Doc. 453

IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

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KATHLEEN NABOZNY,

Plaintiff,

-vs- Case No. 131627

WILLIAM E. CHEPLA, D.D.S.,

Defendant.

* *

DEPOSITION OF IRA E. WILLIAMS, D.D.S.

Monday, **November** 7, 1988

11:50 **o'clock** a.m.

Reported by: **LISA** A. CREERON

DEPOSITION of IRA E. WILLIAMS, D.D.S., a witness of lawful age, taken on behalf of the defendant, wherein Kathleen Nabozny is the plaintiff, and William E. Chepla, D.D.S., is the defendant, pending in the Court of Common Pleas, Cuyahoga County, Ohio, pursuant to stipulation, before LISA A. CREERON, a Notary Public in and for the State of Wisconsin, at 6101 South Highlands Avenue, Madison, Wisconsin, on the 7th day of November, 1988, commencing at 11:50 o'clock a.m.

A P P E A R A N C E S

FRANK R. DeSANTIS,
KAUFMAN & CUMBERLAND, Attorneys at Law, 1404 East Ninth Street, Cleveland, Ohio, 44114-2702, appearing on behalf of the plaintiff

EUGENE B. MEADOR,
KITCHEN, MESSNER & DEERY, Attorneys at Law, 1100 Illuminating Building, 55 Public Square, Cleveland, Ohio, 44113, appearing on behalf of the defendant

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I N D E X

(Original transcript is filed with Attorney Meador)

* * * * *

(Exhibit 1 is marked for identification)

IRA E. WILLIAMS, D.D.S.,

called as a witness, being first duly sworn in the above cause, testified under oath as follows:

MR. MEADOR: This is the discovery deposition of Dr. Ira Williams in the case of Kathleen Nabozny vs. Dr. Chepla. The time, place and other arrangements for this deposition have been agreed to by counsel, is that right?

MR. DeSANTIS: Yes.

MR. MEADOR: We have also agreed that the original transcript of this deposition can be sent to myself, and that's also by agreement of counsel, is that right?

MR. DeSANTIS: That's correct.

MR. MEADOR: Did you administer the oath?

THE REPORTER: Yes, I did.

EXAMINATION

BY MR. MEADOR:

Q Dr. Williams, we've met at the airport My name is

Gene Meador, and I represent Dr. Chepla. You've given a deposition before, I assume?

A Yes.

Q If you don't understand one of my questions, please tell me and I'll be glad to rephrase it for you so that you do understand it, However, if you do answer one of my questions, I'm going to hold you to the answer and assume that you've understood it, is that fair?

A That's correct.

Q For the record, would you tell us your name, please.

A Ira E. Williams, D.D.S.

Q And your residence address, please?

A 6101 South Highlands Avenue, Madison, Wisconsin, 53705.

Q And your business address, please?

A It's the same at this time. I practice out of other offices now. I am semiratired and continuing my private practice in other offices.

Q Okay, And you ate a dentist who specializes in oral surgery, is that correct?

A Correct.

Q Dr. Williams, handing you what's been marked as Exhibit 1 and dated today, it appears to be a resume which is dated on the top January 29th. 1988. Is

that resume an accurate recitation of your education and the associations you belong to?

A *Yes*. Not a complete, but what I consider the more pertinent elements of my curriculum vitae, and this was prepared by myself.

Q Okay. Insofar as it's not complete, *is* there anything *that* you would care *to* add which you believe would be pertinent to the opinions that you're going to be giving in connection with this litigation?

A I just presented a surgical round-table to our clinic that was presented twice at tho -- we refer to as WAQMS, A-A-O-M-S, the American Association of Oral and Maxillofacial Surgeons annual meeting at Boston, and these presentations were September 31 and October 2 of 1988.

I also do not list two articles that I have published in the literature years ago during my internship and shortly after in the beginning of my residency and numerous continuing education sessions that I have maintained through the years.

I have been very active in going to the state and national oral surgery meetings and anesthesia meetings for continuing education in my specialty.

Q Was the round-tabla presentation which you gave in Boston, what was the topic of that. or was it -- let

me rephrase that.

Did your presentation or the two articles that you mentioned or any of the other continuing education courses that you've been continuing to do over the years, did they have anything *to* do with the topics that are going to be discussed in connection with this litigation?

And by that I mean like multiple extractions and the kind of procedure that Dr. Chepla performed, in addition, infections and the treatment €or infections and that sort Of thing.

A My presentation in Boston consisted -- tha *topic* was otogenous bone grafts and Corvin implants to both jaw -- to either jaw and would indicate an area of advanced surgery of the jaws for the new era of implants that we're in.

I have also attended throughout the years several presentations specific on infections and dealing with maxillofacial infections throughout the years, so yes, much of my continuing education has been directly related to the factors involved in this case.

Q When was the last time that you attended a seminar or some kind of an educational course concerning infections?

A It's difficult to be precise in chat I've gone to so many like when I -- since 1966 I have attended over 75 percent of all the annual meetings of our national society and have attended usually three round-tabla3 each year I would go that would be given for specific topics.

One of the topics, without a doubt. was on infections and the treatment of infections of the oral -- of the maxillofacial region. I can't toll you exactly which annual meeting was the last one I attended prior to this.

Q Where that topic was discussed --

A Also, I was on a ski trip about four years ago where the infectious disease department at the University Medical School in St. Louis, St. Louis University, happened to have postgraduate education going on, and I attended that. *It* was primarily for physicians, but I attended that on infectious disease and brought back much of the handouts and material *they* gave and gave them to one of the physicians at the clinic that I was most closely related to here in the city, and I don't know if that was, say, about four years ago.

I forget, whether it was Aspen or Vail or where, but I did attend their meetings and did go to that place to ski. Just coincidentally they had this

meeting, and I thought it was on things that interested me. So I can't remember the exact date, and this was multiple lectures throughout the week, a daily --

Q Would it be fair- *to say,* though, based upon your recollection that the last update that you've had in the infection ares, so to speak, would have been within the last four years?

A Oh, easily, yes.

Q At that ski trip that you're talking about?

A Yes.

Q The two articles that you published, what *were* they on?

A Oh, one was on -- in fact, one has been cited numerous times throughout the literature because it was one of the early examples of showing carcinoma beginning in the lining of a dental cyst, and in my case of the upper jaw, which at that time most experts did not believe that carcinoma would begin in the epithelial lining of dental *cysts.*

So in 1962 when I was in internship at the VA in Memphis, I removed *the* cyst in the upper jaw of a patient, and the pathologist read the slides and said, "In thia case I see early carcinoma."

I presented this, and one of probably the

most noteworthy oral pathologists at that time, who was a General Brenier (ph.) who was head of the dental service for the Army at Walter Reed, at a meeting later disputed that finding.

Since then they have found that carcinomas can and do begin in the lining of cysts, and my article has been cited, oh, 1 would say numerous times throughout the literature throughout tho world as one of the early cases showing this, and the other was just a case report an a fibrous dysplasia *of* the maxilla, just kind of an interesting little case. Didn't add that much to the literature.

Q Have you relied on any particular articles or reference books in arriving at your opinions in this case?

A In this case, the bulk of my opinions have came from my continuous use of our journals. Primarily the Journal *of* Oral Surgery put out by the Association of Oral and Maxillofacial Surgeons and to some extent. the '88 journal and what they call the OOO, the Oral Pathology, Oral Medicine Journal, but primarily it has been my own practice and experience and primarily the Journal *of* Oral Surgery.

Q Are there any articles that come to mind or any articles that yau reviewed in connection with

preparing your opinion in this case?

A Yes. I think it's nine articles and two fetters to the editors concerning those articles, and I had sent copies of these just recently to Attorney --

MR. DeSANTIS: DeSantis.

A -- DeSantis. And he can provide you copies of these or I can provide you copies of these.

Q Okay, If I can do that, I will get copies then of those articles instead of wasting time and going over each of those titles and authors now.

A All right. Now, one thing, the copies I gave Attorney DeSantis I had not marked an, and since sending those and for further preparation, I did go through these and make a small number of marks that would not be shown on his copies.

I could get my wife to copy or I can copy those pages right quick later on to make sure you show the markings that I put on these.

Q Very good.

A And they're not a great deal of markings, but I did them so I would help both of you to focus in on what I believe the series of articles can lead you to.

Q Okay. Is there any one article that you relied on more than the others, or are they all equally persuasive to you?

A My feeling in reviewing them was that they more or less provide a mosaic, and I felt that without trying to overwhelm you with articles that this number would more or less be like pieces of a puzzle that would fit together, and at the end I think would give you a vary clear and concise basis for at least the determinations that I have made.

Q Prior to your retirement, which I believe you said was in August of thia year?

A August 31 I closed my office for the active practice, I have since -- well, last Thursday E surgically implanted four implants in a patient, and so again, I'm still continuing to practice but not on a daily basis, nor do I have an *office* of my own, So that was August 31 of this year,

Q What is your present arrangement to do your work that you still have an interest in doing?

A Right now I'm consulting with patients from any source, not just from the men whose office I might use to do implants, and that's for myself and that patient to know what to later reconstruct on those implants when they're ready far reconstruction.

A5 a surgeon, 1 can only put implants in. I cannot build on then. So any implants I might insert, there would be an understanding we would find

a dentist qualified to build on them later.

So right now the one office I use has three dentists in it and so they will -- I have consulted with one or two patients of theirs that in the future I'll probably put implants in. In fact, I was putting implants in the very last day my office was open, August 31.

I had a patient-, that I *was* inserting implants in because I knew I had a dentist that could build on them later and that if they had any problem, I could see then in their office and so forth. So I practiced right up until the end doing things that could be done in the future, knowing that I would continue to stay and practice to some degree.

Q How are you limiting yourself. in terms of your practice now? What kind of work are you willing to do and how much of your time are you willing *to* devote to your consultation work?

A Well, quite frankly, I had just started doing the bone grafts far implants about the last year and a half, and I find this fascinating and I've got one patient who we were supposed to do the surgery for the bone graft in July of this year, this past July, and her husband's company changed insurance *at* the end of June, and they change to Blue Cross, Blue

Shield, which denied the surgery.

We're appealing that, and we both anticipate that: if Blue Cross, Blue Shield will ultimately approve that, I'm still going to do the bone graft in the hospital for her and then later put implants in it.

So I envision next year to consistently be putting implants in people, that I think this will come to a fairly consistent practice and not just something that I hardly ever do at all, but I haven't got into it far enough to really know. I was so busy closing my office and getting ready for the talks in Boston, I wasn't pursuing it much since the end of August,

But I envision next year to continue to still put implants in, and one of the reasons is that I feel particularly the younger dentists need to get implants in their practice. Mast of them don't have the ability to put them in, and I'm hoping to encourage young dentists to start using implants, end I will be glad to insert them as often, as frequently as I can. So I do anticipate continual practice.

Q With the implants?

A With the implants in other offices.

Q Just so that I understand what you mean by implants,

could you tell us?

A The "new" implant, they call them endosseous, e-n-d-o-s-s-e-o-u-s, and they're actually root form. You're literally drilling slowly on bone and inserting a titanium cylinder, most *of* them are titanium cylinder, into the bone and sew it up and let the bone recover and then uncover them a few months later and if the bone has responded well and it's totally angulosed in the bone, you can then attach a denture, a partial, a bridge, a crown *to* it,

And so whereas they haven't been doing them *for* too many years in this country, in Sweden they have probably 20 years experience now. The success rate is so high that they just had a consortium meeting at NIH in June of thia year, I believe. I have a copy of it, and they believe they're getting close *to* the point of telling practicing dentists that if they don't include those new implants as one of the possible treatment plans of people who can benefit from them, that that in itself might be construed as less than satisfactory care, so *they're* coming an so fast.

I refer *to* them as being very similar to the total hip replacement. You can put them in anyone, regardless of age, if they have enough bone and they

aren't diabetic and have some debilitating disease and later on attach something to them, and they're just fantastic.

I think the dental literature, Including the OOO, i.n the next 5, 10 years is going *to* do enormous expansion of their utilization and the number of dentists putting them in, but each dentist will have to learn how to use them,

The last few years I intend *to* practice, I hope to help in every way I can young dentists get them started. I tell practicing dentists in this area, the longer yau expect to practice, the more important it is far you *to get* implants into your practice because they're going to became such a meaningful part of the future of dentists, and I will put: these in any member *of* my family. I would have one put in myself,

Q Prior to your semiretirement now, you were in private practice since, I believe --

A July '66.

Q '66. Why don't you, if you could, just outline in general while you were in private practice the type of patients that you normally saw and the type *of* treatment that you would give those patients.

