S. Becker 63516

STATE OF NEW HAMPSHIRE

SUPERIOR COURT

ORIGINAL

GEORGE LEPAGE AS EXECUTOR
OF THE ESTATE OF LORRAINE
LEPAGE,

Plaintiff,

vs.

LAWRENCE M. HOEPP, M.D.
AND GENERAL SURGICAL
SPECIALISTS OF NEW ENGLAND,

Defendants.

TRANSCRIPT of testimony in the deposition of Stephen I. Becker M.D. taken by and before Adrienne E. Tisdale-Scott, a Certified Shorthand Reporter and Notary Public of the State of New Jersey, at the offices of DR. STEPHEN I. BECKER, M.D., 33-00 Broadway, Suite 204, Fair Lawn, New Jersey, on Friday, October 29, 2004, commencing at 10:01 in the forenoon.

A P P E A R A N C E S:

Attorneys Representing Plaintiff:

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BY: ROBERT J. LANNEY, ESQ.

I N D E X

WITNESS: STEVEN I. BECKER, M.D.

E X H I B I T S

STEVEN I. BECKER, M.D.,
33-00 Broadway, Suite 204, Fair Lawn, New Jersey, having been duly sworn according to law, testifies as follows:

MR. LANNEY: This deposition will be taken under oath, usual New Hampshire stips, all objections as to the form and motions to strike are preserved to the time of trial, notice and signings are waived 30 days or signatures are deemed waived.

MR. SUCHECKI: We'll waive it.

MR. LANNEY: I think that's it.

MR. SUCHECKI: Yes.

DIRECT EXAMINATION

BY MR. LANNEY:

Q. Good morning, my name is Rob Lanney, we met a few moments ago. I represent Dr. Lawrence Hoepp in his professional association. I'm going to ask you some questions this morning about your opinions and background. If I ask you a

question that you do not understand, would you ask me to repeat or rephrase it?

A. I will.

Q. Please state your name and residence address.

A. Stephen I. Becker, B-E-C-K-E-R, 35 Wendy Lane, and that's Closter, New Jersey.

MR. LANNEY: We are going to be marking as Exhibit 1 your curriculum vitae.

(Whereupon, Exhibit 1, Curriculum Vitae, was received and marked for identification.)

Q. Let me show you Exhibit 1.

Is this an accurate and up-to-date curriculum vitae?

A. I believe it is, yes.

Q. Am I correct in understanding that you have not authored any publications?

A. Correct.

Q. I ask you some questions about your curriculum vitae, I understand you went to the University of Brussels for your

medical degree?
A. I did.
Q. I believe you applied to approximately 20 medical schools in the United States and were not accepted; is that correct?
A. Right.
Q. That is because your credentials in applying to those medical schools were not as strong as others; true?
A. I would assume so.
Q. Looking at your curriculum vitae, in 1980 to 1981 you were a Clinical Instructor in surgery; is that correct?
A. Correct.
Q. Was that your third year of your residency?
A. No, my 5th year chief residency. St. Vincent's and NYU, shared another medical facility called Beekman and I was given a teaching appointment at NYU to teach the people who rotated through Beekman as well as St. Vincent's. So I had a clinical instructorship from NYU as well as being chief resident from St.

Vincent's.
Q. Did you have an academic appointment during that year?
A. That's an academic appointment.
Q. I assume what you are doing, as residents were coming through clinical, you supervised and --
A. Supervised residents, medical students that rotated as well. There were teams and there were lectures. There was practical work, patient work. It's a full day's worth of work.
Q. Since 1981 you have not held any academic appointments or faculty appointments; is that correct?
A. That's correct.
Q. Now, Englewood Hospital and Medical Center, fellow of vascular surgery 1981. You did not complete that fellowship; correct?
A. It was not a fellowship, not approved fellowship, right. I found out it wasn't going to be one and was asked to join another man's group and I told them

I was leaving.
Q. You were actually fired from that position?
A. After I told them I was leaving, yes.
Q. You did not complete that position?
A. Correct.
Q. You still have not received any certification in vascular surgery?
A. I have not received a certificate; correct.
Q. The physicians you worked under at Englewood were Herb and Irving Dardick?
A. Correct.
Q. Do you know where they are currently located?
A. Well, Herb Dardick, I think retired and was in hospital administration and Irving Dardick is in jail.
Q. Where?
A. Someplace in New Jersey for fraud.
Q. Did you actually bring a lawsuit against them?
A. Yes. I brought a lawsuit against the hospital.

Q. They were in conjunction because they prevented the hospital from reviewing my applications for a year and a half to two years, and a lawsuit had to be brung to review the application, you know, it went into court. They first said I didn't have an office in the area and they changed it. Then the hospital changed it, since I was fired from there they wouldn't give me privileges?

Was there a lawsuit against them successful?

A. Ultimately, no.

Q. You mentioned you applied for privileges at, I believe, two hospitals and were denied those privileges.

A. Englewood and St. Joseph's.

Q. Have you ever received privileges at either hospital?

A. Not at Englewood. St. Joseph's took over which is called St. Joseph's Wayne, that's one of their hospitals.

Q. Under employment there is a reference to a preceptorship, Hands on Training with

Mark Taylor in Salt Lake City in 1996. What is that?

A. It really shouldn't be under employment. Certain type of laser procedure, a photoderm laser came into being. I guess it should be certifications, but I worked with him for a couple days in Utah.

Q. Similarly the College of Surgeons Proctor at International Section on 3D Virtual Reality.

A. That was done because I was doing work for a company that created three dimensional laparoscopic viewing I gave with their instrument. Their lecture, and I did get paid for that. So they put it under employment. But I consulted with them for several years.

Q. You have been an attending at Barnert Memorial Hospital?

A. I have.

Q. Have you been on any committees?

A. Over the years, yeah.

Q. What leadership positions have you held

at Barnert, if any?
A. None. I have never been chief of the surgeries.
Q. Are you currently on any committees at Barnert?
A. I probably am. We are only required to take one committee and many of them are once a year, and the last one I believe I was on was the Library Committee.
Q. At the current time, which is 2004, do you know what committee you are on?
A. Offhand, no, I'd have to look.
Q. At Pascack Valley Hospital?
A. Yes.
Q. You've been there on staff since '82?
A. Correct.
Q. Have you held any leadership positions there?
A. No.
Q. Have you served on committees over the years there?
A. I have.
Q. Do you know if you are currently on any committees at Pascack?

A. Basic same response as before, last time I remember I was on the Laser Committee, but I haven't been informed, you know, it's not an active committee. If they have a meeting they tell me about it. If not, I don't know about it.

Q. Have your privileges to practice been suspended, curtailed or in any way limited at any time?

A. No.

Q. Under your certifications and awards section. Am I correct in understanding that the only award is the New Jersey Assembly Resolution?

