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

IN THE COURT OF COMMON PLEAS

Robert Ray Lee, et al,

Plaintiffs,

vs. Case No. 00CV125489

Glen Whitted, M.D., et al,

Defendants.

* * *

Deposition of a Defendant, GLEN WHITTED, M.D., called by the Plaintiffs as upon cross-examination, taken before Kathleen A. Hopkins Durrant, a Notary Public within and for the State of Ohio, at the Offices of Kolczun & Kolczun Orthopaedics, 5800 Cooper Foster Park Road, Lorain, Ohio, on Thursday, the 9th day of November, 2000, at 6:15 p.m., pursuant to agreement of counsel.

* * *

APPEARANCES:

On behalf of the Plaintiffs:

Howard Mishkind
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On behalf of the Defendants:

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CURRICULUM VITATE MARKED PLAINTIFF'S EXHIBIT 1 FOR IDENTIFICATION.

MRI INTERPRETATION MARKED PLAINTIFF'S EXHIBIT 2 FOR IDENTIFICATION.

OPERATIVE REPORT MARKED PLAINTIFF'S EXHIBIT 3 FOR IDENTIFICATION.

PHOTOS MARKED PLAINTIFF'S EXHIBIT 4 THRU 11 FOR IDENTIFICATION.

* * *

GLEN WHITTED, M.D.,

of lawful age, a Defendant herein, called by the Plaintiffs for the purpose of cross-examination as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF GLEN WHITTED, M.D.

BY MR. MISHKIND:

Q. State your name for the record, please.

A. Glen Whitted, M.D.

Q. Dr. Whitted, my name is Howard Mishkind. We were just introduced before the deposition started. As you know, I represent Mr. Lee in connection with the lawsuit that is pending against you.

I'm going to ask you some questions and the Court Reporter is going to take your answers down. The fact that it's about 20 after 6:00 now, let's both do the courtesy to each other in terms of I'll wait until you're done with your answer, wait until I'm done with my question. Even though we may both be tired, we'll resist the urge to cut off each other. Fair enough?

A. That's fair enough.

Q. Okay. Before I start questioning you what I'd

like to do is just take a moment to go off the record and take a look at the original of the chart that you have there. That is your original chart on Mr. Lee?

A. This is a copy for the --

THE WITNESS: This is not your copy?

MR. NORMAN: That's my copy.

A. Yeah, okay.

Q. Where would the original be?

A. It's probably with Mrs. Schoop. Let me see.

* * *

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

* * *

Q. Okay. Doctor, I'm going to hand you what I've had marked for identification as Plaintiff's Exhibit 1. Would you take a look at that and tell me what that is?

A. This is my curriculum vitae.

Q. Two pages, true?

A. Yes.

Q. Is that a current and updated version of your CV?

A. Yes.

Q. Anything that needs to be added or corrected to make it entirely current and updated?

A. Not material.
Q. When you say not material, is there something immaterial that should be added?
A. Not that would substantially change the information in it, no.
Q. Let's come at it from a different way. What is different about the CV, whether it's insubstantial or otherwise?
A. Oh, I might list other employments and other hospital staff appointments.
Q. What are they?
A. Fisher-Titus Medical Center, Elyria Memorial Hospital, the Cleveland Clinic Foundation. And the name of a hospital listed here has changed, so that would be Community Health Partners Hospital.
Q. Any other changes, whether they're material or immaterial?
A. No.
Q. Are you an employee of the Cleveland Clinic Foundation?
A. Yes.
Q. How long have you been an employee of Cleveland Clinic?
A. Nearly two years.
Q. In looking at your CV, I'm curious with regard

to your medical education. You started your medical education in Germany, true?

A. Yes.

Q. And then came back to the U.S. and obtained a medical degree from the Medical College of Ohio, true?

A. That's true.

Q. Why did you go to medical school in Germany initially?

A. Well, I happened to be working as a technical translator in Germany at the time and I had wanted to go to medical school, had been a goal before, but while living oversees and being bilingual, I helped a friend of mine who is an upper level management employee at the Porsche Company get admission to the business school at the University of Virginia, and he then said he would help me fill out applications for medical school in Germany. And both of us were accepted to school.

Q. Did you apply to medical schools in the states prior to pursuing application in Germany for medical school?

A. Yes, but I had made plans by that time to live overseas and considered postponing my medical studies for a period of time due to the opportunity that had arisen.

Q. You were in medical school in Germany, it looks like from 1980 through 1982?
A. That is right. From the beginning of, about the beginning of 1980, February, I think.
Q. When you applied to medical schools in the United States, were you accepted to any of the medical schools that you applied to back in 1980?
A. I think I first applied to medical schools in nineteen seventy-five or six, before planning to go overseas, and I interviewed, but I was not accepted because I notified the admissions board that I had made plans to study overseas.
Q. How many medical schools had you applied to before you made the decision to study overseas?
A. I think it was five or six.
Q. And the five or six that you applied to, you were not accepted to any of them, true?
A. Right. I declined to pursue the acceptance or the admission process at any of those schools.
Q. So technically all of the schools that you had applied to you were not admitted to during that first go around, true?
A. Yes, on having withdrawn my application, then I was no longer considered.
Q. Now, when you decided to pursue education back

in the U.S., that would have been at the Medical College of Ohio, and were you accepted on your first application to the Medical College of Ohio?

A. Yes.

Q. Are you Board certified?

A. Yes.

Q. I don't see the Board certification referenced, or at least the specific date. When did you become Board certified?

A. July 1995.

Q. And how many occasions did you sit for the Boards before successfully completing the requirements and successfully passing the Boards?

A. I took the written Board examination twice and the oral Board examination once.

Q. Did you have to pursue any further training in order to take the Boards again?

A. No. It's a requirement of the Board that in order to complete the certifying process that you pass the written examination and then have two full years of practice in one location before taking the written or, excuse me, the oral Boards to be eligible for certification.

Q. You published two articles that are referenced in your CV, true?

A. Yes.
Q. Have you ever submitted any other articles, book chapters, anything else to the, for publication in the medical literature?
A. No.
Q. Have you ever had you license suspended or revoked or limited in any way?
A. No.
Q. Have you ever been denied privileges at any hospitals?
A. No.
Q. You are an orthopedic surgeon, true?
A. Yes.
Q. Do you have an area that you specialize in?
A. Joint replacement surgery I would say is my specialty.
Q. Do you have any specific subspecialty training in joint replacement?
A. Yes.
Q. From where?
A. From the Central Dupage Hospital in suburban Chicago.
Q. When was that?
A. In 1992.
Q. You have had your deposition taken before,

true?
A. Yes.
Q. You have had you deposition taken both as a defendant as well as a treating doctor, true?
A. Yes.
Q. Tell me just in general numbers on how many occasions have you had your deposition taken as a treating physician testifying as it relates to the care provided to one of your patients?
A. I believe about four or five times.
Q. Have you had your deposition taken in that capacity, as a treating doctor, in the year 2000?
A. No.
Q. How long ago would you say it's been since you --
A. Oh, I'm sorry, I have to, I have to think.
Yes, I think I have been deposed in the year 2000, on a shoulder surgery.
Q. Was it an injury that your patient had and some lawsuit was filed relative to the situation that caused the shoulder injury?
A. I think, no. I think there was a disability question involved in a young person with an unusual type of shoulder problem.
Q. Let's put aside the depositions that you have

given in connection with your patients as the treating physician. Let me start out first and work down.

How many times have you been named as a defendant in a medical negligence case?

A. I believe four times.

Q. Is this the fifth?

A. No, this would be the fourth. Although not chronological in terms of how they have been dealt with, this is the fourth.

Q. Are any of the cases still pending?

A. No.

Q. This is the only malpractice case that you have against you to your knowledge that's pending in a Court?

A. Yes.

Q. Have any of the cases against you in the past dealt with issues relative to a surgical repair of a knee?

A. No.

Q. Have you ever served as an expert witness either on behalf of an orthopedic surgeon or on behalf of a patient bringing a claim against another doctor?

A. No.

Q. The other cases that were filed against you were all in Lorain County, true?

A. Yes.
Q. You and I have never met before, have we?
A. No.
Q. You have met my partner, Mike Becker?
A. Yes.
Q. He took your deposition on a past occasion?
A. Yes.
Q. Is that one of the cases that you were named as a defendant?
A. Yes.
Q. Do you remember the subject matter of that case?
A. I do.
Q. What type of injury or what type of surgical procedure was that case?
A. It was a revision hip replacement.
Q. Do you do any teaching to residents or to medical students?
A. No.
Q. Have you at any time in your career been an assistant, an associate or a full professor at any university or medical school?
A. No.
Q. Let me ask you whether you remember Mr. Lee, *so* that I can determine the scope of my questions. Do

you remember the patient?
A. Yes.
Q. When is the last time you saw Mr. Lee?
A. I believe it would be at his last office visit of September 4th, 1996.
Q. You have not seen him out in the community since then?
A. No.
Q. You know Dr. Williams, Dr. James Williams?
A. Yes.
Q. You are aware that Dr. Williams has provided treatment to Mr. Lee since you last treated him?
A. No, I wasn't aware.
Q. That wasn't brought to your attention by your attorney?
A. No.
MR. NORMAN: Objection to what we discussed.
Q. I take it you have not had an occasion then to talk to Dr. Williams concerning Mr. Lee?
A. No.
Q. All right. If appropriate, if necessary when we get to Dr. Williams' treatment, I will be happy to show you the operative report for the two surgeries that he's performed and give you an opportunity to

take a look at them. If you can answer questions that relate to what he's done and the significance of your treatment then, fine. If not, and you need to study his operative report to respond to those particular questions, when we get to that we'll adjourn and revisit those issues at another time, okay?

A. All right.

Q. But before we get to that point, let's talk about Mr. Lee and the treatment that you provided to him.

Aside from the records that you have in front of you, Doctor, is there anything else that you have reviewed in preparation for today's deposition?

A. No.

Q. Have you reviewed any medical literature as it relates to the treatment of the knee for purposes of this deposition?

A. No.

Q. Are there any authoritative texts or authoritative journals that you believe support the treatment plan in terms of the approach to the suspected anterior cruciate ligament and then the chondroplasty and the notchplasty procedure that you did back in 1996, any literature that you could direct me to that would suggest that the manner in which you

treated Mr. Lee was an accepted mode of therapy?

MR. NORMAN: Objection. *Go* ahead and answer.

A. None which in an analogous manner to finding a precedent case which we might use as the basis of a legal discussion that I could quote to you saying, this is a cookbook description of a problem for which we have this kind of treatment.

Q. I'm not suggesting necessarily a cookbook treatment, but I guess in performing an anterior cruciate ligament repair, frequently notchplasties are done in association with an anterior cruciate ligament repair, true?

A. In our country it is almost the rule.

Q. Okay. Where an anterior cruciate ligament surgery is not necessary after doing a diagnostic arthroscopy, are there any studies, journal articles, book chapters that you can cite me to that would suggest performing a notchplasty in the face of a nondisrupted anterior cruciate ligament is within the standard of care?

A. I'm not sure such literature exists, because it's almost certain that it hasn't been the confined subject of a single study intended to bring about a conclusion on a question arising from that issue.

Q Have you ever performed a notchplasty when have gone in and done a diagnostic arthroscopy and found that the anterior cruciate ligament was not disrupted or torn?

A On Mr. Lee.

Q Aside from Mr. Lee, on any other patient?

A Not that I can recall, because the indication didn't exist that I can bring to mind

Q. Let's talk about -- I'm sorry, did I interrupt you?

A. No.

Q. I thought you were close to done, but your lips were still moving, so I will reiterate back to what I promised you I wouldn't do at the very beginning

I want to talk a little bit about your surgical experience You told me at the very beginning that you have a special interest in joint replacement

In terms of the knee and surgeries on the knee, obviously the knee is a joint, is it not?

A Yes.

Q How many surgical procedures have you performed over the course of your career in approaching a knee or a problem with a knee?

A Over two thousand.

Q And of those two thousand cases, Mr. Lee's is

unique in terms of doing a notchplasty where a patient did not have a disruption or a tear in the anterior cruciate ligament, true?

A. Yes, I would have to say that's true.

Q. I want to ask you some questions about some of your initial visits with Mr. Lee before the surgery, so please use your notes or your memory before I get into the specifics.

Let me ask you this, you mentioned to me a moment ago that do you remember Mr. Lee?

A. Yes.

Q. Can you tell me globally, and I understand this may be too broad of a question, but how would you describe the physician/patient relationship that you had with Mr. Lee?

A. Gosh, I think that's too broad a question.

Q. Fair enough. Let me try to break it down.

Did you feel at any time during the physician/patient relationship with Mr. Lee that he was noncompliant in any respect?

A. No, I feel that he tried his best to perform everything that was asked of him.

Q. Did there come a time during your relationship where you suspected that Mr. Lee was less than confident in the care that you were providing to him?

A. Yes.
Q. Was this toward the end or can you point me to a phase in the treatment?
A. I think it might have been, if I can recall correctly, after his first surgery when it seemed that his marital problems were more important than his physical problems at the time, that his anxiety and concerns about his wife's expectations for his earning ability and so forth were upfront, and also their troubled relationship on other issues.
Q. Do your records reflect anything as it relates to the marital problems or these troubled issues?
A. I would never commit a nonmedical discussion except in a fleeting reference to the medical chart, because it wouldn't impact really on my treatment or recommendations for the patient.
Q. This falls in the category of, these are some of the things that I remember about Mr. Lee independent of the office records?
A. Yes.
Q. Okay. Because I don't have the benefit of anything noted in the record, whether it should or shouldn't be there, tell me what you remember about the marital problems and these troubled issues that were shared with you by Mr. Lee?

A. I think it seemed, and I got the impression from Mr. Lee, that he was afraid that his wife might either have him move out or she would be leaving. And that although we didn't discuss it in detail, I didn't pursue it much. I let him explain to me that underlying issues for him were his, the integrity of his family during this time of problem that he was having with his knee.

Q. I take it from what you're telling me that Mr. Lee was confiding in you on matters that obviously fell outside of your area of expertise?

A. Yes.

Q. So you had somewhat of a friendship, perhaps more than just a physician/patient relationship?

A. No, not really. I felt as though he might be hinting that there were financial issues involved in either supporting his family and maybe not being able to because of his disability from injury. Or that something along the lines that his wife might not think much of him if he couldn't hold a job and bring in an income.

Q. Was this a conversation that was repeated on more than one occasion?

A. Yes, as I recall.

Q. Was it a conversation that occurred almost

continuously on office visits or was it limited to a select group of office visits? I'm just trying to get a sense of whether it was a continuous process or whether it sort of stopped?

A. Well, if I could limit it, I might say that toward the middle third of our period of interaction it seemed to be a recurrent, compelling issue at each office visit.

Q. And Mr. Lee would tell you that he was continuing to have marital problems, is that part of the conversation?

A. As I recall he would bring up that these fears still were upfront for him.

Q. Fears that physically he couldn't support his family, that the marriage would fall apart?

A. More fears that he wouldn't be able to get back to the work that he was doing before, because I think he liked it and did well at it. And fears that, for a lot of reasons I don't believe he was explaining to me, that his wife might leave him. And those were really the two things I got out of his discussions with me.

Q. Did you ever meet his wife?

A. No. I actually, I can't recall that I did. It's possible that I did on one occasion, but it's

been quite sometime and I don't have a distinct recollection of meeting her.

Q. Now, this whole conversation about marital problems started when I asked you about whether he, whether there was a sense that you got from him that he questioned the quality or the type of care that he was receiving, and you brought up the issue of the marital. Did he say something to you that caused you to believe that he was losing confidence in you as a physician?

A. No. I think he was getting very discouraged that he wasn't getting better, and I think he was very discouraged. And really along those lines, I wanted him to hear from other doctors about his problem and his progress and I wanted him to get a second opinion with Dr. Hritz for that reason.

Q. Did you refer him to any other doctors for second opinions other than Dr. Hritz?

A. I don't recall, but I don't believe so.

Q. Did you ever refer him to a marriage counselor or anybody along those lines based upon some of these conversations you were having with him?

A. No, I didn't feel competent really to advise or delve into those problems, but I listened and I tried to be sympathetic.

Q. Aside from medical issues and those things that are reflected in the record, do you remember topics of conversation that you had with Mr. Lee on, on matters going on in his life, for example, you told me about the concerns he had about his ability to work and the impact that would have on the marriage, any other topics that were discussed between you and him that aren't otherwise reflected in the records?

A. I don't have a clear recollection, no.

Q. Again, before we delve into the specifics of the office visits, I failed to ask you, what orthopedic textbooks do you own?

A. You would like a bibliography of them or --

Q. Give me the, I guess, the top shelf ones that you own and have occasion to refer to from time to time.

A. Well, it's really quite a lot of them.

I refer to Campbell's Orthopaedics in general, and Rockwood and Green fracture textbook. And a long lineup of books on arthroplasty, which is joint replacement and arthroscopy, which is probably the biggest volume area of my surgery.

Q. Is there a textbook called arthroscopy?

A. No.

Q. There are topics, there are chapters on

arthroscopy in Rockwell and Green and Campbell's, true?

A. In Campbell's, yes.

Q. And Campbell's is a well respected treatise in the area of orthopedic surgery, true?

A. I believe so, yes.

Q. Rockwood and Green also is a well respected treatise in the area of orthopedic surgery?

A. In the care of fractures, yes.

Q. If one was looking at the most reliable and authoritative texts or journals dealing with arthroscopy, what would you, what would you refer to?

MR. NORMAN: Objection.

A. If I were trying to research an issue, I might look into the journal literature, and Arthroscopy would probably be the first choice.

Q. There is a journal, a journal called Arthroscopy or Journal of Arthroscopy?

A. Yes, yes.

Q. What's it called?

A. I believe it's Journal of Arthroscopy.

Q. I had a feeling it was something like that.

MR. NORMAN: Doctors are very imaginative in naming their journals.

Q. In any event, you have not looked at

Campbell's, Rockwood or Green or the Journal of Arthroscopy in preparation for this deposition, true?

A. No.

Q. But they would be good and reliable sources for information relating to surgery on the knee, whether it be anterior cruciate ligament or diagnostic arthroscopies and the indication for various surgeries, true?

A. These named books and journals would probably provide the compendium of references on the published information about most issues concerning knee surgery, yes.

Q. Sources you would deem reasonably reliable and authoritative, true?

A. Always remembering that journal literature is up-to-date scientific study and is not necessarily accepted as practice reliable, but basically the offering of findings done under controlled conditions for problems that we recognize as surgical issues for the arthroscopist.

Q. Rather artfully put, but I'm not sure that I followed you entirely. The sources that you --

A. You would never -- pardon me for interrupting. Go ahead.

Q. The sources you are referring to, and obviously

you look to journal articles for the most up-to-date references on techniques and studies dealing especially in your area of joint replacement and joint surgery, you would look to journal articles before you would look to textbooks, true?

A. Not for authoritative information, no.

Q. Where would you look for authoritative information?

A. Textbooks.

Q. So Campbell's would be the top shelf, Rockwood and Green right up there as well?

A. For each of their respective areas of application, yes.

Q. And specifically when we're talking about the knee and surgery on the knee, would that be, would those two texts be reliable sources for information as it relates to surgical, standard surgical texts, standard surgical procedures in this area?

MR. NORMAN: Objection

A. Not necessarily for arthroscopy, no. Especially not Campbell's.

Q. Where would we, where would you suggest that one look for reliable and authoritative information on arthroscopy?

MR. NORMAN: Objection. I think

this has already been addressed.
A. The medical library.
Q. And where would you, if you were going to the medical library, where would you go in the medical library for reliable sources on arthroscopy?
A. Well, I would say my favorite text to refer to might be a book by Dr. Andrews on arthroscopy.
Q. Is it called arthroscopy?
A. I don't recall the title. I own it. I wouldn't look in the library.
Q. You don't need to go to the library since you own it?
A. That's right.
Q. And I presume you refer to it from time to time?
A. Yes.
Q. Consider it to be a reliable source of information in the area of arthroscopy, true?
A. Yes.
Q. Dr. Andrews you consider to be an expert in the area of arthroscopy?
A. Unquestionably.
Q. And his book is certainly in your mind an authoritative text, true?
MR. NORMAN: Objection. Go

ahead.

A. I will just answer by saying, I'm always looking for good ideas, and Dr. Andrews is an outstanding source of sometimes even controversial ideas.

Q. You certainly consider Dr. Andrews and his book to be a source of reliable informational, be it perhaps at times controversial?

MR. NORMAN: Objection. Howard, can we move along?

MR. MISHKIND: We will.

A. Yes.

Q. Your answer is yes?

A. Yes.

Q. Okay. Thank you.

Mr. Lee had been a patient of this office before April of 1996, true?

A. Yes.

Q. Had he been your patient?

A. No.

Q. Who had he been a patient of?

A. He had seen Dr. Kolczun and Dr. Treuhaft.

Q. You met him then for the very first time in April of 1996, true?

A. Yes.

Q. Where did you obtain the history in April of '96 that he had sustained this injury on a trampoline?
A. I interviewed the patient.
Q. Do you have a written note for April 22, 1996?
A. No.
Q. Do you have a dictation machine that you keep with you at the time of office visits?
A. Yes.
Q. So your dictation would have been at or near the time of the office visit, true?
A. Yes.
Q. And, in fact, do you dictate your office note right with the patient present or do you normally wait until the patient has left?
A. No, I think it's rude to dictate in front of a patient so I wait until they've left.
Q. So your recollection of the history then would have been shared with your dictation machine shortly after Mr. Lee left, true?
A. Following the logical extension of that thinking, yes.
Q. Well, I try to be logical every once in a while.
MR. NORMAN: He didn't dictate it before he saw the patient.

Q. And I, my curiosity in terms of the trampoline is only based upon the fact that I'm advised by Mr. Lee that the injury did not occur on a trampoline, so I'm just, I'm wondering on what were you basing that statement of sustaining an injury on a trampoline. And it's as you just stated, you believe that's what he told you and you dictated it after he left?

A. Yes.

Q. Okay. No other source for that that you are aware of?

A. No.

Q. Okay. Would you explain briefly to me the Lachman test?

A. Lachman test is a knee examination test performed with the knee in slight flexion, 20 degrees or so, which the upper part of the leg, the thigh, is stabilized with one hand, and the lower part of the leg is shifted forward to test for looseness of the ligaments inside the knee.

Q. It's used, is it not, to aid in the diagnosis of the rupture of an anterior cruciate ligament?

A. Yes.

Q. And you had a one plus result on the test?

A. Yes.

Q. And what did that indicate to you?

A. That there was a, the feel of a, an abnormal amount of travel with the provocative part *of* the test.

Q. There was some opening or movement within the joint based upon your examination?

A. Yes, that the lower leg moved forward with my provocation perhaps a little bit more than might be considered normal. And I stated in the notes, with an indistinct end point.

Q. And one plus result indicates what, about five millimeters or less of joint opening?

A. I would agree with that.

Not joint opening, but of translation of sliding forward.

Q. What was within your differential on April 22 based upon the history that he provided to you and your physical examination?

A. Torn meniscus.

Q. I'm sorry.

A. Torn medial meniscus.

Q. Okay.

A. And torn anterior cruciate ligament.

Q. Nothing else in your differential at that time?

A. No.

Q. Did you consider a subluxed patella within your

differential?
A. Not initially.
Q. Did you at sometime prior to surgery, surgery number one, consider subluxed patella within your differential?
A. I don't recall that I did, no.
Q. Mr. Lee was unable to cooperate with the McMurray's test due to the pain that he was experiencing?
A. Yes.
Q. When you refer to an indistinct end point, help me out with what that means?
A. Well, what you're testing is the tightness of the knee in general terms, and so if you try to make the knee slide in an unnatural way and it won't slide much, number one, and it stops abruptly when the ligaments that you are testing are tensioned, then you have not much travel and a firm end point.

And in his knee he had a little bit of travel, which could be considered abnormal, and kind of a mushy feel at the end, not a firm stop.
Q. In order to arrive at a more definitive diagnosis you recommended an MRI, true?
A. That is right.
Q. And the MRI was done at Drs. Russell-Berkebile

and Associates, is that true?
A. Yes.
Q. Northern Ohio Imaging Center?
A. Yes, that's true.
Q. And Plaintiff's Exhibit 2 is a copy of the report from that MRI?
A. Yes.
Q. You would have received the MRI report back before preceding to the diagnostic arthroscopy on May 3, 1996, true?
A. At the very latest, just prior to the patient's office visit, yes.
Q. And in fact when we move to the next office visit of April 25th, 1995, you indicate that you discussed the findings from the MRI with Mr. Lee, correct?
A. Yes.
Q. Okay. Now, I have some specific questions for you relative to that office visit.

You indicate that, quote, I feel that for his career aspirations and current job requirements, he should have arthroscopic treatment including ACL reconstruction, end quote.

First, did I read that accurately?
A. Yes.

Q. Actually the sentence started with, I discussed these findings with him, and then what I just read, true?

A. I'm not sure you read the words treatment including ACL reconstruction, but, but yes.

Q. Okay. What career aspirations were you referring to in connection with that statement?

A. As I recall, Mr. Lee had a position with the Sheriff's Department in some capacity and was thinking of moving up the ladder a bit.

Q. Given those career aspirations, how would that impact the treatment, the course of treatment that you were recommending to him?

A. Well, first, a middle aged person with this injury would have to qualify as a surgical candidate by physical demands that might be expected to be placed on the knee, because a middle aged person with this injury and very few physical demands in job or recreation might actually do well with rehabilitation alone.

Q. So someone that needed to be more active and physically involved, surgical correction of an ACL is preferable over someone who is more sedentary and less physically active that can get by with a conservative modality?

A. In almost every way
Q. Okay. When you say we discussed the surgical rationale, is that basically what we have just talked about in terms of providing him with the best likelihood of being able to physically be active and handle the demands of an active life-style, or is that, did you mean something different by surgical rationale?
A. Well, it's my way of saying that I discussed the proposed techniques of surgery and why we do them, with all the considerations, life-style included.
Q. All right. What I want you to tell me so that I don't misinterpret anything in your note, I take it, first, you don't remember specifically this office visit of April 19, 1996, true?
A. No.
Q. But you use in many cases similar language in office notes to describe what you discuss with patients, perhaps as part of your custom and practice, true?
A. Yes.
Q. So that when you see a statement in terms of surgical rationale, the technical details, et cetera, you have a fairly common routine that you follow, true?

A. Yes.
Q. While you can't remember this particular office visit, if you followed your normal rationale, your normal routine, you should be able to tell me what you probably said to Mr. Lee even though you don't remember the specific details, true?
MR. NORMAN: I'm going to object a little bit, because I think he's already testified as to some recollections based upon these visits.
MR. MISHKIND: When we talked about that, but I have also asked him whether or not he remembered this particular office visit.
Q. And I think you told me that you did not?
A. I can't recall this specific encounter, anything in particular, except that we had this discussion, yes.
Q. Okay. Now, tell me what would you have told Mr. Lee or, and if you remember specifically telling him this, tell me I remember specifically telling him, but if you don't, tell me what you would have told him as to the technical details of this anticipated surgery. Do you follow me?
A. Yes. I don't recall very specific details of our actual discussion. I do remember realizing that my suspicions as far as his knee injuries were

corroborated by the MRI findings, and we had a discussion about the fact that he should have knee reconstruction in order to have the best result.

Q. Technical details of the surgery, what would you, do you remember telling him or what would you likely have told him?

A. I don't remember specifically what I told him, but what I likely would have told him and is my usual practice so long as the patient cares to hear the details and is not offended by the description of the actual surgical treatment, I tell people that it is my teaching and practice to take a small part of the tendon below the kneecap to use as a graft for the torn ligament, to replace that in the reconstruction process of the knee. And that the operation is performed mostly arthrosocpically, with a small incision to harvest the graft and for insertion of the graft.

Q. And you have no reason to believe that you would have told Mr. Lee anything different than what you have just described a moment ago, true?

A. No, that's true, not regarding that particular operation, no.

Q. Okay. What are the risks and problems of this type of operation that you told Mr. Lee about?

A. Well, the risks involve the general and specific risks of orthopedic operations, and this particular one in terms of bleeding, infection, swelling, stiffness, blood clots, pain, and the problems being failure of fixation, poor tissue quality, unreconstructable injury, things of that nature.

Q. Correct me if I'm wrong, but you don't remember specifically having a conversation with Mr. Lee about the risks, what you just told me was what your normal routine and practice is?

A. Yes, that is my usual patter as far as a discussion about this kind of surgery, yes.

Q. I see the use of the term obligatory on more than one occasion. When you say the obligatory postoperative rehabilitation, what would be your standard and routine practice as it relates to the explanation of that process?

A. Where is the, other than that, the other occurrence of the word obligatory? You mean only with regard to postoperative rehabilitation?

Q. I believe I have seen the use of the term obligatory somewhere else. I may be mistaken.

A. With regard to postoperative rehabilitation, I use that word to remind myself that I had a discussion

with the patient about the individual responsibilities of the person undergoing this operation to achieve their own improvement by the investment of their own time and motivation into the healing process. In other words, attending physical therapy faithfully and regularly.

Q. So the obligatory postoperative rehabilitation is the obligation of the patient to be a compliant patient in the postoperative period?

A. Yes.

Q. And you've already told me you have no basis to say that Mr. Lee was not compliant, true?

A. Yes.

Q. You noted that he understands and wishes to proceed. You wouldn't have put that down if you didn't feel that he understood what you explained to him, true?

A. Yes.

Q. You certainly have an obligation as the surgeon to explain to the patient the material risks and potential complications associated with the contemplated surgery, true?

A. Yes.

Q. And you have an obligation to explain to the patient the alternatives to the recommended surgical

approach as it would relate to the treatment of his condition, true?

A. It's my standard practice to do that.

Q. In this operation, and jumping ahead to the subsequent operation, did you have the patient sign any type of a written informed consent?

A. I recall that the patient signed an informed consent paper for the hospital's purposes.

Q. The general consent form for the hospital, but you didn't have a specific informed consent as it relates to the surgery, setting forth what you were going to do with the material risks and complications per se, true?

A. Right.

Q. The MRI that you have, Exhibit 2 that's in front of you, the interpretation --

A. Yes.

Q. -- was the MRI that was done on, is that April 24th?

A. Yes.

Q. Was that correctly interpreted?

MR. NORMAN: Objection. Answer to the best of your ability.

A. From my understanding of the technology and the way in which the images are constructed, I believe

that it was accurately interpreted, yes.

Q. At the time that you operated on Mr. Lee, you did not discover a torn anterior cruciate ligament, true?

A. I discovered that the anterior cruciate ligament was not torn.

Q. The MRI had at least suggested from a diagnostic standpoint that there was a torn anterior cruciate ligament, true?

A. More than suggesting, Dr. Dengel said that it was the most significant finding on the scan, that it was torn.

Q. And you proceeded with the surgery anticipating a high likelihood of finding a torn anterior cruciate ligament, true?

A. Absolutely.

Q. And when you did your diagnostic arthroscopy you discovered, as happens on occasion, that there was not a disruption or a torn anterior cruciate ligament, true?

A. Yes.

Q. Okay. If I could have Exhibit 2 back for a moment. Thank you.

Exhibit 3 is a copy of the operative report from May 3, 1996, is that correct?

A. Yes.
Q. I'm going to ask you -- do you have a copy of it in your file there?
A. Yes, I believe I do.
Q. Okay. At the time of your surgery, Doctor, on May 3, 1996, your diagnostic arthroscopy detected chondromalacia of the medial femoral condyle, true?
A. Yes.
Q. Grade 3 chondromalacia?
A. Yes.
Q. There is a notation that the anterior cruciate ligament was not torn but a longitudinal disruption was found, is that correct?
A. Yes.
Q. Is that a strain of the anterior cruciate ligament?
A. Yes.
Q. Now, you did not repair or reconstruct the ACL, did you?
A. No.
Q. You performed a chondroplasty, presumably to treat the chondromalacia of the medial femoral condyle, true?
A. No.
Q. Why did you do a chondroplasty?

A. Oh, I'm sorry, I misunderstood the question. Can you ask it again?
Q. Sure. I understand it's late.
A. I thought you said notchplasty.
Q. No, chondroplasty.
The chondroplasty was to treat the chondromalacia of the medial femoral condyle?
A. Yes.
Q. What was the cause of the chondromalacia of the medial femoral condyle?
A. Weight bearing shear force applied to the surface.
Q. Was this an acute process or was this something based upon the grade of the chondromalacia that was more of a long standing phenomenon?
A. Well, it could be either, but it, the degree of chondromalacia doesn't reflect much on the time course of the lesion.
Q. Can you have an acute injury to the knee similar to what Mr. Lee had described as the onset of his symptoms, trampoline or whatever it was that brought him to your office, and within that ten day period or two week period when you go into to do diagnostic arthroscopy you can see chondromalachia of a Grade III or Grade IV within that period of time?

My question may not have been artfully put, but hopefully you --

A. The time period doesn't impact much on the degree of injury. If it is recognized as an injury, chondromalacia grading for the old style of the literature description of the grading system, it was intended basically to reflect on the physiologic health of the cartilage layer covering bone. But in actual fact, most surgeons would understand a grading system for chondromalacia lesions represents the presence of certain physical characteristics and the depth of penetration of the injury to the cartilage layer.

Q. So certainly an acute injury of a significant nature can cause a Grade III or a Grade IV chondromalacia?

A. Yes, and even to the point of being though extensive and deeply penetrating, subtle and not even overtly apparent.

Q. Okay. Nonetheless, the findings on MRI are not consistent with the findings that you made on your diagnostic arthroscopy of the chondromalacia of the medial femoral condyle, true?

A. I don't recall that the MRI scan reflected on the issue of chondromalacia of the medical femoral

condyle. Can I see that report?

Q. Yeah, go right ahead. Absolutely.

A. No, there is no reference, and it is my understanding that though things may have changed somewhat in the interim, most interpreting radiologists at that time would not have reflected on chondromalacia as an MRI finding because I'm not certain everyone would agree that it was within the resolution of MRI scanning to determine a specific type of chondromalacia existing.

And in fact, Dr. Dengel remarks that he sees no specific abnormality in the patella femoral articulation for instance.

Q. Okay.

A. That's an example.

Q. In any event, you did do your diagnostic arthroscopy, you are pleased to see that there is no tear or rupture of the anterior cruciate ligament, true?

A. Yes.

Q. You discover that there is a Grade III chondromalacia of the medial femoral condyle?

A. Right.

Q. And you proceed to perform a chondroplasty to treat that condition?

A. Yes.
Q. And you also perform a notchplasty, true?
A. Yes.
Q. You did not seek any further consent or permission from the patient prior to performing the notchplasty or the chondroplasty, did you?
A. No, it would never have been my practice to wake the patient to explain the circumstances of the injury and the associated findings or to make a second surgical intervention as a plan to deal with an issue associated with the injury findings as a separate consent.
Q. However, and I understand what you're saying, you had not discussed with the patient during this conversation back in the office when you reviewed the MRI findings, the concept of performing a notchplasty or a chondroplasty, true?
A. True. This would presuppose that it might be a plan in the treatment as a, as an individual undertaking for the problem at hand, which it is not, which they are not chondroplasty and notchplasty.
Q. Well, can we certainly agree, Doctor, to maybe make this a little more fluent, is that the treatment of the chondromalacia by a chondroplasty did not mandate that you perform a notchplasty as well, true?

mandate that you perform a notchplasty as well, true?
A. The two are mutually, they are completely unrelated, yes.
Q. So you could have, in discovering the chondromalacia, the Grade III chondromalacia of the medial femoral condyle, regardless of whether you had received consent from the patient to perform that procedure, you could have done the chondroplasty and ended the procedure without performing a notchplasty, true?
MR. NORMAN: Objection. Go ahead.
A. Yes, to what end?
Q. Well, to --
MR. NORMAN: Do you understand his question?
A. Not really.
Q. Yeah, let me, if you don't --
A. I'm just, maybe I can ask a clarifying question from my side.
Q. And I will try to answer it for you.
A. If, if it can't be predetermined that certain associated lesions seen with injuries of specific types might actually exist, then on the one hand I wouldn't specifically consent the patient for a specific stepwise undertaking in a surgical procedure.

And if that's the nature of the question, if it's about the consent, then I wouldn't have listed chondroplasty separately.

The second question I'd ask, if there is a plan to fix a problem in the knee and we're approaching it with a cookbook idea of how it will go, can we not on finding unexpected circumstances or additional injury add to or deviate from the plan? That would be my question, because if we can not at surgery, then we can't be thinking about the injury, we have to just be robotically progressive in performing the operation by plan.

Q. Let me try to address what I think you have just said to me. I'm not suggesting that you perform as a robot or that you do orthopedic surgery by cookbook. My questions are only geared toward establishing several things.

And number one is that in treating the medial femoral condyle with the chondromalacia that was discovered at that time, you did not need to do a notchplasty to be successful in treating the chondromalacia, true?

A. That's true, because they're unrelated in their indications.

Q. Okay. And you've already told me that in

to do a notchplasty in conjunction with an ACL repair, true?

A. That's true.

Q. It is much less common to do a notchplasty where there isn't a disruption or a tear of an anterior cruciate ligament, true?

A. Yes.

Q. And we talked before that Mr. Lee is, of the thousand or couple thousand dollars, couple thousand dollars, couple thousand --

MR. NORMAN: You plaintiffs' lawyers are always thinking in money terms.

Q. Couple thousand knee surgeries, I think that's what you said?

A. Oh, you meant in two thousand knee surgeries, I'm including of course knee replacements and other operations that no notchplasty would ever be part of the procedure anyway so --

Q. But in the total universe of knee surgeries that you've done --

A. Let's compare apples to apples. In the total universe of knee arthroscopies where notchplasty would be a consideration as a treatment, the denominator is much smaller, so probably --

Q. Denominator in terms of your surgeries?

Q. Denominator in terms of your surgeries?
A. The denominator in terms of the number of the knee arthroscopies where notchplasty might be a consideration would never be two thousand, no.
Q. Okay. Whatever that number is, you'd never done, nor have you since done, a notchpiasty on any patient where they didn't have an anterior cruciate ligament tear, true, Mr. Lee aside?
MR. NORMAN: I think he said earlier that he didn't recall.
A. I think that's true. I can't recall, no.
Q. Okay. Now, at the time of your surgery in May, do you make any mention of any chondromalacia, do you make any mention of chondromalacia of the trochlear surface of the femur at the time of your May 1995 surgery?
A. No, I made mention only of the significant positive findings.
Q. Can I presume from that that at the time of your diagnostic arthroscopy that if you saw evidence of chondromalacia of the trochlear surface of the femur you would have noted it?
A. It is my common practice to do so, yes.
Q. Can we further conclude that more likely than not there was no evidence of chondromalacia of the

trochlear surface of the femur in May of 1996?
A. There was no visible surface detectible information that could be obtained arthroscopically which would indicate a chondromalacia lesion of the femoral trochlea on the May 3rd, 1996 operation.
Q. A notchplasty increases the width of the intercondylar space?
A. Yes.
Q. And that's why notchplasty is frequently done in combination with an ACL reconstruction, to prevent the graft from impingement, is that true?
A. Yes.
Q. Impingement within the notch, true?
A. Right.
Q. When one does a notchplasty, is there any potential trauma to the trochlear surface of the femur?
A. There is potential trauma, yes.
Q. Let me jump ahead to the subsequent surgery just for a moment to see, maybe I can save some time.
We know that when you went back in for surgery number two there was a Grade IV chondromalacia of the trochlear surface?
A" Yes.
Q. What's your opinion as to the cause of the

Grade IV chondromalacia of the trochlear surface?
A. Being as extensive as it was and as distant as it was from the intercondylar notch, it was my feeling that probably the patient had had a patellar subluxation as an underlying cause, and another potential cause actually being the patella forced into the femoral trochlea under flexion pressure.
Q. And so there is a two --
A. Two potential mechanisms.
Q. One being the subluxation?
A. Yes.
Q. And what likely causes, if in fact --
A. That's the mechanism.
Q. That's the mechanism, what caused the subluxation?
A. The twisting of the knee.
Q. At what point?
A. In the patient's weight bearing injury.
Q. Okay. So the injury that occurred ten days before he came to you initially?
A. Yes.
Q. And why wasn't that discovered by you at the time of your diagnostic arthroscopy?
A. It most likely wasn't evident. In other words, if the lesion existed, and it can be shown, for

instance, in cases where there is underlying disease or injury to condylar bone of the femur for instance that appears to show the bone dissolving in an area of the weight bearing portion of the femoral condyle, that the arthroscopic appearance of the cartilage in this area may actually be completely normal, where with our thinking we might say, since the bone is the infrastructure supporting the cartilage surface that with this bone dissolving or melting away here, one would think that the appearance in the area of radiographically definable bone trouble, that the outward appearance of the overlying cartilage would show damage. And this is not the case.

What I'm suggesting as a possibility here is that even in the absence of MRI findings of patellofemoral abnormality, that probably, especially in the long central portion of the groove where this chondromalacia lesion exists and distant to the notch, that the cartilage attachment to the underlying bone was insecure, since it's a Grade IV lesion and it's the full thickness of the cartilage itself.

And two and one-half months have elapsed since initial evaluation of this portion of the knee, and now the arthroscopic finding that there is not only a cartilage surface defect but scar tissue grown over

the injury much preceded its discovery in this form arthrosocpically.

Q. Before we talk about the other possibility, can a Grade IV chondromalacia of the trochlear surface be caused by surgical intervention itself?

A. No.

Q. You indicated that the, that the, where you performed the notchplasty would be distal from the trochlear surface or would it --

A. Well, distal is maybe not the best description. I use the word distant, but the two areas, that the area of the chondromalacia lesion is not proximately related to the notch. It's more upward into the groove.

Q. Is the, the notch from a terminology standpoint, can one use the term tuberosity in the same manner?

A. As notch?

Q. Yes.

A. No.

Q. How would that differ?

A. The tuberosity is a bump. A notch is a hole.

Q. You don't mention the medial meniscus in the photos or in your office notes at the time of the original surgery, do you?

A. Yes.
Q. You do?
A. I do, uh-uh.
Q. In the photos?
A. In the photos? Well, I would only mention my finding if it's significantly negative or positive in the operative report itself.
Q. Okay.
A. Our suspicion preoperative of meniscal tear was not born out by the arthroscopy finding, as was the ACL injury not. And so the issue wouldn't necessarily be in an office visit, for instance, that I would discuss the medial meniscus necessarily. I gave no treatment for that.
Q. Fair enough.

The other possibility that we talked about in terms of the cause of the Grade IV chondromalacia of the trochlear surface, remind me again what that was?

A. Which one had we discussed? Subluxation.
Q. Subluxation was one cause?
A. One mechanism.
Q. Okay. And what was the other mechanism?
A. Forced pressure of the central crest of the kneecap or the patella, into the trochlear groove with the knee flexion and weight bearing.

Q. And your opinion is that either one of those would be related to the original injury ten days prior to his office visit?
A. Yes.
Q. And if that's the case and either one existed, you are comfortable in suggesting that such a phenomenon could be present yet not picked up on the original diagnostic arthroscopy?
A. Oh, yes, because my description of systematically examining the knee always follows the same pattern. We walk the same path to the house every time. So I look at that and if I see it as an injury or a problem, and if I inspect it, then it's either damaged or not. And I don't record it as being a damaged part on the first operation.
Q. So the fact that you do not record it as a damaged part, you're suggesting that it was not -- that it was obscured?
A. That it was not discernable by arthroscopic inspection.
Q. Showing you Plaintiff's Exhibit 5 and 6, are these arthroscopic photos from surgery number one?
A. Yes.
Q. The first, which is Exhibit 5, are color photos, and then the Exhibit Number 6 is a black and

white, but are they both from the same surgery or have I mixed them up in any way?

MR. NORMAN: You're back looking at what is Bate Stamped 212 and 213, correct?

THE WITNESS: Yes.

Q. Those are both from the May surgery, true?

A. Yes.

Q. I guess.

MR. NORMAN: Let me just for the record, can I, I mean, if I could clarify, 5, Exhibit 5 is Bate Stamped 212?

THE WITNESS: Yes. I didn't know you were asking me.

MR. MISHKIND: I let him ask questions every once in a while.

MR. NORMAN: I appreciate that.

THE WITNESS: They only come from him.

MR. NORMAN: No, go ahead, I'm sorry. I just wanted to make sure, because we're dealing with several different reproductions and we may as well keep it simple.

MR. MISHKIND: Fair enough.

Q. Why is one set color and one black and white?

A. I don't know.

Q. When the photos are taken in the, when the diagnostic arthroscopy is done, the images are colored, true?

A. Yes.

Q. Can you --

MR. NORMAN: Just maybe we should go off the record and try to clear something up.

* * *

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

* * *

MR. MISHKIND: Let's go back on the record.

Q. Our discussion off the record indicated that the diagnostic arthroscopy photos are generated in color, true?

A. Yes.

Q. And that for some reason innocently the photos that I presented to you, one is in color and one is in black and white, true?

A. Yes.

Q. And we have just indicated when the photos were reproduced when Mr. Norman provided me with a copy, apparently the copy people may have done less than an optimal job in providing us with the duplications.

MR. NORMAN: I hope they didn't

charge me for it though.

MR. MISHKIND: Yeah, right.

Q. We're looking at photos from the May '96 surgery that would show the area of surgical attention, true?

A. Yes.

Q. And if we were looking for the area where the trochlear groove would be located, would you be able to circle an area on any of those photographs that would show us the trochlear groove?

A. Only marginally.

a. Okay. Well, I will accept that.

Perhaps this black pen.

MR. NORMAN: Let's do that with a red pen.

a. Okay. On Exhibit 6, just for the record, you have marked down the words trochlear groove and have made a circle reflecting the area that marginally would reflect the trochlear groove?

A. Yes, it's only the edge, Mr. Mishkind.

Q. Okay. And are you suggesting on the record that Exhibit 6 at the time of your surgery did not reveal any evidence of, any discernible evidence of a Grade IV or any chondromalacia in the trochlear groove?

A. Yes. I didn't record it in the pictures, and on my inspection I found nothing of significance to record at that point.

Q. Grade IV chondromalacia indicates severe degeneration of the articular cartilage, true?

A. Degeneration may, again in the old style of distinction, signify the quality of the tissue rather than the depth of the injury. Grade IV chondromalacia in most accepted terms means a full thickness cartilage defect.

Q. With exposed subchondral bone?

A. Ordinarily, yes.

Q. Yet that's not even suggested or raised as a possible pathology at the time of your initial surgery?

A. That's true.

Q. Did you at any time discuss with Mr. Lee after the original surgery that you did a notchplasty and a chondroplasty when you did not find an anterior cruciate ligament tear?

A. I believe that I did, yes.

Q. Do you remember what Mr. Lee's reaction was when you told him what you had done and what you had found and not found?

A. I recall that he seemed puzzled that if the

injury suspected by my examination preoperatively in view of his injury and corroborated on MRI was not the present injury in the knee, then what could the origin of his problem be that he was having so much trouble with.

Q. What did you explain to him?

A. I don't recall exactly making a specific explanation for the origin of his knee problem at that time. I remember discussing the findings at surgery and the treatment performed, because ordinarily I would do that and often with the arthrosocpic photographs themselves.

Q. Is it your opinion that this Grade IV chondromalacia as well as, of the trochlear groove, as well as the Grade III chondromalacia of the medial condyle were both caused by the original injury ten days before your April '96 visit?

A. It's my thinking that almost certainly the Grade IV chondromalacia injury was caused by the original injury by one of the mechanisms we discussed, and that very likely the weight bearing medial condylar Grade III chondromalacia lesion was also caused by the injury.

Q. Why didn't you consider a subluxed patella from the get go?

A. The biggest reason would be that in the absence of a grossly unstable knee such as a two plus Lachman finding and obvious pivot shift, that the patella is not normally involved in the instability process with an injury like this as demonstrably in an athletic male as it would be, for instance, in a female, for anatomic reasons.

Q. Okay.

A. And, therefore, with a male patient with this injury and not a big degree as to make gross instability, I might surmise later by observations within the knee that the patella had been incidentally involved, but it would not be a key point in my evaluation with a lesser injury, especially in a male.

Q. Okay. Can chondromalacia be treated conservatively?

A. Yes. Not often successfully.

Q. What's the therapy for a conservative regimen of treatment for chondromalacia?

A. The premise of that question is extremely broad, because it depends very much on the degree of chondromalacia and the location in a given joint.

Q. Well, let's take the chondromalacia of the medial femoral condyle as discovered by you in May of '96.

A. As an isolated and proven lesion existing only and by itself in a knee, in a middle aged person and not the elderly, probably -- a symptomatic lesion is what we're speaking about, right? In a symptomatic lesion where it can be documented that it exists as shown here arthrosocpically, a conservative treatment might involve protective weight bearing, exercise to maintain mobility of the knee, use of antiinflammatory medication, and consideration of pain medication.

Q. What is the documented success of a conservative regimen for the type of lesion that we see on the arthroscopic photographs?

A. In the younger active patients, extremely poor.

Q. What kind of statistics are you referring to?

A. Gosh, I'm not certain that a specifically directed scientific study in this age group for this isolated lesion actually exists in print in the orthopedic literature, but it's the common anecdotal finding of the experienced knee surgeon evaluating people in this age group for this problem, surgically and nonsurgically, that younger active people with obvious or surmised chondromalacia of moderate to severe degree will probably routinely do poorly because of their activity demands on a weight bearing abnormal surface.

Q. We can certainly agree that Mr. Lee deserved the right to make an informed decision on what type of therapy he wanted for the diagnosed injuries to his knee, true?

A. That's true. And that's the basis of the discussion of alternative treatment, meaning conservative versus, conservative nonsurgical versus arthroscopic surgical treatments, which were the issues at discussion.

Q. In doing a diagnostic arthroscopy one doesn't automatically have to go ahead and do further interventions, true?

A. If diagnostic arthroscopy is the sole undertaking, then this would mean only that the surgery is a fact finding mission.

Q. Well, don't misunderstand my question. I'm not saying to you that -- I understand that diagnostic arthroscopy frequently will lead to intervention once the fact finding has taken place, but one can do a diagnostic arthroscopy without further interventions being performed, true?

A. That's true. I might add only that it's probably exceedingly uncommon to do this in our time.

Q. Okay. Let's talk about the -- let me have that photo back.

You have in Plaintiff's Exhibit 5 in the upper right hand corner what you describe as a crowded notch, true?

A. Yes.

Q. And what in your opinion caused the crowded notch?

A. This is the anatomic endowment of the patient.

Q. That condition essentially existed in this man long before he had had his injury, true?

A. Yes.

Q. Okay. And may go back to perhaps a congenital abnormality or something that certainly had existed for years?

A. I would say it's an anatomic variant.

Q. Okay. Something that was most likely asymptomatic in this patient, true?

A. In the absence of injurious force, it would probably always be asymptomatic.

Q. Is there any evidence that the crowded notch was causing any symptomatology in this patient as a consequence of the injury that he sustained in April of 1996?

A. Yes.

Q. And what, what was it that you believe the crowded notch was precipitating?

A. The crowded notch has a more defineably A-frame appearance versus a more oval and open structure and as such, with the knee in flexion and weight bearing with slight pivoting, the notch acts like a frame, like a shear, and scissors against the structures that it encloses, and that would account for the effusion as a response to injury, the laxity as a presumed disruption of the ligament and the MRI findings indicating the disruption of the ligament associated with that.

