IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

NABILA BASTAWROS,

Plaintiff,

-vs-

JUDGE CALABRESE
CASE NO. 291775

CHARLES C. SHIN, M.D., et al.,

Defendants.

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Deposition of ALAN H. WILDE, M.D., taken as if upon cross'-examination before Katherine A. Koczan, a Notary Public within and for the State of Ohio, at the Cleveland Center for Joint Reconstruction, 2322 East 22nd Street, Cleveland, Ohio, at 2:05 p.m. on Tuesday, May 4, 1999, pursuant to notice and/or stipulations of counsel, on behalf of the Plaintiff in this cause.

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On behalf of the Plaintiff;

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On behalf of the Defendants.

ALAN H. WILDE, M.D., of lawful age, called by the Plaintiff for the purpose of cross-examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION OF ALAN H. WILDE, M.D.

BY MS. EKLUND:

Q. Dr. Wilde, you've been through this before, so I won't --

A; Yeah.

Q. -- go through all the ground rules, okay?

State your full name for the record.

A. Alan Hugh Wilde, M.D.

Q. And your residence address?

A. My home address?

Q. Yes, sir.

A. My goodness.

MR. FOGARTY: Do you need that?

Q. Do you have any problem?

A. No, I don't have a problem with that. Why do I have a blank with that? We just moved, I just moved not too long ago. 58 -- why do I have a blank?

Windsor Way, Broadview Heights, 8540, I

think that's right, yeah.
Q. How long have you lived there?
A. Two years.
Q. Where did you live previously?
A. Cleveland Heights.
Q. And your office is here?
A. 2322 East 22nd Street.
Q. And you are partners with Dr. Stulberg?
A. Yes.
Q. And together you have a company called Cleveland Center for Joint Reconstruction?
A. Yes.
Q. Is that incorporated?
A. Yes.
Q. When was that incorporated?
A. About seven years ago.
Q. When did you begin partnership with Dr. Stulberg?
A. Seven years ago.
Q. Do you work primarily out of St. Vincent Charity Hospital?
A. No, we work primarily out of Lutheran Hospital now.
Q. Was there a time when you were primarily associated with St. Vincent's?

A. Yes.
Q. When did that begin and end?
A. It ended February, this year.
Q. When did it begin?
A. Began in 1991.
Q. And why did that relationship terminate?
A. Hospital terminated the contract.
Q. With your group?
A. Yes.
Q. Do you know the reason?
A. They didn't give us a reason.
Q. So you've been under contract now with Lutheran Hospital since February of '99 to the present?
A. Yes, urn-hum.
Q. Do you have any employees besides yourself and Dr. Stulberg? I'm talking about medical people.
A. Doctors you mean?
Q. Yes, sir.
A. No.
Q. Do you have a CV with you by chance?
A. Yeah, I can get one.
She's going to print one out.
Q. Okay. Doctor, prior to your partnership with Dr. Stulberg, where were you practicing

medicine, with which group I mean?
A. University Hospital. University Orthopedic Associates.
Q. How long were you with University Orthopedic Associates?
A. Well, let's see. Would have been October, November, December -- eight months.
Q. During which year?
A. Let's see, we came here in '91, so that would have been October of '90 to May of '91.
Q. Was Dr. Stulberg also with University Orthopedic Associates?
A. Yes.
Q. Did you two leave that group together and form --
A. Yes.
Q. -- your own partnership?
A. Yes.
Q. Prior to University Orthopedic Associates, where were you affiliated?
A. I was chief of orthopedics at Cleveland Clinic.
Q. And how long did you hold that position?
A. 15 years.
Q. Can you tell me the years?
A. Yeah. As a matter of fact, 19 -- 1990 would

have been the last year, so 15 before that would have been '75, yeah.

Q. Why did you leave University Orthopedic Associates?

A. To form the Cleveland Center for Joint Reconstruction.

Q. Was there anything other than wanting to form a new association that caused you to leave University Orthopedics?

A. We had wanted to set up our own unit without the restrictions placed on us by the University.

Q. What type of restrictions was that?

A. Ability to do our work, for instance.

Q. Can you be more specific?

A. Well, we wanted to do cases, surgical cases and I really didn't want to do those at night. I also wanted to be able to do surgical cases with instruments, with the proper instruments. I wanted to do cases, for instance, I wanted to do hip cases with hip instruments.

Q. You mean prosthetics?

A. And I wanted to do shoulder cases with shoulder instruments.

Q. Let me just stop you. Do you mean prosthetic devices or the tools to do the surgery?

A. Instruments.
Q. To implant in the body?
A. No, the instruments to put those in with.
Q. And those were not provided to you at University Hospital?
A. They would not do that.
Q. How can you do those surgeries without the instruments?
A. It's difficult. I mean I was told by the O.R. people that they wouldn't do that.
Q. Okay.
A. Also, that in order to schedule cases, to do three cases a day, the third case had to be done on emergency schedule, which meant that you waited until all the emergencies were done and then you would do that. Well, I didn't want to do surgery on patients that have been waiting all day, to do them at 8:00, 9:00, 10:00 at night.
Q. Would that have required some rotation in the emergency room, in the emergency room department on your part?
A. No, that, these were elective cases.
Q. Okay.
A. That's the way they run the operating room.

Q. And your reason for leaving The Cleveland Clinic?
A. Well, I had, I had the opportunity, Dr. Stulberg was an associate of mine at The Cleveland Clinic, and in fact, I recruited him and he left to go to University Hospital. I had stepped down as chief and I had the opportunity to join the University, so I took it.
Q. Okay. When were you first licensed to practice medicine?
A. When?
Q. Yes, sir.
A. 19, 1959.
Q. Was that in Ohio?
A. No, that would have been in Pennsylvania.
Q. When were you licensed in Ohio?
A. 1966.
Q. Did you ever practice in Pennsylvania?
A. No.
Q. What did you do between -- if I had your CV I probably wouldn't have to ask you these things.
A. Yes, I did. I interned in the Army, began in 1959 and spent three years on active duty in the Army. That would have been until 1960 -- oh, let's see. '62, took my residency at University

of Pittsburgh, finished there in '65, took a fellowship in arthritis surgery, University of Edinboro, and then went to the research laboratory, University of Pittsburgh, finished that in June of '66 and then began practice in Cleveland.

Q. What brought you to Cleveland?

A. I was recruited by, by one of the staff at The Cleveland Clinic when I was in Scotland.

Q. Has your entire medical career focused on the practice of orthopedic surgery?

A. Yes.

Q. You are board certified?

A. Yes.

Q. Do you have any subspecialty within that broad category of orthopedic surgery?

A. Yeah, I do joint replacements.

Q. Any particular joint that you specialize in?

A. I do knees, hips, shoulders, elbows.

Q. Be fair to say that over the years, of at least your practice, the procedures have changed dramatically?

A. Yes.

Q. And I assume that the changes have been for the better?

A. For the most part.
Q. Has knee replacement evolved to a point where it is a fairly routine procedure in orthopedic surgery?
A. Yeah, there have been some minor changes in, in knee replacements, but for the most part, it's a routine procedure.
Q. How much of your professional time presently do you devote to the practice of medicine?
A' Just about all of it. You mean how much is administrative or --
Q. Correct.
A. I don't know if there is -- only about five percent probably is administrative at this point.
Q. And you re practicing full time?
A. Yes.
Q. Do you do any teaching?
A. Not now.
a. When was the last time you taught?
A. I, you're talking about medical students or residents or --
Q. Either.
4. Either. About a year ago is when I stopped.
Q. Was that medical students on rotation?

A. Residents, orthopedic residents.
Q. And they would do rounds with you, that kind of thing?
A. Rounds, surgery.
Q. Did you ever hold a teaching position at any of the area medical schools?
A. Yes.

- - - -

(Off the record.)

- - - -

A. Yeah, at University and at The Cleveland Clinic.
Q. Okay.

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

- - - -

Q. I see from your CV you were a professor of orthopedic surgery at Case Western Reserve University?
A. Yes.
Q. From '91 to '92?
A. Yes.
Q. Have you taught students how to perform knee replacement surgery?
A. Yes.

Q Have you written anything for students on the procedure for performing knee replacement surgery?
A Yes.
Q And do you have copies of anything you've written here at your office?
A Yeah. I probably do
Q Okay Would you, if not now, sometime after this deposition, locate whatever you have written?
A. We have the titles that are listed in there.
Q I understand, but they are not usually as easy to find as one might think, so whatever you do have here --
A Yeah, I may not have copies of all of them
Q All right Whatever you have concerning knee replacements, if you will provide that to Mr. Fogarty and he will provide them to me
A Okay

MR FOGARTY: Are you talking about articles he may have authored or --

Q I'm talking about articles or anything you prepared for instruction of medical students or residents

MR. FOGARTY: Okay So not

articles then for publication?

MS. EKLUND: Correct.

MR. FOGARTY: Okay.

A. You don't want articles for publication?

Q. No, the articles that are published, I can locate. It's things you wrote for interns, residents, medical students, anything like that, lectures.

A. I don't have that specifically. The thing, most of the things that I've done have been for, in the way of publications or national courses on knee replacement, which you'll see in this, instructional course lectures for orthopedic surgeons about knee replacements.

Q. Okay.

A. But not any sort of a teaching outline or syllabus for medical students or -- I don't have anything like that.

- - - -

(Thereupon, Plaintiff's Exhibit 1 was marked for purposes of identification.)

- - - -

Q. Okay. Doctor, we are just going to mark as Exhibit 1 a copy of the CV that you provided to me. And I'll just ask you, is this a fairly

current version of your CV?

It has your new address, it must be within the last two years?

A. I was right.

Q. Right.

A. Yeah, I think it's, it should be.

Q. Okay.

A. Probably doesn't have all the papers. Oh, it doesn't have papers for '98, so it's not complete, but it's up-to-date in '97.

Q. Okay. Is there somewhere a list of what you've written for 1998?

A. I don't think she's put that in the computer. I think that's what the problem is.

Q. Have you written anything on the subject of knee replacement or knee revision, to your knowledge?

A. Wear debris, but not specifically about knee revision.

Q. Okay. Are those all things that have been published?

A. Yes.

Q. Doctor, when did you first begin reviewing cases as a medical expert?

A. Oh, boy, I've been doing this for probably 15 years.

Q. And how did you first get involved in this process?
A. Attorney called me, asked me if I'd review a case.
Q. Have you ever advertised your services as a medical reviewer?
A. No.
Q. How many cases would you estimate you review on a weekly or monthly basis at the present time?
A. This year I'm busier, I think, than I have been. Last year, for instance, I did I think four cases the whole year. This year I think I probably got four so far, four or five so far.
Q. Now, does that mean, you say four this year, four last year, does that mean four cases you reviewed or four cases you've testified in?
A. Four cases I reviewed.
Q. Do you have any estimate of the number of cases you've reviewed in the 15 years that you've been doing this?
A. Oh, probably not any more than say a dozen.
Q. 12 cases in 15 years reviewed?
A. Um-hum.
Q. And how many cases have you actually testified in in trial, either by deposition or appearing

is person?
A You mean by video deposition for trial, or you mean actually in court?
Q Exactly.
A In court, it's probably only been two or three been in a number of video depositions
Q Do you know how many?
A Oh, probably eight or nine, something like that
Q Have you ever testified as an expert in a knee replacement surgery other tha this case?
A Are you, again, you're talking about video deposition or testifying in court?
Q Either Let me, let me retract that question and ask you this one:
Have you reviewed other cases involving the standard of care in knee replacement surgery?
A Yeah I think I have
Q Do you know how many?
A Probably a couple
Q Did you review those on behalf of the injured party or the physician?
A I can't remember specifically about the knee replacement cases, but if you're asking was I reviewed for a plaintiff's attorney, yes I have also reviewed for the defense, yes, so I'm

reviewed for both sides.
Q. Okay. How does your review fall in terms of what percentage plaintiff, what percentage defendant?
A. More for the defense than the plaintiff.
Q. Are you able to break it down, 80/20?
A. Oh, it's probably 90/10 for defense.
Q. 90 defendant, 10 plaintiff?
A. Um-hum.
Q. When was the last time you were asked to testify on behalf of a plaintiff in a malpractice case as an expert?
A. This year, I think I had a case this year.
Q. Do you recall who the attorney was?
A. No.
Q. Do you recall the attorneys that you've worked for in the past on the defense side?
A. Buckingham, Doolittle.
Q. Do you recall any individual attorneys there?
A. No, I don't remember their name.
Q. Jacobson, Maynard?
A. Yeah, I did. I did, was asked, I was on their panel for a little while, so -- I was on their panel, so I did review some cases for them.
Q. What kind of a panel was that, doctor?

A. There were, I think, two other orthopedic surgeons that were on that panel, and they presented cases to us.

Q. The lawyers at Jacobson, Maynard would present cases to you?

A. Yes.

Q. And you would evaluate them for purposes of determining whether there was any merit to the case?

A. Right.

Q. Were you paid for that work?

A. Yes.

Q. Which years were you involved as a panel member for Jacobson, Maynard?

A. I can't remember the exact years, but that would have been prior to 1990, 1991.

Q. And how long were you on that panel?

A. Oh, probably a year maybe.

Q. Would you estimate the time period between like 1989 and 1990?

A. Somewhere in there.

Q. How many cases per year would you review as a panel member for Jacobson, Maynard?

A. I think I only went down there two or three times. They would typically maybe go through

three cases or so.
Q. Were you --
A. I'd forgotten about those in that estimate of number of cases that I, that I've reviewed.
Q. Okay. In your capacity as a panel member for Jacobson, Maynard, were you paid by the case or paid per session?
A. Per session.
Q. So if you reviewed three cases per session, you were paid one flat fee?
You have to say yes.
A. Yes.
Q. And what were you paid?
A. Oh, I don't remember.
Q. And have you been retained by Jacobson, Maynard other than as a panel member for their firm?
A. No.
MR. FOGARTY: You mean other than this case, Claudia?
Q. Obviously they retained you in the Bastawros case.
A. Right.
Q. Okay. Other --
A. But you're talking --
Q. Other than the Bastawros case?

A. No.
Q. Have you been employed by Weston, Hurd?
A. I can't remember law firms.
Q. Do you remember the attorneys?
A. Or even the names of the attorneys, for the most part.
Q. Can you tell me when the last time was that you testified in a courtroom in a malpractice case?
A. Last year.
Q. Do you recall the name of the patient in that case?
A. No, I can't remember the name of the patient.
Q. Can you remember the names of any of the attorneys?
A. There was, I think that was Buckingham, that was Buckingham, Doolittle, Gary Benos, yeah.
Q. Did you testify in Akron or in Cleveland?
A. Akron.
Q. Do you remember the judge?
A. No.
Q. Do you remember the nature of the case?
A. It was a fractured tibia.
Q. And you testified for the defendant?
A. Yes.
Q. Doctor, how many knee replacement surgeries do

you personally do per month?
A. I probably do three or four a month now.
Q. Is there one type of joint replacement that takes up most of your practice?
A. I currently am doing the AMK knee replacement for my primaries. I've done the Insall Bernstein, too, as well. I did probably 500 Insall Bernsteins.
Q. I'm sorry, how many?
A. I probably did 500 Insall Bernstein knee replacements.
Q. And I assume over your career you've probably done thousands of knee replacements?
A, Yeah, I've probably done 1,500 or so.
Q. Of that 1,500 roughly estimated, how many of those have you had to revise?
A. Of my own or other people's?
Q. Your own.
A. Of my own. Of, those 1,500 are not only mine but they're everybody else's. Roughly would be around one to two percent of mine would have been revised.

MR. FOGARTY: Just so we are clear, when you say revised, Claudia, you mean take out and put in new prostheses?

MS. EKLUND: Redo it in any fashion.

A. Yes.

Q. One to two percent of yours?

A. Yeah.

Q. And were those revisions necessitated because of loosening or infection?

A. Yes.

Q. Have any of those been revised because of malalignment of the component parts?

A. Only if there's a problem that the malalignment has caused.

Q. Such as pain?

A. Such as instability or loosening.

Q. Would pain be a problem caused by malalignment of component parts?

A. Not per se.

Q. Why not?

A. Because I see a number of knee replacements that are not in perfect alignment that don't have pain, so malalignment doesn't mean that somebody has to have pain.

Q. Okay. But malalignment can cause pain?

A. I don't think so.

Q. Okay.

A. Per se, I don't think so.
Q. So am I correct that of the 1,500 knee replacements that you have performed, one to two percent have needed revision, and those have been primarily for loosening or infection?
A. Yeah, that would be the commonest reasons, yes.
Q. And that's generally true in orthopedic surgery, isn't it?
A. Yes.
Q. In fact, revision of knee replacement is a fairly rare occurrence, isn't it?
A. It's not a common occurrence, although I, I've done more knee revisions, I think, than most people.
Q. Okay. Are you aware of a national study that indicates there's a two to three percent revision rate for knee replacement surgery, nationally?
A. You want to give me the author or the title of that?
Q. I meant to bring it but I think I did not.
You're not familiar with that statistic; does it sound about right?
A. Yeah, the statistic I gave you is about right, too, so --

Q. Have you performed revisions of knee replacement surgery for reasons of malalignment that others have originally performed?
A. Just for malalignment?
Q. Yes.
A. No, I don't think I've done anybody just for strictly malalignment without any other problem.
Q. Have you done any because of malalignment that's causing pain?
MR. FOGARTY: Objection.
A. Yeah, I would offer somebody a revision if they were having pain and if it was malaligned, but I don't think I would, I don't think I have revised anybody who, who had a malalignment who didn't have other problems.
Q. What other problems would you have with a malalignment that would cause you --
A. Loosening, loosening or instability.
Q. What about reduction in range of motion, would that be a reason to offer someone a revision?
A. If the components are right, then it wouldn't be a reason to revise somebody. If they were stiff, then they usually need a release of adhesions rather than changing the prosthesis.
Q. Do you agree that in performing a knee

replacement, the component parts need to be aligned properly?

A. Ideally, yeah, you would like to have the components aligned, ideally.

Q. And you would like to have the component parts sized properly, correct?

A. Yeah, but again, what is ideal and what happens in practice are two different things.

Q. Okay. I understand there's a difference between perfect and what's acceptable, is that what you're saying?

A. Right, yes.

Q. And perfection is desirable but not always attainable?

A. Absolutely.

Q. But there is a range of tolerance, isn't there, in what's an acceptable deviation from perfection and what is not, do you agree with that?