A. Correct.

Q. What is that?

A. I had mentioned I worked with a company three dimensional viewing for laparoscopic surgery. I started doing laparoscopic surgery in '89, '90 era, and made The Next Step in the Discovery Channel, and apparently the local congressman saw it and recommended because it was so innovative that I

be -- he nominated me for the award for the this innovative technology, and I got this in the mail and he called me.

Q. So the resolution passed?

A. I guess it did. I got the certificate.

Q. The rest of the materials cited under certifications and awards are in classes that you have taken over the years on various medical procedures?

A. Courses, certification, yes.

Q. Do any of those certifications deal with the diagnosis and treatment of wound infection?

A. I don't believe so.

Q. Have you used physician assistants in your practice?

A. No. Jersey has limited physician assistants.

Q. The Endoscopic Vein Harvesting Ethicon Endosurgery?

A. Right.

Q. Do you use that in surgeries currently?

A. No.

Q. Can we agree that's Ethicon System is

within the standard of care?
A. Sure.
Q. At the current time, are you still practicing vascular surgeries, approximately 20 percent of your time?
A. Yeah, 15, 20, 25. Depends on the number of cases.
Q. I will pick the middle and say 20 percent?
A. Fine.
Q. What percent of that practice would involve fem-pop?
A. Probably within the 20 percent. I'd be guessing. Seven, eight, nine, ten, depending on if you are talking about all the distal bypasses.
Q. Yes, sir?
A. More than fem-pop distal bypasses, about 7 to 10 percent.
Q. Of the 20 percent of total practice?
A. No. No. The 20 percent.
Q. How many distal bypasses do you think you do on a regular basis, approximately?

A. 10, 15. Depending on the year.
Q. Do you use the same saphenous vein that was the technique that was used by Dr. Hoepp in this case?
A. I don't use the same technique but there's nothing --
Q. Do you have any criticism of the surgical technique or surgical technique performed by Dr. Hoepp?
A. None at all. It was fine. It was indicated there was no problem with that.
Q. Do you have a specialty within your field of practice?
A. I -- in general surgery, I do more endoscopic laparoscopic work than open work now. I have been doing that since about 1990.
Q. What is the national infection rate for distal bypass surgeries such as the one performed on Mrs. Lepage?
A. I don't have a specific number. Depends on who you read and what times.
Q. Do you know the range that's quoted?

A. I'm going to say usually it's 1 to 2 percent that I'm aware of, but each institution has their own statistics on specifics because they have their own bacterial environments, so that's -- that was the number I would generally accept it.
Q. Do you know what your rate is for infection on distal surgery?
A. To tell you the truth, I have not had an infection in quite a while. I mean, I can't say I have never had an infection, but I can't remember my last one.
Q. Can we agree that wound infection is a known risk of distal bypass surgery?
A. Absolutely, sure.
Q. Now, I wanted to talk to you about medical legal review for a moment.
A. Sure.
Q. Are you currently still reviewing about three cases a month?
A. I get three to four cases a month on average. Some months more, some months less. General average.

Q. That has been the case since at least 1995, I believe; is that right?
A. Thereabouts. Thereabouts.
Q. Your work as a medical legal consultant began in 1981 when you were a chief resident?
A. No, it started in 1981 when I worked for a group. It actually started probably 1982, '83, when I worked for a group that did mainly workmen's comp and liability. I came in contact with a number of attorneys and then periodically they'd have me review a chart, and for many years it was just an occasional review that I would do.
Q. But didn't that review for attorneys start in 1981?
A. I started working for the group in 1981. I don't know if the original charts of negligence cases rather than liability cases but I worked for a group. They only did liability and compensation work in New Jersey.
Q. Over the years 90 to 95 percent of cases

you have reviewed have been on behalf of plaintiffs; is that correct?

A. Earlier in my career of doing that, yes. Over the course of five years, I see about 25 percent defense work. Again, it varies a little bit, and 5 percent plaintiff work, but prior to that, yes, it was 90, 95 percent, but there were less cases, too.

Q. Do you think that you estimate the total number of cases you reviewed to be hundreds; true?

A. True.

Q. Does that mean 200, 300, 400, can you narrow it down for me?

A. If you ask me to be over, I can't give you the exact number. Probably over 20 years over 200, I wouldn't argue.

Q. You've given over 100 depositions?

A. Yes.

Q. Do you think it's opened up to a 150 by now?

A. Probably with this one.

Q. Am I correct in understanding that --

what percentage of your depositions have been on behalf of plaintiffs?

A. Probably the places that have depositions you're asking for a number, I can't tell you. The majority would be plaintiff depositions. I would say probably 85 to 90 percent would be plaintiff depositions, but you do realize they don't have depositions such as New York. If you do defense work there, I would be deposed.

Q. But it's fair to say approximately 90 percent of the depositions you've given have been on behalf of plaintiffs?

A. I'll agree with that.

Q. You've testified over 60 trials?

A. 60, sure.

Q. Any on behalf of defendants?

A. No, I have never done a defendant trial.

Q. I want to ask you about the states in which you have provided expert testimony, either by deposition or in court. I'm going to give you a list of those states and ask if that's correct.

Missouri?
A. I have.
Q. Florida?
A. I have.
Q. West Virginia?
A. I have.
Q. Virginia?
A. I have.
Q. Massachusetts?
A. Have.
Q. Pennsylvania?
A. Excuse me. Massachusetts, trial testimony, no depositions. In talking trial.
Q. Trial or deposition any testimony under oath.
A. Okay. Sure.
Q. Pennsylvania?
A. Yes.
Q. New York?
A. Yes.
Q. Kansas?
A. Don't remember. I may have given a deposition, I don't remember.

Q. New Jersey?
A. Yes.
Q. Ohio?
A. Yes.
Q. Georgia?
A. Yes.
Q. Louisiana?
A. Deposition maybe, never been in Louisiana for trial.
Q. Illinois?
A. Yes, deposition there.
Q. Texas?
A. Yes.
Q. Connecticut?
A. Yes.
Q. North Carolina?
A. I'm going to say yes. I think so.
Q. Iowa?
A. Yes.
Q. Montana?
A. Don't remember ever doing anything in Montana.
Q. Utah?
A. Yes.