Q. A subluxed patella can cause the effusion, true?

A. That is also true, yes.

Q. A subluxed patella can cause the laxity?

A. No. If the patella returns to its anatomic position in the groove, then laxity of the kind we look for in ligamentous disruption won't exist.

Q. In performing the notchplasty was there any disruption to the anterior cruciate ligament?

A. I'm not sure I understand your question. As a consequence of the procedure was there a disruption of the ligament?

Q. Yes.

A. No.

Q. In performing the notchplasty what are the

risks inherent in doing that type of procedure where one is not also repairing or treating a torn or disrupted anterior cruciate ligament?

A. Provided the correct instruments are used, there is a very limited potential for injury to the enclosed ligaments and to the adjacent articular surfaces.

Q. Assuming the notchplasty is done other than by standard and accepted technique, what are some of the potential complications associated with doing such a procedure where anterior cruciate ligament repair is not also being performed?

MR. NORMAN: Objection. Can you read that back, please?

(Notary read back last question.)

Q. Do you understand the question, Doctor?

MR. MISHKIND: Forrest, you're hesitating.

MR. NORMAN: Yes, I'm hesitating. I'm not sure that -- can you rephrase that? Can you go about that from another way? I think that might be objectionable and I, depending on what you're trying to get at, maybe if you come at it from another angle you will put me at ease.

MR. MISHKIND: Well, I want to

put you at ease and I always aim to do that.
Q. But before I do that, do you understand my question? If you don't, Doctor, I will try to --
A. I don't really.
Q. I asked you initially in terms of what are some of the potential complications associated with performing a notchplasty, and you indicated to me that if done with the appropriate instruments basically there is no potential complications associated with notchplasty.
A. No, I didn't say that.
Q. Okay. Maybe I misunderstood you then.
A. I listed two complications.
Q. What were the two complications? Perhaps I dozed off.
A. Done with the correct instrumentation, I mean, I can't precisely quote myself on the prior existing record, but I am assuming I said, using the correct instrumentation there is a very limited risk of injury to the enclosed ligaments in the notch and the adjacent articular surfaces.
Q. Okay. And the adjacent articular surface, would that include the trochlear groove?
A. Yes.
Q. Okay. And the adjacent, the adjacent articular

surfaces and the --

A. Enclosed ligaments in the notch.

Q. And the enclosed ligaments, okay.

And the enclosed ligaments would be the anterior cruciate?

A. And the posterior cruciate ligament.

Q. Okay. At their, their crossroads, if you will?

A. Uh-huh.

Q. That's a yes?

A. Yes.

Q. Okay. So we can agree that by performing the notchplasty in this case, one of the risks was that there would be injury to the trochlear groove?

A. It would have a very limited risk as I explained, yes. And as documented in the photographs, the notchplasty is confined and distant to the later discovered chondromalacia lesion.

Q. The later discovered Grade IV chondromalacia of the trochlear groove?

A. Yes.

Q. Describe for me patellar tracking syndrome?

A. Patellar tracking syndrome is a general term to describe the subjective complaints of a person who has pain in the front of the knee due to the kneecap not engaging in the groove with completely normal

mechanics.

Q. Did Mr. Lee develop patellar tracking syndrome?

A. Yes.

Q. Did the patellar tracking syndrome result from the chondromalacia of the trochlear groove?

A. It would appear.

Q. What caused this?

A. This was the prior question that you asked about the cause of the chondromalacia lesion?

Q. Well, no, I guess it, I'm taking it one step further.

The patellar tracking syndrome was caused by the chondromalacia of the trochlear groove, true?

A. Yes.

Q. Okay. And the trochlear, the chondromalacia of the trochlear groove, it is your opinion was caused by the initial injury that he sustained?

A. Right.

Q. Now, he didn't have patellar tracking syndrome at the time of your first surgery, did he, or evidence of it I should say?

A. It was not part of his description of knee problems, remembering that patellar tracking syndrome is subjective.

Q. Well, when did you first discover evidence to

support a diagnosis of patellar tracking syndrome?
A. Upon recording the patient's complaints after the second surgery in which the chondromalacia lesion was identified.
Q. If you had performed the notch, the chondroplasty and not the notchplasty, just the chondroplasty for the Grade III chondromalacia, would that have been an acceptable form of surgical intervention for this patient?
MR. NORMAN: Objection. Go ahead and answer.
A. I believe that for the chondromalacia on the medial femoral condyle that was discovered, that chondroplasty would be an acceptable treatment and after which I feel that the patient would have developed his symptoms of patellar tracking syndrome with the presence of an undiscerned lesion of chondromalacia in the femoral trochlea.
Q. Well, let's approach it from this vantage point.
Had you done just the chondroplasty and not the notchplasty, what you're saying to me is that the chondromalacia of the trochlear groove would have surfaced so to speak irrespective of what you'd done at the time of the first surgery, correct?

A. Yes.
Q. And that the performance of the notchplasty did not in any way enhance or increase the likelihood of developing a Grade IV trochlear chondromalacia, Grade IV trochlear chondromalacia?
A. That's true.
And based on evidence of many other notchplasties I have performed in which a Grade IV chondromalacia lesion as a consequence has never been documented.
Q. But, again, those notchplasties that you have done have been in combination with an ACL repair, true?
A. And totally unrelated to patellar maltracking or to chondromalacia lesions of the groove.
Q. Are you saying that you have discovered trochlear lesions subsequent to the repair of an ACL?
A. No, I'm saying in fact the opposite, that chondromalacia lesions of the trochlear groove where none existed before do not surface after performing notchplasties under any other circumstances as I can document from my own patients' treatment.
Q. Okay.

* * *

Thereupon, a short recess was had.

Thereupon, the deposition was continued pursuant to recess.

* * *

Q. Going back to the photographs, the photographs from the May surgery, do we have documented the notch before and after the notchplasty?

A. Yes.

Q. Okay. Can you perhaps point to me what the appearance of the notch was before?

A. This is the notch before.

Q. Okay.

A. And this is the notch after.

Q. All right. So on Exhibit 5, the upper right hand corner of the four groupings was the notch before, the lower left hand corner on Exhibit 5 is the notch after the procedure?

A. Yes.

Q. Okay. Is it your opinion that the crowded notch was causing some of Mr. Lee's symptoms?

A. No.

Q. Mr. Lee's symptoms were caused by what?

A. Mr. Lee's symptoms were caused by the ACL sprain which was due to the shape of his notch shearing the anterior cruciate ligament with the injury he described.

Q. Exhibit 6, lower left, lower right-hand corner you have ACL sprain. Is that the shearing that you are referring to?

A. No, it's the result of shear.

Q. Okay. Do you have an opinion as to what the outcome would have been with regard to the ACL had you not performed the notchplasty?

A. Yes.

Q. What's your opinion?

A. That with a later similar incident, he most likely would have ruptured the anterior cruciate ligament.

Q. And on what do you base that?

A. Because the crowded notch and A-frame anatomy predisposed this ligament to that injury with that force.

Q. Which was more a cause of the patient's symptoms in May of '96, the chondromalacia or the injury to the anterior cruciate ligament?

A. I don't have an opinion about that.

Q. Isn't it just as likely that with the treatment of the chondromalacia and conservative treatment of the ACL sprain without performance of notchplasty that Mr. Lee would have done just fine?

A. No, not necessarily. Particularly given the

finding of a well developed medial synovial plica with demonstrated frictional contact on the ridge of the medial femoral condyle also making chondromalacia

Q. Was that in the May surgery?

A. Those are, that finding is documented on Plaintiff's Exhibit 6.

Q. And of what significance is that, Doctor?

This is in the upper left-hand corner of Plaintiff's Exhibit 6, true?

A. Yes.

Q. Of what significance is that in terms of the causative components that we talked about?

A. If we presuppose that chondromalacia would be a source of his symptoms, then the demonstrable frictional contact of a synovial fold on the ridge of the medial femoral condyle making chondromalacia as seen here would be a source of pain, not treated. And we were saying that treating the chondromalacia with chondroplasty and the performance of no other procedure would have left the patient with a result that was, I believe you said fine.

Q. And you dispute that?

A. Yes, because it's my experience that people who have a large well developed medial synovial plica making frictional contact on the ridge of the medial

femoral condyle resulting in chondromalacia have pain from this source as well.

Q. How do you treat the medial plica as well as the, we talked about the chondromalacia, but how do you treat the medial plica?

A. One might resect the medial plica to remove the frictional contact.

Q. Did you do that in this case?

A. I don't record that I did.

Q. Wouldn't that have been a reasonable and prudent thing to have done?

A. In the weighting of importance of the injuries I identified in the knee this seemed to be of the least importance of all. And especially considering that even if the irritating factor of the medial plica were removed, that the chondromalacia would still exist as a source of pain, without further irritation on the ridge of the medial femoral condyle.

Q. But you addressed the chondromalacia on the medial femoral condyle at the time of your surgery?

A. But not on the ridge of the groove where the plica made frictional contact. This is the weight bearing area of the condyle which is a central articular surface. This is of the very edge and a nonweight bearing surface.

Q. So the medial plica was of less significance, true?
A. Of minor significance.
Q. And probably not productive of any symptomatology in the patient?
A. I disagree with that.
Q. Then why not address it at the time that you're doing the Grade III chondroplasty?
A. Remembering that we don't want to do more than is necessary, the treatment of this has a very small contribution to the problem in the knee would not have resulted in much symptomatic improvement, believing of course that most of his symptoms come from elsewhere and would have been like a long run for a short slide.
Q. What type of symptomatic improvement were you anticipating obtaining by doing a notchplasty?
A. That treatment was not indicated for symptomatic improvement. Notchplasty is performed based on an anatomic variant predisposing to ACL injury for the purpose of removing the potential for later injury, not as a symptomatic treatment.
Q. So you were doing this sort of in a prophylactic manner to prevent further injury to the anterior cruciate ligament, true?
A. Yes, since the weighting in that issue is

extreme, given that the anterior cruciate ligament is a major supporting structure of the knee.

Q. What caused Mr. Lee's persistent popping and snapping in the knee and his inability to progress with the quadriceps conditioning?

A. There are two issues there, the popping and snapping occurred with the patella, the kneecap, nesting into the defect, which was the chondromalacia lesion, in the femoral trochlea with motion of the knee.

Q. Okay,

A. And the second is, the inability to progress with quadriceps strengthening was likely due to what might be described as reflex inhibition due to pain. In other words, the kneecap painfully grinding across an irregular surface in the groove of the femur might send pain signals to the brain where the response would be to lower the nerve signals or voltage if you will to the quadriceps musculature and not allow it to be trained or built up.

