extended or modified procedures as he or they may judge desirable if I am unable at such time to grant such permission.

☐ 6. ANESTHETICS - I consent to the administration of such anesthetics under the direction and/or supervision of Dr. Dobbins as he/she may deem advisable with the exception of Benadryl - Torodol

☐ 7. TRANSFUSIONS - I consent to the transfusion of blood and/or blood products under the direction and/or supervision of my physician as warranted by my condition.

☐ 8. REMOVAL OF BODY MATERIAL - If it is necessary to remove any body material, I hereby authorize the hospital pathologist to use his discretion in its disposal.

☐ 9. SOCIAL SECURITY NUMBER - I hereby authorize the release of my Social Security number to the manufacturer of the medical device I receive.

I give my consent for the above listed procedure and for all clauses which have been checked.

Witness — Date/Time 5/15/97 — Patient's Signature Mary Jo Brown

Patient unable to sign. Please state reason:

Witness — Date/Time — Legal Guardian Signature/Relationship

Second Witness Required for Telephone Consent

MERCER CO[illegible] [illegible]
COMMUNITY HOSPITAL
COLDWATER, OHIO

FREQUENT VITAL SIGNS RECORD

PLAINTIFF'S EXHIBIT
4-6-99
NO. 3
PEIGAD-Bayonne, N. J.

INITIAL	SIGNATURE		
MG	MGheen RN		

000012077

561260 3/96
BRAUN MARY JO
SPECA JOHN M
5/15/97

From 276
281
038

Date / Time	Temp	B/P	P	R	SaO_2	Urine Output	IV Fluids Medication	Progress Notes 2/27/59
							using 2 different dopplers.	SDS
1020							Dr Keighley here. Also unable to palpate pt's or Rear pulses. Decision made per surgeon to open leg. Dr JMS requests husband not be notified yet (find cause of bleeding first). Pt placed supine & both heels on bed. Foley inserted 5 difficulty. Urine ret'd clear amber to gravity flow. K pad placed over pt's chest over sheets & gown. Warmed blankets supplied. Pt prepped & draped.	
1150							Dr JMS called pt & husband re: pt. condition & urgency surgery.	
1345							Husband notified of urgency surgery	

000177

NAME:

Date: