[redacted]	*	IN THE
600 BELVEDERE TERRACE SALISBURY, MD 21804 PLAINTIFF	*	ORIGINAL
	*	CIRCUIT COURT
v.	*	
[redacted], M.D. 522 CYNWOOD DRIVE EASTON, MD 21601	*	FOR
AND	*	
DICKINSON MEDICAL GROUP, LLC (A DELAWARE CORPORATION) 800 NORTH DUPONT HIGHWAY MILFORD, DE 19963 DEFENDANTS	*	TALBOT COUNTY
	*	CASE NO.:
	*	20-C-05-005540 MM

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Deposition of [redacted], M.D., taken pursuant to notice before Robert Wayne Wilcox, Jr., Registered Professional Reporter and Notary Public, in the offices of Dickinson Medical Group, 800 North DuPont Highway, Milford, Delaware, on Tuesday, May 30, 2006, beginning at approximately 5:10 p.m., there being present:

APPEARANCES:

RODNEY M. GASTON, ESQUIRE
MILLER & ZOIS, LLC
Empire Towers - Suite 1001
7310 Ritchie Highway
Glen Burnie, Maryland 21061
for Plaintiff,
410-553-6000

APPEARANCES (CONT'D):

DENNIS D. FERRI, ESQUIRE
MORRIS, JAMES, HITCHENS & WILLIAMS LLP
222 Delaware Avenue
10th Floor, P.O. Box 2306
Wilmington, Delaware 19801-2306
for Defendants.
302-888-6800

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[redacted], M.D.,

the witness herein, having first been duly sworn on oath, was examined and testified as follows:

([redacted] Deposition Exhibit Nos. 1 through 4, respectively, were marked for identification.)

BY MR. GASTON:

Q. Doctor, my name is Rodney Gaston. I'm an attorney. I represent Ms. [redacted] in the action that's currently pending in the Circuit Court for Talbot County.

Have you had your deposition taken before?

A. Yes.

Q. Okay. I'll just go over a few of the rules, but you probably already know them. The court reporter is taking down everything we say. I would ask that your responses be verbal. The court reporter can't take down a shake of the head or a nod. Also if I ask you a question and you don't understand, please stop me and let me know; otherwise, we'll assume that you understand all of the questions and your answers are in response to the questions. And if you have to take a break at any time,

please let me know, and we'll take a break.

A. Okay.

Q. All right. Doctor, has anything changed on your curriculum vitae that was attached to the answers to interrogatories?

A. Can I see the one that you have?

Q. Sure.

A. Well, this is -- this one isn't mine.

Q. Oh, I'm sorry. Excuse me.

Actually, I asked you to bring a copy of yours with you.

MR. FERRI: We have it. It's in there.

THE WITNESS: Okay.

BY MR. GASTON:

Q. Okay. May I have that copy?

A. Yeah, sure.

Q. Okay.

A. The only thing that might have changed is I've given a -- I've probably given a couple of lectures.

Q. What? Since then?

A. I've probably given two -- a couple more seminars. The last one was "Complications in Total Knee

Replacements" at the American Association -- American Orthopaedic RN annual meeting, May 10th, 2006.

Q. Okay. I'm just going to refer to your copy.

MR. GASTON: All right. If I can have that, I'll have that marked as the next exhibit, please.

([redacted] Deposition Exhibit No. 5 was marked for identification.)

BY MR. GASTON:

Q. Okay. Doctor, we've just marked your curriculum vitae as Exhibit No. 5. Is that accurate?

A. Yes.

Q. Okay. Thank you.

Please state your name and address.

A. [redacted], M.D., 800 North DuPont Highway, Milford, Delaware 19963.

Q. And your date of birth?

A. 6/28/54.

Q. Okay. Doctor, in this case we've asked you to submit certain answers to interrogatories. I want to show you what's been marked as Exhibit No. 2 and Exhibit No. 1. I'm going to ask if you remember answering those questions.

A. Yes.

Q. Has anything changed since the time that those questions were answered, and/or do you want to make any changes to those answers?

A. Has anything changed? No. And I don't wish to make any changes.

Q. Okay. Were those answers correct when you answered them?

A. Yes.

Q. Okay. And the same with respect to the answers to interrogatories for the Dickinson Medical Group?

A. Yes.

Q. Okay. Thank you.

Doctor, has your license to practice medicine ever been restricted, suspended or censored?

A. No.

Q. Okay. Have you ever had any of your privileges at any hospitals or medical facilities suspended or restricted or revoked?

A. No.

Q. Doctor, do you hold yourself out as a

highly-skilled and experienced orthopaedic surgeon?

A. Yes.

Q. Do you also hold yourself out as an orthopaedic surgeon that has a specialty in joint replacements?

A. Yes.

Q. Over the course of your medical profession, can you tell me approximately how many knee replacements you have performed?

A. 2,000.

Q. 2,000.

Doctor, over the course of your medical profession, can you tell me the names of your insurance carriers?

MR. FERRI: Is that relevant?

MR. GASTON: Yes.

A. I can't remember all of them, but one of them was NCRIC.

Q. NCRIC? Do you know where they were located?

A. No.

MR. FERRI: That's the current carrier.

BY MR. GASTON:

Q. That's your current carrier.

How long have you been with NCRIC?

A. A year.

Q. Okay.

A. I'm just guessing. I don't really know.

Q. All right. Do you know the carrier that was in place at the time this incident happened in December of '03?

A. No.

Q. Any way we can find that out?

MR. FERRI: Yeah. For the record, it's NCRIC.

BY MR. GASTON:

Q. Okay. Doctor, do you know who your previous carrier was?

A. Was it MedChi? I don't know who the previous one was.

Q. Okay. How many years have you been practicing medicine?

A. Twenty-one.

Q. Do you hold licenses in Maryland and Delaware?

A. Yes.

Q. Any other state?

A. Georgia.

Q. Any other state?

A. No.

Q. Okay. Doctor, have you ever had any prior medical malpractice claims filed against you?

A. Yes.

Q. Can you tell me how many and the years?

A. Two main ones. And I was named in a malpractice case maybe ten years ago where a patient died from unrelated orthopaedic problems. And every doctor that seen her was named. I saw this patient as -- in consultation for a failed hip replacement. And I was dropped from the case after they reviewed information.

Q. Okay. That was one.

What about the other one?