Q. Missouri?
A. Yes.
Q. Rhode Island?
A. I don't remember.
Q. If we had a transcript from a Rhode Island deposition?
A. No, but Rhode Island is a very unusual -- I don't remember seeing something from Rhode Island but I may, in deed, have.
Q. Colorado?
A. Yes.
Q. Indiana?
A. Yes, I think so.
Q. Can you think of any others that I left out?
A. Michigan.
Q. Any others?
A. That's about it. And now New Hampshire is the first one.
Q. Have you worked with Mr. Suchecki's law firm in the past?
A. Not to my recollection, no.
Q. Some of this partners are Liz Mulvey or

Phil Crowe?
A. I don't know if it's the same Mulvey. Mulvey rings a bell.
Q. How about the firm of Lubic & Meyer?
A. Yes.
Q. They used to be somehow related?
A. Lubic & Meyer I remembered seeing a case from a while back.
Q. Now I understand that over the years you have been affiliated with expert witness services?
A. I have occasionally been, they've called me to review cases. The two services mainly have been Tasa and -- which is no longer in existence, and Andel which has split up. They have used me more consistently over the years. But some review organizations would have me review cases, yes.
Q. Over the years, Tasa and Andel?
A. Yes.
Q. Medical expert services in Florida?
A. As I said, years ago I think that's what it was called. I had seen a couple

cases for them. You're talking maybe 15 years ago.

Q. Okay.

A. And I never heard from them afterwards.

Q. I don't believe that you received this case through one of these services. Rather I think you were contacted directly?

A. I probably was.

Q. Do you advertise your services to review medical legal cases at all?

A. I don't advertise in the strict sense of advertising. I have a Web site which I don't think it's working anymore. It did ask if you did anything in the office. I've also occasionally seen lawyers within sites and have e-mailed them if they do what I do basically.

Q. What would you e-mail them?

A. That I do medical review if they're interested. The areas I do it in, and I sometimes get a response. Most times don't.

Q. Would you bring me up-to-date on your

hourly rates.

A. 450 an hour for review time. Deposition is $500 and hour, four hour minimum, and my testimony is $6,000 a day.

Q. Plus expenses?

A. Plus expenses, sure.

Q. Do you have any records of the bills you have made to date on this case?

A. Not with me, but I can get it.

Q. Is that something you can get for us?

A. Yes.

Q. I don't need it today.

A. Sure.

Q. Are you able to estimate for me, for example, over the past five years how much income you earn a year in medical legal?

A. I can only give you percentage. It's been 5 to 7 percent over the past several years.

Q. As of the last transcript, I believe there have been eight malpractice claims brought against --

A. Over 20 years three never went anywhere,

two we tried, I won. Two were settled and one was lost.

Q. Did any of those cases involve issues surrounding infection?

A. One involved the one that we -- one had an appendix and had an infection after an abscess after an appendicitis.

Q. That was the one you succeeded at trial?

A. Yes.

Q. Do you remember the name of that patient?

A. No.

Q. Do you know where the case was brought?

A. It would be Paterson so that would be Passaic County.

Q. State court?

A. Yes.

Q. When was that filed, do you know, approximately?

A. I'm going to say '92, but I don't know exactly.

Q. Do you have any records that would tell you the name of the patient?

A. Not accessible right now. I'd have to

go back to some old records if I have them.

Q. Would you be willing to look for us?

A. I'd be more than happy to, if I can find it easily, if it becomes a problem.

Q. Yeah?

A. Coleman.

Q. C-O-L-E-M-A-N?

A. I don't know the first name.

Q. Thank you. Are there any journals that you subscribe to?

A. At this point I don't subscribe to journals. I go to the hospitals and use them. Pascack Valley has a very good library and Wayne General has a very good library. So I use them as --

Q. You personally don't subscribe to journals?

A. No.

Q. Are there textbooks in medicine that you consider authoritative on the issues surrounding this ~~question~~ case?

A. No, but let me go back to the previous question. I'm a member of Geriatric

Surgical Society, and they have a journal that is sent to me, it's not a subscription, it's part of the membership.

Q. Are you available to come to trial in this case in January?

A. Sure.

Q. In New Hampshire?

A. Depends, arrangements and stuff like that.

Q. Have you been in New Hampshire?

A. Yes.

Q. Practice medicine?

A. No.

Q. Do you know Dr. Lawrence Hoepp?

A. No.

Q. Do you know his physician/assistant Mr. Massey?

A. No.

MR. LANNEY: I want to mark as our next exhibit a three-page letter from Crowe & Mulvey to you. I do not know who sent the letter because the signature page doesn't appear to be

here, but it's dated March 14, 2003, Exhibit 2.

(Whereupon, Exhibit 2, Letter, dated 3/14/03, was received and marked for identification.)

Q. Could you read into the record for me the handwriting? First of all, is that your handwriting?

A. Some of it is, some is not.

Q. The "3/24/02 Spoke " is that your handwriting?

A. Yes.

Q. Below that "Limit CR to 1-2 hours?"

A. That's not my handwriting.

Q. Do you know whose it is?

A. I have two people in the office, one Barbara, one Beth. That would be their handwriting. It's too neat.

Q. That was you were supposed to limit your casework one to two hours?

A. They obviously had a conversation when this came.

Q. The handwriting?

A. Says, graft. Next to it it says, in

situ; next, sign of infection, no evaluation WBC. I can't read after that. Infected graft, bled, low flow, bowel infarction, death. No sign indication. I can't read it. Something bloody. Just high. That's what it says.

Q. Where it says "no sign, " do you know what that means?

A. No. Those are just random marks.

MR. LANNEY: I want to mark as my next Exhibit 3-A and 3B, two pages of handwritten notes actually three pages, two on one page.

Q. But we made copies and you had in your original files.

A. Right. I should have three.

(Whereupon, Exhibits 3A and 3B, Notes, were received and marked for identification.)

Q. Let's start with this one here. Could you read into the record Exhibit 3A starting with the 4/27. Read it all in verbatim.

A. Okay. Arterial ulcer. Right -- I think it says, right fem done, ABP 70 over 150, 5/02 need arterial bypass, 5/23 popliteal bypass, knee area open. 5/26/, no overt infection, lower wound open, serous drainage, assess, Dr. Hoepp, probed with exclamation points, admitted 5/9, 5/14 arteriogram 5/9, on that 5/10/02 -- 5/10/00. A small, AAA, 2.8 sonometer infrarenal, OP note in situ, arteriogram, AAA left renal stenosis, right occlusion superficial femoral artery.

Q. What is the significance on 5/26/00 of the notation, quote, no overt infection?

A. That's a quote from the note that day.

Q. And you have probed with two exclamation points. Explain why?

A. It's not in the note. But it's in the deposition that it was probed.

Q. Does it also appear in any of the medical records from the subsequent admission to Catholic Medical Center?

A. That I don't remember by heart. I know

it was mentioned specifically on deposition, and I made two exclamation points because it's an important issue.

Q. Why?

A. Because the wound is able to be probed when it's opened, any open wounds by definition is infected and any probing would necessitate culture.