A All right. In 1966 we were classified as oral

surgeons, and a high percentage *of* those practitioners would have been more accurately termed exodontists, primarily limited to removing teeth, impacted teeth, fixing fractures in the office. Fractures and things might be in the hospital, not a great: deal of major surgery,

Beginning in the mid and late '60s, oral surgery started to expand rapidly into much more sophisticated major surgery of the maxillofacial region, meaning the upper and lower jaw and the ability and relationship of these jaws, and function is considered the maxillofacial -- the lower part of the orbit and beneath the skull and all *of the* bone and teeth and so forth would make up the oral and maxillofacial region, and 1 think it was *late* '70s that *our* American Association of Oral Surgeons changed its name to American Society of *Oral* and Maxillofacial. Surgeons.

What I'm getting *at* is when I came out of training, I primarily was trained to do office oral surgery, a little -- name trauma and removing teeth and so forth. I made a very specific endeavor to stay up with my specialty, and so I expanded my scope throughout the years to include orthognathic surgery, which is the surgical correction of deformities with

the surgical repositioning of one or both jaws, of doing operations for the elimination of major pathology of the jaws, including bone grafts, and then tha addition of implant surgery.

There is one aspect of oral and maxillofacial surgery I specifically did not incorporate into my practice, and that was surgery of the TM joint. I treated patients -- I treated and diagnosed TMJ problems and treated patients conservatively but elected specifically not *to* add surgery of the TM joint to my scope because, quite frankly, I felt like the degree *of* success was not encouraging, and I just didn't want: to operate on those type of patients where a lot of them really didn't get a lot better.

I personally relate TMJ surgery to a typical neurosurgical practice, not all your patients survive, and so I eliminated that part, but almost everything else in oral surgery I feel I've kept up with.

So by the time I ended my complete active practice in '88, I had a fairly full range *of* oral surgery practice except €*or* specific surgery of the TM joint and cleft palate and I did not include -- I never did add surgery of cleft palates. I did very limited surgery on cleft palate, very, very limited

but basically the surgical bone, grafting of the clefts I didn't include because in this area almost all of the work was done at ths university.

I knew I would see so few of those patients, it wasn't worth adding that to my scope of practice because I would just see too few. The important ingredients of this case and of the care received by Mrs. --

Q Nabozny.

A -- Nabozny are very germane tu the typical. oral surgery practice in the '60s, '70s and '80s, and everything here is very run-of-the-mill, bread and butter work of almost every oral surgery practice in this country.

Q In general how have your patients been referred to you?

A I joined a group of three oral surgeons who had been in practice for a number of years and, in fact, in '66 was the only oral surgery office -- no, correct that. We were not the only surgeons in town, but it was a three-man group that had been here for a number of years and did the vast majority of the oral surgery work in this city.

So over the years we have received referrals from the dental community primarily and from word of

mouth from our past patients. A third source in a Limited amount would be the medical community, and even above that, I guess the third choice would just be Yellow Pages or what have you, someone needing an oral surgeon.

So it would be primarily from the dental community, then from past patient referrals, then Yellow Pages, what have you, then the medical community.

Q Do you know how many oral surgeons practice in the Madison area?

A Right now there are, and I still consider myself practicing, right now there are 10. There are four each in *two* groups. There is one other oral surgeon who has practiced alone here since about 1969 or '70 and who does not have hospital privileges, does strictly office oral surgery and then myself,

Q And I believe that when you retired you were with three other oral surgeons?

A No, I was practicing alone since March -- I'm sorry, April 1, 1985 I practiced alone. From April 1, 1985 until August 31, 1988.

Q When did you first become involved with the review of cases in connection with lawsuits?

A All *of* my experience with malpractice litigation of

professional services has been in the Madison community, and probably I became involved with that in 1980.

Q How did you become involved in that7

A In that I was the second surgeon who assumed responsibility for a patient who required corrective surgery from previous oral maxillofacial surgery administered by physicians, arid these physicians voluntarily turned this patient's care over to me with the statement, "We can't provide what she needs."

Over the ensuing periods I did the surgical correction, made necessary efforts for in-depth peer review within the medical community of that hospital with nothing being done, and subsequently the patient did take the matter to litigation, and I served as the patient's expert witness because I had been the correcting surgeon. And even though the original surgery was by M.D.s, I was qualified to assume all the responsibilities and to perform the corrective surgery that was necessary.

Since then I have been involved with similar situations in every hospital in the city but the VA, and although it's rare to find a practicing surgeon of any degree in this country who has served as a

plaintiff's expert witness in legal matters in the city in which he practices, I have done this multiple times because I was intimately aware of all the conditions *of* the patient because I had to do the corrective surgery and because I, quite frankly, professionally felt that ethically I had no other choice but to testify.

Q When you started in 1980 with this litigation process involving malpractice and all the way up until the present, excluding this case, were you always the treating physician who later became involved in it and then thereafter was a treating physician and also an expert witness?

A Not always. And primarily because at the University Hospital, which is an entirely different wurld, I did end up writing a smoking gun letter which forced the medical staff *to* have a formal board review of a chairman *of* one of the subsurgical specialties, and in that letter there was one patient mentioned that I had not operated but *of* which I knew the details *of.*

But at the other private hospitals it dealt *with* patients that it had been necessary for me to do corrective surgery for.

Q Since 1980 how many malpractice actions have you been involved in either as *an* expert, witness or reviewing

the matter on behalf of either -- I assume for the plaintiff?

MR. DeSANTIS: Objection, go ahead.

A Yea. Years ago, very fleetingly, I testified for a defendant, a dentist, in the city Ear a case that should have never gone to court, and it was an older man that had had some teeth out by a general dentist, and I had seen the man and he! had a rough area of hone near his tongue, and I had testified for the defendant in that case because I didn't feel the dentist had done anything wrong, and it was a very small matter, happened probably in '67 or '68. I vaguely remember it.

Since then I have testified four times as an expert witness in this city and given multiple depositions, and they were all for cases that I had operated for corrective surgery, Beginning in --

Q When you say multiple depositions, you're talking about in connection with the four times?

A With each case, yes, yes. Beginning in January '88, with much urging by an attorney friend of mine over the last several years of beginning to advertise as an expert witness, my first ad in Trial Magazine was in, I'm positive, January of 1988.

Since that time I have been involved with

possibly a dozen canes. In two or three *of* these, from my recommendation, any consideration for suit was ceased. I am actively working on -- actively. I have six to eight cases where I have reviewed material, made determinations, written letters.

This is the first deposition I have ever given for a case outside of the City of Madison or the State *of* Wisconsin that stemmed from the advertising in Trial Magazine, and I do have a deposition scheduled for two weeks from today here, and I am in the process of setting up a deposition for probably the first week of December in Jacksonville, Florida.

Q Can you give me the names of any of the cases that you testified in while you were in the City *of* Madison here?

A Stemming here?

Q *Yes.*

A Oh, now, three af the four only dealt with the Wisconsin physicians compensation -- malpractice compensation panel, They didn't go to circuit court, if that would help you. Three of the four -- three of the four depositions, you know, *were* with the malpractice panel, and so there are cases. One *of* them was Agnes Woodbury,

Q Well, let me ask you this. I don't need *to* know the names of these if they're not in any way similar to the fact pattern in this case.

A Oh, no. They were -- no. The one at the University Hospital was vaguely similar, just vaguely, and it was a fracture, but he came out with a permanent numb lip, and I had seen the patient to taka out multiple abscessed teeth shortly after they had treated the fracture, and I was greatly suspect of the treatment rendered for two reasons.

In treating the fracture, they should have removed the multiple abscessed teeth and didn't have the capability, and two, the manner in which they treated the fracture, the young man was numb and probably numb forever on both sides, but I was treating him only to remove abscessed teeth after they treated the fracture.

This never went to a deposition, never went to -- but it was one aspect of the letter I wrote to the vice chancellor at the university. So the others wore -- *two* were fractures with continuing infection but nothing as severe as this case, and the third was an orthognathic surgery trying to reposition part *of* the lower jaw with long-term infection, but nothing similar *to* this, *to* the type of infection we were

dealing with in this case.

Q You've testified or you will be testifying regarding the failure to meet the standard of care. Have any of your other cases been similar in the sense that the physician failed to meet the standard of care like the allegation here in this case?

MR. DeSANTIS: Objection. Go ahead.

THE WITNESS: I'm sorry, go ahead.

MR. DeSANTIS: No, I'm just registering my objection. You go ahead and answer.

A As best I understand your question, to some degree, yes. When I say failure to meet the standard, in my opinion, as a board certified oral surgeon and one I assume to be an expert; in this area from my practice and my qualifications, so from my determination, yes, in chat they were treating infections, postoperative infections inadequately and totally -- in most cases I feel like I can say almost a totally inept manner, in all cases of treating postop infections.

But the: original cause of the treatments were triggered differently, were triggered by fractures or attempting to reposition a portion of the jaw.

Q Well, I'm trying to find out the names of the cases

where you've gone on record either in deposition or in the court system itself where you have come out and criticized another physician regarding their failure to treat somebody postoperatively and an infection resulted. Whether or not it's the same severity doesn't matter to me, hut you understand my question?

A Yes, and I can give you two of those. There's Agnes Woodbury vs. Donovan and Donovan. Well, the real case was Donovan, Donovan, Dibble and St. Marys Hospital, hut Dibble and St. Marys Hospital were relieved of any connection with the case, and the Panel findings were for the plaintiff at the Panel Level against Donovan and Donovan, and this was --

Q How would one go about getting a copy of your testimony regarding this matter?

A You could either contact Agnes Woodbury's attornay, which would be Jeffrey Kravat, and I can give you his name and address or the Wisconsin Panel, which they -- while they've done away with the panels as of '87, they still have all the files and they still have the Compensation Panel office,

Q Now do you spell Jeffrey's last name?

A K-r-a-v-a-t.

Q And he's an attorney practicing in Madison?

a Yes, and I can get you his address and phone number.

Q The Wisconsin Panel, what's the full name of that organization?

A Wisconsin medical compensation -- Wisconsin Compensation Panel. I don't know. It had about four or five term with it. It's in the Yellow Pages. I can find it in the baok for you. They still have a phone number, and they still are involved.

There is one other case that never went to deposition or anything that -- well, no, I better not. There wasn't enough to that for that to be of any substance, The other case of infection would be Beardsley, John Beardsley, B-e-ar-d-s--1-e-y, I think. Beardsley vs. Demergian.

Q How do you spell that one?

a D-e-m-e-r-g-i-a-n. He is since deceased, Demergian, but he was found guilty by the Panel.

Q Was this also a matter that was presented to *the* Wisconsin medical compensation panel?

A *Yes.* Neither of these went *to* circuit: court. In both cases the panel found for the plaintiffs, and so they did not go into circuit court. Either side could have pursued that further, but neither side chose to,

Q So if I understand your testimony all total, you've

been involved in approximately four different matters in the Madison area regarding testifying as an expert witness, and then since your ad that was placed in the Trial Magazine in January of '88 you've had approximately a dozen requests for you to review matters?

A Yes. I think I've had more than a dozen contacts. I've had maybe -- I think I'm getting close to 10 or 12 where I've actually reviewed matters and probably 12, in that area. In two or three of those my review initiated cessation of the matter, and in the others that are being reviewed, this is the first one that has gone to a deposition.

I have written opinion letters in four or five cases where I felt I had enough information to state an opinion -- that's four or five where I felt I could state, an opinion of substandard care, That doesn't include the two or three where my opinion caused the actions to *cease.*

Q Where do you stand with respect to the other four to six?

A Again, I have a deposition scheduled for November 21 here and am to set up a deposition in Jacksonville, Florida for probably early December,

I just wrote a detailed letter on a matter in

Iowa that I don't know if it will go into an additional deposition or not, and X've got two cases in Michigan, I think, where I believe the next step would be a deposition if they choose, and I'm waiting -- I've just got the initial information on a case from Atlanta, Georgia that there's no doubt in my mind I have enough material to know that I believe there is substandard care but haven't even initiated anything with the attorney.

Q Other than the *two* or three which you said that after your review resulted in the cessation of the litigation, as far as you know, have the other 10 or so matters, have you found there to be substandard care?

A My opinion has been from the information I'm given that there was, yes.

Q Have any of those other cases where you did find substandard care? or in the two or three where you have found no substandard care, have they been similar to the facts in this case?

A One of the cases where I felt there was no substandard care was somewhat similar, and that was infection of the upper jaw, but it was anterior -- it did not get: to be near as severe as this or near as complicated, and once I felt I got sufficient

documents to review and, in fact, my initial opinion from just what was relayed to me over the phone, I felt there was probable substandard care.

Once they were able to send me all the details and I could put things together, I was able to contact them and say in this matter, I don't believe the oral surgeon did anything whatsoever substandard and here's why, and there was a couple of little missing ingredients you had to put together to show that while this was an unfortunate series of circumstances and the patient did have some discomfort and went through some problems and some infection problem, was in the hospital for one night for IV antibiotics and everything, I felt there was absolutely -- it was a unique series of little. circumstances and not really substandard care by the oral surgeon.

Q How do you refer to that particular fils'? Is there a name, that you can recall, *to* that file?

A No. It was from Illinois, and I can lay my hand on it fairly quick. It's in my basement in my files, but *this* was sometime last year, and I wrote them a detailed letter,

In fact, it was the wife of a senior partner *of* the attorney who contacted me and three years was

running out, and it was a small town with the same group of oral surgeons that were two older brothers and two sons and so forth and a very small town and it was ticklish, and the lady just wanted to find out what happened and was I wronged and everything,

On the surface *it* looked like she really was, and when you got right down to it, it was just very unfortunate and could have happened to anyone at *any* time, and she just wasn't getting any answers. Nobody wanted *to* talk about it, so nobody wanted *to* tell her what happened,

I could lay my hand on it, but once I *got* all the x-rays and saw the sequence of events and everything, I felt like I was able *to* give them a good rationale for what had occurred, the sequence of events.

6 Would you be willing to provide Mr. DeSantis and myself with a copy of your file in that case?

A Sure. I can pull that.

Q How did you become involved to review this particular case, the Nabozny case?

A I assume through my ad in Trial Magazine.

Q Wow were you contacted and when?

A I received a letter, I guess -- wait a minute. So I received my first letter May 5, 1988 -- no, I

received a phone call first.

Q From whom?

A The first letter is signed by Richard Zeiger, so either from Attorney Zeiger or Attorney DeSantis from their office, the office of Kaufman & Cumberland.

Q You don't remember the date when you received the first telephone call?

A I did not keep a record because I'm sure at that time we talked for a while about my qualifications, and I sent them a copy of my CV and *of* my fee schedule for expert witness and left it to them if they wanted to send me any other information.

So with the first letter via Federal Express X received a packet, and the letter is dated May 5, 1988, and they indicate the documents that they sent me.

Q Can I ask you if *you* have a copy of your fee schedule?

A I do. I can get it. *Yes,* and I don't have that -- that's in the basement, Let's make a list, and I'll *get* these.

Q Do you recall what your fee arrangement is?

A Yes. Basically it's $900 tu review a case, *$200* an hour and $1,800 a day and if I travel, plus expenses, and that's pretty much it.

Q By the way, what is the arrangement for your deposition today?

A We just talked about that, and I guess my bill to you would be primarily just *for* the time today, you know, in a round number, and I'll be glad to come up with something we both agree on, three or four hours or whatever, whatever is customary, but Mr. DeSantis said that anything that I did prior, which has been quite a few hours, should be to his office.

So primarily yours would be just for what we would agree OR for today,

Q Okay. The Letter that you received fram Mr. Zeiger, could I look at it?

A Oh, certainly. And I believe. I still have everything that was listed that he sent me. I don't think I returned anything. In one or two cases I've returned some x-rays or some photographs, but in this case I think I still have everything that was originally sent to me.

Q Would it be possible for us to *get* copies --

A Sure.

Q -- of your *file*, including the articles and then we can mark these?

MR. MEADOR: Is that agreeable, Frank, to do that that way instead of me

marking everything now and slowing down the deposition?

MR. DeSANTIS: Yes. What do you want, just not to --

MR. MEADOR: I just want to get the whole file and have it all marked,

MR. DeSANTIS: Sure. You want to take a break and do that?

THE WITNESS: I can get Shirley.

MR. MEADOR: Why don't we wait until the end.

THE WITNESS: Or I can get Shirley to do it real quick.

MR. MEADOR: We can do it afterwards.

THE WITNESS: Okay. I've got a pretty good copy machine down *there.* We can just *go* down and fire them off.

Q So you showed me the May 5th, 1988 letter from Wr. Zeiger?

A *Yes.*

Q And the items that are listed 1 through 8 are the items that were enclosed with that letter?

a Yes.

Q And may I look at the statement *of* Mrs. Nabozny that

was provided to you?

MR. DeSANTIS: Objection. I don't think it says the statement of Ms. Nabozny. I think, number one, it says a fact summary.

A Yes, I assume that's --

Q That's what I wanted, thank you,

(Short recess is taken)

Q So you reviewed the materials that were sent to you with the May 5th, 1988 letter, is that right?

A Yen.

Q And then what did you do after you reviewed the materials?

A We had a conversation ok we had probably two or three conversations, and when I say we, I can't: recall how many times I might have talked to Mr. Zeiger or if -- the bulk of my conversations have been with Mr. DeSantis, but somewhere -- well, as of May 12th, '88 I wrote them a letter that I felt documented my opinion of reading the file,

Q Between your review, which I assume occurred on or after May 5th of 1983, and your letter expressing your opinion, and the letter is dated May 12th, 1988 there was approximately --

A A week,

Q -- a week's time in there. How many conversations,

if you can recall, did you have with the attorneys from Kaufman & Cumberland?

A Possibly one or two very brief ones as to the fact that they were ready for me to give them a written report of my views of, you know, what I felt I could determine from the racords.

Q You had an opinion, though, after your review of the records?

A Yes, and I stated it in that letter of May 12th.

Q Did your opinion after you reviewed the records on May 5th change at all after you had the conversations during the week before you --

A Oh, no.

Q Before you wrote down your opinion?

A No.

Q And does your opinion today, fa it consistent with your letter of May 12th of 1988?

A It's consistent, but it's expanded. It's in more depth. The opinions I have now from going over the articles and other factors, basically it's the same opinion, but --

Q It may be more detailed?

A Yes.

Q Prior to writing your opinion, which is in the May 12th, 1988 letter and, by the way, why don't we

mark that Exhibit 2. Can I use this one?

A Sure.

(Exhibit 2 is marked for identification)

Q Doctor, handing you what's been marked as Williams Exhibit 2, that is the opinion which you have expressed, is that correct?

A Yes.

Q And that's the May 12th, 1988 letter?

A Yes.

Q Prior to arriving at your opinion in the May 12th, 1988 letter, you had reviewed only those materials that were sent to you with the May 5th, 1988 letter, is that right?

A Correct.

Q And there were no other things that you reviewed, is that true?

A That's true.

Q When did you review those articles, the nine articles which you're going to copy for me?

A Oh, wall, I started accumulating them over the summer as I was getting ready to close my office. I went through all my journals from '65 or '66 and was taking out articles under various subjects, copying them or taking them aut and for some various subjects, and one of them was for infections.

And since then I have reviewed the articles that I took out, this series specifically, for the care of Ms. Nabozny.

Q Those articles would have baen gathered by you after your letter of May 12th, 1988?

A Yea, yes,

Q During the course of your many years in practice, I assume that you have performed multiple extractions where it would involve 12 teeth?

A Hundreds of times. In fact, unfortunately, in the '60s and early '70s we extracted far more *teeth* than we do now, and when 3 first joined the group in the '60s, we used to take out a lot of teeth, and I have had people under general anesthetic in my office for over an hour at one time, and I've taken up to 32 teeth, including four impactions,

Q In one sitting?

A On a young man that was in his teens and every third tooth was decayed, and it was just nothing else to do, and I still think of him, and that was '66.

a What's your typical procedure when you perform multiple extractions?

A The vast majority of my patients were treated under general anesthetic administorod by myself, and I have told people over the years I truly believe that, no

matter how many teeth they needed out, it was far better to do them all at once, and it was very, very infrequent that I would put someone in the hospital just to remove teeth unless they had a medical problem that demanded hospitalization.

Most of the cases throughout the years were done in either office that I practiced in in pretty much the same way.

Q What do you normally review prior to doing the extractions?

A Well, we're far better now than we were in the '60s, but we would have a medical history and anything from the referring dentist we might have, although a lot of people would come in and say, "I want all my" -- "I need all my teeth out," and even before they had an appointment had gone to a dentist, say, in a smaller town and said, "I'm going to have all my teeth out up at Kelly, Griffin, Lynn in Madison. Will you make my dentures" or something like this.

So it wasn't an infrequent thing for me *to* maybe make the initial diagnosis and treatment plan, and I have spent many hours trying to tell people they didn't need as many teeth *out* as they thought they did, but there was quite a few people who were not referred from anyone, and the first real x-ray

they had would be in our office.

But her case and the material I see here, and I used this phrase earlier, is just a run-of-the-mill oral surgery case, very typical of things I have seen since dental school even and internship, much less my residency and private practice.

Q In your private practice in those cases where a patient was referred to you by a dentist who already had a treatment plan for her, what would you normally, if you were just a phase or part of that treatment plan, what would you normally see when you first saw the patient, the x-rays that were taken, is that right?

A Usually in my practice the front office people would get the pertinent history and paperwork, and as the patient was being first taken! sent to the bathroom because they were going to have general anesthetic and then taken to operatory, the surgical assistant would give me the chart with the x-rays. And in moat cases I would have seen the x-ray before I might see the patient, but in a very short period of time I would see both x-ray and patient.

Q Were these any other materials that you normally reviewed prior to doing the multiple extractions?

A Well, again the medical history was the -- first

determination is is this patient a good candidate for an office surgery and then, in most cases, for a general anesthetic.

so our biggest decision, which is technically a history and physical as one would get in a hospital by a physician, is the determination can you do this patient in the office and then can you do them under general anesthetic. Are they a good risk for either or both of these categories.

Q And then in your private practice prior *to* performing the surgery, do you explain to the patient what you're about to do?

A Yes.

Q Do you have a consent form that you used in your practice?

A My consent form in my solo practice of the last three years was -- in fact, most of the years I practiced we did not have a consent form, We did not: use one.

Q When did you start using a consent form?

A I can't recall. We had a consent form when I was with the group, and I don't know how many years, and then when I started my privata practice, I had a consent. form for most typical oral surgery work in the office.

Then I also went to a separate consent form

for orthognathic surgery and a separate consent form for implants and in rare cases a separate consent form for any unusual thing that I might do.

Q When you said in your private practice, you mean when you went aut on your own?

A My solo practice from '85 to '88. I went: to multiple consent forms for different specific types of surgery -- orthognathic surgery, bone grafts, implants, things of this nature which were much more detailed than the small half sheet type consent form I use for the routine office clinical oral surgery extractions, impactions.

Q What DE-. Chepla did for Mrs. Nabozny would have been the routine oral surgery?

A Very, vary routine, run-of-the-mill.

Q Which would have used the shorter consent form in your practice?

A Yea.

Q Do you still have copies --

A Yes.

Q -- of the short form?

A Yes. Yes, I can get you a copy of my consent form.

Q Does your consent form deal with the possibility of complications after the surgery?

a Yes.

Q And what are the complications that, the patient is advised of on your consent form either in writing or by yourself orally?

A Well, I think all of tho surgical assistants who worked in either office I worked at, either the group or when I had my solo office, will tell you I tended to spend a considerable period of time with my patients and would talk in mare specific things for any factors I saw related to their case.

So if I saw someone with an ora1 condition that indicated possible consideration for postoperative infection or something, I would tend to go into that with these patients and things of this nature. It would deal with infections, it would deaf with impactions, with numb lip, It would deal in severe impactions with possible fracture of the jaw.

It would deal with a multitude of possible postoperative complications that would vary depending on the case, so routine extractions, one of the biggest things would be infection for these people.

Q Let's assume that Mrs. Nabozny went into your office in June of '86. What kind of complications would you have explained to her that may result after the multiple extractions?

A In looking at the copy of the x-rays sent to me,

again, I consider these x-rays and things to indicate a typical. routine oral surgery case, nothing out of the ordinary, something I've seen literally hundreds of times, and one of the things that I would say to her -- of course, from the records that I've read, she went in indicating that she had been very lax about dental care.

She knew her teeth were in bad condition. Dr. Sangrick's notes indicated that she had gum disease and red gums and everything, so the potential for infection is certainly there for anyone taking out her teeth.

Q So you would have told her that?

A Without a question this would be one factor, Also, the impacted wisdom tooth shows the roots near the nerve canal, so you would consider possible numb lip paresthesia.

Q Of what?