A. The second one was a case where I repaired a crushed finger, or a mallet finger, and the patient ended up with a necrosis of her fingertip and from -- presumably from the crush injury. And I won that case.

Q. Did that matter go all the way to trial?

A. Yes.

Q. What state was that in?
A. Maryland.
Q. Maryland.
Do you know how many years ago?
A. Probably five.
Q. Five years.
So those were the only two medical malpractice claims that have been brought against you during the entire time that you've been practicing medicine as a doctor?
A. No. The other one -- there was another one.
Q. Okay.
A. It was what's called a tibial tubercleplasty or Fulkerson -- that's F-u-l-k-e-r-s-o-n -- procedure. The patient developed an infection and claimed that I hadn't treated the infection quickly enough. They said I treated her seven days instead of five. That one settled.
Q. Settled.
How long ago was that case?
A. That was about three -- maybe three years ago.
Q. Three years.

Was that case in Maryland?

A. Yes.

Q. Do you know who the plaintiff's attorney might have been in that case?

A. I can't remember his name.

Q. Okay. You had your deposition taken before.

Would it be in one of the three cases we just talked about?

A. Yes.

Q. Have you ever testified as an expert witness in any medical malpractice case?

A. In court?

Q. Where you might have given a deposition in a case that may have settled or may have went to court.

A. Yes.

Q. Can you tell me how many times?

MR. FERRI: Are you talking about in medical negligence cases?

MR. GASTON: Medical malpractice cases.

MR. FERRI: A malpractice case.

MR. GASTON: Mm-hmm.

A. Let me think.

Can I just say what they were?

Q. Well, do you know what state they were in?

A. One was in Maryland.

Q. In Maryland.

Now, did you testify on behalf of the patient or behalf of the doctor who was sued?

A. The doctor.

Q. Okay. What doctor was that?

A. Wilson Choi.

Q. C-h-o-i?

A. Yeah.

Q. Where is Dr. Choi located?

A. Lewes, Delaware.

Q. Okay. Do you remember what year that was where you provided deposition testimony on behalf of Dr. Choi?

A. It was roughly 1990.

Q. 1990.

Did that case --

A. Let me think. Hold on a second.

Q. Okay.

A. It's 2006. Probably about 1990.

Q. Did that case ever go to trial?

A. No.

Q. Okay. Any other cases?

A. I reviewed a case on a lady who had a knee replacement -- hip and a knee done in D.C. that was -- ended up with an amputation. And I gave a deposition on that case. And that did not go to trial. That settled.

Q. Do you know what doctor you testified on behalf of?

A. Oh, no. I was the plaintiff's expert on that one.

Q. Oh, okay.

Do you know the lawyer who asked you to come to court for the patient on that case?

A. No.

Q. Don't remember. Okay.

MR. FERRI: By the way, Choy is C-h-o-y.

MR. GASTON: Oh, I'm sorry.

MR. FERRI: That's all right.

MR. GASTON: Thank you.

BY MR. GASTON:

Q. Any other cases, Doctor?

A. Depositions? I can't remember any offhand. I have reviewed other records for -- I reviewed a couple other records for plaintiffs' attorneys and have -- I can think of two cases that I've reviewed and I determined that I didn't think negligence was involved. And I advised the attorneys to that effect.

Q. I'm more interested in the cases where you had to give sworn testimony under oath. Other than the ones you talked about, are there any additional ones?

A. No. Not that I can remember.

Q. Okay. Do you intend to offer any opinions at trial in the event that you testify?

MR. FERRI: Yes.

MR. GASTON: Okay.

MR. FERRI: I can answer that one.

BY MR. GASTON:

Q. Okay. The next question is: Can you tell me all the opinions that you are going to offer at trial?

A. You have to ask -- yeah, I can, but I have to be asked a question first.

Q. Well, I need --

MR. FERRI: You're talking about in

terms of --

MR. GASTON: Any opinions.

BY MR. GASTON:

Q. When your lawyer asks you, Doctor, do you have an opinion within a reasonable degree of medical probability XYZ, I need to know what are those opinions -- what you're going to testify to in this case.

MR. FERRI: He wants to know, for example, if you're going to testify on your standard of care and whether or not you met standard of care and issues dealing with what did or didn't cause injury in this case and the extent of damages. That type of --

THE WITNESS: Yes.

MR. FERRI: -- testimony.

BY MR. GASTON:

Q. Okay. Can you tell me what these opinions are, Doctor?

A. Well, I'll just -- it's my opinion that I didn't -- did not breach the standards of care in any way in the care of this patient.

Q. Okay. Any other opinions?

A. It's my opinion that the last knee revision

surgery that she had was unnecessary.

Q. That's the total knee replacement performed by Dr. Petrera?

A. Yes.

Q. Have you had an opportunity to review those medical procedures from Dr. Petrera pertaining to that last knee replacement?

A. Yes.

Q. Okay. Doctor, why in your opinion is that last knee replacement unnecessary? Why was it unnecessary?

A. Because I disagree with his opinions as to why her -- this patient had a painful knee and disagree with his opinions as to sizes of components and joint level and as to what was causing her pain. I think Dr. Petrera was -- I think that he made some bad decisions.

Q. Okay. What is your opinion as to what was causing her painful knee that you disagreed with Dr. Petrera?

A. That his -- anywhere from 3 to 5 percent of patients who have had knee replacements develop a painful knee. Sometimes stiff, sometimes not. But there's a

certain percentage of patients who do not get a great result after a knee replacement. It doesn't matter whether it's Dr. [redacted], Dr. Petrera, whether it's done at Harvard Hospital for Special Surgery, Hopkins, Stanford. There are certain -- no matter how many you've done or how good you are, how perfect you do the surgery, there are a certain percentage of patients who do not get a good result.

Q. Okay. That just tells me that there's a percentage of patients who will have a painful knee. But what about [redacted] case? Why do you disagree as to what Dr. Petrera says about why she had a painful knee? That's what I'm getting at.

A. Well, there's a couple of reasons. One is I don't agree -- I was the one that did the surgery. I was there. And having done a couple thousand total knee replacements, I know when a component is the right size and when it's not.

And the fact that she did not get complete relief of her pain after he did her revision -- last revision surgery tells me that perhaps -- tells me that the component -- his allegation the components were

too big was not the cause. Otherwise, she would have had a great result after the surgery with no -- with complete relief of her pain.