A. I think if it's gross, yes.

Q. Doctor, what do you charge for reviewing malpractice cases?

A. It's $500 an hour.

Q. For anything that you do?

A. Yes.

Q. You don't charge any more for courtroom testimony?
A. No.
Q. Same price for a videotape deposition?
A. Um-hum.
Q. Yes?
A. Yes. Sorry.
Q. Same price for just reviewing records?
A. Right.
Q. How many cases have you advised attorneys you could not be an expert in because you didn't support their side of the case?
A. That's happened a couple times, somebody's asked me to review a case and I tell them that I don't think that I can defend that.
Q. Doctor, before we started the deposition, I had an opportunity to go through your file as it concerns Mrs. Bastawros, correct?
A. Um-hum, yes.
Q. Okay. You brought your entire file into the deposition room, correct?
A. Except for there's some billing things that I didn't, invoice and bills that I didn't bring in.
Q. Okay. You had initially not brought in

correspondence from Mr. Fogarty?
A. Right.
Q. Do you know where that correspondence might be?
A. I gave it to you.
Q. Mr. Fogarty gave it to me?
MR. FOGARTY: I gave them my copies.
A. I gave you my copies.
Q. You gave me copies of correspondence from Jacobson, Maynard. There's no correspondence here from Mr. Fogarty.
No, I don't want you to go look for it, doctor.
A. I'll bring in the whole thing. You're welcome to look at the whole thing, but I don't, unless I missed it.
- - - -
(Off the record.)
- - - -
A. Here it is.
Q. Okay.
A. The whole thing.
Q. Okay. Doctor, why didn't you bring this in the first time you brought your file in?
A. That's about appointments, about invoices, about

bills.

MR. FOGARTY: And, Claudia, I didn't instruct him to do anything about, I didn't tell him.

Q. Okay. That's what I'm getting at, doctor. Have you been told by attorneys in the past not to bring in or to remove from your file correspondence or things like that?

A. No, no, I just didn't think that letters about, you know, what my fee was going to be and what the invoice was going to be or when the appointments were going to be were of interest to you.

MR. FOGARTY: They are.

A. No, nobody instructed me to leave those things out.

Q. Okay. Now, doctor, you were originally contacted by Jacobson, Maynard to review the care of Dr. Shin in regard to Mrs. Bastawros, correct?

A. You have the correspondence, I guess.

Q. I do.

A. Yeah.

Q. And judging from the correspondence, it looks like the first contact you have from Jacobson,

Maynard was from Marilyn Miller, a letter dated February 26th or 28th, '97?

A. Yes.

Q. And she gives you some very limited information about the case and said she would like to discuss this with you in detail?

A. Yes.

Q. Do you have any notes from your conversation with Ms. Miller in regard to this case?

A. You have all my notes.

Q. Okay. Well, I don't see --

A. I think those notes are about review of the records.

Q. Yeah, these notes -- apparently, doctor, there's some yellow sheets attached to a rather lengthy letter from Miss Miller and Ed Taber, but I think those notes refer solely to the time expenditure?

A. Yeah.

Q. You have no notes that you took based on any conversations you had with Mr. Taber or Miss Miller, is that correct?

A. No.

Q. And again, there's one other handwritten note by yourself, maybe you can read that for me.

A. Yeah, Shin, "Bastawros versus Shin. Arthorscopic shaving, August, 1993. Total knee replacement. Pain until February, '96. X-rays six months later. Aspiration. No infection at Metro, Patterson revision."
Q. Okay. And as far as I can tell, doctor, that is the only handwritten note you have in this part of the file, which would be the correspondence?
A. Here's some notes I made just today about implants.
Q. Okay. Can I see that?
A. Yeah.
Q. Okay. This looks like you were attempting to get information about the size of the implants?
A. Yes.
Q. Okay. And you found that Dr. Shin had put in a 74 millimeter femoral component?
A. Yes.
Q. And Dr. Patterson, when he did the revision, put in a 65 millimeter?
A. Yes.
Q. Okay.
A. That's a medial lateral dimension.
Q. And the AP on Dr. Shin's surgery was 47?

Q. And on Dr. Patterson it was 63?
A. Right.
Q. Okay?
A. 63.9, I think.
Q. There's, do you consider that a significant difference in the sizing of the component parts from original surgery to revision?
A. No, they're two different implants.
Q. Okay. But the measurements are different, aren't they?
A. The measurements are different.
Q. What prompted you to, apparently you called the instrumentation companies, is it Depuy?
A. Depuy, yes.
Q. Depuy. What prompted you to contact them?
A. I had a conversation with, with the attorney.
Q. Mr. Fogarty?
A. Yes.
Q. Is this before the deposition?
A. Yes.
Q. Did he ask you to determine whether there was a significant difference between the sizing of the component parts that Dr. Shin used and Dr. Patterson?
A. He told me that in the deposition, that the

sizing had come up as an issue, and I thought that I should check the sizing of the implants.

Q. Okay. You had not considered that point prior to Mr. Fogarty's suggestion?

A. No.

Q. Doctor, I notice in the letter dated April 14th from Jacobson, Maynard signed by Dr. Taber?

MR. FOGARTY: Attorney Taber.

Q. Sorry, yes, Attorney Taber.

MR. FOGARTY: Sure he'd appreciate that.

Q. Yeah. In the second paragraph it says, "Upon your completion of your review of the medical records and x-rays, please call either me or Marilyn Miller to discuss your opinions before drafting an expert report."

Did you do that, sir?

A. I'm sure I did.

Q. Okay. Did you ask Mr. Miller -- or Miss Miller to review any drafts of your reports prior to the final copy?

A. No.

Q. Did they do so?

A. I didn't send a draft, I sent a final report.

Q. Okay. Were there any additions or deletions to

your report based upon conversations you had with Miss Miller or Mr. Taber?

A. No, this is the one, the one report which is not altered.

Q. Did Miss Miller or Mr. Taber discuss with you what the contents of your report should be?

A. No. When I talked to them on the phone, I gave them my opinion as to, about the case, and they, I think, subsequently asked me to provide a written report.

Q.. Okay. And in the same paragraph, doctor, Mr. Taber writes, "In general, any notes you make in preparation for drafting your report or rough drafts of your expert report may be admissable as evidence."

Obviously you didn't make any, correct?

A. I have **all** my notes.

Q. Okay. He suggested, "We would therefore prefer to have your opinions compiled in one final draft," and you followed those instructions, correct?

A. Yes, those are the letters that you see.

Q. And they sent you a rather lengthy letter detailing Dr. Shin's treatment of Mrs. Bastawros in a letter dated April 2nd, 1997, is that

correct, sir?
A. Yes.
Q. Did you also have the benefit of the actual records?
A. Yes.
Q. And did you review the records yourself?
A. Yes.
Q. Did you rely on the information provided to you in the letter from Jacobson, Maynard?
A. No, I reviewed the records myself.
Q. Doctor, have you had an opportunity to review the deposition of Dr. Patterson in this case?
A. No.
Q. Have you asked to see that?
A. No, I haven't.
Q. Were you aware that he was deposed?
A. I learned of that today.
Q. Were you advised of the essence of his testimony?
A. Of -- yes.
Q. Were you advised that he testified that he performed the revision because the replacement which Dr. Shin had done was malaligned?
MR. FOGARTY: Objection.
A. I reviewed Dr. Patterson's operative records --

Q. Okay.
A. -- and his discharge summary.
And in there, the discharge summary specifically talks about infection, does not talk about malalignment.
Q. Not anywhere, doctor?
A. I don't think so.
Q. Well, take a look at his operative report and see what it says.
A. The operative report does mention --
MR. FOGARTY: He's referring to the discharge summary.
A. I was talking about the discharge summary, but the operative report he does talk about pain and malalignment.
Q. If you can find it, doctor.
A. Here is the discharge summary.
Q. Okay. Let's look at the discharge summary.
A. Here it is. "Patient was determined to need a revision of her total knee arthroplasty in an attempt to rule out infection at the time of her initial surgery."
Q. Could you read maybe the next three sentences, doctor?
A. Yes. "Patient was admitted to the orthopedic

service on 2-28-96 and she was taken to the O.R. later that day. Preoperative diagnosis was a painful left total knee arthroplasty with malalignment."

Q. Okay. So it does talk about malalignment there, doesn't it?

A. Yes, it does.

Q. And what is the postoperative diagnosis?

A. It is the same.

Q. Which is painful left total knee arthroplasty with malalignment, correct?

A. Yes.

Q. And if you can find this in your records, doctor, on 2-23-96, there is an orthopedic attending note by Dr. Patterson. I'll show you what it looks like, it might be easier for you to find.

A. That's the 2-28? Yeah.

Q. Yes.

A. Okay.

Q. Did you find that?

A. Yes.

Q. You even had that tabbed, didn't you, doctor?

A. Yes.

Q. Meaning you had reviewed that previously,

correct?
A. Yes.
Q. And Dr. Patterson's orthopedic attending note, this is prior to surgery, can you read what he wrote, doctor?
A. Yes.
Q. Would you, please?
A. Orthopedic, ortho attending note, "Patient with history of increasing pain since last knee surgery in '93. Radiograph shows subsidence," s-u-b-s-i-d-e-n-c-e.
Q. With a question mark?
A. Question mark. "Malposition," something, "component with 13 degrees varus, 15 degrees flexion, tibial," something, "no HO," history, "of CW," I don't know what CW is, "sepsis. Patient has no history of fever, chills, pain at night *or* post-op wound problem."
Q. Let me just stop you.
That would relate to possibility of infection wouldn't it?
A. Yes.
Q. And those factors are not present or were not present?
A. No. "Plan outline for revision to" poster --

"PS," that's probably posterior stabilized "knee to correct the alignment, tibial component."

Q. Would you gather from that that Dr. Patterson believed the tibial component was malaligned?

A. Yes, I think, I think he said that.

Q. Okay. And he then writes his preoperative diagnosis as painful total knee replacement with malalignment?

A. Yes.

Q. What does the term malalignment mean to you, doctor?

A. Be something to me that would mean a gross alignment or out of alignment.

Q. Gross meaning beyond the deviation you would expect --

A. Yeah.

Q. -- from the standard of care?

A. Well, malalignment may mean something different than what somebody else, if you're going to say that anything that's not ideal is malaligned, that would be one way of, of defining that, that all cases that are not ideally aligned therefore are malaligned, you could make that case, but I don't know that all cases that are not ideally

aligned would represent failure, because there are quite a lot of them that would then fall into the, quote, malalignment category that are functioning very well.

Q. Okay. But we already talked about perfect alignment versus acceptable alignment?

A. Right.

Q. Would malalignment suggest to you that it is unacceptable alignment?

A. Not necessarily.

Q. Could it?

A. I think if it's gross, yes.

Q. Okay. If it's gross enough to cause an orthopedic surgeon to revise a previous surgery?

MR. FOGARTY: Objection.

A. I think he's, he's revising it for pain.

Q. Doesn't he say painful total knee replacement with malalignment?

A. Yes, he does.

Q. Okay. So it's a combination of two things, isn't it?

A. Yes. He's, but he's revising it for pain.

Q. And malalignment?

MR. FOGARTY: Objection.

A. He's noting that there's malalignment there,

yes.
Q. Okay. Doctor, turn to Dr. Patterson's operative note, under the paragraph indicated -- sorry -- the paragraph titled indications?
A. Yes.
Q. Dr. Patterson indicates she has significant pain, x-rays reveal that the tibial component has a significant slope from posterior to anterior. Given her symptoms and the position of the components, revision was recommended.
A. Yes.
Q. Correct?
A. Yes.
Q. Does that indicate to you that revision is recommended or being performed because of the malalignment of the tibial component on Dr. Shin's surgery?
MR. FOGARTY: Objection.
A. He says that she has significant pain. I think that's the, the main reason to do the revision --
Q. Would you agree --
A. -- and not, not the, quote, malalignment.
Q. So you think if she had pain but no malalignment, Dr. Patterson would have done the

revision anyway?
A. He might have done an exploration, not necessarily revision. Perhaps a revision, but not necessarily.
Q. Doctor, do you agree that the malpositioning of the tibial component can affect motion and cause pain?
A. No, I don't think, I don't think it always causes pain.
Q. I didn't say always, doctor.
A. Or, or even most *of* the time causes pain.
Q. Now, are you talking about --
A. Or limited motion, she didn't have limited motion.
Q. If Dr. Patterson said she had limited motion, you would say he was wrong?
A. She had 95 degrees of motion, 0 to 95, that's not limited.
Q. And who determined she had 95 degrees of motion?
A. That's in her chart.
Q. Is it done by a physician?
A. That's done by a physical therapist.
Q. So if Dr. Patterson testified that she had limited range of motion, which was one of the reasons he performed the revision, you would

disagree with him?

MR. FOGARTY: Objection.

A. I don't think 95 degrees of flexion or 95 degrees of motion is limited.

Q. Dr. Patterson testified that she had something more in the range of 40 to 50 degrees of motion, would you say he was wrong?

MR. FOGARTY: Objection.

A. I don't think she had that. She had at one time.

Q. Have you ever seen this patient?

A. At one time she may have had that, but I think before her surgery she didn't.

Q. You never examined this patient, correct, doctor?

A. No, but I have reviewed the records and people -- here, there is a note from the outpatient department on 2-13-96 in which there was a measured range of motion from 0 to 95 degrees. That's where I got that from. Somebody else did that. And I don't think that's limited.

Q. Okay.

A. Now, sometime earlier she may have, I think she did have 40 degrees, only 40 degrees of

movement, but before surgery on 2-13-96, her range of motion was 0 to 95 degrees.

Q. Doctor, is it your opinion that the revision surgery which Dr. Patterson did was not appropriate?

A. No.

Q. Do you think it -- then I take it you do not disagree with Dr. Patterson's decision to do a revision?

A. No.

Q. And I take it you agree with Dr. Patterson's decision because Mrs. Bastawros had pain?

A. Yeah, I think he wanted to see if he could relieve her pain, I think that was the major thing.

Q. And the major thing he did to try to relieve her pain was to remove Dr. Shin's hardware and reposition the tibial tray and replace the femoral component?

A. Yes, he revised the knee.

Q. Okay. And with those changes, she improved, didn't she?

A. That would not have been the only reason that she could have improved.

Q Well, what else would you attribute to her

improvement after Dr. Patterson's revision surgery?

A. Well, there are quite a number of physical therapy notes the second time where she attended physical therapy and she did the physical therapy.

Q. Are you testifying that she was more compliant with physical therapy after the second surgery?

A. I think that's likely. Certainly there are no notes about noncompliance after the second surgery. There are no, there are no notes by the physical therapist where it said she couldn't remember her home exercise program, or there are no notes from the physical therapist after the first operation that says she, she didn't, she didn't do her exercises, she just relied on the CPM machine.

Q. So you think her improvement was really based on the physical therapy and that she participated?

A. I think she, I've seen that quite a number of times; the second time, second operation, they listen and they comply and they do the things that they're asked to do.

Q. Is it your opinion that if she had faithfully performed her physical therapy after the first

surgery, that she wouldn't have needed revisional surgery?
A. That's likely.
Q. Because you believe she was noncompliant with her physical therapy, correct?
A. I have, there are documented notes in her chart that she was not compliant, that she couldn't even remember her, her exercise program, and there also are instances where she cancelled appointments, didn't show up for appointments.
Q. You would agree that by far and away she attended most of her physical therapy sessions, wouldn't you?
MR. FOGARTY: Which surgery?
Q. After the first surgery.
A. Which one? Oh, there are several that she didn't attend.
Q. Right. And many more that she did attend?
A. And the physical therapist called her and said there's no sense in her coming again because she wasn't compliant. That did not happen after the second surgery.
Q. And one of the reasons they discontinued physical therapy after the first surgery was because she had not made any progress?

A She couldn't remember -- or made -- She couldn't remember the exercises She admitted she wasn't doing the exercises at home

Q Do you remember her reason?

A She wasn't showing up for appointments

Q Not at all. Doctor?

A Not -- well, she's -- no. I didn't say not at all.

Q Well. let's be fair

A Where were several, there were several appointments she didn't show up on, and she didn't call to cancel

Q How many were several?

A Well. I think we can go through the records and find out how many were several

Q Well. Doctor. I'll tell you I have 28 physical therapy visits

A Yeah.

Q One absence, one cancel and two misses

MR. FOGARTY: Objection

A Two what?

Q Two misses with no call, no show.

MR FOGARTY: Objection.

A Yeah

Q. In your opinion that is noncompliance with physical therapy?
A. Noncompliance is if she can't remember her exercise program, that means that she didn't do it, she couldn't remember. The therapist asked her to show them what her home exercise was and she couldn't remember what the exercises were.
Q. That was on one occasion, wasn't it, doctor?
A. That's enough.
Q. Okay.
A. Somebody says I can't remember, particularly after they've been to therapy and they're supposed to be doing their home exercise program, she was instructed in a home exercise program and she admitted she didn't do, she couldn't even remember her exercise.
Q. You're omitting where it shows that she did demonstrate the exercises to the physical therapist in the records, aren't you?
A. What I'm saying, there is a note specifically by the physical therapist where the patient could not remember the exercises.
Q. But there are also notes from the physical therapist that she, in fact, showed them her home exercises, didn't she?

A. Yes, and also that the physical therapist discontinued her for, from treatment because of noncompliance.
Q. And lack of progress?
A. Well, that, the two go together.
Q. And if it's too painful to perform home exercise programs, patients won't do it, will they?
A. Well, some people won't do it because it hurts and -- but all patients have pain after, after a knee replacement.
Q. Okay. But her physical therapy went for many months after her surgery?
A. Yes, it did.
Q. And she had pain throughout all of her physical therapy after the first surgery, didn't she?
A. I think she did, yes, she was complaining of pain.
Q. And she had swelling of the knee, didn't she?
A. Yes.
Q. And that was noted by the physical therapist, wasn't it?
A. Yes.
Q. And she complained that the home exercises were too painful to perform, didn't she?
A. She said it hurts, yes.

Q. Do you think she was lying?
A. No, I don't think she was lying.
Q. You note in your report that, somewhere in the first paragraph of your first report, Dr. Wilde, "Postoperative x-rays revealed tibial component was in varus with an anterior tilting of the prosthesis"?
A. Yes.
Q. Okay. That is not an ideal alignment, is it, doctor?
A. No.
Q. Do you teach your students to perform knee surgery with that type of alignment of the tibial component?
A. No.
Q. Do you teach them to put the tibial component in at a perpendicular angle to the tibia?
A. Yes, it ought to be in, the tibial component ought to be perpendicular.
Q. And when you perform a knee replacement surgery, if the patient has a varus, you are supposed to correct it, aren't you?
A. Ideally, yes.
Q. And Dr. Shin did not correct Mrs. Bastawros' varus in the first surgery, did he?

A. No, she still had varus.
Q. And you read Dr. Shin's deposition, I take it, do you recall, I think it was provided to you?
A. Yeah. Yes.
Q. Okay. And in that deposition, Dr. Shin testified that he corrected her varus deformity?
A. I don't remember that, but --
Q. If he did testify to that, he would be mistaken, correct?
A. Well, he may have thought he did that at surgery.
Q. But he didn't do it, did he?
MR. FOGARTY: Objection.
A. Post-op x-rays shows that he didn't.
Q. And if Dr. Shin testified that he placed the tibial tray at a right angle with the shaft of the tibia, he would be mistaken in that, also, wouldn't he?
A. He may have thought he did that at surgery.
Q. But he didn't do it, did he?
A. His post-op x-rays shows that he didn't.
Q. You said in your report that Dr. Shin's surgery was not ideal. In what way was it not ideal, Dr. Wilde?
A. Well, I think you want to have a, the overall

alignment of the knee in five to seven degrees of valgus.

Q. And what degree of varus did Dr. Shin use or create?

A. Actually, I measured the initial post-op x-ray, I measured four degrees of varus.

Q. How does that, or what does that translate to in relation to five to seven degrees of valgus? Let me just -- varus is one direction, valgus is the opposite direction, correct?

A. Correct.

Q. So if ideally you want a five to seven-degree of valgus and you end up with a four or five-degree of varus, you're off by quite a bit, aren't you?

A. You're off.

Q. Significantly?

A. No, I don't think four degrees is significant.

Q. is it four degrees or is it four plus the valgus that you're missing on the other side?

A. i don't think four degrees of varus is significant.

Q. Okay. But if you're looking to be four degrees in the varus position, or are you four degrees in a varus position and you want to be five to seven in a valgus?

A. Well, I still --
Q. You're off by somewhere between 9 and 11 degrees, is that fair?
A. Yeah, that's fair, but I still don't think that four degrees of varus is significant.
Q. Do you teach your medical students to have a five to seven-degree of valgus?
A. Yes, that's what, again, that's the ideal position.
Q. Is that what you yourself do in knee surgery?
A. That's what we try to do.
Q. If the femoral component in knee revision is too large, is it fair to say that you can have a painful knee?
A. I don't think anybody's shown that, that if it's too large it has to hurt.
Q. Well, if it's too large, can it hurt?
A. I don't think anybody has shown that.
Q. Do the manufacturers of these devices instruct physicians to be careful in sizing the component pieces?
A. They provide templates for sizing.
Q. Okay.
A. Yeah.
Q. They make it easy for the surgeon to determine

the appropriate size €or the component parts, correct?

MR. FOGARTY: Objection.

A. They help in that. The size that you finally use depends on what the fit is at surgery, so it's not always the same as the template.

Q. But a template is a pretty good guide, isn't it?

A. It's helpful.

Q. And in sizing the component parts, you'd want to reproduce the natural anatomy of the patient, correct?

A. Well, you want to fit the prosthesis to the bone.

Q. You don't want the prosthesis to, let's say the tibial tray portion of it, to hang over the bone, correct?

A. You'd like for it not to hang over.

Q. And you can size it so it doesn't hang over, can't you?

A. It's, sometimes it's a decision that, that has to be made based on the size of the femoral part in relationship to the tibia, because there might not be an exact fit between the femur and the tibia, so the decision may have to be made that maybe you are going to let some of it hang

over.
Q. You can have custom made component parts, can't you, doctor?
A. Yes, you can.
Q. Okay. And in Dr. Shin's operative note he doesn't make any mention of any difficulty sizing the femoral component to the tibial component, does he?
A. I don't think he does.
Q. You think he does?
A. I said I don't think he does.
Q. Okay. You don't think he does.
So if he has a six-millimeter overhang of the tibial tray, that would be inappropriate?
A. No, I don't think it's inappropriate.
Q. Is that within the acceptable range of --
A. Yes.
Q. -- what might be ideal?
A. I think that's acceptable.
Q. And should the tibial tray be centered over the tibia?
A. Ideally, perfectly, yes. It doesn't have to be.
Q. Well --
A. Doesn't have to be for a good function.
Q. How much deviation can you have from, let's say,

perfect centering, since we can never achieve perfection?

A. That's a good -- I don't think anybody's looked at that specifically, see the exact position --

Q. Doesn't the --

A. -- centering of it.

Q. -- manufacturer of the AMK device that you use indicate that the tibial template should not overhang the bone?

A. Yeah, they may say that. I'm sure you've got that outlined.

Q. Yeah, that's what they say, don't they?

A. Yeah. Again, ideally you would not want to do that.

Q. And sometimes it may be unavoidable, is that what you're saying?

A. Yeah. In order to fit, in order to fit the prosthesis, you may have to.

Q. But if you can avoid it, you should avoid it?

A. If you can, yes.

Q. On the second page of your first report, doctor, you say, in the middle you say, "Therefore, while postoperative position of the tibial component following Dr. Shin's surgery on 8-27-93 was not ideal."

I just want to stop there, and when you say not ideal, do you mean it wasn't perfect?

A. Right.

Q. Was it acceptable?

A. I think it was acceptable.

Q. And you would teach your medical students that the type of alignment that Dr. Shin achieved is appropriate --

MR. FOGARTY: Objection.

Q. -- for your patients?

A. I think I already testified that I would teach my residents what the ideal position is, as I've already testified is.

Q. And if they deviated from that ideal position, such as Dr. Shin did, you would find that acceptable?

A. I think that the position of Dr. Shin's prosthesis was acceptable.

Q. Okay. That wasn't my question.

If your students positioned a tibial component in one of your patients like Dr. Shin did for Mrs. Bastawros, would you find that acceptable?

A. Would I find -- yes. Yeah. If it's acceptable for Shin, it's acceptable for me.

Q. That's the question.

Then the rest of that sentence says, "While it was not ideal, it did not result in loosening and did not influence the range of motion of the knee."

A. That's right.

Q. Okay. We can agree there was no loosening of the prosthesis, right?

A. Right. Dr. Patterson did not find the prosthesis was loose.

Q. But he did find it influenced the range of motion of the knee?

A. Well, I don't think that range of motion from 0 to 95 degrees, I think that's a very good range of motion.

Q. Okay.

A. So I don't think the varus positioning influenced the range of motion.

Q. Let's assume that it did affect her range of motion, that is the positioning of the tibial component. Would your opinion be different as to whether or not Dr. Shin's placement conformed with the standard of care?

A. Well, but it didn't, it didn't affect her range of motion.

Q. Doctor, I want you to assume that it did.

MR. FOGARTY: I'm sorry, that what did?

Q. That the positioning of the tibial component influenced the range of motion. If it did, would you agree that Dr. Shin's placement of the tibial component was beneath the standard of care?

A. Whether -- well, there are lots of reasons for the loss of range of motion, and so I can't agree with your statement that if she had loss of motion and she had malalignment, that the malalignment did it.

Q. I want you to assume that she had loss of motion because of malalignment, and if you assume that to be true, do you agree that it's beneath the standard of care?

MR. FOGARTY: Claudia, are you talking about this case?

Q. I'm just asking you hypothetically.

A. I don't think I can separate those two things, even, even hypothetically.

Q. What do you mean?

A. That, that I certainly have seen a number of knees that, that are in four degrees of varus or

more that are functioning without pain and without stiffness, and I've seen far more knees that may be even ideally aligned that are stiff and painful, so that's why I have a problem in trying to say that malalignment causes pain, because I don't, I don't see that.

Q. Okay. But I asked you to assume that it did If -- let me put it to you this way, doctor.

A. Yeah, but your hypothetical question may be not the real world.

Q. Maybe not. But I think I still should have an answer.

A. I don't see these, this thing in the real situation.

Q. You have never seen malalignment of knee replacement components that have caused pain in a patient?

A. Oh, I've seen if somebody's maybe got 25 degrees of valgus or varus that it could be painful, but we are talking about somebody that's got four degrees, or maybe it's unstable and it's painful or it's stiff and it's painful, but I don't think that four degrees of varus is, is significant.

Q. What about four degrees of varus with the

anterior tilting of the prosthesis?
A. I don't think that affected her motion either. I mean the proof of that is that she has 95 degrees of motion.
Q. Okay.
A. I mean the fact is, it didn't.
Q. And that's one physical therapy note you're relying upon by a physical therapist?
A. Well, we can go through all the physical therapy notes, but that was the last note before the surgery.
Q. All right. Before surgery, you would agree that Dr. Patterson examined this woman?
A. I can't recall exactly when he examined her.
Q. Okay. Were you -- we referred earlier to his preoperative note.
A. He does not have a range of motion in that note.
Q. Would an orthopedic surgeon test range of motion when he's examining a patient?
A. Yes.
Q. Do you have any reason to think that Dr. Patterson is not a competent surgeon?
A. Well, someone else may have measured the range of motion, but he doesn't have it in his notes.
Q. So he then, he just failed to check it?

A. He may have been relying on his resident to put a range of motion in the chart, but we don't see that in his note, it's not there. Or he may have already reviewed the physical therapy note before that, which is what I, where I got that number.

Q. Okay. You conclude in the first report that you wrote, doctor, that Mrs. Bastawros' complaints of pain were on the basis of continued muscle weakness as a result of her lack of compliance with the home exercise program?

A. Yes.

Q. And, therefore, Dr. Shin met the standard of care in this case?

A. Yes.

Q. So I'm assuming that your conclusion that Dr. Shin met the standard of care is based upon your belief that Mrs. Bastawros' pain was related to her lack of compliance with her home exercise program --

A. Yes.

Q. -- is that correct?

A. The reasons, reasons for pain would be infection, and that certainly was ruled out before her second surgery.

Or the other reason for pain would have been stiffness. She wasn't stiff. She had 95 degrees of motion.

Or it was loose, and Dr. Patterson testified and his notes, operative notes document that she wasn't loose; or she was unstable, and there was no instability. Dr. Patterson did not document any instability.

Therefore, she wasn't stiff, she wasn't loose, she wasn't infected and she wasn't unstable, and what's left is, is muscle weakness.

Q. Okay. And you would disagree with malalignment as a cause of pain, correct?

A. Yeah, I don't, I don't think that did it.

Q. Okay. And even if it did, you would still believe Dr. Shin met the standard of care, correct?

A. I don't think the malalignment did it because the --

Q. Doctor, I know you don't, but I'm asking you even if it did, it isn't going to make any difference to you because you think Dr. Shin met the standard of care?

MR. FOGARTY: Objection.

A. Yeah, I don't, I don't see where it did because the malalignment didn't cause a problem with, with motion or with stability, or the reason we worry about a varus alignment is that there is a statistical relationship between varus alignment and loosening, but Mrs. Bastawros' prosthesis was not loose.