A Of paresthesia, numb lip from removing an impacted wisdom tooth in a mature individual, and slim chance here of maybe opening into the sinus and some sinus, you know, complications.

That's basically the biggest things you would you see would be considerations with impaction, considerations with potential postop infection and a

slim chance for maybe opening into the sinus, which would delay healing.

Q Would you say that based upon what you do know about Mrs. Nabozny, not knowing what has happened after her surgery, what would you *say* the percentages of her developing an infection would be based upon your review of her x-rays as they were back in June *of* '86?

A That's easy for me to answer in that when I talked to my patients, I tried to give them some specific -- I used a lot of analogies.

And in something like this, I would say something very typical to if I were to operate on 10 patients like this, less than halt of them will need antibiotics, but a few of them will, and we don't know who.

So I probnbly would not have started her on antibiotics at the time of extraction but would have assumed that this very readily could occur postoperatively, and so when I talked to patients, I would usually relate things in numbers like that, that if I do 10 or 20 *of* these, I know that less than half are going to get infection.

But I know that a small percent probably definitely will and that I may well have to put you

on antibiotics later and occasionally -- mare than occasionally I would actually say to patients, "Do you tend to get infections easy, would you be mare comfortable if I started you on an antibiotic," because I've occasionally had people tall me, "Oh, I get infections easy. I want to be on antibiotics."

With a condition like this, multiple sources, I would be comfortable starting them, but only if a patient kind of nudged me, pushed me into starting the day of surgery. In *most* cases looking like this, I would not have started her on antibiotics but would assume the potential is there.

Q You've talked about what you would have told the patient in regards to the possibility of infection. Would you also have told the patient what you would have expected in terms of the pain that may result after the surgery?

A Yes, I tended to tell these patients, and it's very specific, about if I felt I had *to* tell them they fell in a category that showed some potential for needing antibiotics, then I would tell them.

See, I normally used sutures that dissolved, cut sutures, and so I would tell my patients, "I don't have to see you if you're doing fine, but I need to see you for the slightest thing," and for

these patients I would say, "I have to know if you're having any problem. You don't call me. You come in. I have *to* see you. I have to know if you're starting to *get* any problem," and so these things I would be very specific with.

Q In the case of Mrs. Nabozny with her having 12 teeth extracted, what would you have expected the length of her pain would have baen?

A My feeling --

Q Not knowing what we know,

a Yes. I think I know what you mean. Normally I told people who were having multiple extractions that, quite frankly, I have less problem with this type of patient than any other type patients, i.e., impactions, root canal, apicoectomies, and I've said this often.

Usually when I take multiple teeth out of people, I expect them to feel a lot better within four or five days. Now, her impaction would throw en entirely different light on that, and I would have *to* say from the site of your impaction that's going to be totally different, but these other areas 1 would expect you to feel a lot better in four to five days.

a So four to five days of pain in the area --

A *of* simple extraction.

Q -- of the simple extraction would be normal as far as you would say?

A Yes.

Q And as far as the area involving the impacted tooth, that would be an area where you would expect pain a little bit longer?

A In four or five days you would start to know if you're getting into the dry socket postoperative osteitis syndrome, the one that most people have heard about where you have your wisdom teeth out and it can hurt for a week or 10 days.

Those people that would get "dry socket" would have symptoms of that within four or five days, and then you can start to separate, which is primarily just packed, medicated gauze in this big hole that the wisdom tooth farmerly occupied. Or if you're having problems from the other mora routine extraction sites but two entirely different postoperative clinical scenarios, you would expect what a practicing oral surgeon would expect.

Q Mrs. Nabozny, her impacted tooth was on which side of her face?

A I can't tell from this. Oh, wait a minute. I think he said 17 was impacted, which would be the left side, but let me find his chart. Seventeen, which

would be the left side, so the opposite of the side where she ultimately had the problems.

Q So on the left side you could expect pain for about a week?

A Sure.

Q And that would still be within normal limit?

A Sure.

Q And that would not be alarming to you as an oral surgeon; however, on the other side, the right side of Mrs. Nabozny's face, you would expect the pain to be four to five days, and that would still be in the range of normalcy, is that true?

A Yes, I agree with that, but I would add something additional in that any time you work in the mouth, the potential for infection is there. Postoperative infections related with lower impacted wisdom teeth are quite different fram postoperative infections of the upper jaws. Postoperative infections in the upper jaws are less frequent, but can be far, far more serious.

Q Which kind of infection did Mrs. Nabozny have?

A From the upper jaw, back in the spaces and from the upper jaw, and so the --

Q How do you know that the site of infection isn't on the lower jaw and that it moves to the upper jaw and

moves into --

A What you don't know for sure, except I believe they got drainage from that area, from the area and from reading the reports, I sense that they felt like it was from the upper extraction sockets. Plus when you read the articles I have and if you were to go into them, usually lower jaws will be in different spaces than upper jaws, but it could have come from either one. You're absolutely right.

The other indication is that during the peals of her infection, shortly after admission to the hospital, she also had her right sinus completely full of pus -- of exudate, and this would not have occurred from the lower socket, She could have had some from both.

From looking at her x-ray, I just feel that the primary source was from the upper, but this we're kind of splitting hairs, Whatever its source, once it was there, it's kind of a moot point was it from the upper or lower tooth.

Q We don't really know the actual source of the infection?

a No, but I think that people going over all the records, the consensus of a group of maxillofacial experts would feel that it was from the upper

primarily.

Q No, but I mean we dan't know what actually introduced the! infection into Mrs. Nabozny's system, do we?

A Oh, there's no question in my mind it was the day of extractions. In my mind from reading it, I feel that the initial -- the initiating source of the infection was the extractions. In other wards, I'm not surprised that she ended up with what she had from the series of events that I read through the records.

Q No, I don't know if we're talking about the same thing. Do you know what it was that actually introduced the infection into Mrs. Nabozny's system?

A I think the forceps extraction of the teeth and roots.

Q So you think it was Dr. Chepla's forceps that introduced the bacteria that eventually resulted in her infection and her problem?

A I think any oral surgeon in the country removing those teeth would have had the potential to get the exact same infection. I don't think it was just Dr. Chepla.

I think anyone with the ability to assume the responsibility in removing those teeth would have had the potential of getting the same infection just from the act of removing those teeth. 1 think the! removal

of the teeth on, was it July 8th or whatever, was the initial source of her infection, was the date of extraction -- the things that happened in her mouth on the dote of extraction was the initiating cause of her future infection.

Q Okay. I think I understand your answer, but I still am not certain whether or not you're saying that the source of the bacteria which was introduced into her system, where that source was.

A Oh, from the teeth, from the retained roots and the low grade chronic infection around the teeth and just the infection *of* the mouth, the inflamed gums and so forth,

So I don't think in any way Dr. Chepla caused the infection by inadequate means of removing the teeth. I think just the fact that this lady has chronic infection in her mouth and has for months or years, which she claims, and so she has a low grade infection in her mouth all the time. The mouth on everyone is filthy and has more bacteria than any other part of the body.

She has a constant low grade infection, and I think the mere fact of trying to remove these teeth, which needed *to* be removed, introduced some of this bacteria into deeper levels of the maxillary area and

particularly back behind the tuberosity and back behind the bone of the alveolus, and then when you get beneath the attached soft tissue, gum tissue that's tightly attached, you start getting into areas of tissue spaces and tissue that is not tightly attached, and some bacteria just inadvertently got seated in this area and proceeded to slowly incubate.

Q How do you know that the bacteria that caused her infection is the same kind of bacteria that was in her, as you say, her low grade chronic condition?

A Well, now, no one can ever say precisely, you know, where the bacteria of her infection or where it came from because the amount of organisms and the variation of organisms in everyone's mouth *is* very broad.

It is rare to have an infection with pus, a cellulitis or an abscess in the mouth and be able to get a culture and sensitivity and give an unequivocal specific diagnosis because if you get pus out of the mouth, it will almost always come back normal oral flora, but with an abundance of such and such, staph, strep, what have, you, which abounds in the mouth.

So the trouble in dealing with infections in *the* mouth is you can't be precise as to what the bacteria was or what its source was because if he put

her to sleep and then injected with a local anesthetic, the needle might have transmitted some, which can happen, As he removed -- he says he did an alveolectomy of the tuberosity. Sa that means cutting the gum, pulling the tissue back a little bit, smoothing the bone, curating out the low grade infection, she had the chronic abscesses, and suturing her up, So that's introducing under the tissues.

Any and every oral surgeon that does this would have probably done it roughly the same way he did, and so I don't believe his getting the teeth out was substandard, but I think what he had to do and what he describes was the most logical way that the organisms which initiated subsequent events got deeply beneath the tissues enough to cause this, and I think the series of events that she shows and haw the infection progresses, in my mind, supports that took her awhile, too.

Q What is your understanding of Mrs. Nabozny's condition as she presented to Dr. Chepla? And by that I mean the health of her mouth,

A I'm sorry, the original presentation?

Q Yes.

A On the day of extraction?

Q Yes.

A Again, a routine, run-of-the-mill oral surgery case of someone who has refrained from routine dental care for a considerable period of time and now needs things cleaned up rapidly to salvage what is salvageable and get her back where she can function orally.

So the service of the oral surgeon is to get out all the things that arc in the way from getting the rehabilitation work done and so just remove everything that needs to be removed and clean things up so that usually the referring dentist can get on with his treatment plan.

And again, what I see here is so typical of things that I've seen in my office over the years that it is just run-of-the-mill oral surgery.

Q You had talked about a chronic condition that she had, and I know there's a lot of technical terms for that. Periodontitis, I believe, is one term that I've read. Is that what Mrs. Nabozny had when she came to Dr. Chepla?

A All right. Gingivitis is inflammation of just the gum tissue. Periodontitis is when this inflammation starts getting to the attachment of the gum tissue, to the tooth and the bone and is starting to cause

some bone loss and going deeper. She also has --

Q Do you see evidence of that in the x-rays?

A Not a great deal, a very little, and this is not uncommon in some people. People who are more prone to *decay*, many of them will be less prone to periodontal bone loss, and they feel some of this is because of the pH of tho mouth, acidic and alkaline.

People wha are very acidic will tend to have decay *and* vary little bone; loss, and people who, vice versa, can have a lot of bone loss, "Oh, my teeth are great, but my gums are bad," and you'll see very little decay but tremendous bone loss,

She shows very little bone loss. She just shows that her teeth in many cases have just rotted off to the guns, and why these people never get acute abscess where they suddenly swell up you don't know, but she's had these for years and yet -- so she has a chronic infection that has rarely, if ever, become acute.

She didn't go in with a lot of great gain. She said, "Well, I've got a couple teeth that are starting to hurt me with cold water," but the ones with the decay started getting close to the nerves where the crowns hadn't decayed dawn *to* nothing, and she said finally, "I've got such a mess. It's

finally time for me to really clean it up and do something good,"

But she does have chronic granuloma, which *is* inflamed tissue, but not bad. You know, you don't see a lot here. Her body seems to be very resistant, and I'm sure the people that used to cross the Plains, there would be some people who'd get an abscessed tooth and maybe die in a *few* days, and there are other people who have teeth rot off to the gums and never get abscesses, never swell bad, never -- you know, there's no way to explain it,

But she appears to be one of these people that when the decay starts getting near the nerve, it will hurt her fur while, If she can get through that and then the nerve might die, then she could keep going. This crown, if she bites on it hard, this upper third molar, it would probably just crumble to nothing and yet maybe not have pain for a day or two, and you wonder how they can do it,

So she has had long-standing decay with retained roots and not even a lot of obvious granulomas at the root tips, so she's a very hardy individual. Her body indicates that it has very good response to infection, and I think from what I read, for her sake, that *was* fortunate, but you see very

little apical infection,

So the next thing that you go on is from Dr. Sangrick's chart that she does have red gums and gingivitis and certainly an unhealthy, a chronic infection of the soft tissue attachments around the teeth, so we know it's not real healthy,

Q Do you know what the treatment plan was for Mrs. Nabozny?

A His record is in here, and it seemed that basically he was going to get the bad teeth out, send her to a periodontist, a gum specialist, to clean up around the teeth they were going to retain, and then he anticipated doing uper and lower partials, He said mainly amalgam fillings, but he was going to get a few crowns so he could go to precision attachments, which would not have the clasp.

So it sounded as though he had a very good treatment plan overall for her that would retain the teeth in the front of both arches with precision attachments, would give her posterior function, which she really hadn't had for years. She hadn't really been chewing food for years.

Q Let's take a look at your May 12th, 1988 report.