Q. Do you have an opinion as to what is the cause of her pain now if it wasn't the incorrect component size? What do you think is causing the pain now?

A. There's -- some people develop scar after a knee replacement surgery. And it's painful. That's my opinion.

Q. With respect to Ms. [redacted], do you have any specific opinion as to what is causing her continued complaints of pain now?

A. There's a certain percentage of patients that you never know. There's no answer to that.

Q. Okay. Thank you. There's no answer.

Let's see. Now, you said his surgery was unnecessary. Why do you think it was unnecessary in light of her complaints she had at the time she saw him?

A. Because she was improving. It had been less than a year since she had had the surgery. And anybody who does a lot of knee replacement surgeries will know that patients get better for a whole year. It's prudent

to wait, because I've seen scores of patients who've had stiff and painful knees at three months, six months that come back in a year with a good result.

Q. How --

A. And I just think that, you know, his concept that the components were too big was -- and that's what was causing the pain was wrong.

Q. Okay.

A. I don't agree with him.

Q. In your opinion, what is the period of time that Dr. Petrera should have waited before he did the total knee replacement again?

A. I don't think it was ever indicated to do a revision in her -- another revision.

Q. It was not ever indicated?

A. No. Because I don't think her components were too big.

Q. Okay. Any other opinions that you intend to elicit at trial?

A. No. Not unless I'm actually asked to give opinions. Then I'll be happy to give my opinion.

Q. Put it this way: The reason I'm asking you

all these is because -- the reason we take the deposition is so there's no surprises -- so that we know -- when you come to trial I know what your opinions are going to be.

Other than what you told me, do you have any other opinions that you intend to give at trial?

A. No.

MR. FERRI: Do you want me to ask a few questions now or do you want me to wait until the end while we'll on this?

MR. GASTON: You can assist with the question.

MR. FERRI: Okay. Are you going to offer any opinion with regard to whether or not Mrs. [redacted] fell within that category of the 3 to 5 percent of patients who wind up with a painful knee?

THE WITNESS: I would say that that was -- she falls into that category at 3 to 5 percent -- patients who get a bad result.

BY MR. GASTON:

Q. Can you explain why you believe she falls into that category?

A. Because she had a knee that still hurt. Her

range of motion was not that bad before she had her last revision. I can't remember what it was off the top of my head, but it had been improving for quite some time.

And the two reasons I give that opinion is: No. 1, I was the one that put the knee in, and I know it was the right size, because I was there. And that's what I'm trained to do. And No. 2, she did not get a great result after the last revision. And if indeed the components had been oversized and that had been the cause of her pain, then you would have anticipated that she would have had a pain-free knee afterwards.

Q. Even with all the prior surgeries she had you would anticipate a pain-free knee?

A. Oftentimes, you can do a third -- you know, do a third revision and have a patient with a knee that doesn't hurt.

Q. Okay.

A. But if you're operating on a patient who just fits into that category of a bad result as a stiff and painful knee, you can operate on them a hundred times and they're still going to have a bad result.

Q. Okay.

A. The mistake is to operate on somebody like her -- when they have a stiff and painful knee is to operate on her again. And I think that's what was the mistake -- to operate on her the last time.

MR. GASTON: Go ahead.

MR. FERRI: I have two more areas.

Are you going to offer any opinion as to whether or not you used a proper tibial insert in this case?

THE WITNESS: Yes. And I'm sure it was the right size.

MR. FERRI: Okay. Are you going to offer any opinion as to whether or not the joint line was proper?

THE WITNESS: It was -- the joint line was proper.

MR. FERRI: And the last one: Are you going to offer any opinion as to what you think, if anything, should have been done for Mrs. [redacted] had she continued to treat with you?

THE WITNESS: My plan -- and I believe

she left my practice at about three months after her last surgery. I could be off on -- a little bit on that. But I think it was about three months.

My plan was to wait, because a lot of times if you wait the patients get better. And if she did not improve, my plan was to look in her knee with an arthroscope and release the scar tissue, which is a much more benign surgery than a revision. It's an outpatient surgery. Recovery is a whole lot quicker. You don't have the blood loss. It's just a much more benign surgery. And many of those patients with stiff knees will get better just from that.

And I know I've probably done 30 or 40 of those. Maybe 50. Now some of my own patients, some other doctor's patients. And I'm actually considered, more or less, an expert in that area. As you can see from my CV, I've been invited to give that talk -- arthroscopic lysis of adhesions -- on multiple occasions. I've given that talk at a bunch of meetings as recently as last summer.

And my plan was to give her at least another three months. And if she wasn't happy with her

range of motion -- was to perform an outpatient lysis of adhesions in hopes of improving her range of motion. Now, if I thought that her components were too big, then I would have considered revising her knee. But having put them in, I knew that they weren't.

MR. FERRI: I'll just finish with one other. I'm sorry. I forgot.

Are you going to offer any opinion with regard to the release of the popliteus tendon?

THE WITNESS: I think that's -- any surgeon who's done a lot of knee replacements will do that. Some surgeons release the popliteus tendon every time they do a knee replacement. My partner, Dr. Quinn, is one of those surgeons. He's released the popliteus tendon in every knee he's done in the last 25 years because you do occasionally get an impingement of the tendon with a snapped -- tendon with a snapping tendon, which can with be painful.

Me personally, I've always left it intact. And if it causes snapping, I've released it. Sometimes you release it right at the time of surgery. And I've actually had to go in on a couple of knees -- as

least one knee -- and released the tendon after the surgery had been done through the arthroscope.

MR. GASTON: Any other opinions?

MR. FERRI: No.

BY MR. GASTON:

Q. Okay. Doctor, do you know how far the joint line was raised in Ms. [redacted] case after you did your surgery?

A. It was pretty close to the original joint line. And I'll tell you that -- there's two reasons I say that. One is, when you make the femoral cut, the jigs are standard. You put a drill hole in the femur, put a guide that goes down the femoral canal. And there's a cutting guide attached to the end of that. And it only allows you to take off a certain amount of bone. It says 0, 2 and 4, and, you know, I always make the cut at zero. So I remove the same amount of bone every time. And so I know that the femoral component was right where it was supposed to be.

I can take my postoperative x-rays and compare that to the preoperative x-rays, and I can see that the joint line is the same place it was before.

It's acceptable to adjust a joint line by a few millimeters. Sometimes if you release the posterior cruciate ligament you can even adjust it by as much as a centimeter and it shouldn't make any difference as far as causing limited motion or pain. And I can tell you that her -- from having done her surgery, looked at her x-rays and knowing how I did the surgery, the joint line is well within the accepted levels.

Q. You said the joint line before was the same as the joint line after?

A. Yeah.

Q. Is that correct?

A. Yeah.

Q. Okay. You used a setting of zero?

A. Yes.

MR. GASTON: Okay. All right. Any other opinions?

MR. FERRI: I don't believe so.

MR. GASTON: Okay.

BY MR. GASTON:

Q. All right. Doctor, did you bring Ms. [redacted] medical chart with you today?

A. Yes.

Q. I'm going to ask you some questions about the surgery. You can feel free to open up to the surgical note. Doctor, what was the date of the surgery on Ms. [redacted] left knee?

A. Which one?

Q. The December surgery.

A. The last one?

Q. Yes, sir.

A. The last one that I did -- 12/10/03.

Q. Okay. Doctor, prior to that surgery, did you do what would be considered a partial knee replacement --

A. Yes.

Q. -- on that same knee?

A. Yes.

Q. I asked you to bring some x-rays to the deposition today -- what has been marked as [redacted] No. 3. I will ask if you can identify that x-ray.

A. Yes.

Q. What is that, Doctor?

A. That's the left knee with a unicondylar arthroplasty.

Q. Is that x-ray of Ms. [redacted] knee?

A. Yes, it is.

Q. Doctor, from the date on the film, when was that taken?

A. May 6th, 2003.

Q. Okay. I show you what's been marked as [redacted] No. 4. I'll ask you if you can identify that x-ray.

A. Yes. It's a left knee with a unicondylar arthroplasty dated September 23rd, 2003.

Q. Okay. Both of Ms. [redacted] left knee. Correct?

A. Yes.

Q. Doctor, did you do the unicondylar replacement that's depicted in that surgery?

A. Yes, I did.

Q. Do you remember how soon before the December 10th, '03 full knee replacement that you did the unicondylar surgery? How many months?

A. The question again?

Q. How many months before the December 10th, '03 surgery did you perform the unicondylar surgery?

A. Oh. When was that unicondylar arthroplasty done?

Q. Mm-hmm.

A. Let me look it up for you. October 28, 2003.

Q. And the full knee replacement was done two months later?

A. 12/10/03. Let me check. Let's see. No. I'm sorry. The dates -- I'm wrong.

Q. Okay.

A. The date of the unicondylar arthroplasty was 4/21/03.

Q. Okay. Doctor, normally how long is a unicondylar joint replacement supposed to last? The average.

A. Ten years, if they work.

Q. Okay. Let me ask you this question: Why did you decide to do the total knee replacement?

A. Well, she had troubles with her -- the unicondylar -- continued to complain of pain after that surgery. And I actually -- one of the causes for failure of a unicondylar is that patients develop a patellofemoral disease -- arthritis under the kneecap.

And I actually looked at her knee with an arthroscope on September 26th of '03 and found that she had developed arthrosis of the patellofemoral joint.

Q. Is that noted in one of your operative notes, Doctor?

A. Yes.

Q. Which operative note is that?

A. The arthroscopic surgery from 9/26 of '03.

Q. 9/26/03.

Did she have the same type of disease when you put the unicondylar joint in?

A. No. It looked like -- if you go back to my operative report from then -- if I can find it -- it says that she had a -- it said that she had arthritis. Osteonecrosis of the medial tibial plateau secondary to degenerative arthritis of the medial compartment. And my operative note under Findings said that the rest of the knee was normal.

Q. Okay. Why do you believe the unicondylar failed?

A. I thought it was because of the arthritis in the patellofemoral joint, which can be a cause of pain.

It may have been that she was one of these people who's going to have a painful knee no matter what we did. That's kind of what turned out -- kind of the way it worked out anyway.

It was a beautiful unicondylar. If you look at the x-rays, it looks like it came out of a textbook. And it was disappointing that she had a -- continue to complain of pain afterwards -- disappointing that she had that problem.

I did everything I could to help her. When I looked at her knee, I tried to make it work. I shaved the patella, and I did what's called a lateral release to try to realign the patella some or take some of the pressure off that side.

And at any rate...

Q. The lateral release, is that of a ligament?

A. The lateral retinaculum is a ligament on the side of the knee.

Q. Which side? Inside or outside?

A. The lateral side. The outer side.

Q. Outer side?

A. Yes.

Q. This was done during the time of the unicondylar replacement or the time of the full knee replacement?

A. No, no. The lateral release was done when I did the arthroscopy. That was the second surgery that I did on her.

Q. Okay. Again, I don't mean to belabor the question. But what was the reason you decided to do the full joint replacement?

A. Well, after the -- after I did the arthroscopic surgery where I shaved the patella and did a lateral release, she continued to complain of pain. And I -- the only explanation I could give was that she had -- the pain was coming from the patella -- a painful patellofemoral joint. And the only -- which happens after unicondylar knee replacements -- is one of the problems with them or one of the drawbacks. And I tell patients generally when we do a partial knee replacement or a Uni, as we call it, is that not all of them work and that on occasion we do have to go in and convert that to a complete knee replacement, which is what we did with her.

Q. Okay. All right. Doctor, if you can refer to the operative note from this surgery, I do have a couple questions for you.

A. Which surgery?

Q. The total knee replacement.

A. The complete?

Q. Yes.

A. Okay. Let me find it again. Okay.

Q. On the surgical note that I have from Bayhealth Medical Center, I have the surgeon as Dr. [redacted]. That's you. First assistant, Greg Sender. Who is Mr. Sender?

A. He's a physician assistant.

Q. Did anyone else assist you during that surgical procedure other than Mr. Sender?

A. Well, there's a second assistant, which would have been one of the nurses, but I can't remember who that was. There's different ones all the time.

Q. Let me ask you this: All the decisions that are made during the surgical procedure, are they the decisions that you yourself alone make?

A. Yes.

Q. Okay. Doctor, what are the types of the size of the curved inserts that go into the large bone in the leg that you could have used in this case?