Q. Even if there's no depth to the wound?

A. If you can probe the wound there's depth.

Q. Do you believe in this case there was depth to the wound?

A. Yes, and drainage.

Q. I'm asking about depth right now. Was it your opinion there was depth from the wound?

A. Yes. Yes.

Q. Still on Exhibit 3A there's a note for 5/26/00. What does that say?

A. Open serous drainage, not sure if she was seen by M.D., probed, Q-tip, no sign of infection.

Q. Why did you write no sign of infection?

A. This is probably from a deposition.
Q. Okay. Then 5/30 to 6/2?
A. It just says unresponsive.
Q. Finally Exhibit 3B, if you could just read that into the record?
A. 5/30 to 6/2 ER. Bled out from fem-pop bypass, infected wound engrafted. Lower and mid portion blow out. Next, below, it just says 5, right leg ischemia, abdominal pain, CT. Not sure what the next word is. Probably executed or assumption like that. Says CT ischemia. Sorry. OR 6/2, abdominal exploration, bolus ischemia small bowel. 5/30, a white count is 10.50. It says H&H and 5/31 says tense pneumo.
Q. Do you have any criticisms of the management of the patient during her 5/30 to 6/2 hospitalization?
A. No.
Q. Everything that Dr. Hoepp did was appropriate?
A. Correct.
Q. Good quality care?

A. Good quality care in the face of a devastating injury.
Q. I next want to just put on the record, Dave, if you look over my shoulder to make sure I do this accurately, put on the record what is contained in your file. First, let me ask you, is this your complete file?
A. Yes.
Q. Nothing has been removed?
A. Not by me.
Q. Plaintiff's expert disclosure. Have you reviewed all these materials?
A. I have reviewed all the materials.
Q. Dr. Hoepp's Answers to Interrogatories propounded by the plaintiff, I take it, informing your -- strike that.

Mr. Lepage, George Lepage's Answers to Interrogatories propounded by the defendant. I take it, in rendering your opinions in this case you relied upon the opinions contained in this file as well as your education and background and training?

A. Correct.
Q. Records from Dr. Hoepp's office; records of Dr. Docken; general surgical specialist's answers to plaintiff's interrogatories; supplemental answers to Answers to Interrogatories by Dr. Hoepp; General Surgical Specialists of New England response to plaintiff's second request for documents; plaintiff's answers to Dr. Hoepp's interrogatories, again, by Mr. Lepage; report of Michael Murphy, M.D.; prescription records from Brook Pharmacy; Deaconess and Catholic Medical Center records. Depositions of Dorothy Loy, Larry Hoepp, Bob Massey, Dawn Lepage and George Lepage. And that is your complete file, Doctor?
A. Yes.
MR. LANNEY: I will let you take those and put them wherever you'd like.
Let's mark as the next Exhibit 4, the Plaintiff's Expert Disclosure.
(Whereupon, Exhibit P-4,

Plaintiff's Expert Disclosure, was received and marked for identification.)

Q. I will show you Exhibit 4. Have you seen this document before?

A. Yes, I have briefly read through it.

Q. When was the first time you saw that?

A. In my review probably about a week ago.

Q. Does that accurately summarize your opinions in this case?

A. In general, yes. In general, yes.

Q. Is there some hesitancy?

A. Certain things that are factual in here, they're not really opinions, they're factual statements, but, in any event, in general, yes.

Q. If you look to Page 3, I believe the third paragraph from the bottom, in essence, starts to set forth your opinions in this case. It runs from Page 3 to Page 4?

A. Right.

Q. Are those are your opinions in this case accurately summarized in those paragraphs?

A. As I said here, it's a little bit of a statement more than a fact. It's a little complicated. Goes along with the whole process. In other words, again, this is an individual statement, it has to be taken -- some of these have entwined in itself.

Q. I'll take you through it specifically in a moment?

A. Okay.

Q. A few moments. Again, you stated any open wound by definition is infected, it needs to be cultured.

A. The statement is any open wound is infected, not every open wound has to be cultured, but every open wound is infected.

Q. What is the basis for making that statement?

A. That is standard medical opinion that any open wound is infected, infected means there's growth of bacteria. The issue that you may say is it colonized superficially or seminated, every wound

is infected if it's open.
Q. Because of the growth of bacteria?
A. Correct, which is the definition of infection.
Q. When you say "any open wound by definition is infected," does that mean there is, in fact, infection in the wound?
A. Yes.
Q. We have gone through your entire file in this case. Have you asked for any additional materials?
A. No.
MR. LANNEY: Dave, can we agree if he reviews any additional materials you'd let us know?
MR. SUCHECKI: Certainly.
MR. LANNEY: Off the record.
(Whereupon, a brief recess was taken.)
Q. Is it your opinion that Mrs. Lepage had an infection in the incision at the level of the knee at some period of time?

A. Yes.
Q. Do you believe that she had an infection at the knee on 5/23 when she was seen by Dr. Hoepp in his office?
A. I do not.
Q. You do not have an opinion one way or the other?
A. Right.
Q. Do you believe that she -- I know the answer that you do believe she had an infection at the knee on 5/26?
A. Absolutely.
Q. Do you have an opinion on how long that infection was present prior to 5/23 -- I'm sorry, 5/26?
A. I know that, first of all, an infection had to be there several days prior to that. I do know from depositions that the day before, I believe the family had called and said there was an open draining material from the lower wound. So it was infected at least 24 hours before and maybe earlier, since it takes a while for infection to be there.

Q. So your best estimate between -- somewhere between the 24th and 25th you of may it became infected?
A. There was no question when the bacteria seated there. I can't tell you how it seated there. Nobody can.
Q. Right. It may, in deed, have been infected on the 23rd, but there's nothing for me to say that I could tell that it was at that point. You know, possibilities and probabilities?
A. Right.
Q. So what you could say, it probably became infected sometime between the 24th and 25th of May, before that you can't say in probability?
A. I'd say more likely than not it infected before. But there was no way of telling that it was, but by the time of the 25th.
Q. There was no question it was infected, that's an absolute, the 25th?
A. And, of course, the 26th.
Q. So where are you comfortable in going

back in terms of probabilities in terms of when it was infected?

A. It takes at least 48 to 72 hours at the fastest -- but the bacteria we are talking about to start becoming colonized into an infection. Some bacteria take longer, but anyway it's at least 72 hours before that the bacteria had to have been present and infected the area. Signs were definitely there on the 25th with the drainage that the family had noted.

Q. Do you accept as truthful and correct in this case that the patient had pus draining from that wound on the 25th?

A. It's a family member. Okay. And when I review what a family member says to me, they know what pus is, they may not know, I accept it. There was drainage at that particular point in time and they recognize the smell at that particular point in time. Pus has a specific color, specific consistency. I don't know if they know what pus is, but

they know what drainage is. So I'm accepting it is a foul-smelling drainage. I can't tell. I wasn't there. It may, in deed, have been a pus they saw but, again, I can't tell. If medical person says pus, I know what they are talking about. If a layman, I'm not sure if they are talking about what I was talking about. I accept that there was drainage and foul smelling.