A Okay.

a In the first paragraph of your report you have

written, "I have reviewed in detail the documents and x-rays pertaining to Mrs. Nabozny's treatment by Dr. William E. Chepla in July of 1986." The x-rays that you reviewed that you're referring to are the ones that were provided to Dr. Chepla, is that right?

A Yea. I'm sure the duplicates -- and I think it noted that he received duplicates, didn't he? I think. I'm not sure.

Q Yes, you're talking about Dr. Sangrick's x-rays?

A Yes.

Q Which were provided to Dr. Chepla?

A Yes.

Q Those are the only x-rays that you have reviewed in connection with this matter?

A Yes.

Q And the documents that you refer to in that first paragraph would have been the documents that are listed in Mr. Zeiger's letter of May 5th, 1988, is that right?

A Right.

Q Have you received any other documents since that time?

A I have not received any, no.

Q No other depositions os anything of that nature?

A No -- did the deposition come with that? Let's see.

Yes, I received the deposition transcript at the same time, so yes;. So this is all X've received was all ---

Q The deposition transcript that you have reviewed is Dr. Chepla's deposition, is that correct?

A Yes, *Yes, it* was taken on Monday, the 30th of November, 1987.

Q Have you seen the other depositions that have bean taken in this case, for example, Dr. Sangrick gave a deposition?

A No, I haven't seen it.

Q Did you look at Mrs. Nabozny's deposition?

A Not her deposition, only her summary.

Q Okay.

A I haven't seen her deposition, no. I haven't seen any other deposition.

Q In the third paragraph *of* your May 12th, 1988 letter, the last sentence it reads, "Her initial oral surgery treatment on July 8, 1986 by Dr. Chepla was an ordinary procedure in the *average* oral surgery practice," Have you found any fault with the procedure that Dr. Chepla performed on July 8th of *19861*

A *2X0.*

Q Your next sentence in the next paragraph reads, "And

while her oral health on that day did not demand tho immediate use of antibiotics, that condition did indicate that an absolute need for antibiotics might present itself during the postoperative recovery period."

Do I understand you to mean by that sentence that you did not believe that antibiotics were necessary on the day of the surgery, July 8th, 1986, however, that afterwards this patient should have been monitored more closely to determine whether antibiotics were needed postoperatively?

NR, DeSANTIS: Objection, asked and answered, Go ahead and answer.

A I think I can give you the answer you're seeking in that, sap, there are some oral surgeons that I've heard of and some general dentists that extract teeth who put almost every patient on antibiotics and if Dr. Chepla or anyone else had started Ms. Nabozny on antibiotics, I think it would be difficult for anyone to find fault with that.

I also don't feel you can find fault with the fact that he didn't, so I think in a cross sectien of oral surgery practices, some would have started her, Some wouldn't.

Q I believe that if I understood what you said earlier

this afternoon, if you had been treating Mrs. Nabozny in June of '86 instead of Dr. Chepla, you would not have put her an any antibiotics?

A Probably not --

MR. DeSANTIS: Objection. That's not an accurate characterization of what he said. What he said is he wasn't sure at this time what he would do,

He would discuss with the patient whether she was the type of patient who infected easily, whether the patient had some desire to be on antibiotics beforehand, but he didn't say absolutely that he would not put her an them.

A Any patient with this type mouth and this type treatment plan could tip me into starting them on antibiotics the day of surgery, but most of them from the description of how she presented without acute abscess, without acute swelling, I probably would not have started her on antibiotics that date, July 8th.

Q Are you aware of whether or not Mrs. Nabozny had any acute abscess or acute swelling on June 8th of 1986?

A July 8th.

Q July 8th, 1986.

A Only from the records that neither Dr. Sangrick nor

Dr. Chepla nor her summary in any way indicates she came in with any swelling or acute abscess.

So there appears to be from three sources no evidence of any acute Infection, and so that's why I feel comfortable that on that particular day I find no fault with he! or anyone else not starting har on antibiotics OR that day.

Q Xn the next sentence in your report it reads, "Evidence supports the fact that such an absolute need did arise, that Mrs. Nabozny contacted Dr. Chepla's office more than once with indications of less than uneventful progress and that Dr. Chepla's responses were far less than adequate."

Let's start with the first part of that sentence where you say,. "Evidence supports the fact that such an absolute need did arise." What evidence are you referring to in that sentence?

A All of the events from her coming in to him on, I think, ths 18th and finally being started an antibiotics and her ending up in the hospital with the need for critical care in the treatment of an infection.

Q Can you be more specific? In particular, what evidence?

A Well, all right. Number one, there is no doubt in my

mind that the infection that Mrs. Nabozny acquired and was forced to deal with originated and stemmed from the extraction of her teeth on July 8th, 1986 and that these extractions themselves were not done in substandard care. But I have no doubt in my mind that she had just an unfortunate typical postoperative infection from routine extractions that subsequently led to an extremely severe maxillofacial infection that required hospitalization,

So 1 feel the series of events; as you go down the records and follow the people seeing her and the comments that it is a day-to-day series of events of her leading into a more infected condition that ultimately led ta hospitalization in which sophisticated x-rays showed without a doubt she had a major maxillofacial abscess.

Q Would you agree with me that the infection itself is not evidence of malpractice in and of itself?

A Oh, I agree with you, yes.

Q And the fault that you find with Dr. Chepla is not that an infection developed in Mrs. Nabozny after the multiple extractions but rather the failure to treat the infection once it became evident?

A Correct.

Q And you have indicated in your letter here that. there

was evidence to support a need to treat that infection?

A Correct.

Q What was the first bit of evidence that Dr. Chepla should have been aware of or was aware of that would have caused him to take some action or should have caused him to take some action?

A Mrs. Nabozny states in her summary that she called him on the 10th, two days postop, complaining of severe pain and stiffness in the jaw and temple and was told that this was to be expected and called again on the 11th complaining of severe pain and stiffness and again told that this was normal and was not seen until her prearranged postoperative visit for the 15th, which was seven days postop, and four additional days after her second day of complaint.

I believe that she was describing the cardinal clinical sign for potentially significant infection, postoperative infection, after routine oral surgery.

Q Let me ask you this. The July 10th call that she claims that she made to Dr. Chepla, she talks about severe pain and stiffness in the jaw, is that right?

A Um-hum.

Q Is there anything significant about what she's

describing to Dr. Chepla to you?

A Overwhelmingly.

Q What is significant and why? I'm just talking about the July 10th telephone call at that point.

A As you review these articles that I have, the thing that you will see in my mind that won't be hard for you as a nonmedical trained person to pick up on, the one key sign and symptom you look for in something like this where the potential was there the day of original surgery is trismus, stiffness.

She describes it -- well, severe pain and stiffness. Again, if I extract teeth, 12 or 15 or 20, and she calls me on the 10th and says she has severe pain and stiffness, even if I don't say anything then or don't assume anything then and she calls me again the next day, she is giving me every warning she can that something bad is brewing because I expect on simple extractions -- now, with her case if she said stiffness and extreme pain just in the lower left with the wisdom tooth, I'd still want to see her, but I would think wisdom tooth, dry socket, what have you.

But if she's saying the other side, which I assume she would say right side, but if she's saying elsewhere or all over or anything that's just not

consistent with an impacted wisdom tooth, I believe that that immediately should call attention to something other than something routine going on, because when you do simple extractions of roots where she's had these for months and years and she doesn't even have abscesses around them and her body is responding to these so well, from the extraction sites, she should be feeling tremendously better in two, three, four days.

I tell most people where I'm routinely extracting teeth that you may be sore for a couple of days, but in three, four, five you should be surprised how good you feel.

Q Do you find anything alarming about the fact that she had the severe pain on July 10th and Ilth? I understand what you're saying about tha trismus, but I'm trying to talk about the pain now for a minute.

Is the pain that she was experiencing, could that be within normal limits given what was done to her in terms of the surgery and the information that you have on her?

A I think truly in this case it would be significant as to which side. If she says severe --

Q Does her statement say which side?

A I don't know that she does, and I'm assuming that she

would have because everything indicates it was on the right side, That's where the infection was and that she never showed any real problems with the wisdom tooth socket, and so -- but in her case, you would anticipate and you would react differently as to which side because of tha impaction on one side and not on the other.

If she were to tell me, "Hey, it doesn't hurt on the side the impaction came out, it hurts more on the other side," this pain, severe pain would be highly significant also, to me highly significant.

Q So that you would not expect her to have severe pain on the right side of her face two or three days after the surgery?

A No, no. I would expect in most cases for them to say, "Gee, that feels a lot better. I sure om glad to have those rotten teeth *aut*," something *to* that effect.

Q Wow long a period *of* time would you expect them to experience severe pain, though?

A A couple days without postoperative problems. Those people who had no postoperative infection or problems, and some would, and that no one could treat a number of patients like her without getting the postoperative conditione he's getting in, but more

than half of them wauld just say in two or three or four days, "Boy, does it feel great to have those out."

Q Lat me look at this statement for a minute, if I could.

Do you know that; the July 10th and llth telephone calls that you are referring to were not contained in Dr. Chepla's records?

A Well, I have the copies of his records and see they were not, but I think she did call Dr. Sangrick on one or two of those occasions, didn't she? I believe she called him. I forget when she first called him, but I saw that they were not contained in his record.

Q Of course, if Dr. Chepla didn't have that information, then you can't judge him to react to something he didn't know about?

MR. DeSANTIS: You're talking about the information on July 10th?

NR. MEADOR: I'm talking about the July 10th and 31th telephone calls.

A Well, not true in that it's the captain of the ship situation.

Q Do you think that Dr. Chepla should have called her then on July 10th or llth?

A I think that Dr. Chepla has -- his office has to have

the policy of responding to calls of this type and even if no one told him she called, it's a failure of his office.

Q Wave you considered the possibility that Mrs. Nabozny didn't calf anyone, either his office or Dr. Chepla and has said this after the fact?

A I have not considered that for this reason, and I feel it a vary important reason. As I go through these records, in fact, I make the comment somewhere in my notes, this patient gives all the indications of a super patient.

She calla you when she's got a problem, she tells you and if you say, "Well, don't do anything," she lets it go. She's not second guessing. She's not -- the previous cases I talked to you about where I gave expert testimony here, it's amazing how long some of these people will go being a perfect patient to the doctor and after three or four months you wonder how long would they continue under that care, that doctor's care when *they're* not really doing anything.

So from the record I sense a feeling that she's being a very good patient, so I never had the slightest doubt that she called those two days.

Q In your next paragraph of your May 12th, 1988 letter

you said that, "Dr. Chepla's records are extremely inadequate but still capable of revealing a litany of poetoperative care omissions," and you go on to list four various omissions.

What about Dr. Chepla's records are in your words extremely inadequate?

A Well, times have -- you know, I practiced 22 years, and times have changed a great deal because of the malpractice crisis and everything, and our society, as many others, have started with the risk management programs and so forth.

Quite frankly, I would hazard to guess that at least 80 percent of all -- of most medical and dental records are "inadequate," Now that I've taken some risk management courses and now that I -- when I opened my own practise, I started making far better records than I did before of actually putting dawn things *that* happen and things that *were* said and things that might be anticipated.

Q Anticipating litigation?

A No, no, of potential infection. Like I probably would have put a note on her if I didn't start antibiotics, the need for future antibiotics may arise or something to that effect, and so I have kept records similar to Dr. Chepla many times over many

years, and I just believe in thia day and tine they are totally inadequate.

He does not describe in any detail what he really did or what his thought processes ox what he considered, and unfortunately, I've done the same thing. And he doesn't say that he talked to her about possible antibiotics, that it might be a consideration, and then there's no note anywhere that she did or did not calf.

So 1 would have to assume she did, and so these are things where, unfortunately, this is a very typical record which is -- they are typically inadequate.

Q You're not prepared to say that they're substandard just because of the record keeping itself-?

A Oh, I think as a record keeping, this is substandard.

Q Is that malpractice?

A In my mind, yes. Yes, without a doubt from the cases that I've reviewed and from the positions I've had on medical staffs, I personally believe that a substandard record is malpractice,

Q Well, I'm talking about Dr. Chepla's records.

A Yes.

Q You believe that his --

A I personally believe, yes.

Q That his record keeping in this case in and of itself is malpractice?

A I do and for this reason, When you go back and review substandard care and review the records, I think in almost all the cases you will find where a qualified expert will give you an opinion this patient received substandard care, you will also find a substandard record.

And to carry that further, I think it is an absolute requirement of someone assuming significant responsibilities in the care of someone, it's absolutely required to document not only what they did but some of the more important considerations they made, and I rarely did it in the bulk of my practice, but in this day and age I think it's an absolute requirement because I think in her case the potential consideration for future antibiotics was an absolute requirement.