A. The tibial inserts?

Q. Yes.

A. The plastic liners?

Q. Yes. That goes up into the thigh bone.

A. The smallest is a 10.

Q. Okay.

A. The thinnest is a 10. It does 10, 12, 14 and 17, 20, 23. You can get all the way up to a 30.

Q. Okay. Is there a 15 in there as well?

A. I originally put a 15 in, and after I had -- was finished, I felt that it was a bit -- little bit loose. So I took the 15 liner out and put a 17 in. And when I checked her stability and range of motion with the 17, to me, it -- the knee was stable.

Q. Okay. Doctor, are all of these inserts available for your use during the surgery?

A. Yes.

Q. All sizes.

So whatever size you needed, it would

have been available at the operating table itself?

A. Yes.

Q. Okay. Doctor, how many times did you close the knee and then reopen it in Mrs. [redacted] case for the total knee replacement?

A. Once.

Q. When did you close and reopen? At what point in the surgery?

A. It was after I had released the popliteus tendon. I felt like the knee was a little lax on the lateral side. And so I -- it only takes five minutes. I opened the knee up and put a trial -- first put a trial 17 liner in. Of course, not in the op note. But that's the way -- what we routinely do is use a trial first to make sure you like it - a trial liner. And you check the range of motion, stability and make sure that the knee shows a full range of motion, particularly full extension.

And it's one of those things that you -- you know, a lot of it comes with experience. You know, after a couple thousand knee replacements, you know when you've got the right size liner in for trial. And a 17

was just right. So we switched her to the 17.

Quite frankly, a lot of guys wouldn't have cared. They would have just accepted a little bit of instability, a little bit of laxity. I'm a perfectionist -- a total perfectionist when it comes to my knee replacements. Some guys probably would have even left a little snapping, you know.

Q. Okay.

A. I try to make sure they're perfect.

Q. I want to go back to a little bit where you said you put a trial 17 in but it's not noted in the operative report. Are there any other procedures or steps that you took in this operation that are not spelled out in the operative report?

A. No.

Q. Okay. When was the trial 17 used? I'm trying to figure out at what point of the surgery.

A. Oh, that's pretty easy. When you -- when we took the 15 out -- go down to the last maybe ten lines of the operative report. It says the patient had some laxity because of the posterior lateral release. Therefore, we opened the knee back up and removed the 15

curve liner and snapped in a 17-millimeter curve liner. With that, the knee was stable to varus and valgus stress and the popping of the tendon -- popliteus tendon had been eliminated.

Q. I'm still trying to understand the trial. It says here you removed the 15 and put in a 17. Where does the trial come in? I don't understand that.

A. Well, normally, we would have put a trial 17 in and tested the stability range of motion with a 17.

Q. Okay.

A. And maybe I didn't put a trial in and maybe I just switched to a 17.

Q. Okay.

A. So being as it's not in the operative report -- normally, that's what I do. I'm not sure how else to answer that.

Q. Okay.

A. The bottom line is, with a 17 liner in, the knee was stable. And I was happy with the way the knee locked with a 17.

Q. Okay. Let me go back up a few more lines.

When were the devices cemented in place?

A. When?

Q. Yes.

A. Well, that would be just at the beginning of the second page right after it says the knee was irrigated with pulsatile lavage. All three components were then cemented in place -- it says "and." That's a typo -- cemented in place simultaneously with the knee in full extension to provide for maximum bone cement compression.

Q. Did you hear the tendon snapping at that point when you flexed the knee and extended it?

A. After the cement hardened, yes.

Q. Okay. Did you hear it snapping before the knee was closed?

A. No. Wait a minute. I'm off a little bit on that. I'm just going to have to read the operative report.

After the cement hardened, the knee was flexed and excess cement was removed. That means any extra cement that's gotten around the implant is taken out. You use little, teeny chisels or osteotomes for

that.

And it says here a 15 millimeter curved insert was then snapped into the tibial tray. The curved insert is the plastic liner that's inserted into the metal tray that's cemented to the tibia.

And then the ConstaVac drain was inserted into the knee. That's a drain that we use -- I use. The blood that comes out of that drain is then retransfused -- later used to give back to the patient.

The medial capsule and retinaculum was then closed. The medial capsule and retinaculum, that's -- you make an incision on the medial -- or inner side of the patella so that you can get inside the knee -- was enclosed with interrupted No. 1 Vicryl sutures. Those are just big sutures.

The knee was placed through a range of motion. There's another typo there. It says "in range of motion." Her knee was placed through a range of motion. At that point we detected a snapping of the popliteus tendon along the lateral border of the tibial insert. And I've seen that happen before.

Q. Let me stop you right there.

At that point is the outside incision stapled?

A. No.

Q. Okay. When it says "We therefore opened the knee back up" --

A. Right.

Q. -- what does that mean?

A. Took the No. 1 Vicryl sutures out --

Q. Okay.

A. -- medial capsule and retinaculum.

Q. Okay. Then when it says you tried to release the tendon, what do you mean when you say you "tried" to release it? What do you do?

A. It's hard to get to it with the components in place. And I couldn't get to it with the components in place. So I --

Q. When you mean "get to it," do you mean put a --

A. I made a mistake earlier. It looks like I opened the knee back up twice. That's what you were getting -- okay. I'm sorry about that.

Q. All right. You're doing okay so far. Let's

follow through. Now we're down to you're opening the knee back up. You're trying to release the tendon.

Is "release" another word for cut?

A. Yes.

Q. Okay. So you tried to cut the tendon.

A. Right.

Q. At that point what access did you have to the tendon with your scalpel?

A. It sits between -- if you look at a -- well, I can just describe it. You got your metal femoral component in and your metal tibial component. And they're both cemented in place, so you can't take them out. And there's a little gap there. And the popliteus tendon is way in the back. And it's hard to get to it with the components -- with the trials in place -- I mean, with the -- after you've made the cuts and there's no components in place, it's pretty easy. And I -- you know, I just couldn't get to it safely.

Q. Were there any other ligaments or any other soft tissues or tendons that you had to go through in order to get to that tendon?

A. After -- you mean later?

that tendon?

A. No. Not other tendons.

Q. Any other soft tissues?

A. Well, the thing that gets in the way is the femoral component, which is metal.

Q. Okay. Now, you were unable to release it.

Does that mean you just couldn't get to it to cut it?