Q. But she was malaligned?

A. She was malaligned but she was not loose.

Q. Doctor, I want to look at your second report dated February 2nd which you wrote this time to Mr. Fogarty.

A. Yes.

Q. I'll be right with you.

You state in your report, you're now critiquing Dr. Roth's report, correct?

A. Yes.

Q. And you note that he states there that the varus deformity that allowed her patella to track incorrectly?

A. Yes.

Q. All right. And you then state, "In reviewing her records, which include her multiple visits preoperatively to MetroHealth Medical Center prior to her revision from both orthopedic

surgeons and also her physical therapy records from Metro, there is no specific mention of patellar maltracking."

A. Yes.

Q. "Therefore, there is no objective evidence of patellar maltracking," is that your --

A. Yes. The next sentence says there's a faculty visit note at MetroHealth Medical Center on 12-13-94, there is a specific note that states there is good patellar tracking.

Q. Okay. And, doctor, you failed to note the physical therapy note of 8-11-94 in the MetroHealth records where it's indicated that she has probable patellar maltracking?

A. Which one was that?

Q. Dated 8-11-94.

A. 8-11-94.

Q. Yes. It looks like this, doctor. You don't have that note?

A. I don't have -- 1-19-94, she was discontinued 1-19-94.

Q. You don't --

A. That was when her therapy was discontinued was 1-19-94, so I don't have any notes from physical therapy after that because it was discontinued.

Q. Okay. So you would be surprised to know that she actually had physical therapy at MetroHealth from 8-2-94 all the way to 2-6-96 -- I'm sorry, 2-13-96?

A. The last note I have from the Department of Physical Medicine/Rehabilitation, MetroHealth was 1-19-94 in which the therapist states she's talked with the patient on the phone on that date, patient was informed that she would not be continuing, secondary to a lack of progress, and there's an arrow going down and a D, compliance with home exercise program.

Q. Okay. So you don't have any of the physical therapy records from 8-2-94 to 2-13-96, is that correct?

A. No, I don't. Next note I have is 12-4-96.

Q. Okay. So you don't know that patellar maltracking was noted in the physical therapy department at MetroHealth, correct?

MR. FOGARTY: Objection. That's not what that record said, Claudia.

Q. You don't know anything about that?

A. I just told you.

Q. Does that surprise you, doctor?

A. That's the last record I have at MetroHealth

until April 12th of '96.
Q. Okay. And on January 3rd, 1995, you are probably unaware that the note indicates that there's probably two large of a femoral component in Mrs. Bastawros' knee, fair to say?
A. Who said that?
Q. Physical therapy department.
A. Physical therapist said that the component was too large?
Q. I'll find it for you, try to tell you exactly who said it, but you're unaware of any note like that, correct?
A. Yeah.
Q. And it actually was signed by a physician, doctor. 1-3-95, I'll show it to you. The part is highlighted in yellow. And I'll show it to you.
A. Okay. That's a faculty note, that's not, that's not a physical therapy note.
Q. Signed by a physician, isn't it?
A. Yeah, but that's a faculty note, it's not a physical therapy note. You stated that these were physical therapy notes, did you not?
Q. I did.
A. Yeah. Well, it says at the top of the page that

you just gave me, this is a faculty visit note.
Q. Okay. Do you have those records?
A. That's not a physical therapy note.
Q. Do you have those records, doctor?
A. Yeah, I do.
Q. You do have those?
A. If, let me see, what's the date on that?
Q. It's at the top on the stamp.
A. 1-13-95. Okay. Let's try that.
MR. FOGARTY: Claudia, what was the date of that note that you were referring to, the patellar maltracking?
MS. EKLUND: 8-11-94.
A. 8-11-94?
Q. Yes.
A. 8-9 *of* '94. Yeah, 8-11-94.
Q. Okay. Then you do have that information about probable patellar maltracking?
A. It says probable.
Q. Right. And then you also have the note we just talked about, which would be 1-3-95, which indicates probable too large femoral?
A. Let me see. What was the date on that again?
Q. 1-3-95.
A. Okay. May I ask who signed that?

Q. I can't read it any better than you can, but there is a line that says physician's signature and a signature?
A. It's not Patterson, is it?
Q. Doesn't look to be.
A. No. Would it be safe to say that that was most likely a resident in training?
Q. Well, I really wouldn't know, but it's signed as a physician, isn't it?
A. Yeah.
Q. Okay.
A. But it's most likely a resident,
Q. Does that cause you to doubt what's written on the page?
A. No, but we are dealing with someone who's not fully trained, aren't we?
Q. Right, but you're willing to accept all of the other notes in this record as the gospel, weren't you?

MR. FOGARTY: Objection.

A. I -- the physical therapist who saw him worked for a physical therapist. This is a resident in training. I don't know what his level is.
Q. Okay.
A. Could be a first year as well as a senior, and I

really don't know.

Q. You omitted to include, doctor, those references to real problems with her knee surgery in your recitation of the physical therapy notes and the records from MetroHealth, didn't you?

MR. FOGARTY: Objection.

A. Wait, say that one again.

MS. EKLUND: Can you read that back?

- - - -

(Thereupon, the requested portion of the record was read by the Notary.)

- - - -

MR. FOGARTY: Objection.

A. These were not physical therapy notes, these were notes written by residents in training.

Q. Okay. But you didn't make mention of those notes in your report, did you?

A. No, I didn't.

Q. You also rendered the opinion that her pain may have been the result of reflex sympathetic dystrophy?

A. Yes.

Q. You know, in fact, that she did very well after Dr. Patterson's revision surgery, don't you?

A. Yes.
Q. Okay. Do you believe today that she has reflex sympathetic dystrophy?
A. She could have.
Q. Do you have --
A. She certainly --
Q. Do you have an opinion as to a reasonable probability as to whether she had that condition?
A. She certainly had the symptoms and signs of it.
Q. Did anybody make that diagnosis at MetroHealth?
A. Nobody did.
Q. Did Dr. Patterson even indicate that he entertained that diagnosis?
A. No, he didn't.
Q. And she was seen at MetroHealth over a period of about a year-and-a-half or more?
A. They didn't explain the dysesthias, they did not explain the dysesthias that she was having.
Q. Okay. Now, doctor, you make mention that there's one note in all of these records, and it's a faculty visit note on 9-6-94 where Mrs. Bastawros is complaining of dysesthesia of her left thigh?
A. Right.

Q. And based on that one note from a faculty visit, which, by the way, you questioned the training level of previously?
A. Yes.
Q. You're willing to give the opinion that she had reflex sympathetic dystrophy, correct?
A. She has -- some things are observations that anybody can make and some things require some experience, and some of the comments that are made in here are really questions.
Q. Okay. But in your report --
A. Is this patellar maltracking? Is this prosthesis too large?
Q. Doctor --
A. And I think these are, these are ideas that residents have, they're thinking why is she having pain? Is it because the patella is not tracking right? Is it because it's too large? Is it because it's infected? And so there, I think what we are looking at is their thought processes.
Q. Doctor, you're not going to try to tell me what's in the minds of the residents at MetroHealth when they're treating and examining Mrs. Bastawros, are you?

A. Well, I think that's what the record reflects, I think that's what they're thinking about.
Q. That's your summation of what the records reflect, correct?
A. Yes.
Q. You know what's in the mind of every resident in the City of Cleveland?
A. No, but I have trained enough residents and certainly read enough of their notes to know what they're, what they put down, it's not the same as what, what the real case is.
Q. Okay. But you never saw this patient --
A. No, I never saw the patient. I do have --
Q. -- Mrs. Bastawros?
A. I do have Dr. Patterson's notes.
Q. And Dr. Patterson is an orthopedic surgeon?
A. He's a fully trained orthopedic surgeon.
Q. Do you know Dr. Patterson?
A. I don't know him personally, I know him professionally.
Q. Does he have a good reputation?
A. Yes, he has a good reputation.
Q. Is he a competent surgeon?
A. Yes, he is.
Q. Is he a careful surgeon?

A. Yes.
Q. Would he take good care of a patient?
A. Yes, I think that he would.
Q. Would you refer patients to him for care?
A. If I had somebody that had to go to Metro, yes.
Q. Do you have any reason to think the medical care Mrs. Bastawros received at MetroHealth was inadequate in any way?
A. No.
Q. Now, my question to you before we got to this was that you rendered an opinion that Mrs. Bastawros had reflex sympathetic dystrophy on the basis of one faculty note on 9-6-94 where she is complaining of dysesthias, correct?
A. Okay. 1-3-95, they also, there's another faculty note that says burning pain. That's a neurologic complaint, so there's another one.
Q. In your report you mention one, though?
A. Yeah, well, here's another one.
Q. All right. And that's a faculty note, doctor?
A. Yeah, that's a faculty note.
Q. You're willing to accept that one as accurate?
A. Yeah, because the resident is writing down what the patient has told him.
Q. Okay.

A. So I think the resident is an accurate recorder of, of what the patient's told him.
Q. Okay. And you, the last paragraph of your second report you begin with, "It would seem that Mrs. Bastawros' knee was revised because of pain not because of stiffness as the range of motion preoperatively was 0 to 95 degrees"?
A. Yeah, she wasn't stiff.
Q. And that is your basis for concluding that that was --
A. She's not stiff, not with a range of motion of 0 to 95 degrees, that's not stiff.
Q. Do you agree that no amount of physical therapy can compensate for malaligned component parts?
A Physical therapy's not going to change the alignment of the parts, no.
Q. Do you treat patients here at St. Vicinity who are 100 percent compliant with physical therapy?
A. Of course not.
Q. Okay. What's the average compliance you expect with your patients after knee revision?
A. Oh, I think if I get 50 percent, I'm probably doing pretty good.
Q. Meaning 50 percent of their physical therapy visits?