The consideration that she may need them was absolute and in the treatment she received on July the 8th and that she might be one of these people that's going to need postop antibiotics down the road from what he saw when he took her teeth out.

Q Did I hear you say that approximately 80 percent of records nowadays are extremely inadequate?

A Well, I said that for this reason --

MR. DeSANTIS: objection. I don't know if he said extremely or not. I think he said inadequate.

A What I base this an is I have been chairman of the dental department for two two-year periods. I have been deeply involved in medical malpractice hero and plus on the medical staff receiving literature like from in Wisconsin they have the WISPRQ, the PRO agencies that I have to review for Medicare and so forth, and I've seen comments like in staff newsletters, tho medical records people asking for medical staff members to come down and help them review records for Medicare treatment and with the comments you need to come see the records. You won't believe them.

I have spent a lot of time in medical records talking to people about substandard care. I truly believe the bulk of hospital records, patient records and of dental records would fail any close scrutiny of what should be adequate today. We don't keep good records, anybody, and when you fall into something like this is where it suddenly becomes so important because in the bulk of the cases, nobody ever has to go back and Look at them. So there's no problem, who

cares.

Q But Dr. Chepla may want better records also?

A Yes.

Q And I'm not commenting on that one way or the other, but if I understand what you're saying, you're saying that the bulk of the records nowadays if they were scrutinized would fail the scrutiny?

A Yes, I believe that,

Q And what I'm trying to find out from you is why you would say that if Dr. Chepla's records fa13 within the majority or the bulk of the record keeping nowadays, why you consider that to be malpractice when malpractice is by definition failing to meet the standard of care, and I believe that the standard of care is defined by what the custom and practice is,

A Well, I --

MR. DeSANTIS: Objection, Wait a minute, wait a minute,

THE WITNESS: All right.

MR. DeSANTIS: I'm not going to let him answer that question because, first of all, 1 think it calls for a legal opinion about what malpractice is, and second of all, I'm not sure I understand it because it was so complex.

A Well, I can --

THE WITNESS: You don't want me to? I can answer it.

MR. MEADOR: Well, if he understands the question, Frank --

A I think it's very simple, and I can see why ha doesn't want me to answer it, and I think this will help you a great deal. The record is a specific part of the traatment. The record is as much a part of the treatment as putting the needle in her arm to put her to sleep, if that's what he used, in putting the local anesthetic needle under the gum to inject and putting the forceps up to remove the teeth.

The record is a specific part of the treatment and if you've got a record that is substandard, you've got substandard care because he cannot from this record go back and specifically identify whether ha talked to her about potential antibiotics, whether it ever crossed his mind whether she called or she didn't. All those are pertinent factors stemming to my unequivocal opinion that he rendered substandard care in this, and so the record is part of the treatment,,and this is what people fail to understand. It is as much as cutting the skin.

If you can't write down and document what you did, then you haven't done it properly because it's -- you can't separate the two. You've got to dictate an operative report. You've got to dictate a discharge summary. When you're in the hospital you've got to say what you did, and that's as important in the cases I've dealt with that I talked about before, The doctors would put the patients have complications and in a discharge summary would say no complications, no consultations, and they were dealing with something they didn't know what they were dealing with.

The record was as substandard as any part of the care they gave.

Q Let ma ask you this. What should Dr. Chepla have done then to bring his records up to the standard of care in this case? What should his record contain, in other words, to bring it up to your standards of care?

A Well, now, the only way I can answer on this case is that, quite frankly, I believe that Dr. Chepla gave substandard care -- I'm assuming she called, and if he didn't know, he should have on those two dates.

I believe he gave substandard care on July 10, questionable care on July 10, the first

call. I believe ha extended gross substandard cars Yuly llth, the eacond day she called, and he did nothing. On July 15th when he took the sutures out after seven days, they get to be mora of a harm than a help. Sutures, that is the only positive thing that I find, and from his record and his actions, I don't find he did anything right, and 3 find great gaps in even his surgical judgment in that I don't see he's thinking the right thing at the right time at any point in this is what concerns me.

So what I'm getting at is I don't know from this one case, and I'm not trying to classify him as a totally inadequate surgeon, T'm talking about one case, the care that he gave this lady in this one instance. From this I don't know if he knew enough on July 5th to make an adequate record -- I mean 8th, July 8th, because I don't see that he's even thinking about possible infection on the 10th, llth, the 15th, the 18th, and what really brings that home is when she comes in on the 15th and he's got a couple little lines here.

Now, this in the third time, as far as I know, to his office she is giving big red flags and big horns and big noisemakers I got problems going, significant problems, and he's got two little lines

in here, and he says something about possible TMJ ynin.

Q What happened on July 15th, 19867

A He took standard postop care of something, warm something, right -- he talks about right swelling, and then he says, "'Possible TMJ pain." You can hardly read it. There *is* I think in his deposition --

MR. DeSANTIS: Let me interject something. You ware referring to Dr. Chepla's notes?

THE WITNESS: Office record, yes, for 7-15-86.

Q And in the notes I had of his deposition, here it *is*, 7-15 if we go back to about Page 94 in his deposition, I'm not suggesting -- wait a minute.

"What was *the* next communication that your office had?"

"To my knowledge, it was her next appointment, July 15, '86. That's right, she came back. She was instructed to come back. That was a planned follow-up visit."

I'm just reading what he says, and --

MR. DeSANTIS: Let ma interject, Doctor. Why don't you read it to yourself

and see if it refreshes your recollection and than answer his question.

A Here it is, talking about what he wrote down. SR means suture removing. The stitches were taken out. Then it says, "H well." That means healing well. Okay, that's shorthand.

Then it says CO. That means complaining of and then pain right ear. Okay. "Then I wrote down possible or POS, which means possible TMJ pain." And whet is TMJ pain? Temporomandibular joint gain.

Q So that's what Dr. Chepla found on July 15th according to his notes?

A That's what his records states he found,

Q What, if anything, did Dr. Chepla do or not do on July 15th that constitutes malpractice?

A In my opinion, other than removing the sutures, he did absolutely nothing else right. Ha did everything wrong in that he did nothing plus --

Q Well, let me ask you this.

A -- he indicates --

MR. DeSANTIS; Let him finish, Why don't you let him finish his answer.

Q What should he have done?

A Plus he indicates he's looking -- well, it's so hard to explain. He says in shorthand, "Healing well,"

which is totally untrue from -- no, wait a minute. And then he says, "Chief complaint of right: Bar pain," and he says, "Possible TMJ pain."

Now, unless she comes in and says, "I have had a blow to my jaw, my husband hit me, I had an auto accident, I fell dawn the stairs," which she doesn't, from what he did the week before and for her to have swelling, for him to start to inject into this possible scenarios for her pain and so forth, possible TMJ pain is -- it scares me.

I see no rationale for it, So what I mean is she's coming in with clinical signs that he doesn't describe well, signs and symptoms,

Q What arcs the clinical signs that he didn't describe well?

A She's been calling since the 10th.

Q I'm not talking about the telephone calls, Doctor, because that is something --

A Yes, but it all leads up. I'm sorry.

Q That is something you're assuming because of the written summary that Mrs. Nabozny gave you, and that may very well be her testimony. I believe it was.

A Yes.

Q But my question to you is going by Dr. Chepla's records and what he saw on July 15th. According to

his notes, what did he do wrong?

A All right.

MR. DeSANTIS: Wait a minute?. I'm going to object. You want him *to* get into Dr. Chepla's head? I mean I don't understand your question. What he's telling you io what he --

MR. MEADOR: Let me rephrase *it* then.

MR. DeSANTIS: -- opines this doctor did wrong based on all the facts he has before him.

Are you asking him to opine on what this doctor did wrong based on limited facts? I don't know if that's possible.

MR. MEADOR: I'm asking the Doctor to answer my question based upon the recorda that we have and Dr. Chepla's office records and what his notes are and what it is that he did not da that he should have done.

A All right. I think I've answered.

Q And why?

A I think I can answer you and answer you fairly well. Excluding removing sutures, which was scheduled the day of surgery and which is typical at least by seven

days after surgery, excluding that, he did in my estimation from the factors I had to go by, her summary and his --

Q I'm asking you not to go by har summary.

A Okay. Even with that --

Q Assume that Dr. Chepla never got those two calls on July 10th and 11th and just assume what you have in Eront of you with respect to Dr. Chepla's notes and focusing in on July 15th.

MR. DeSANTIS: Let me interject. Let me, object and inject. Are you asking -- does this hypothetical include what happened afterwards too?

A That's what I was asking, Does that include subsequent events?

Q No.

A I can't take one day, I can't just by one day.

Q You have to *go* by what Dr. Chepla did and was told at the time it occurred, It's easy to judge in retrospect.

A Wait a minute. Let ma tell you why this is so important. As you go further in that on the 18th when she calls Sangrick and Sangrick calls Chepla and so forth, we know later on that she ha3 to be having trismus and stiffness before the 15th.

so I can't assume from his note that she doesn't have any stiffness and that she doesn't come in -- she says, "I could hardly open my mouth for him to get the sutures out:," and I believe that although ha didn't write it down for that day, he was looking at a patient that had a significant clinical trismus.

So, you know, I can't separate that from how I give you an opinion because there are *too* many factors after to show that had to be there, the day -- 7-15, Even though he didn't write it down, she's got to come in with a stiff jaw, she can't open very wide.

Q Just for the record, her first call to Dr. Sangrick was the day after, an the 16th.

A Yes, okay.

Q So 1 don't know if you're basing it upon some call that she made to Dr. Sangrick before the 15th. That's erroneous information because I don't believe the records indicate that.

So assuming now that her first call to Dr. Sangrick was on the 16th of July and assuming only the facts that you have in Dr. Chepla's office records for July 15th of 1986, what --

MR, DeSANTIS: Wait a minute now, and the testimony that he had at that

deposition explaining what he saw at that office visit.

Q And Dr. Chepla's testimony that's in his deposition regarding what he saw on July 15th, 1986, what did Dr. Chepla do *or* not do that *you* believe should have bean dona?

MR. DeSANTIS: And wait a minute now. Just so I understand your hypothetical, you want him to assume that she did not call on the 10th and the 11th?

MR. MEADOR: That's correct.

MR. DeSANTIS: You understand the hypothetical you're given?

THE WITNESS: Sure.

A Fram what I can surmise here!, you know, from later on --

Q Doctor, You know, the problem that we're having here -- I'm running out of time here, and even though I'm not trying to not let you explain yourself, I need to know specific answers to specific questions.

A Yes.

Q Not assuming any additional information, and I want you to only go by what Dr. Chepla says that he was told at that time, not assume --

A Okay.

Q -- subsequent events and not judge him in retrospect and also not include telephone calls that may or may not have been made before the 15th.

A Okay.

Q And if you could, could you tell me what it was that Dr. Chepla should have done on July 15th of 1986 based only upon what he says he was told at his deposition and his records for that day?

A Okay. I think I can do that for this reason --

Q You don't have to give me the reason why you can do it. Just give me the answer.

MR. DeSANTIS: And I'm going to ask you to take a look *at* the deposition transcript so that you know what he says that he saw or did on July 15th.

a I'll review what he says. "Suture removal, H well, means healing well, complaining of pain right ear, possible TMJ pain,"

All right. He says healing well. That's his summation.

Q Right.

A Shs says pain in right ear.

Q Right.

A That ain't healing well. That is a *total* contradiction, you know, one to the other.

Q Do you know what he means when he says healing well?

A He says, and I'm quotkng, "Then it says H well. That means healing well," okay,

Q Right. Do you know what is healing well'?

A That's shorthand. Sure, because? X've written it down thousands of times. It means clinically things look as you would anticipate them to look in this case seven days postop when he takes the sutures out.

There is nothing contra to what you *expect,* yet he says his term is healing well, and then the very next thing complaining of pain right ear. That's not healing well.

Now, what I'm trying to get at and I think what you want to know, my feeling is on the 15th he does absolutely nothing --

Q Let me ask you this.

A Now, wait a minute. -- specific. His actions are zero. He does nothing. He doesn't write a prescription. He doesn't tell her to come back. He didn't give her another appointment to see her the next day.

He does nothing from his record and his opinion, his surgical logic is totally faulty in that his summation *i*s she's healing well.

Q Right.

A And her summation is, "I've got a right ear that's hurting."

Q So you think it's inconsistent tor him to putting down healing well and at the same time put down that she's complaining of ear pain?