Q. You accept foul smelling?

A. Yes, had an odor.

Q. Family testify?

A. Yes.

Q. Mr. Massey testified there was no odor. Do you discount that testimony?

A. I don't discount it. I take it he noted a drainage, he probed the wound at that particular point in time, his deposition and note, I think he authored, basically said there was no foul-smelling. It's a statement that they made. Family says it was. I'm not going to argue the two. I'm going to say there was. There's no

question there's drainage 25th and 26th.
Q. I want to just to make sure we are going to be using the same term together to describe this wound infection. It's a surgical wound infection, cellulitis surgical wound infection. What do you want to name it?
A. Not cellulitis. It's defined as an infection. It's an open draining wound, which is obviously deep enough to be probed, not swabbed which is another term used in superficial probe, means sticks probe into a cavity and at that point it was draining material.
Q. Just looking for a term we can use moving forward. Would we call it a wound infection?
A. Definitely a wound infection.
Q. What are the signs and symptoms of wound infection?
A. Open draining wound. You can have redness to the wound, you can have -- depending on the fluid, can smell. Doesn't have to smell, depends on

bacteria that creates it. There are bacteria that form pus, there are bacteria that don't form pus. There are bacteria that smell, some don't. Many times there are mixed bacteria, you can have a fever, you can have an elevated white count, you can have pain.

Q. As of the 26th, was there any redness, any evidence of redness to this wound?

A. There's nothing in the note.

Q. And Mr. Massey has testified there was no redness; correct?

A. Correct.

Q. Wouldn't expect to see redness or erythema in an infected wound?

A. Not necessarily, you can.

Q. Is it most commonly present if the wound is infected?

A. Many times the wound depends on the bacteria, many times the edges are infected or the skin around it is red, yes.

Q. That is true in the majority of cases of infection; is it not?

A. Probably majority, they are red to some extent.
Q. Fever is generally present with infection; is it not?
A. Not necessarily.
Q. Majority?
A. No majority if systemic, if locally infected there is no elevation of fever.
Q. What about swelling?
A. Yes. There is usually swelling around the area of the wound.
Q. In this case there was no swelling?
A. There's no mention of it.
Q. Mrs. Lepage did not complain of pain, did she?
A. Not according to the note.
Q. So, therefore, for you the key here is that you've got an opening in the wound with drainage, that's the key -- strike that.

You base your opinion that there was a wound infection upon two findings; number one, there is an opening in the wound, and number two,

there was drainage; correct?
A. Correct.
Q. In terms of the drainage, to you it does not matter whether it was pus or serous fluid the mere fact it is infection?
A. Mere fact the wound is open. It's infected and mere fact the drainage is infected, it has to grow infection. Patient was on an antibiotic so you may not get pus. The antibiotic may not control infection but may infect it to the point where you wouldn't get the clinical signs of pus but an open wound infected the drainage from that is infected drainage.
Q. Those are the two keys opening and drainage; correct?
A. Correct.
Q. How does the surgeon evaluate for wound infection?
A. Well, first of all, they -- you mean a wound that's open and draining?
Q. Correct.
A. An open and draining. I just want to

clarify in this case or in general?
Q. In general.
A. In general an open draining wound is you cultured. The probe that's used to swab is usually you have a culture taken at that particular point in time. They may debride the area, take some tissue for culture as well. The wound is then irrigated. It may be packed. If it's a wound, it's explored to see its depths, and then usually wound care is started at that particular point in time, which is local and systemic, usually an antibiotic is given and culture comes back narrowed down, specified as to what we are covering.
Q. How large was the opening that Mrs. Lepage experienced on the 23rd and the 26th?
A. I don't see a dimension that I can remember. I do remember there was a probe able to be placed into the wound.
Q. Does the size of the opening make any difference to you?

A. No. Opening is an infection, means you have an infection going on.
Q. Would it make a difference if there was no depth to the opening or to the wound?
A. No.
Q. So even if it's a superficial opening with no depth, you still believe it would be infected by definition?
A. Yes.
Q. So even if there is no clinical evidence of infection based upon the examination, meaning there's no redness, no swelling, fever, chills, pain, you still believe the standard of care would require a culture because of the opening and the drainage; correct?
A. First of all, when you say no sign of infection, that's not true. An open wound draining is sign of infection, that's number one. Number two, culture is only one step, we do culture the wound, culture a draining wound, yes. There's more to this. But an open draining wound would be cultured, yes.

Q. Even in the absence of any other signs and symptoms of infection?
A. An open draining wound is cultured.
Q. Right. And an open draining wound requires antibiotics at the time?
A. Requires antibiotic as one part of it, yes.
Q. What else?
A. It needs to be -- you need local care. That wound has to be -- you want to control, controlling the infection involves local care and systemic care. So local care would be more, such as irrigation, peroxide, betadine, solution and there are a hundred ways you could do care. I do it form packing, plain packing, but there's local care, systemic care. So local draining wound needs to be treated locally and systemically.
Q. On the 26th, there was local care to that wound; correct?
A. In what?
Q. In Mr. Massey's care?

A. I saw a probe. We have to go to his note. I saw a probing of the wound.
Q. I can read it for you. It says the wound is dressed with bacitracin ointment and dry sterile dressings?
A. He probed the wound. Local care. That's simple. That's just on the edges. You need to control the deep infection. That doesn't control, that is, put bacitracin and dressing to catch the drainage. That's not local control.
Q. What is your definition of serous drainage?
A. Usually serous drainage, that is yellowish to clear, it's thick and it's meant to mean serum and blood. You can have blood but usually serous drainage is not bloody. You can have bloody, that's a term that's used. Serous usually means the term when you separate blood cells from the fluid, you get a serum. It can be milky, it can be slightly orangy, it can be clear, it can be cloudy. All those are serous

drainage. Normally serous means no blood in it.

Q. Did you say serous drainage indicates drainage is thick?

A. It can be. Again, it varies with the thickness of the serum, but it's usually sticky, it's usually. I told you it can be clear, it could be cloudy, it can be thick. Varying thickness of serous drainage.

Q. Is it your testimony that in any patient with a postoperative wound that if there is serous drainage from that wound, it requires a culture and treatment?

A. In any wound that has drainage that hasn't had a culture, yes.

Q. Even in the absence of other clinical signs and symptoms of infection, if you have got a postoperative wound and draining any fluid whatsoever, the standard of care requires a culture of that fluid and appropriate treatment?

A. Correct.

Q. Let's talk about vital signs for a

moment.
A. All right.
Q. Do you believe the standard of care requires every patient who has a surgical wound with some form of drainage to have their vital signs obtained?
A. Only part of vital signs that's important is temperature. It's routine to have the blood pressure and pulse checked and temperature, but in wound infection, drainage of wound, temperature becomes more important because you want to know if there's systemic involvement of infection.
Q. So is it your testimony that in any patient with a surgical wound that is draining, regardless of what the drainage is, any patient with a surgical wound that has drainage, the standard of care requires the patient's vital signs to be obtained?
A. I'm not saying standard of care. I'm saying routine evaluations in an

infection, is temperature one of the indications so you know the extent from being simply local or systemic. No, I'm not saying standard of care, I'm saying this is routine that we do in part of evaluation to see how extensive.