A. That's right.

Q. Okay. I have a question.

If you couldn't get to it that point, you actually eventually went to it by making an incision on the outside of the knee to get to it?

A. Yes.

Q. Is there a reason why you closed the knee up before you cut the tendon instead of just going over and cutting it and then closing it up?

A. Yeah. Because --

Q. Okay.

A. -- I didn't necessarily think that I was going to have to put in a different liner.

You could have gone either way on that.

Q. Either way --

A. You could have done it with the capsule still open. I just elected to go ahead and close it.

Q. Okay.

A. I didn't anticipate having to go back in the second time and put the 17-millimeter liner in.

Q. Okay. Now, when you made a one-inch incision over the posterior lateral aspect of the knee, that's the outside aspect towards the back?

A. Yes.

Q. Okay.

(The deposition was interrupted.)

THE WITNESS: Do you mind if I answer that?

MR. GASTON: We can take a break.

(A recess was taken.)

(The reporter read back the last question and answer.)

- - - - -

[redacted], M.D., resumes

BY MR. GASTON:

Q. Okay. Did you use an arthroscopic device to do that?

A. No.

Q. Tell me what you did.

A. Well, I just made a small incision, split the tensor fascia. That makes it pretty easy to get to the popliteus tendon. And then I just release the tendon.

Q. Okay. Now, before you did the one-inch incision, did you then have to sew the inside of the knee back up after you had opened it up the first time?

A. I didn't have to, but I did.

Q. You did.

Then after you released the tendon, I note here that the patient had some laxity because of the posterior lateral release. That would be the release that you just performed?

A. Yes.

Q. Then you decided to open the knee back up again and took out the 15 curved liner and snapped in the 17-millimeter curved liner. Why did you go from one

liner size to the other?

A. I felt like she could use a slightly thicker insert. I felt like there was a little bit of laxity to varus and valgus stress. And I made the decision to put -- take the 14 out and put a 17 in. And with the 17 the knee felt great. And the truth is, if I had to do this knee a hundred times, I probably would do it the exact same way every time. And 99 times I would get a good result.

Q. After you released the tendon and checked the knee for stability, did you notice any popping of the tendon at that time?

A. No. It was gone.

Q. Okay. Before going into the surgery, did you inform Ms. [redacted] that you might have to cut one of the tendons as part of the surgical procedure?

A. You don't specifically go over that kind of detail -- that you might have to release posterior cruciate ligaments, anterior cruciate ligaments, popliteus tendons, subperiosteal releases. You know, it's not -- it's just kind of generally considered as part of the procedure that you do the necessary tendon

releases.

But we don't sit down with every patient because, first of all, they're not going to understand what a popliteus tendon is versus an anterior cruciate, posterior cruciate tendon. So in answer to your question, no, we don't go and tell any patient that we're going to -- that we might specifically release particular tendons.

Q. Other than the popliteus tendon, would there be any reason in this surgery to release any other tendons or ligaments in Ms. [redacted] knee?

A. Yes.

Q. What other tendons or ligaments was it appropriate to release in Ms. [redacted] knee in this surgery?

A. Well, in any knee replacement, you excise or remove the anterior cruciate ligament. Then another big decision in a total knee is whether or not to remove the posterior cruciate ligament. And if you do remove the posterior cruciate ligament, then the next question is: Do you use a curved liner like I used? Do you use a posterior stabilized -- posterior cruciate --

substituting knee? Do you -- if you leave the posterior cruciate ligament intact, do you completely release it? Do you recess it? Do you lengthen it? Do you excise it? There's, you know, just so many different options at the time.

Q. In this case, other than the popliteus tendon, what are the other ligaments or tendons that you released if you can look at your operative report, if you could tell me?

A. Here is one here. A subperiosteal medial release was then performed for exposure.

Q. What ligament did you release at that point?

A. That's the superficial medial collateral ligament.

Q. Thank you, Doctor.

Any other ligaments?

A. It would be the deep meniscal femoral and deep meniscal tibial ligaments.

Q. Anything else?

A. No.

Q. Doctor, a tourniquet was used on Ms. [redacted] leg. Is that correct?

A. Yes.

Q. Would that be to prevent the blood from flowing down into the surgery site during the operation?

A. Yes.

Q. Tourniquet time is one hour and 45 minutes.

Can you tell me whether or not at any time when you had closed the knee that the tourniquet was released and you had to put it back on again?

A. Not that I remember.

Q. Okay. The total operation, does that equal the tourniquet time? About an hour and 45 minutes?

A. Yes.

Q. Doctor, have you ever had a knee surgery where you had to go back in and open up the knee two or three times such as in Ms. [redacted] case?

A. Yes.

Q. Approximately how many?

A. Probably ten or twelve.

Q. Ten or twelve.

Okay. At the end of the surgery, did you have a chance to speak to Ms. [redacted] about the surgical procedure?

A. Well, yes.

Q. Do you recall what you told her?

A. No.

Q. Do you recall if you specifically told her that you had cut the popliteus tendon during the surgery?

A. No.

Q. Do you have any recollection at all of any conversation you had with Ms. [redacted] after a total knee replacement surgery?

A. You mean about the surgery itself?

Q. Any conversation.

Do you recall the content of any conversation you had with her after the total knee replacement surgery?

A. You mean in the hospital?

Q. Anytime. Any conversation, if you can recall.

MR. FERRI: Anytime from the time you did the surgery to the time that she was no longer a patient.

A. She left -- the only thing that I can remember is basically what I put in my records.

Q. So if it wasn't in the records, then you don't

have a recollection of the conversation?

A. No. I mean --

Q. "No" meaning --

A. I'm not sure what you mean.

Q. What I mean is --

A. I don't really follow that.

Q. We'll have your medical chart. What you said is whatever conversation you had with her would be reflected in the chart. Is there anything in addition to what's in the chart that you remember?

A. You know, I do remember that day she and her husband were unhappy with her progress. And I -- you know, you always remember when you have somebody that doesn't do as well as you want them to. And I remember that she and her husband were struggling after the surgery. And when I -- to tell you the truth, I always do this. You know, if I have somebody that's struggling or not doing well, I tell them that I'm sorry they're having trouble. You know, I wish I could do something different to help them.