Q. Did you feel and do you feel as you sit here right now, that the surgery that you performed in May of 1996 was successful?

A. No, I don't feel that it was successful for the reason that the patient had other and worsening

symptoms requiring reoperation.
Q. Why wasn't the surgery successful?
A. A separate and subsequent problem came to light, namely the development or the appearance of a chondromalacia lesion in the femoral trochlea.
Q. This lesion of which you feel existed but yet was not discernible?
A. Yes.
Q. A lesion of which you feel was not precipitated by your original surgery, true?
A. Most definitely.
Q. You eventually referred Mr. Lee to Dr. Hritz for a second opinion, true?
A. Yes.
Q. How frequently do you refer patients to Dr. Hritz for second opinions?
A. Rarely.
Q. Why did you choose Dr. Hritz for Mr. Lee?
A. Because the potential treatment which might be considered as more definitive for the patient's continuing problems involved an operation which in our area would only commonly be performed, other than myself, by Dr. Hritz.
Q. What type of expertise does he have that --
A. Dr. Hritz has experience in this technique.

Q. Is this the, for the patellar tracking syndrome?
A. Well, for the finding of advanced patellar, patellofemoral gonarthrosis, which is the defective chondromalacia making pain with patellar maltracking.
Q. Even after your second surgery he continued to have the maltracking problem, true?
A. Yes.
Q. And for the record, Exhibit 4 is a copy of the operative report from surgery number two?
A. That's correct.
Q. Okay. And again I'm going to try to abbreviate this only because of the hour, but what did you, what were you attempting to accomplish in performing surgery number two?
A. Number one, was to discover the source of his pain.
Q. Okay. Anything else?
A. Well, in the potential discovery of a source of pain to determine whether this might be treatable.
Q. What did you discover at the time of your surgery number two?
A. I discovered that he had a significant chondromalacia lesion in the femoral trochlea.
Q. The atrophy that he was developing in the

quadriceps was, I think it was described as marked, was it not?
A. Yes.
Q. Very concerning, true?
A. Yes.
Q. That wasn't due to any failure on the part of the patient to do that which he was obligatorily required to do, true?
A. That's true.
Q. Was this more a component of the mal, malfunctioning of the knee joint?
A. Yes.
Q. You performed a procedure -- if I could have the operative report back a second. Was your second procedure essentially a chondroplasty of the trochlear surface?
A. Yes.
Q. No other interventions at that time from a therapeutic standpoint I should say?
A. No.
Q. You saw him after his surgery in August, yet he continued to have the painful snapping in the mid range of active extension, true?
A. Yes.
Q. There was a discussion sometime in August, I

believe, of performing a Maquet, M-A-Q-U-E-T, procedure?

A. Maquet.

Q. Maquet.

MR. NORMAN: I used that pronunciation earlier. He corrected me too.

A. He's a Belgium surgeon of, must be of French extraction.

MR. MISHKIND: Off the record.

* * *

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

* * *

MR. MISHKIND: Back on the record.

Q. Why the Maquet procedure?

A. Maquet procedure is an operation performed to slightly lift the kneecap out of the joint, out of the groove, so that the usual firm nesting pressure of the kneecap in the groove does not come to bear on rough surfaces, such as the chondromalacia lesion that he had developed.

Q. Did you recommend that procedure to him?

A. I told him that it was a possibility as a pain relieving measure, but that it was a very drastic procedure and considered more a salvage operation.

Q. He was continuing to have painful patellofemoral mechanics?
A. Right.
Q. He had patellar shift, true?
A. Yes.
Q. Loud snapping with knee motion, true?
A. Yes.
Q. Why wasn't this addressed at the time of your second surgery?
A. It was addressed. In fact, my operative comments are that the shifting and snapping could not be reproduced in the absence of normal muscle tone with the patient being asleep. But that it was obvious by the presence of such a large lesion centrally in the main groove where the kneecap tracked that this was the source of his problem of maltracking seen in the office examinations.
Q. What else could you have done at the time of your second surgery to increase the likelihood of a more favorable outcome?
A. It might be argued as a point that a lateral retinacular release could be considered, but this presupposes since a retinacular release actually divides intact tissue that surrounds the knee and is attached to the kneecap tracking mechanism, that the

kneecap tracking mechanism is actually excentric or out of kilter to one side and, therefore, we release on the side where the mechanism is tracking wrongly.

However, I documented by placement of the arthroscope at an accessory portal to evaluate the actual tracking of the patella, that the patellar mechanism was nicely centralized with motion of the knee and therefore did not drift to either one side or the other and wouldn't in my view of the understanding of lateral retinacular release justify any intervention of that type.

Q. Were you satisfied with the outcome from the second surgery?

A. No. Because I realized that I had identified a new lesion in the patient for which we don't have, even to this day, very satisfying treatment.

Q. Is an osteoarticular bone graft transplantation an accepted treatment for Grade IV trochlear lesions?

A. Yes. And this is an unusual procedure performed, not commonly performed, nor widely performed, and also does not have the longevity of good outcome performance that other procedures do.

Q. Such as?

A. The Maquet.

Q. Okay. Would you have recommended performing

the osteoarticular bone graft transplantation?
A. It certainly might have been considered as a possibility, but knowing, especially at that time, that this procedure was much less common and with a, not nearly the long documentation of successful outcome of other procedures, I would not have made it a recommendation except to consider it as a possible experimental undertaking only at the hands of an experienced surgeon.
Q. I take it you didn't have the kind of experience that was necessary to undertake that type of surgery?
A. In fact, I couldn't have identified anyone in our community who did.
Q. What about Dr. Williams?
A. Dr. Williams is not in our community, nor would I say that he might be recognized as someone who has or who had at that time the commonly recognized experience to perform that procedure. The knowledge of which we all understand about how to perform it, but the experience and personal patient population documenting the good outcome wouldn't have necessarily been known to the orthopedic community as indicating Dr. Williams being the experienced doctor for this procedure.

Q. Have you ever worked with Dr. Williams on any cases?
A. No.
Q. Do you have an opinion as to his standing in the orthopedic community?
A. Oh, yes.
Q. What is that?
A. It's a good one. He's a well trained orthopedic surgeon with, I think, good judgment, who I have shared mutual patients with, who as I recall have not required surgery from my referrals, but with very good treatment at his hands.
Q. Doctor, I'm going to show you Exhibit 7 through 11, which I believe are pictures from the arthroscopy in July of 1996. And I guess I would ask you first to take a look at them, confirm that they are what I have just said. Do that first silently.

Are Exhibit 7 through whatever, 7 through 11 from your July 1996 surgery?
A. Yes, with the addition of some enlargements of a few of the photographs and missing an enlargement of one of the photographs.
Q. Okay. Are any of those photographs or sections of the photographs demonstrative of what you found relative to the trochlear lesion at the time of your

July '96 surgery?
A. Yes.
Q. Which ones?
A. They all appear to be demonstrative of my arthroscopic findings at the July surgery.
Q. All demonstrating Grade IV chondromalacia?
A. No.
Q. Which ones demonstrate?
A. Well, there are various features demonstrated since there are numerous pictures. But the Grade IV chondromalacia lesion is demonstrated in a few of the pictures among these.
Q. Identify which exhibits we're referring to.
A. Exhibit 8, the upper left and upper right pictures, both demonstrate the lesion.
MR. NORMAN: Again for the record 8 is Bate Stamped which number?
THE WITNESS: 211.
A. And then Exhibit 9, I would say all of those photos show the chondromalacia lesion.
And of Exhibit 11, the upper left and upper right show the chondromalacia lesion.
And Exhibit 10, the three enlargements depicted each show the chondromalacia lesion.
Q. What did you explain to Mr. Lee following this

diagnostic arthroscopy and in the procedure that you did in July of '96 as to the, your findings?

A. I don't recall specifically our discussion, but my record shows that on follow-up evaluation that we discussed the findings at arthroscopy and that a chondromalacia lesion existed in the groove of the femur. And that I explained this as the source of his painful popping.

Q. Did you indicate to him that you were or were not able to do anything to try to resolve this painful popping?

A. I don't recall our specific discussion. I do know that for the treatment I rendered that my explanation to patients is that the technique is to try to bevel the margins of the lesion so that the interface between normal and abnormal tissue is a smoother transition and hopefully will make tracking less irregular and less painful.

Q. Did you eventually recommend to Mr. Lee that he pursue a disability claim through Social Security?

A. I don't recall specifically advising him to pursue disability. I do remember saying that it appeared by the situation that he had come into that probably he would not be able to return to the work that he had done previously.

Q. And if it was going to be a job involving a nonsedentary position, that he would likely not be able to accomplish that position given the problem with his knee, true?

A. Yes.

Q. And if that were the case that do you recall indicating to him that you would suggest that he consider pursuing a disability claim?

A. No, I don't remember advising him to pursue a disability claim.

Q. Or pursuing Social Security because of his inability to return to the type of gainful employment that he had previously?

A. No, I seem to recall that we had a discussion about alternative work and for the department that he had worked in previously, whether or not there was more sedentary work available.

Q. Can patients with chondromalacia, even of the trochlear groove, be treated and benefit from nonoperative treatment?

A. I'm sorry, can you read that back to me?

Q. I'll rephrase it.

Can patients that have chondromalacia of the trochlear groove benefit from a period of nonoperative treatment?

A. Yes, knowing that the benefit during that period might come, depending on the nature and extent of the lesion, be variable.

Q. When you went in in July, did you do basically a shaving or a curettage to remove the diseased cartilage?

A. That would be a crude description, yes.

Q. Well, I'm a lawyer, I'm not a doctor, but basically is that what you did?

A. Yes, electronically.

Q. While leaving as smooth a chondral surface as possible?

A. Yes,

Q. Doctor, I want you to assume that Dr. Williams in April of 1997, did perform an osteoarticular bone graft transplantation due to Mr. Lee's repeated pain and clicking and problems in the knee. Assuming that to be the case, and again in April of 1997, so roughly seven months, ten months after your last surgery, would that be a reasonable approach to trying to resolve Mr. Lee's ongoing disability with the knee?

MR. NORMAN: Objection.

A. I think in the right hands for the correct problem doing it would be a reasonable consideration.

Q. Do you have any reason to believe that in April

of 1997, Dr. Williams did not have the knowledge or training and experience to perform an osteoarticular bone graft transplantation?

MR. NORMAN: Objection. Go ahead.