Q. So in this case you are not prepared to testify that the failure to obtain the patient's temperature on the 23rd or 26th violated the standard of reasonable care?

A. Correct.

Q. Do you keep a thermometer in your office?

A. Yes.

Q. Do you think that that is -- do most surgeons do?

A. I think most doctors do. I think we have stethoscopes, thermometers, not one, we have several.

Q. You do know that both thermometer and blood pressure and other vital sign -- you are aware that -- do you know the proximity of Dr. Hoepp's office to the

Elliot Hospital and Catholic Medical Center?

A. I have no idea.

Q. Do you know that instruments are available for completing vital signs in Dr. Hoepp's office?

A. I hope so.

Q. Do you agree that a small opening of an incision line is not uncommon postoperatively?

A. You have to define uncommon. It's not something I want to see. I mean if the question is have I seen it, yes. I have had wound infections. Most of the time, no. Most of the time the majority of wound that I've seen and done, no, there is no opening.

Q. What percentage of cases that you have done to patients experience some small opening of an incision line?

A. You mean just separation so you could see subcutaneous tissue.

Q. Yes?

A. Maybe 10 percent.

Q. That can be treated successfully only with Neosporin; correct?
A. Depends on where, but, yes, you can.
Q. I think I may have asked you this. You do not have a memory or opinion as to what the size of this opening for Mrs. Lepage?
A. Correct.
Q. Do you use Neosporin in your practice?
A. I have.
Q. When do you?
A. I use it on a superficial wound mainly ulcers, ulcerations of the skin as a bacterial control over, you know, with a dressing over it most of the time.
Q. If Mrs. Lepage simply had a superficial opening with the serous drainage that Mr. Massey records, do you still believe that cultures and antibiotics were required by the standard?
A. In open wound cultures, yes.
Q. Regardless of whether any depth surface opening or depth to it?
A. With drainage, yes. Yes.

Q. I'm coming back to that issue of probing really doesn't matter to you whether depth to that wound or not because of the mere fact of an opening plus drainage equal culture and antibiotics?
A. Yes. I want to make sure there's another part but the fact as far as culture alone, yes, the fact that it's draining it requires culture, yes. That requires culture, requires in this case more, but you haven't asked that question yet.
Q. What do you --
A. Well, this is a wound that's probed over a graft which is a little different than you are asking general wound care.
Q. Okay.
A. This is much more different. Infected wound over graft, not only the wound can be infected, the graft as well, which makes it a devastating complication for the graft because a graft that's infected, it does one of two things, it will close down or in this case disrupt

and bleed. What you want to do is initiate care, if it is a superficial wound or small wound that's a minimal cavity, you want to make sure it stays a minimal, so that's why you need to put people in the hospital, take cultures. That's why you have to initiate aggressive wound care and systemic and the cultures eventually lead you to maybe narrow down your antibiotic rather than what we call shotgun or broad spectrum antibiotic.

Q. Now, you understand that Mrs. Lepage developed a mid graft perforation or disruption?

A. Disruption.

Q. Would you like to use disruption?

A. It was described disruption more than perforation, the graft opens up basically.

Q. Do you have an opinion as to the probable cause of that mid graft disruption?

A. Yes.

Q. What is that?
A. Infection caused by what? The wound, being it was infected, the wound infection progressed to infect the graft, the graft was infected and disrupted.
Q. When you say the wound infection, we are talking about the wound infected that you believe existed at the knee?
A. Correct.
Q. You believe that infection at the knee spread to the mid graft?
A. It spread to the graft.
Q. If spread to the mid graft?
A. Well, right. On exploration it was in the mid graft. It extended to the lower part of the graft which was infected and the graft disrupted.
Q. Perhaps you could draw for me the leg?
A. Yeah. I can draw the leg but, again, from what I saw and again from what I gathered.
Q. What I want you to be able to show me the knee incision.

A. I need the operative report. That was there because I have to use this landmark because I don't know from memory.
Q. You want the operative report --
A. I think for your question I need the first operative report and second operative report when they determined there was a mid section graft.
Q. Let me ask you this question first. In general terms, it is your opinion there was an infection of the incision at the knee?
A. Of the wound at the knee, yes.
Q. You believe there was an infection of the wound at the knee; true?
A. True.
Q. And you believe that that infection spread north, if you will, to the mid graft; correct?
A. To the graft -- I'm going to say to the lower part of the graft. I don't know what point got infected first. From the operative report I remember they said

the infection was up to the mid graft, had not extended above that. So the lower part of the graft is infected, too. So the whole lower graft was infected. At some point there was a disruption of that graft and the disruption bled.

Q. So it would be your opinion as of time Dr. Hoepp went in to do the second surgery what he would have necessarily found infection at the level of the knee spreading up toward the mid graft; correct?

A. Yes.

Q. What if Dr. Hoepp found that there was completely normal tissue surrounding the incision at the knee, would you then agree with me that it is unlikely that what you believe was a wound infection at the knee spread to the mid graft?

A. The graft was infected in its own note most of the time we consider the graft totally infected. If infected anywhere, what he was talking about was adhesions

of surrounding tissue and he said it was adhesions and he called it up to the middle graft that means the lower graft infected. Let me just -- the infection came no matter where it was. As I said, I have to go to the records to pinpoint it. The infection inflamed the graft. The graft infection caused disruption and bleed exactly where it was. It's in his note the graft was infected up to the mid portion.

Q. I'm asking a different question.

A. Okay.

Q. Let me try to break it down. I'm going to go to those records in a moment.

A. We'll talk from the records.

Q. In lay terms what you are saying is that this infection at the knee level, the wound?

A. Right.

Q. Spread up to into the graft causing the perforation of the knee graft level?

A. Causing the graft to disrupt, yes.

Q. Therefore, when Dr. Hoepp performed his surgery on the 30th, you would have expected him to find infection from the knee level up to the area of the disruption; correct?
A. Lower part of the graft up to the mid graft, yes.
Q. But you would expect him to find infection from the knee wound up to the lower left of the graft?
A. Correct.
Q. It would be throughout that entire area?
A. Well, it may be track. In other words, you could have an area you could have tracking infection doesn't necessarily grow out like a balloon, there are pathways it finds. In other words, the bacteria made it's way to the graft.
Q. Right. But the track would extend from the wound at the knee up to the disruption?
A. It might be microscopically, yes. Bacteria very small. Your track up there might be microscopic. You might

not see it visually but the bacteria started from the wound and tracked up to the graft. Whether milliliter opening or micro, it went up there. It made its way to the graft. Graft was infected there, but there would be evidence of infected tissue from the knee up through the track to the disruption. Again --

Q. True. True.

A. Yes. If you culture that tissue when you say infected tissue, in order to determine that, you would have to take cultures periodically along and send it to the bacterial lab, and they would culture it and they would tell you there was a track up there all the way up. It is not -- what I'm trying to say, I don't know what you mean by infected. You know how it got there. It got there through an infected track, true. The infected track may be very small. They didn't do wound cultures all the way up, so you don't know that wound wasn't infected.