A. Home exercise program.
Q. Okay. What about physical therapy visits to the hospital?
A. Usually, usually they will go to the physical therapy visits, although if they don't, then I get a call from the physical therapist, just as Dr. Shin got a call from the physical therapist saying this patient's not doing it.
Q. Okay. Have you had patients who have been unable to comply with your physical therapy exercise because of pain?
A. Everybody that has a knee replacement has pain.
Q. That wasn't my question.
A. There are patients that won't do the physical therapy because it hurts, yes.
Q. And with those patients, what do you do as a surgeon?
A. Well, I tell them what the consequences of not doing the therapy are likely to be.
Q. What about in those patients where you end up doing a revision?
A. I usually give a patient a year after a knee replacement before deciding as to whether to do something about it. Telling them that, you know, that a lot of their pain may go away in

the course of the year if they'd do the therapy. If they don't do the therapy, then we are going to do surgery again.

Q. Okay. And what do you do in a year after they haven't improved or they're still painful?

A. Well, if they are having pain, I'll explore them.

Q. Are you looking for infection?

A. Well, we look for infection, but we also do all the things that Dr. Patterson did, with an aspiration, with a blood test.

Q. You can tell that before you open the knee, can't you?

A. Most of the time.

Q. Okay. But you're always on the alert for infection that isn't detected preoperatively?

A. Yes.

Q. And in those patients that remain painful one year after surgery, do you offer revision?

A. I'll offer an exploration. The revision depends on, you know, whether, whether they're unstable or what, whether they're unstable or the prosthesis is loose or what have you.

Q. Were you a PIE insured, Dr. Wilde?

A. No.

Q. Ever?
A. May have been when I first came here, I'm not sure. Is that in one of the letters?
Q. No.
MR. FOGARTY: If you know, you know; if you don't, you don't.
A. I can't remember who we were insured with when we first came here.
Q. You were not insured with PIE when they went under I take it?
A. I think that's right.
Q. You were not?
A. I was not.
Q. Okay. Have you ever been a defendant in a malpractice action?
A. Yes.
Q. How many times?
A. Oh, probably -- oh, let's see. Probably five or six times.
Q. Any of those cases involve knee replacement surgery?
A. Yes.
Q. How many?
A. One.
Q. Do you remember the name of the patient in that

case?
A. Frederica.
Q. I take it that was the last name of the patient?
A. That's the last name.
Q. Who defended you in that case?
A. Marc Groedel, G-r-o-e-d-e-l.
Q. He's with Reminger?
A. Yes.
Q. Did that case go to trial?
A. No.
Q. Did it settle?
A. I was, I was dismissed from the case.
Q. Did you testify in that case?
A. No.
Q. No depositions?
A. No deposition -- yes, there was a deposition.
Q. What was the claim of malpractice in that case?
A. It was against the hospital.
Q. What was the nature of the malpractice?
A. Someone who had a vascular problem following a knee replacement.
Q. Did it result in death or amputation?
A. Amputation.
Q. Did you testify at the trial *of* that matter, even though you were dismissed?

A. There wasn't a trial.
Q. What was the year of that case?
A. It was last year.
Q. In the other five, or four or five cases, what type of malpractice did the claims involve?
MR. FOGARTY: Just show a continuing objection to this line of questions.
A. Oh, one was a patient who slipped and fell in The Cleveland Clinic Hospital.
Q. And you were named as a defendant?
A. I was named as a defendant on that one.
Q. Did you have any contact with the patient?
A. No.
Q. Did you treat the patient?
A. It was my patient.
Q. Do you have any idea why you were named in the lawsuit?
A. I think he named a lot of people. I was dismissed from that one.
Q. Okay. Any others?
A. There was a patient that had had a hip fusion that I did a hip replacement on that several years later dislocated.
Q. Who defended you in that case?

A. I can't remember. It didn't, never went to court, never was a deposition, it was dismissed, never brought the, never brought the case to trial.
Q. Okay. And the others?
A. There was a patient that had a femoral nerve palsy after a hip replacement.
Q. Who defended you in that case?
A. I don't know. I can't remember, that was a long time ago.
Q. I assume these were all in Cuyahoga County?
A. The dislocation probably was from Indiana, would have been out of state. Does that mean where the suit was brought?
Q. Correct.
A. I think that was out of state. The others would have been Cuyahoga County.
Q. Okay. Do you remember any of the others?
A. There was a case where the, where the hip replacement leg was longer, but the case was dropped because of lack of expert witnesses to testify.
Q. Do you remember the name of the patient in that case?
A. No. No, I don't.

Q. Do you know the year of that case?
A. No.
Q. Do you know who defended you in that case?
A. No. I don't think it ever went that far. Patient came back, apologized to me.
Q. Any others that you recall?
A. No, I think that's, I think that's pretty much it.
Q. Doctor, you, in terms of the telephone call you made concerning the size of the component parts, are you telling me that the DePuy, is that --
A. Depuy.
Q. Depuy. They should spell it differently so I could pronounce it then.

That the Depuy device which measures 74 millimeters is the same size as the device Dr. Patterson used?
A. No.
Q. Okay.
A. No, it isn't the same size.
Q. Okay. They're both replacing the same part of the anatomy, correct?
A. Right.
Q. Do you have any explanation why Dr. Shin used a 74 millimeter component part and Dr. Patterson

used a 65 millimeter?
A. Yes.
Q. What is that?
A. Dr. Shin, the femoral prosthesis completely covered the femoral, the end of the femur. Dr. Patterson's prosthesis did not.
Q. Have you seen an x-ray following --
A. Yeah.
Q. -- Dr. Patterson's surgery?
A. Yes.
Q. So you're talking about the diameter of the prosthesis?
A. The width.
Q. The width.
A. Medial lateral width.
Q. And is that just the difference in instrumentation?
A. No, it's an, it's a difference in the prosthesis that was chosen.
Q. Okay. There's nothing about the patient's anatomy that demands one type of instrumentation over another, is there?
A. Well, they were both trying to fit the prosthesis to the patient. There were different systems, and the prosthesis, one prosthesis

might fit the femoral very well but not fit the tibia, same size prosthesis, and Dr. Shin and Dr. Patterson took two different ways of dealing with that.

Q. What was Dr. Shin's method of dealing with that?

A. He used a large femoral prosthesis that fit the end of the femur, used a smaller tibial prosthesis which had a special insert that, that tracked with the femoral part, so he recognized that the tibia was smaller than the femur.

Q. Does he note that anywhere in his operative note?

A. No, but you can look in the x-ray and see what the, what his problem was. You can also see the way that Dr. Patterson solved it. Dr. Patterson solved it by using a smaller femoral prosthesis which fit a smaller tibial prosthesis,

Q. Don't the femoral prostheses and the tibial prostheses have to match?

A. Yes, and that's what they both did.

Q. Would it be a violation of the standard of care if they did not match?

A. Yeah, if it was a mismatch, yes, but that wasn't the case.

Q. Dr. Shin has labels from five different

component parts in his operative report?
A. Right.
Q. Do you know which he used and which he didn't?
A. I think he used them all. If they were put there, they were used. Oh, yeah. Okay. All right. He has two, there are two different polyethylene inserts. He may have tried one, and then there's an 8 millimeter in the tibial and a 10 millimeter polyethylene insert, and they may have actually taken both of them out of the packages and put them on the table, and he may have tried one and found out that it --
Q. Which one did he use?
A. Well, let's see if we have that in his operative note.

He used the 8.

Q. And that insert is to adjust for the difference in size between the femoral component and the tibial component?
A. No, that's to provide stability. Really, the thickness is to provide stability.
Q. So it's 8 millimeters of thickness?
A. Yes.
Q. Okay. And Dr. Patterson used 10 millimeters of thickness, didn't he?

A. Was it 10 or 12? Let me look at it.
12.
Q. So Dr. Patterson s was four millimeters bigger than Dr. Shin's?
A. Yes.
Q. And Dr. Patterson's was a 64 size femur and a 64 size tibia?
A. Right.
Q. So they're the same size?
A. Yes.
Q. Doctor, did you see in the physical therapy notes from MetroHealth the physical therapist notation that the patient is a weiner and a whiner?
A. I recall seeing that.
MR. FOGARTY: A weiner?
Q. Um-hum.
A. A whiner?
Q. Yeah, would you consider that very professional for --
A. I don't remember specifically seeing that.
Q. Okay. If I told you that that appears in the physical therapy records, would you find that offensive?
MR. FOGARTY: Objection.

A. They may have been describing her behavior.
Q. You think that's an appropriate notation in a medical chart for a physical therapist to make?
A. I think if somebody's complaining a lot, yes.
Q. Have you seen physical therapy people make notations like that in charts in your hospital?
A. Yeah, I've seen that sort of thing before.
Q. Okay.

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

- - - -

Q. Just about done, doctor.
Doctor, did you have, other than with counsel, in reviewing medical records, did you have any conversations with Dr. Shin concerning Miss Bastawros?
A. No.
Q. Do you know Dr. Shin?
A. I know who he is.
Q. Do you know him socially?
A. No.
Q. Do you know him professionally?
A. I just know who he is, that's all. I don't think I ever met him.