A. No, in fact I don't have any information that would lead me to believe that he did have the skills.

Q. Well, a moment ago you said in the right hands. What did you mean by that?

A. The person trained in the procedure with the experience and the acknowledgement of others that this is a procedure that's performed for that reason and that they have performed previously with success.

Q. And does Dr. Williams meet that criteria?

A. I think I just remarked that I didn't have any information to indicate that he did have those qualifications. I don't have that information.

Q. Am I to conclude that you are suggesting that he did not have those qualifications or were you --

A. No, I think I only said that I didn't have the information that this doctor that you're querying about had those qualifications.

Q. *You are* not trying *to* suggest by that, and I guess it's a question of my not understanding your verbiage, that he was unqualified, it's just that you

don't know one way or another whether --

A. I don't think --

MR. NORMAN: He's not offering an opinion on the qualifications.

A. No, I don't know anything about this Doctor's qualifications to perform that operation. That would summarize my thinking on the issue.

Q. Okay. Doctor, let me just check my notes. I may be done.

Unfortunately, I have some more questions for you.

An abrasion chondroplasty that removes excessive cartilage can cause joint incongruities, true?

A. Yes, performed as an intentional procedure for a given reason, that might be the result.

Q. When you did the chondroplasty in July, was it an abrasion chondroplasty?

A. Oh, no, this is performed with very specific instruments of which I made no use.

Q. What type of instruments would you need to use to cause an abrasion chondroplasty?

A. Abrasion is caused with the use of an abrader, which is a burr like instrument.

Q. What did you use for your chondroplasty?

A. I used an electronic device which is a cluster electrode that vaporizes free tissue.
Q. It does not lead to any potential for abrasion?
A. No. Abrasion is not part of its mechanism.
Q. Mr. Lee did not have any abnormal articulation between the patella and the femur prior to your first surgery, did he?
A. I did not know the patient prior to that time.
Q. Well, on physical examination did you see any evidence of any abnormal articulation between the patella and the femur?
A. I did not document any, no.
Q. At the time of your second surgery did you do patellar tracking?
A. I'm afraid I don't understand the question.
Q. Did you evaluate the patellar tracking at the time of the second surgery?
A. Yes.
Q. And what was causing the abnormality in the patellar tracking at that time?
A. It was my judgment based on the findings that the trochlear chondromalacia lesion was the cause of the maltracking.
Q. Doctor, if you were to do this all over again, approach this case, clean the slate and go back and

operate on Mr. Lee anew, would you have done anything any differently?

MR. NORMAN: Objection. Can you clarify that?

MR. MISHKIND: I think it was pretty clear.

Q. You know the outcome, you know what you did. If you had it to do over again would you have approached the case any differently?

MR. NORMAN: Objection.

A. I would use my same skills of judgment and experience in making decisions regarding how to treat the findings that I could document.

Q. Okay. And let's try the question again, having recognized that you are going to apply your professional judgment, you recognize that if you apply professional judgment in a substandard manner that this is considered to be malpractice, true?

A. Yes.

Q. So that even though you apply judgment, if the judgment is poor or below accepted standards, that's not an excuse for the outcome, true?

MR. NORMAN: Objection.

A. I'm not sure I understand the form of the question.

Q. If you apply judgment that is unacceptable or below minimal standards, one cannot, one cannot just excuse the outcome by saying I applied my judgment, true?

A. True.

MR. NORMAI Objection.

Q. Let's go back to, let's go back to the original question that I had for you.

If you had to do the case over again, and again applying your professional judgment in a reasonable and prudent manner, would you have done things differently in the first surgery than what you did?

MR. NORMAN: Objection. Don't answer that as phrased. I'm not, that's, it's too vague. I understand, I think, where you're trying to go with this, but that's, you're not taking into account what he knows at what point,

MR. MISHKIND: Well, number one, I'm not going to sit here and have you instruct him not to answer a question, but being that it is a quarter after 9:00 and we started the deposition as late as we did, I will rephrase the question to try to get an answer from him which I'm entitled to ask him.

Q. But what I'm trying to find out from you, Doctor, is, you had a physical exam, you did a

physical exam on a patient, you did an MRI, you had certain information going into the first surgery, you had an outcome after the first surgery which you indicated to me you weren't satisfied with, true?

A. Yes.

Q. You acknowledge that it was essentially an unsuccessful surgery, true?

A. Which?

Q. The first one.

MR. NORMAN: Objection.

A. No, not the first surgery.

Q. The second surgery?

A. The second surgery I believe we discussed as being unsuccessful.

Q. Okay. All right. The first surgery you weren't satisfied with the outcome, true?

A. That's true.

Q. As far as if you had to do it again, you'd go back in and operate on the patient again, would you have approached the surgery or done anything differently with regard to the first surgery?

MR. NORMAN: Objection. Are you asking that knowing what he knows the outcome to be.

MR. MISHKIND: Sure, absolutely, absolutely.

MR. NORMAN: That's an impossibility. He can't answer that, and I'm not going to have him answering an impossibility.

MR. MISHKIND: It's not an impossibility. It may be an impossibility in your mind.

Q. But I'm asking him, knowing what you saw at the time of the surgery, knowing what you did, would you, if you had it to do over again, would you say to me, Mr. Mishkind, I wish I had done things differently?

A. No.

Q. So you were, you are comfortable and you are willing to stand on the proposition that whether it was a successful result or not, what you did was an acceptable means of treating this man?

A. Yes.

Q. And the surgery that you did you believe was a surgery that Mr. Lee consented to and appreciated what you were going to do to him?

A. Yes.

Q. Certainly if it was not a surgery that he consented to and appreciated what you were going to do, that would be substandard care, true?

MR. NORMAN: Objection.

A. I guess I'm not exactly certain of what the

precise and limited definition of substandard care could actually be.

Q. If you --

A. It seems vague is my point.

Q. Okay. Fair enough.

If in fact you did not provide Mr. Lee with sufficient information for him to appreciate what you were going to do at the time of the surgery in May of 1996, can we agree that that would be below accepted standard of care?

MR. NORMAN: Objection.

A. No, because I think that poses a hypothetical situation that actually could not exist.

Q. Why is that?

A. Because it is often the situation, particularly in view of examination findings that lead us to propose surgery, based also on objective findings from associated studies, that the surgery we propose may often be modified from the proposal in a minor way based on new findings which cannot be discerned either by physical examination or other noninvasive studies preoperatively.

Q. I take it *it's* your opinion that the notchplasty that you performed was not in any way causative of any of the complications which ultimately

then resulted in the need for the July '96 surgery, true?

A. Yes, that is my opinion.

Q. Okay. From the standpoint of that which you recall in terms of your interactions with Mr. Lee, aside from what's documented in the records, I can read the records and I can go through line by line with you and we'd be here for another two hours, but is there anything else from the standpoint of your interactions with Mr. Lee that you recall independent of the records prior to or after the first and second surgery that we have not talked about?

A. No.

Q. Okay. Do you recall your conversation with Dr. Hritz after the second opinion?

MR. NORMAN: After the second operation?

MR. MISHKIND: After the second opinion, Dr. Hritz' second opinion.

MR. NORMAN: Oh.

Q. I think there was only one second opinion.

A. Vaguely.

Q. Tell me what you recall him telling you?

A. I vaguely recall the gist of our conversation being that this patient was not a candidate for Maquet

procedure in his mind and that as I had proposed in referring the patient to him, that other surgery might be necessary, but probably not Maquet.

Q. What was the other surgery?

A. No, that in general terms it might be said that other surgery might be necessary in the future, if the patient did not do well with nonsurgical treatment, but that Maquet would not be Dr. Hritz' recommendation.

Q. But, again, what would the other surgery that might be necessary if conservative measures was not successful, if Maquet was not the procedure?

A. Oh, I think he was speaking in general terms and not elaborating.

Q. Do you know what other surgery would have included if the Maquet was not in the offing?

A. Probably the books and journals are replete with possibilities, and I'm not going to enumerate them.

Q. Why?

A. They are numerous.

Q. What would be the most likely and the most reasonable surgical intervention to try to resolve this problem for Mr. Lee?

A. That would certainly be a matter of opinion,

not of fact.
Q. What would be your opinion as to the most likely and reasonable future surgical approach to this ongoing dilemma that Mr. Lee had in, after the July --
MR. NORMAN: How far into the future?
Q. -- after July 1996?
MR. NORMAN: I'm sorry for interrupting.
How far into the future?
Q. Well, we've talked about that he might need future surgery other than the Maquet procedure and at whatever time that surgery would be what would be the most likely and reasonable surgical intervention?
A. It would depend very much on the patient's symptoms and exam findings, his age and his expectations. There might be, easily be a very long list of possibilities.
Q. How did you leave things with Mr. Lee when you last saw him?
A. I'm not sure how you mean that.
Q. Was he to come back to you, did you quit him, did he fire you, what was Dr. Whitted's and Mr. Lee's relationship at the last juncture?
A. Gosh, I don't think I can comment on our

relationship at the last juncture. I'm not sure I look at it in those terms, but my record states that I told the patient that he might return as needed for reevaluation after consulting with Dr. Hritz.

Q. Did he come back to see you after consulting with Dr. Hritz?

A. I don't document any further interactions in our office in the chart.

Q. I take it then you don't have any recollection of any interactions, true?

A. No. Yes.

Q. You didn't make any further attempt to follow-up with him after the referral to Dr. Hritz, did you?

A. No. Leaving it at the suggestion that he might return at his leisure to me after consulting with Dr. Hritz, I did not pursue him.

Q. Did you refer him to Dr. Hritz because you realized that you no longer were able to adequately resolve Mr. Lee's ongoing problems?

A. No. In actuality, when patients have problems I have always felt that it good for the patient to confer with another uninvolved surgeon to look at the problem objectively and have a discussion on the patient's terms about how the problem looks from that

doctor's perspective as a way of supporting the patient and giving them the opportunity to ask questions in a different environment about the same problem.

MR. MISHKIND: Okay. Doctor, I don't think I have any further questions for you. Thanks for your time.

MR. NORMAN: We'll read.

C E R T I F I C A T E

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

I, Kathleen A. Hopkins Durrant, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, GLEN WHITTED, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was reduced by me to stenotype in the presence of said witness, subsequently transcribed into typewriting under my direction, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Elyria, Ohio, this 17th day of November, 2000.

Kathleen A. Durrant

Kathleen A. Durrant, Notary Public
My Commission expires 1-10-05
Recorded in Lorain County, Ohio

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