Q. In that case would you expect the area distally near the popliteal incision to be well encased in normal tissue, or would you expect to see evidence of infection?
A. Again, I would expect it to be infected, and from another point, also just from what I remember from the emergency room record, they clamped this graft so it would have to be exposed which means exposed, exposed to the wound.
Q. I think you answered my question. Just to make sure it's clear. You would not expect the area distally at a popliteal?
A. I would expect it to be infected.
Q. Thank you.
A. Again, but you -- well-encased in normal tissue. I'm not sure what they mean by well-encased since cultures weren't taken. It could be well-encased infected material.
Q. You would expect not normal tissue?
A. Again, since no determination of infection -- there are no tissue

cultures, so you don't know if normal or not. You only know it was inherent tissue. Not infected would have to be the determination made on culture.

Let me just -- I want to add to your question from the operative note so that we're perfectly clear. Distally The graft was dissected free, all infected area was removed.

So he acknowledges there's infected area there.

Q. At the mid graft?

A. Doesn't say it means distally. It means farther down distally. The graft was also dissected free, all infected material was removed, so there was infected material around the graft that they did note. Now, it says the groin was totally -- when is the upper part of the graft was fine so the upper part of the graft he didn't see infection.

Q. All right. Keep going. Are we looking at the report of operation?

A. 5/30/00.

Q. It goes on to state, quote, surprisingly the area in the groin and at the knee anastomosis area was totally in tact and not in any way infected, close quote.
A. That's what I'm saying. My point is -- he says in that area he did remove infected material.
Q. From the mid graft?
A. Yes, but --
Q. Hang on. Let me ask the question.
A. Okay.
Q. He removed the infected material from the mid graft?
A. Correct.
Q. There was no evidence of infection at the knee?
A. At the lowering part of the incision he says it was encased basically inherent material neither at the groin site nor at the distal area was tissue cultures made.
Q. Right.
A. I'm not saying they should have been made. I'm saying, as a matter of fact,

I understand what he's saying it's inherent. What I'm saying to you the graft that is infected is totally infected. There is no such thing as it's only infected one inch. The whole graft is infected. The graft would not be used again. He is making note infected material in the mid graft which is where the disruption occurred.

Q. That's fine.

A. It doesn't matter whether the tissue around that graft had become infected enough to be noticed as infection, but I'm saying you can't tell me there was no infection without showing me a tissue culture and the microbiology saying this doesn't grow anything which, in reality, doesn't exist.

Q. Do you know anything about Larry Hoepp's background?

A. I have no idea.

Q. Do you think that if you've opened a wound you will be able to visually tell me if there's evidence of infection?

A. Again, sometimes you can tell if the tissue is infected, but you can't say that the tissue is not infected because it seems to be in tact. In order to be that -- infection means bacteria growing in that tissue. In order for me to say that with absolute certainty, he's making an observation in his report, I'm not, not obvious is incorrect. I'm saying there's no proof here that the tissue cultures of that area would come back perfectly normal.

Q. You don't have any proof to the contrary, do you?

A. Correct. I'm not arguing what he says in the report. My point, there was infected material around the graft and by definition the graft is totally infected. The fact the upper part was inherent and lower part inherent. Does not mean -- I understand. He says here doesn't appear to be infected. If he doesn't do tissue culture, that's not an absolute statement.

Q. You've made your point perfectly clear. I understand it. You have no evidence in this case that the area around the knee anastomosis was, in fact, infected, do you?
A. No.
Q. Number two, if there was infection at the knee sufficient to cause a disruption of the mid graft, isn't it likely you're going to be able to see that clinically when you open up that wound?
A. Not necessarily. Not necessarily. As you see here, he says he removed infected material after the graft -- the graft was infected. It was clamped off. So the graft was exposed and infected.
Q. I want to go to your report now.
A. Sure.
Q. What I'd like to do now is go to your report. What I'd like to do is to get a list from you of all of the violations of the standard of care that you believe occurred in this case. Then I can come

back and talk to you about them.
A. Sure.
Q. I don't know if you want to do it by the report. Let's try it this way. Let me just start. I think we can agree up until May 23rd that the care was perfectly appropriate and consistent and always with the standard of care?
A. Absolutely.
Q. Let's start with the 23rd. Dr. Hoepp saw Mrs. Lepage in his office.
A. Right.
Q. Do you believe that Dr. Hoepp violated the standard of care in any way on 5/23?
A. No.
Q. Next, there was a phone call on the 25th, we're not quite sure what time, and the patient was asked to come into the office the next morning on the 26th to be evaluated. Was that appropriate?
A. Yes.
Q. So there's no violation of the standard of care on the 25th. Is my statement; correct?

A. Yes, it is.
Q. First occurs 26th?
A. Yes.
Q. Would you list for me all violations?
A. Patient had an open and draining wound over a graft site. Patient should have been admitted to the hospital, aggressive local wound care should have been started, cultures should have been taken. I'm not giving to the exact order, but, antibiotics should have been started and obviously changed from what she was on, and it should have been evaluated basically in the hospital. That's the issues in this case on the 26th.
Q. So on the 26th because of the opened and draining wound over the graft, Mrs. Lepage should have been admitted to the hospital?
A. Correct.
Q. Aggressive wound care should have been instituted?
A. Correct.

Q. Cultures obtained?
A. Correct.
Q. Antibiotics started and changed and evaluated in the hospital, that needed to occur?
A. Correct.
Q. Are there any other items of the standard of care that occurred, violations?
A. No.
Q. Any that occurred after the 26th?
A. No.
Q. When you say cultures should have been obtained, what type of culture?
A. Wound cultures to find out -- again, this patient was on antibiotic, had a draining wound. You want to at least start to find out what type of bacteria you are dealing with, so a wound culture should have been taken.
Q. How long would it take those wound cultures to grow out bacteria?
A. 24 to 48 hours with culture and sensitivity.

Q. What antibiotic do you believe should have been started pending those culture results?
A. I would have believed since she was on a Keflex, if I remember correctly, it wasn't controlling or probably wasn't controlling the infection, a more broad antibiotic.
Q. Such as?
A. There's like a hundred. You could change it to a carbenicillin (Ph) type empypenum (Phonetic). You can go to a more aggressive vancomycin type of staff drug. It would have changed to a much more broad spectrum, stronger antibiotic. But that's not the key. The key is she needed to be in the hospital and local wound care had to be started to control the infection, the cultures would have come back in two days with an idea what the bacteria was, and then you can narrow down your systemic treatment.
Q. I understand. My first question while

waiting for the culture antibiotic, all you can tell me is broad spectrum?