Q. Have you ever testified on Dr. Shin's behalf before?
A. Don't believe I have.
Q. You had no conversations with Dr. Patterson?
A. No.
Q. No conversations with any of the physical therapists?
A. No.
Q. Doctor, does the evaluation of range of motion, does pain factor into that at all?
A. Well, someone, is your question will somebody who's having pain won't be able to move their knee, is that your question?
Q. No, it was a bad question. Let me try it again.
A. Yeah.
Q. When we talk about range of motion, and you say Mrs. Bastawros had a 90-degree range of motion prior to surgery, is that 90 degrees with pain or without pain?
A. She was complaining of pain.
Q. Okay. Does that make a difference in evaluating range of motion?
A. Not particularly.
Q. Is 90 degrees range of motion with pain

considered good?
A. She had 95 and it, that's a good range of motion.
Q. So irregardless of whether there's pain?
A. It still is a good range of motion.
Q. Okay. So you evaluate range of motion irrespective of pain?
A. Yes.
Q. And you evaluate range of motion passive or active?
A. Active.
Q. And the notations that you recite, was that active or passive?
A. I have to look and see what the physical therapist did.
MR. FOGARTY: At the top.
A. 2-13-96.
Q. It's right here, doctor, make it easier for you.
A. Yeah, I, it doesn't say --
Q. Okay.
A. -- whether that's active or passive.
Q. Okay. Doctor, you brought some --
A. These are x-ray templates, yeah.
Q. Were they for purposes of this case or this

deposition?
A. Well, I just looked at the x-rays and, with the template to see.
Q. What were you looking for?
A. Size of the implants, differences, because whether it's a 64 in one implant doesn't necessarily correspond to a 64 in another.
Q. So 64 isn't only 64?
A. I don't, I'm not sure where I get the 64 because it's, it may be the AI? dimension, I'm not sure how they numbered them
Q. Are you familiar with other instrumentation?
A. Oh, I've done both of these knee replacements.
Q. Okay. Both what Dr. Shin used and what Dr. Patterson used?
A. Yes, I've used both of them.
Q. You presently use both of them?
A. Yeah, still do. Once in a while I'll use an IB.
Q. IB?
A. IB. That's what's in the records. We don't want to fuzzy it up.
Q. Do these -- what do you want to call them?
A. Templates.
Q. -- templates have anything to do with the opinions that you have in this case?

A. The measurements that I got were more significant.
Q. In what way?
A. Well, these are x-ray templates and they're, they're not as accurate in measuring something as an actual measurement, which is why I wanted to know the actual numbers.
Q. Okay. So the templates that --
A. Give you an idea.
Q. -- you looked at weren't accurate enough, so you called the company to see what the exact measurements were?
A. Well, I looked at the templates and there's, there's a difference in the sizes of the two templates, but I wanted to know what the exact numbers were. That's why I called the two companies.
Q. I don't think I understand at all.
A. Okay. X-rays, x-rays can be taken at different distances, and therefore, there will be a difference in the size on that x-ray, just because --
Q. Just because of distance?
A. Just because of the way the x-ray is taken, and so that's why x-ray templates are not as

accurate as actually looking at somebody's knee in surgery. They're a guide. So I was not going to rely on what appeared to be a difference in size on the templates. I wanted to know what the actual measurements were.

Q. Okay. And was there a big difference between what the templates indicated and the actual measurements?

A. No, I saw the same sort of things, but between the templates and here --

Q. So there was a difference or there wasn't a difference?

A. There's a difference.

Q. How much of a difference?

A. Well, it's here, I've given the difference here.

Q. Between Dr. Patterson's and Dr. Shin's?

A. Yes.

Q. Okay. Are these templates that you actually use in surgery?

A. Use them in surgery or before. Usually use them for planning before, then you can tell the operating room what size implants you're likely to use.

Q. Do you do your surgeries with the representative of the instrumentation company in the operating

room?
A. Yeah, usually they're there because they have the implants and they know the labeling system. Sometimes the O.R. nurses may have to deal with half a dozen different knees, and so it's useful to have a salesman there who can pick out the implant that you want rather than relying on somebody who may or may not be familiar with the particular labeling system that the company uses.
Q. When you're doing surgery, doctor, do you actually lay these templates over the patient's anatomy to see what's going to fit best?
A. No, they go on the x-ray, preoperative x-ray.
Q. So you take the preoperative x-ray, you lay the templates over, see what's going to fit best?
A. Yes.
Q. And that's how you select your component part?
A. Right. But then it has to work, and once you decide on the template, that may not be what you actually wind up using.
Q. Okay. That's why you do a trial, right?
A. Right.
Q. Because once you put it in permanently, it's in?
A. It's in there.

Q. And is this the instrumentation that Dr. Patterson used?
A. Yes.
Q. That's Insall Bernstein, that's what you were talking about, I-n-s-a-1-l?
A. I think Dr. Patterson referred to it as IB, too, so that's fine.
Q. Are there any other opinions, doctor, that you have in this case that you intend to offer at trial that we have not discussed?

MR. FOGARTY: Object to the question.

A. Do I have to answer that?
Q. Yes --

MR. FOGARTY: If you know. Are you personally aware of any?

Q. -- you do.
A. Any other opinions?
Q. Yes, sir.

THE WITNESS: Can I discuss this with you privately? Can we go off the record and discuss it?

Q. No.

MR. FOGARTY: No, we can't do that.

I'm not sure he knows. I know what you're talking about. I'm not sure he knows how to answer your question.

Q. Well, you seem to have some opinions that we haven't discussed.

MR. FOGARTY: I don't know if it's opinions or observations. Would it be more accurate for her to say observations?

A. Observation.

Q. Well, then I'll ask you what other observations you have that we haven't discussed?

A. Well, we presented the data to you. You have the information, so we haven't withheld any information from you.

Q. Okay.

A. As it turns out, Dr. Patterson's prosthesis is larger than Dr. Shin's prosthesis.

Q. In what way?

A. In this dimension. The anterior posterior.

Q. The AP?

A. Yeah, and it's significantly larger. Dr. Shin's prosthesis measures 47 millimeters, Dr. Patterson's prosthesis measures almost 64; that's a significant difference.

Q. What do you attribute to that difference?

A. Well, there are different implants.
Q. Okay.
A. Okay.
Q. But the goal of each surgery is to duplicate as close as possible the normal anatomy of the knee?
A. Yeah, but you can, and 1 can make the point here that this is very large in comparison to this. It's large, it's larger than what Dr. Shin put in.
Q. In that one dimension?
A. Yeah.
Q. Okay.
A. And that one dimension raises the patella up so, and it could interfere with motion. So if you're going to say that one implant is too large, like Dr. Shin's implant is too large, then I have objective evidence here that Dr. Patterson's prosthesis is larger.
Q. So you would expect Mrs. Bastawros to have problems with Dr. Patterson's surgery?
A. I could argue with that, if you're going to say that Dr. Shin's prosthesis is too large, I can point out that Dr. Patterson's prosthesis is larger.

Q. Okay. And you know that because you called the company and asked them?
A. Those are, those are, that's information provided to me by those two companies. So --
Q. When you compared the two prosthesis with the templates --
A. Dr. Patterson's prosthesis also is larger, that's why I wanted to get the actual dimensions.
Q. You're not saying that Dr. Patterson failed to meet the standard of care, are you?
A. Absolutely not.
MR. FOGARTY: Objection.
A. No, I think, I think it was well done.
Q. Does a revision --
A. I also would point out that Dr. Patterson has an overhang on his tibial prosthesis just like Dr. Shin does. You can see that on the post-op x-rays.
Q. Would you agree that a revision of a prior knee surgery has more complications than the original surgery?
A. Potentially, yes.
Q Okay. Potential for more bone loss?
A. Yeah, you're, you certainly can and do take out

more bone.
Q. So you have a greater potential to have not a perfect fit of your component pieces?
A. Yes.
Q. Is the recovery from a revision knee surgery more difficult than the original surgery?
A. Usually not.
Q. Is it the same or less?
A. It's usually less.
Q. Do you have any understanding as to why?
A. Yeah. I think people know what to expect, and it's also their second surgery and they, they want it to work and they do what is necessary to make it work.
Q. Did you note in Dr. Shin's deposition that in the post-op x-ray he noted the malalignment of the prosthesis?
A. I can't remember that specifically. You've got it on a page --
MR. FOGARTY: Do you have the page, because it would take forever to find? I didn't mark the page. You don't recall?
A. I don't recall that.
Q. That testimony?
A. If he said it, I'll take your word that he said

it.

One other observation, maybe while we are at this, is Dr. Patterson's alignment is in zero degrees, it's not five to seven, it's zero. That's not ideal either.

Q. Do you find fault with that?

A. No, I don't, but Dr. Patterson didn't perform the knee replacement and put it in an ideal position either.

Q. Is there any indication from Dr. Patterson's records as to why he has it in a zero position?

A. No. I think that he thought that he had it well aligned in surgery, too. There are alignment guides that he used. Those are the things that everybody uses, but again you can't guarantee that that's going to give you the ideal position every time. No, I don't find any fault with. Dr. Patterson's surgery.

MS. EKLUND: Okay. Doctor, I don't have any more questions for you, unless there are other observations you have.

THE WITNESS: I think that's all the observations we have got.

MS. EKLUND: Okay.

MR. FOGARTY: There may be other

observations, but I'll let you know what those are.

Doctor, you know at the end of a deposition you're required to indicate whether you would waive or whether you'd like to review the transcript. I note since you were soft-spoken and Kathie was leaning in, why don't, we won't waive, you can read the transcript, just in case.

THE WITNESS: Yeah, just in case.

_____

ALAN H. WILDE, M.D.

C E R T I F I C A T E

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

I, Katherine A. Koczan, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named ALAN H. WILDE, M.D., was by me, before the giving of his deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness, and was subscribed by said witness in my presence; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulations of counsel; that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland, Ohio, this ____ day of _____, A.D. 19 __.

_____
Katherine A. Koczan
Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires August 27, 2001

W I T N E S S I N D E X

E X H I B I T I N D E X