A Right, and then wait a minute, You've got to go a little further than that. When she says right ear pain and then he says he suspects possible TMJ pain when there's nothing anywhere in any of this, wherever you go, that she would have! any reason to have TMJ pain unless something from the extractions caused it.

Now, there arcs a couple of ways you could have TMJ pain. You can have infaction going there or when he puts her to sleep and opens her mouth kind of wide and fast some people would, but the pain if she gives no history of being hit or trauma anywhere, he's got to wander why would it be TMJ.

This is something completely new, foreign to what we should suspect should be anything connected with what we did. It's got to be foreign to this.

Q So are you saying that the TMJ pain that might result from a person's mouth being opened wide during the procedure would not last a week?

A Well, or even if it did, you know, he's got to have

some rationals to write down possible TMJ pain. I find nothing anywhere that gives him this rationale.

Q Do you know how --

A When you take these two lines, I have tu assume from these two lines he doesn't have any idea what's going on, and that's what scares me. His surgical judgment here from indicating what he writes down here approaches zero. (Indicating)

Q Rased upon what you have in front of you --

A With the two lines here.

Q -- regarding the two lines from Dr. Chepla's notes for July 15th of '86, what in your opinion should Dr. Chepla have done?

A Several things an that day, antibiotics quick,

Q Antibiotics, what kind *of* antibiotic?

a Well, she's allergic to penicillin, and he a few days later started her on Keflex, which probably would have been the one to start three days sooner, and the heat.

Q What else? And what?

A And he's got to see her the next day.

8 So he should have seen her the next day, and she should have been prescribed Keflex or some other antibiotic?

a And he should have started to find out why this pain,

where is it.

Q How does he do that?

A Clinically he's gat to examine her.

Q What kind of examination?

A Well, he's got to see how wide she can open her mouth. See, I can't totally divorce from her calling twice. What I'm getting at, though, I'm positive in my mind on the 15th when he's writing the note she's got trismus, and I'm positive he didn't put trismus in the note, and that blows his note to smithereens.

Q What's trismus?

A Trismus --

Q What's your definition of trismus? I can read the articles later on,

A Well, they had just one little thing that I wanted to read to you here in the first article, but tightness of the muscle, inability to open the jaw freely.

Q Okay. And you don't know how much she could opan her jaw on July 15th of '86, do you? You don't know how far she could open her mouth on July 15th of 1986?

A All the indications are from different sources significantly limited.

Q All the indications? The only indication is her summary of her calls, isn't that right? I mean what other indication do you have?

A Well, by the time she finally got in the hospital she had extreme stiffness and so --

Q That's about a week or so later, isn't it, Doctor?

A She gets in the hospital --

Q On the 22nd of July?

A 22nd.

Q The 15th is a week before that?

A Yes, that's really bad.

Q What besides her summary that you have read --

A Well, and the fact that all the people that have seen her, which were quite a few by the time she got in the hospital, no one had any doubt that she had been having trismus and where the infection was finally found.

And see, here's what you're missing and here's where I think you're -- if you look at where this infection is and what goes on in there and where the muscles are, you start to understand that with pus there, which you can't see it outside much, it is right between the muscle: -- two of the major muscles where you can open the jaw and that the trismus is all part of it. She's not going to get an infection there without having trismus. You can't have it without having trismus.

So clinically from the other notes and

everything, there is no doubt in my mind she's got trismus on the 15th, and she's starting to get it on the 10th and 11th, whether she called or not because of where they found -- when they finally got the MRI and showed it and when they finally treated her for it, she's got *to* have trismus.

Q So because of where they found her infection, the abscess on 7-15, right --

A See, you're trying to Limit me to 7-15 only, and I'm trying *to* say from the other things that are in here, everything is going to show you that. His note is so faulty, there is so much left out of his note. That has to be there. Me's missing so many things on the 15th. It is so sad.

Q And I'm trying to understand what are your other reasons, not confining you to July 15th. I know you're relying on *the* phone calls that she said she made on July 10th and 11th. I know now that you're relying on the fact of where the abscess was found, that she would have had to have had trismus a week before that, is that right?

A Yes.

Q How long before when they found the abscess are you able to go back in time and say she had trismus?

MR. DeSANTIS: Let me object. Now,

are you not letting him use the phone calls; to Sangrick? You asked him not to consider those earlier.

MR. MEADOR: Right. And your understanding, Frank, may not be the same --

THE WITNESS: This is so run-af-the-mill for me.

MR. DeSANTIS: Let me just tell you, Doctor, when Gene and I are talking about objections, you've got to wait until we resolve it.

THE WITNESS: I'm sorry,

MR. DeSANTIS: I just want to make sura the record is clear, I don't care if I understand or he understands. It's got to be clear on the record what you're asking him, what facts you're assuming to include in his opinions.

Q Using all the facts you know now, why do you believe that on July 15th of 1986 Mrs. Nabozny had trismus?

A When you go through these articles and have -- you know, some appreciation of the anatomy of where things are cooking in her anatomy, you will see that, number one, the thing that dings a chime on this particular thing is trismus because it's right up

between two major muscles and you get an abscess there, and the first thing that's going to give you any indication being a treating surgeon is trismus.

A patient's going to walk in and say, "Hi, I'm tired, I can't open wide, what's wrong," and you say, "I don't know," and you can't see the swelling, and that's why I go back to the 8th. If I don't start her on antibiotics, I know the least sign I get from her, I get her on antibiotics then.

Because if somebody comes in to me with significant trismus postop and I can't tell for sure where it is and can't get at it, it scares the devil out of me because if you dan't get them on the right antibiotics, they can start deteriorating quick and this is the problem.

Q I think I understand what you're saying. Because of the location of the abscess, it would have affected those muscles?

A Yes. Trismus is your primary key. Trismus is -- that's where it is, baby.

Q Can the infection not be severe enough to actually cause the trismus? Can it be in that location but not be large enough or severe enough at that point to actually cause trismus?

MR. DeSANTIS: As of July 15th or

at any time?

A Well, here's what I think is going on.

MR. DeSANTIS: Wait a minute. Let him -- I mean I don't understand the question, Gene.

I'm not sure that you're asking him in any case can infection be in a particular place and not cause trismus or in this particular case with Ms. Nabozny on July 15th could there have been an infection that could not have caused trismus.

Q I'm asking with respect to trismus in Mrs. Nabozny, could there have been an infection but it could not have caused trismus on July 15th, 1986, even assuming its final location?

A No, I don't believe so.

Q Can the infection move? In other words, on July 15th of 1986 could the infection not have been in the location whera it was eventually found?

A The infection can spread but not move in total. It won't move from starting here and all of it going here, but it will start here and spread. (Indicating)

Q Well, how do you know that the infection didn't start somewhere else and then spread to where it was

eventually found?

A Well, number one, from the x-ray, and the anatomy x-ray I haven't seen, but I can show you a picture of it from a report that kind of clears it up for you, from where they know it was and have proof to where it was and everything.

It had to start there where it truly became an infection that had to be treated and everything, because that's where the bulk of it was found and where it remained. When they finally two weeks later get her in the hospital and get the x-ray and start giving her antibiotics, the hulk of the infection are in this fossa, pterygopalatine fossa. (Indicating)

Q That happens to be a nice area. Is it a cavity area?

A Well, what it is is when you run your finger up in here behind the last tooth in the jaw and right up the base of the skull and you got nerves and major vessels, artery and veins and everything and than you've got muscles coming, you've *got* a muscle coming from in here to the head of the condyle and you've got a muscle coming down the two pterygoids, so you're in smaller -- (Indicating)

MR. DeSANTIS: Let me interrupt, Doctor. The record is not going to demonstrate that he's been referring to a

skull., and I don't knaw how you want to handle that.

MR. MEADOR: Doesn't matter to me.

A No, I can tell you how to handle it. One of the articles I've got goes over the anatomy of the spaces. So what I'm trying to do while you ask me questions is give you a better idea of what we're dealing with.

So you're dealing with an area about this big that part of its boundaries are muscles, are these two muscles that affect the movement of the jaw, and once you get an abscess in that area, their function is going to be impaired, and that is trismus. (Indicating)

Q And the area you've indicated for the record is about the size of a half dollar?

A Yes.

Q Is that a space?

A It's a space.

Q That's where the abscess was found with Mrs. Nabozny?

A Yes, and I think this will help you a lot, This is an MRI of a localization of a maxillofacial infection, and you see this big space, this is all pus. This is where -- this side you don't see it. This patient is infected like her in this area, and

all you'll sea is a pus. Sa the trismus is an automatic clinical -- (Indicating)

Q Automatic clinical finding after you get --

A -- first clue.

Q After you get *to* the point where the infection *is* in tho fossa, in the space area, then you're going to find the trismus?

A Yes.

Q Do you concede that an infection can start somewhere else and then spread into the fossa area and that you will not have the trismus until it actually reaches the fossa, which then would affect the muscles?

A Well --

Q Can you answer that yes *or* no?

A No, in that when does an infection become an infection? In other words, when he took the teeth out and you got the germs migrating back in the space behind the end of the jaw, upper jawbone and up on the edge of the space just in the front part *of* the space, this bacteria cooks for a few days and starts to get bigger and bigger, and sooner or later, if it continues to grow, affects the muscles enough to where your first sign in this area is trismus.

Q Okay.

A Alteration of function of muscle.

MR. DeSANTIS: Let me just interrupt, Gene. Just for the sake of the record, the MRI the Doctor was referring to earlier in his testimony came from a Journal of Oral and Maxillofacial Surgery, Volume 45, Page 549. He was referring to the upper right-hand image.

THE WITNESS; Yes.

A I'm going to give you all these,

Q Good.

A So I hate to -- I'm not trying to confuse you so much as I'm trying to hopefully make you better understand the area that you're dealing with.

Q At this point in time I'm going to have to go with what I feel is most important, and if we could, I'll try to move along as fast as possible given the time constraints.

Item D an Page 2 of your May 12th, 1988 report talks about failure to refer Mrs. Nabozny *to* a qualified source for treatment of her infection. When do you believe that Dr. Chepla should have referred her to another qualified individual?

A When he felt her postoperative complications were beyond his capabilities,

Q When was that? When should he have done that?

A Well, the 15th he did nothing, The 18th he finally started her on antibiotics, and then I don't think he saw her again after that other than to talk to her on the phone,

She should have been under the care of someone who's going to actively treat her symptoms, which we, now know are etched in stone to be a pterygopalatine abscess, She should have been having active treatment minimum by tha 15th, would have been best by the 11th if she made the phone calls Gut minimum by the 15th.

Q So it was malpractice *for* Dr. Chepla not to have referred her to another specialist on July 15th of 3.9863

A To treat her or refer her. He did neither. He didn't give her any active treatment. He gave her no treatment an the 15th, so it was.

Q What was it about the 15th that should have caused him to refer her to another specialist?

A Well, again I said treat or refer.

Q Right.

A So what was it about the 15th was primarily the trismus and the symptoms of a significant, potentially significant maxillofacial infection which demands treatment quick then, now.

Q Well, your opinion as to that he should have referred her, either treated her or referred her to another specialist on the 15th of Yuly is based upon your belief that she was having trismus on that day?

A Yes.

Q Was she having trismus before the 15th of July?

A I believe that she definitely did call him on the 10th and llth, and I believe trismus was beginning just a few days postop.

Q A few days postop would have made it --

A From the 8th to the 10th.

Q So you believe she was experiencing trismus on July 10th?

A Yes. I think early signs of trismus, yes, and I believe the llth, and this is why.

Q And certainly by the 15th?

A And this is why --

Q Is that true?

A I think by the 15th, yes, By the 15th.

Q So he should have referred her by the 15th or treated her --

A If he didn't want to treat her.

Q -- an the 15th? Did he have an obligation to refer her any earlier than the 15th or have another specialist treat her?

A He didn't see her. I think he haa an obligation to see her sometime first, and he didn't see her until the 15th.

Q When do you think that he should have seen her first?

a 10th would have been best, 11th without a doubt, assuming she made the phone calls, and I assume she did.

Q What was required *of* him, though, pursuant to the standard *of* care?

A In my mind to at least talk to her on the 10th and tell her that if she's no batter the next day, he has to see her and see her on the 11th and institute -- begin antibiotics on the 11th.

The 10th, you know, depending on what's going on that day and everything, but he's got to see her by the next day. Without a doubt, he's got to know she called on 10th, and he's got to see her on the 11th and from two days, baing the second day postop and the third day postop, and getting certainly no better, probably worse. She was getting no better, She had to be the same or worse. Start treatment then unless he didn't want to continue responsibility and then tu get her in the hands of somebody, a qualified source.