I do remember talking to them about, look, I know you're upset. You know, you've got to be

patient. I'm sorry you're having trouble. If you wait long enough, we'll get you through this, which is, you know, in my opinion, part of being a good doctor. And just trying to reassure them that -- because I could tell that they were not happy. And most patients that aren't doing well a couple months after surgery aren't happy. You know, it's just -- I've been through it myself. I've had bad, you know, results from surgery. And you get out in two, three months and you're not happy. You think about going somewhere else.

Q. Anything else that you can recall?

A. Not -- nothing particular other than I do remember that we -- I tried to reassure them that we were going -- things were going to be okay.

Q. Okay. Did you then have Ms. [redacted] come back in perhaps a month later for a manipulation of the leg?

A. She did have a knee manipulation, yes.

Q. Can you tell me what you did during that procedure?

A. It's pretty basic. A lot of patients, if they're not getting their range of motion as quickly as you'd like them to -- and it's standard of care. I mean,

it's -- everybody that does knee replacements do some manipulations. You put them to sleep briefly -- a minute or two. And the first thing you do is you straighten the knee out. And then you bend it. And it breaks up the adhesions or the scar tissue in the knee.

Some patients do great afterwards. Some of them really start flying when it comes to their range of motion. Some of them it doesn't help. And it can be very discouraging to have a patient who's range of motion is not what you want it to be -- or not what they want it to be.

And it's one -- when I think about knee replacements, though, I can tell you that anybody who does total knees, no matter how many they've done, has got knees that are stiff. And I give that talk at national meetings. And I usually poll the audience: How many people here have had problems with stiff knees? Everybody in the whole room will raise their hands.

Q. Doctor, I believe you mentioned before when you commented on Dr. Petrera's subsequent treatment of Ms. [redacted] that the really only thing left for her was to go in and try to remove some scar tissue. Is my

recollection accurate?

A. I think that would have been the next best choice.

Q. Next best thing.

When you did the manipulation to break up the adhesions or scar tissue, would there be more scar tissue after a period of time that you would have to go back in and break up again through either a manipulation or a surgical procedure?

A. I'm not really totally sure what your question is. But a lot of times when you do a knee manipulation the scar tissue does not reform and the patients are able to maintain that range of motion. When you go in and you do an arthroscopic -- and you can do a knee manipulation within the first couple months. If you wait more than two or three months after the surgery and you try to do it, you can fracture femurs, tibias, rupture tendons. It's really not safe to do it after a few months, although some people do.

Q. Well --

A. If you do an arthroscopic lysis of adhesions, you can do that two or three years after their surgery.

And it's very safe, because you're actually going in and you're removing the scar tissue, which is relatively mature. And for some reason most of those patients do not reform the kind of scar -- the type of scar tissue they had before.

Q. Is there anything in the records that you reviewed from Dr. Petrera's treatment of Mrs. [redacted] that suggested or indicated that there was scar tissue present when he did the subsequent total knee replacement?

A. Can I look at his operative report?

Q. Sure.

A. I don't know that I have it, though.

(The deposition was interrupted.)

THE WITNESS: Do you mind if I answer this pager?

MR. GASTON: Go right ahead.

(A recess was taken.)

- - - - -

[redacted], M.D., resumes

(The reporter read the pending question.)

BY MR. GASTON:

Q. Okay. In tha ... least the procedure would have been benefici ... the scar tissue present at the time. Wc ... with that?

A. No.

Q. Why not?

A. Because the a ... tissue removed was basically just part of t ... A subperiosteal medial release, which is ... does -- there was some hypertrophic synovi ... the gutters. I don't really understand ...

Again, ... mind.

Q. Well, you inc ... one of the reasons for problems with knees ... replacement surgery is that scar tissue buil ...

A. Yes.

Q. One of the op ... patient is to go back in and have the scar tis ... In this case it could be by arthroscopic ...

A. That's true.

Q. Is there anyt ... operative note that

you just reviewed from D[redacted]'s total knee replacement of Ms. [redacted] suggested that there was scar tissue there that c[redacted]een removed that may have benefited the patie[redacted] of motion in her knee?

A. Yes.

Q. Okay. Where

A. He talks abou[redacted]rtrophic synovium which you can remove thr[redacted]hroscope. It also says release the gutters[redacted]ers are on either side of the knee. There's -- [redacted]tart of the joint space -- and as part of [redacted]copic release of adhesions, that's what's [redacted] the areas you concentrate on is you re[redacted]car tissue in the medial-lateral gutters.

Q. Okay. Thank

Let me [redacted]w some of your answers, Doctor. Your attorney r[redacted]assist you with that. I just want to go over t

Do you [redacted]o Raisis?

MR. FEI[redacted]aisis.

BY MR. GASTON:

Q. He's one of t[redacted] who have been

identified in the case.

A. Yes.

Q. How do you kr

A. Just because ert witness.

Q. I mean, do yc professional relationship with him? on him in the past? Anything of that nature?

A. No.

Q. Okay. Have y Dr. Leo Raisis regarding this case?

A. No.

Q. How about Dr. -l-l? Do you also know him?

A. Yes.

Q. How do you kr

A. He and I have kers at a lot of meetings together. Not uple.

Q. Okay.

A. We've never s r -- if that's what you mean.

Q. Have you spol ail about this case?

A. No.

Q. Okay. Other [illegible], Dr. Raisis and Dr. Vail, is there any c[illegible] that you're aware of that has knowledge of th[illegible]erial to this case?

The rea[illegible]ing you this is that I need to know if there's [illegible]erson who's going to come to testify so I car[illegible] deposition. No one was specifically identif[illegible]nswers to interrogatories.

A. No.

Q. Okay. Are yc[illegible]hat Ms. [redacted] did anything or acted in a n[illegible]ontributed to her condition?

A. No.

Q. Okay. Did th[illegible] Dr. Petrera contribute to Ms. [redacted] [illegible] condition of pain in the knee?

A. Yes.

Q. How did that [illegible]o that condition?

A. I think he sh[illegible]eft her alone and given her more time.

Q. What specific [illegible]his treatment do you believe contributed to h[illegible]

A. I don't think [illegible] any better off than she was before. All he [illegible] another surgery.

Q. That's sort [illegible] question.

My ques[illegible]y specifically: Did he do anything that caus[illegible]ibuted to her current complaints of pain?

A. He's the one [illegible] last surgery, and she still has pain. So [illegible]'s got now was -- it's just as likely that [illegible]y was contributing to her knee as anyone else' [illegible]ow as anybody's.

Q. Can you expla[illegible]at basis for that statement that his surge[illegible] just as likely that his surgery -- I'm sorry [illegible]t as likely that her current complaints are a[illegible] result of his surgery and not your surgery tha[illegible] redone?

MR. FEI[illegible] to form. But that's okay.

A. I don't reall[illegible] the question.

Q. What medical [illegible]d Dr. Petrera perform that you believe is caus[illegible] [redacted] current complaints of pain?

A. I just think [illegible] unnecessary knee

revision.

Q. Okay. Do you [illegible]inion as to whether her complaints of pain r[illegible]ame, more or less than before the surgery?

A. I have not se[illegible] can't say.

Q. Okay. Can yc[illegible]he correct name of the medical group that you w[illegible]

A. It's Dickinsc[illegible]roup.

Q. Do you know i[illegible]orporation or a partnership?

A. A corporatior[illegible].

(The de[illegible]n interrupted.)

THE WI[illegible] I get this?

MR. GAS[illegible].

[redacted]., resumes

BY MR. GASTON:

Q. Is that legal[illegible] same now as it was when you performed the t[illegible]eplacement on Ms. [redacted]?

A. No.

Q. Can you

A. It used to be [illegible] Bone & Joint Specialists. Is that wh[illegible]

Q. Well, what I'[illegible] understand is: We filed a claim against yo[illegible] person you worked for at the time. We identif[illegible] group as the Dickinson Medical Group. Is that [illegible] group?

A. Yes, it is.

Q. Thank you.

One que[illegible] lawyer might assist me with, because I can't as[illegible] lawyer individual questions. It's Questio[illegible]

MR. FEI[illegible] Let me see. 20.

BY MR. GASTON:

Q. I asked you, [illegible] were the defendant, if you claim that the ex[illegible] certificate and report filed in any way does not sat[illegible] statutory requirements. It's more of a legal que[illegible] anything, but I can't ask an attorney a specif[illegible]. That's why I have to direct it to a party. [illegible] was, yes, it did not conform to statute. I w[illegible] if you're still

making the contention at .

MR. FEI , I can speak to that.

MR. GAS . Thank you.

MR. FEI speak to that. And I think, to the best of my on, that was put in there -- and I would hav iew the certificate. But I think it did not s r. Petrera did not -- the 20 percent rule, I t basis for that.

Okay. nd corrected.

BY MR. GASTON:

Q. Okay. So wou air to say that with respect to the answer t ory No. 20 that there is not going to be a cha to the expert certificate or expert re by the plaintiff in this case?

MR. FEI 's correct.

MR. GAS you very much.

BY MR. GASTON:

Q. Have you eve a partial or total knee replacement where go back in and put in a different size componen ?

A. On a partial ? You go in and do a

different insert?

MR. FEI [illegible] or a total?

MR. GAS [illegible], we'll do partial and total.

MR. FEI [illegible]

BY MR. GASTON:

Q. Did --

A. Yes.

Q. Okay. How ab [illegible]?

A. You mean as a [illegible] As a redo? Or during the surgery?

Q. No. A redo.

A. Oh, yes. Yea [illegible] to redo some tibial liners.

Q. Can you expla [illegible] circumstances under which you had to go back [illegible] to the tibial liner?

A. Well, there's [illegible] ple of circumstances. One is where it's worn c [illegible]'s been an abnormal or excessive wear. I've ha [illegible] and redo some tibial liners for knees that we [illegible] ments weren't balanced. That's pretty much the t [illegible] sons for doing a...

Q. No. 30 is a l [illegible] on. I ask if you

claimed at any time tha [illegible] made a false
statement with regard t [illegible] of the claim.
MR. FE [illegible] answer. No known to
date. And we would upd [illegible] if we discover.
MR. GA [illegible] you. I think I'm
almost done. Give me o
BY MR. GASTON:
Q. You made a c [illegible] believe that
Dr. Petrera's total kne [illegible] of Ms. [redacted] was
unnecessary. I'm going [illegible] you have an opinion
whether or not he commi [illegible] ice during that
surgery or not.
A. No more so t
Q. Well, that d [illegible] no.
All ri [illegible] claiming he
committed malpractice d [illegible] reatment of
Ms. [redacted]?
A. Do I claim it
Q. Yes, sir.
Did he [illegible] low the standard of
care during his treatmer [redacted]?
A. It doesn't re [illegible] whether I think he

has or not.

Q. Well, I need [illegible] you're going to make that claim at trial, in [illegible] or a statement to that degree that he committed [illegible].

MR. FEI [illegible] sure I would ask it, but I will let him answe [illegible] ion in the event that I do. I haven't made th [illegible]. If you have an opinion. If you don't h [illegible] ion at this time, you can so state, and we car

A. Yeah. I don [illegible] opinion at this time.

MR. FEI [illegible] ise you if there is going to be any such op:

MR. GA: [illegible] se he doesn't have one now, if that comes about [illegible] have the option to, then, reconvene the depo [illegible] get his factual basis for that opinion?

MR. FEI [illegible] nly.

MR. GA: [illegible] 's all the questions I have.

The pa: [illegible] greed that Dr. [redacted] will make [illegible] position Exhibits 3 and 4. Copies will be [illegible] me with the originals

to be retained by defen[illegible] for trial.

MR. FE[illegible] no questions. We'll read.

(The d[illegible] concluded at 6:35 p.m. this same day.)

- -

(I HAV[illegible] FOREGOING DEPOSITION, AND IT IS TRUE AND CORR[illegible] BEST OF MY KNOWLEDGE.)

WITNES

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C E R T I F

STATE OF DELAWARE:
:
NEW CASTLE COUNTY:

I, Robert Wayne ., a Registered Professional Reporter and ic, within and for the County and State afore hereby certify that the foregoing deposition c [redacted] M.D., was taken before me, pursuant , at the time and place indicated; that said was by me duly sworn to tell the truth, the whc , and nothing but the truth; that the testimony ponent was correctly recorded in machine shorth and thereafter transcribed under my super computer-aided transcription; that the de a true record of the testimony given by the and that I am neither of counsel nor kin to any ild action, nor interested in the outcome

WITNESS my hand l seal this 1st day of June A.D. 2006.

ROBERT WAYNE
REGISTERED PF REPORTER
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(Expires Janu)

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