Q If he had decided to treat her on the 10th or llth,

what would the treatment have been?

A What ha finally did on the 15th, to at least begin with Keflex, at least begin with Keflex at that time,

Q Now, did you see his notes regarding the 18th of July?

A *Yas*, and the deposition, all. right, -- I've got Page 99 and 100 in his deposition. By the way, he was asked in the deposition, "How long would normal postoperativa swelling usually occur,'' and he said up to two weeks and maybe a little longer. That boggles my mind.

Q What is your opinion as to the normal range of swelling?

A For what he did?

Q Yes.

A Three to five days at the most or you've got problems, Ha says hers, "There's no indication that there was any swelling on the 15th or abnormal swelling." Swelling I can agree with. Trismus I don't. Now, getting back to the 18th --

Q Let me just --

A Here it is. That's when he starts talking about a possible parotid infection, parotid gland infection on the 18th.

Q Do you agree that the symptoms that he was seeing on

July 18th of '86, according to his notes here, not assuming other facts, could have been as a result of a parotid gland infection?

A Not so that he shouldn't be able to tell the difference, no. No, I think he should have been able to.

Q Well, what was inconsistent then looking at his notes from the 18th and knowing what you know about his notes from the 15th? What was inconsistent with a parotid gland infection?

A Well, several things. Number one, and I can't separate on the 15th, he said possible TMJ.

Q Right.

A Then three days later he says possible parotic? gland because she's getting more swelling, but she has gat -- and does he mention trismus in there yet? I don't know if he ever mentions it.

Q Let's assume he doesn't mention trismus.

A It's got to be in there. At this point in time he's run out of time to say possible this, possible that. He's gat to be doing everything he can to find out what it is now, and if he can't find out, to get somebody that can.

Q Well, let me ask you this. Looking at his notes from the 15th and the 18th, what is inconsistent in those

notes with the possibility of a parotid gland infection?

A Probably the degree of trismus. Now, I'm sorry --

Q The trismus is not in his notes.

A Yes, well --

Q I understand that you believe there was trismus at chat time, but without an indication of trismus, assuming that from my question, what about the notes of the 15th or the 18th as to her symptoms is inconsistent with a possible parotid gland infection?

A The possible source, the clinical evidence that you would get from milking the gland inside the mouth, what I'm trying to say is that while he's writing this note an the 18th, he's gat to be doing more than writing the note.

He's got to be doing specific things to find *out* like milking the gland to see *if* he's getting -- the duct comes out here. (Indicating) You can milk to see if you're getting saliva or a milky excretion.

He's *got* to be finding specific answers at this time, not just putting her on Keflex at this time. And he's gone from possible TMJ on the 15th to possible parotid gland, but he's not talking about probable, What is it probably? And this is what scares me about the whole thing.

He's too slow in finding out what is it most likely, and it's got to be something. This lady is getting more and more swelling. She's not getting any better, What is it most likely, and this is running a long time, and this, is what scares me about the whale thing. It's taking him too long to do anything more than, you know, possibles, and that's not good enough now.

Q Let me ask you this. What was it that this lady eventually ended up with?

A Well, she ended up with over a month in the hospital.

Q Pterygopalatine abscess?

A Abscess, yeah.

Q Well, based upon the notes here that you have on July 25th and July 18th, Dr. Chepla was considering the possibility of TMJ pain and he also considered the possibility of a parotid gland infection. Do you think he should have been considering at that time the pterygopalatine abscess?

A I'm embarrassed if these? are the best two things he could come up with.

Q Do you think that the pterygopalatine abscess was more probable at that point than TMJ pain or a parotid gland infection?

A Yes.

Q Why3

A Because from what he had done on the; 8th and the condition of her mouth, a postoperative infection stemming from removal of teeth was something that was more probable than a coincidental TMJ pain and swelling or a coincidental parotid gland infection and -- wait a minute.

And if you read these articles, you will see that when you get this infection, these lead to death and/or extrema morbidity, loss of sight, loss of sensation. You're dealing with something -- this lady, there's no doubt in my mind, got very close to death's door, and nobody will ever know how close, but she got close to dying,

These are life-threatening infections, and so he doesn't have time here to be thinking on one day possible TMJ and three days later possible parotid. He's got to be thinking am I dealing with the big bad one.

Q You've done hundreds of multiple extractions, you said that. How many pterygopalatine abscesses have resulted?

A God, less than 10, less than five, thank God.

Q Out of how many you said hundreds, can you give me an idea of what the number would be?

A Of what?

Q The 900, 800, 700 of these multiple extractions you've done over the years.

A I worked 22 years, and would I do five a month? Let's say 2,000, I don't know, 1,500, 2,000.

Q You've had five pterygopalatine abscesses?

A oh, less. Lass than five, I think, I don't know, but very few.

Q And out of those 2,000 or so that you've had, how many have you had where they've had TMJ pain a week after your extractions?

A I don't recall that any were?, that significant, that TMJ pain was a significant postoperative complaint from routine extractions. I dan't recall that played a part.

Q When you say significant, what kind of number would you put on the word significant?

A The best way to answer it is that if I did multiple extractions on Someone who later had TMJ pain, I can't recall where I wouldn't have clinical signs; and symptoms where I could diagnose it as TMJ pain and what the cause was, where it stemmed from.

It's impossible to have TMJ pain multiple days after -- in just routine multiple extractions and if it's truly TMJ pain not be able *to* cipher back

and see why. Oh, yes, I know why you have TMJ pain. I think I opened the prop too fast or something.

So it's not something that's usually related to this. The TMS and the parotid, to me it looks like he's grasping at straws, I don't know where these thoughts come.

Q Out of the 2,000 multiple extractions you've done or so, how many times have your patients developed a parotid gland infection?

A None or one. You know, I can't remember any. Now, one other thing, Gene, about going thraugh these articles and one of the things, they tall -- these articles, I started in '70 and went up through '85. The thing you've got to appreciate is before antibiotics, people *got* these and all of them died, as far as they can tell, and in one or two of these articles they talked about before antibiotics they assumed all people died when they had this infection.

Since antibiotics, these are very infrequent, very rare, and most oral surgeons will tell I've had one, I've had two, but if they happen, you're dealing with possible death, and if you let it get out of hand, it's just going downhill fast, and that's what the problem is.

MR. DeSANTIS: Let's go off the

record for a minute.

(Short recess is taken)

Q Doctor, have we discussed all of your opinions that you have regarding the treatment rendered in this case?

A My only opinion is that I feel that Dr. Chepla in thia case rendered substandard care to a groat degree, and I find his series of actions to be in my mind indefensible and I would want to say to him 3 have no malice to him. I hope he will read this and learn.

I hope this will never happen to him or one of his patients again, but in this case 1 believe he did nothing right and everything wrong, I will send you copies of these -- leave me your card, and I will send you copies of everything I've talked to you about.

Q Have we discussed, though, all of the areas in which you are critical of Dr. Chepla?

A I believe from what I just said there, we have in that --

Q I understand you said he did everything wrong and --

A It pains me --

Q -- I've tried to find out from you what it is in particular that he has done wrong.

A Well, there's one other thing that I haven't mentioned. He said in his deposition he did the right thing sending her to a neurologist.

Q Yes.

A Two things I disagree with, Number one, I don't think he really made the referral. He told her ta call one, and number two, a neurologist was not a qualified referral. She needed three things at that time.

Q At what time?

A When she finally got admitted to the hospital. She needed an adequate special type x-ray and CAT scan or MRI was the best, and she got an MRI.

She needed an infectious disease person to tell him what is the best bullet to grab, what antibiotic because they don't have time for culture and sensitivity, and she needed somebody who would get in there and try and stab and get some drainage in that area. When you look at that picture I showed you, It shows what she had to get.

Q She did finally receive all those three things?

A Yes, but a neurologist can't do any of *those* things, and a neurologist could only say she sure does have neurological signs and she's lost some sensation, but he doesn't deal with infections and he doesn't stab

and drain, and so he was not a qualified source for her.

She needed the combination of a good x-ray, an infectious disease person *to* say what is the best antibiotics right now, we've *got* to grab something quick and *get* in her vein and who can get back there and stab and drain, and Dr. Chepla says he does orthognathic surgery, which means he probably moves the upper jaw.

You can't move the upper jaw without not baing agreeable to go back in that area and try drainage. He should have been qualified *to* try that, and if he didn't want to, he had *to* get some people to do that, but you had to do those three things, and a neurologist can't do those,

Q You haven't prepared any other reports besides the one you looked at?

A No. I will send you copies. Leave me your card, and I'll send you copies. I'll send you copies *of* how I've marked these.

(2:37 p.m.)

STATE OF WISCONSIN)
) ss.
COUNTY OF DANE)

I, LISA A. CREERON, Notary Public duly commissioned and qualified in and for the State of Wisconsin, do hereby certify that pursuant to stipulation, there came before me an the 7th day of November, 1988, at 6101 South Highlands Avenue, Madison, Wisconsin, the following named person, to wit: IRA E. WILLIAMS, D.D.S. KATZ, who was by me duly to testify to the truth and nothing but the truth touching and concerning the matters in controversy in this cause: that the witness was thereupon carefully examined upon oath and reduced to writing by me; that the deposition is a true and correct transcription of the testimony given by the witness; and that the witness read and signed the same; I certify that I am neither attorney or counsel for, nor related to or employed by, any of the parties to the action in which this deposition is taken, and further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially interested in the action. In witness whereof I have hereunto set my hand and affixed my notarial seal this 15th day of November, 1988.

My commission expires:
2-28-89

Notary Public, State of Wisconsin

IRA E. WILLIAMS, D.D.S.
DIPLOMATE, AMERICAN BOARD OF ORAL AND MAXILLOFACIAL SURGERY ✦ PRACTICE LIMITED TO ORAL AND MAXILLOFACIAL SURGERY

January 29, 1988

Curriculum vitae:

Graduated University of Tennessee Dental School 1961

Dental Internship - VA Hospital Memphis Tenn. 1362

Oral Surgery Residency - VA Hospital and Marquette University Milwaukee, Wis 1963-66

Private Practice of Oral Surgery, Madison, WI 1966 - Present

Membership in:

Dane County Dental Society

Wisconsin Dental Association

American Dental Association

Fellow American Dental Society of Anesthesiology

Wisconsin Society of Oral and Maxillofacial Surgeons (President 1977-79)

Fellow American Association of Oral and Maxillofacial Surgeons

Diplomate American Board of Oral and Maxillofacial Surgeons

Executive Committee and Board of Directors
Member of Dane County Unit of American Cancer Society 1972-78

Board of Directors Wisconsin Division
American Cancer Society 1978-80

Wisconsin Council for Cancer Control 1977-79

Chairman of Dental Department and Executive Committee
Medical Staff Methodist Hospital 1974-76, 1980-82

Clinical Instructor ENT/Plastic University of Wisconsin
Medical School & Hospital 1977-82

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May 12, 1988

Mr. Richard C. Zeiger
Kaufman & Cumberland
Attorneys and Counselors at Law
1401 East Ninth Street, Suite 300
Cleveland, Ohio 44114-1779

Re: Kathleen Nabozny

Dear Mr. Zeiger,

I have reviewed in detail the documents and x-rays pertaining to Mrs. Nabozny's treatment by Dr. William E. Chepla in July, 1386.

It is my opinion that Mrs. Nabozny received treatment which fell below a reasonable standard of oral and maxillo-facial care by Dr. Chepla during the period in question.

Mrs. Nabozny's treatment history and x-rays reveal a person who has been referred by Dr. Sangrick and is presenting herself to Dr. Chepla with a desire and intent to rehabilitate her current oral condition and function. Her initial oral surgery treatment on July 8, 1986 by Dr. Chepla was an ordinary procedure in the average oral surgery practice.

And while her oral health on that day did not demand the immediate use of antibiotics, that condition did indicate that an absolute need for antibiotics might present itself during the post-operative recovery period. Evidence supports the fact that such an absolute need did arise, that Mrs. Nabozny contacted Dr. Chepla's office more than once with indications of less than uneventful progress, and that Dr. Chepla's responses were far less than adequate.

Dr. Chepla's records are extremely inadequate but still capable of revealing a litany of post-operative care omissions, i.e.

a - failure to see Mrs. Nabozny on either July 10 or llth, after her calls regarding post-operative problems,
b - failure to start her on antibiotics on July 15th, the date of her "scheduled" post-operative visit,
c - failure to act with regard for her extremely significant complaint of "trismus," which in and of itself demanded antibiotic therapy, and

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