A. Yes, because he has choices, not just one choice. Choice would be if a patient who has that I'd be worried about staff, I'd go to vancomycin.

Q. Would that antibiotic be sensitive to the infection that Mrs. Lepage eventually had?

A. Yes.

Q. Would that have been given IV, oral?

A. IV.

Q. So we've now covered all of your claims of the violation of standard of care?

A. Yes.

MR. LANNEY: Dave, if additional claims you'll let us know?

MR. SUCHECKI: Sure thing.

Q. Let's start with the standard of care for a minute. What the standard of care requires in terms of specific antibiotics that would have been given to this patient.

A. Again, there's no -- standard didn't

specify. What I'm trying to say most important part is place in the hospital. Number two, local wound care after cultures taken, local wound care and controlled, patient should be put on broad spectrum antibiotics.

If asking my opinion I would be very worried about staff infection, and I would go to a vancomycin type of drug, and vancomycin would be my first choice. I'm not saying he's stuck to one thing as a standard of care in the hospital. Local wound care started, IV and evaluation done plus observations. She's in the hospital. The problem you are dealing with here when the wound is infected the graft can be infected. If these graphs get infected at minimum you lose the graft, which creates limb loss. So you want to protect. You want to limit that infection as quickly as possible and you go to the hospital, and then evaluation to try to limit and control infection.

That's what I'm saying. You can't go to any one antibiotic. I'm sure infectious disease would probably had five he could have chosen if it was a broad staff infection.

Q. Broad spectrum staff antibiotic, appropriate antibiotics?

A. Right. I'm going to say -- right.

Q. Is it your opinion aggressive wound care, if appropriate antibiotics started on the 26th, that it probably would have prevented the disruption of that graft?

A. Yes, more likely than not.

Q. What is the basis for that?

A. Apparently from what I see, the wound infection if it was probed and apparently was not deep enough to concern him that he had gone to the graft, so it was limited at that particular point in time. If you take care of local wound care, which is basically irrigation and local medication you may have kept that graft from becoming infected. More likely

than not, if local wound care was started, you would have controlled the local infection and the graft wouldn't have been infected.

Q. How can you say that in probability, certainly if possible that aggressive wound care and antibiotics would have prevented disruption of the graft. How could you say more likely than not?

A. In my experience we are very aggressive in controlling that wound because we don't want to penetrate down to the area, we open up the wound more, we irrigate it, we pack it, we try to keep the infection moving out as opposed to moving in because we know what's under there.

Q. This is based on your personal experience?

A. My experience and training is to control the local wound from progressing.

Q. That's not what I'm asking. What is the basis for your opinion, stating that controlling the local wound in this case

by aggressive wound care and antibiotics would probably have prevented this obstruction?

A. Training and experience.

Q. Can you point to any medical literature?

A. I haven't done research on this disruption and infection, but I do know that infected wound can lead to infected grafts and infected grafts can become disruptive, so if you controlled and didn't penetrate down and you won't have a disrupted graft and it won't be disrupted.

Q. Do you know how this infection occurred?

A. I specifically -- nobody knows. We do know resistant staff is a bacteria found in a hospital. We don't find it outside the hospital. So it occurred, and this bacteria is a hospital grown bacteria.

Q. Nosocomial infection?

A. Yes, but let's talk about the bacteria itself, lives in the hospital because you don't find this type of bacteria outside the hospitals.

MR. LANNEY: Off the record.

(Whereupon, a brief recess was taken.)

Q. Going back to vital signs for a moment. From what you told me, and I take it that even if a temperature had been taken on the patient, either the 23rd or the 26th, that you cannot state whether there would have been evidence of fever because some infections have fever and some don't?

A. Correct. Correct.

Q. Let's see -- off the record.

(Whereupon, a brief recess was taken.)

Q. Did you accept as accurate, Mr. Massey's testimony that when he examined this wound on the 26th there was no purulent drainage?

A. The statement is there. I can't argue with the statement.

Q. You did not dispute the accuracy?

A. No.

Q. Do you accept as accurate Mr. Massey's

observation that there was no erythema?
A. Again the statement he made, I'm not disputing. I wasn't there.
Q. There was no swelling, ~~this~~ No statement, ~~no~~ of fever or shaking, ~~had~~ chills; correct?
A. Correct.
Q. And no complaints of pain?
A. Correct.
Q. I think we have agreed there's no evidence of cellulitis?
A. Correct.
Q. Do you know what a tunnel hematoma is?
A. Sure.
Q. What is it?
A. When you tunnel down usually for where you do your grafts where you, in situ, you go along to clip the vessels or you do a saphenous graft, there's a tunnel created, very often blood in the tunnel and it's tunnel hematoma.
Q. Do you know if there was a tunnel hematoma in this case?
A. I believe there wasn't, just from memory, but I have to look at the

records.

Q. Let me ask you, hypothetically speaking, if there was a tunnel hematoma following surgery that was noted while the patient was still in the hospital, is it likely that the drainage that Mr. Massey saw on the 26th was secondary to that tunnel hematoma?

A. No, because tunnel hematoma you have blood in there, you have old blood in there. The drainage from that is at least zero sanguinous, has some blood in or old blood type of thing. So tunnel hematoma would drain more bloody type of fluid but not a serous.

Q. And I take it that little bit of eschar that Dr. Hoepp noticed would be expected?

A. I wouldn't use the word "expected," but I would say not unusual, especially if a little crusting of blood in the area.

Q. That's not an abnormal finding?

A. Well, it's not a normal, you don't want to find it, but it's usually very

limited. It's not something that you'd necessarily jump on to do anything with.

Q. It is not evidence of infection?

A. No.

Q. I may have asked you this and I apologize. I think you told me that you cannot testify one way or the other whether Mrs. Lepage had an infection at that knee incision on the 23rd; correct?

A. Correct.

Q. Dr. Hoepp pointed out that there was no complaint of fever, no drainage, the wound appeared to be clean with no signs of thickness, redness over this induration or purulent drainage based upon that observation. Can we agree the wound was probably not infected as of the 23rd?

A. I don't really want to go to probably or possibly. All I can say, the observation at that point, there didn't appear to be any infection at that point, there may in deed, whether the bacteria were there already working,

more probably than not they were already there but there were no signs until at least the 25th.

Q. I want to read to you a portion of Dr. Hoepp's deposition from Page 85, Line 5. The question was "What can cause drainage of a wound? " And the answer, and I will ask whether you agree or disagree with this answer. "Drainage of the wound can be caused by just a splitting of the skin because the internal milieu in the body is liquid and there are significant amounts of fluids in the tissue which can leak out. It can also be related to an injury of a channel that carries fluids and also eventually in some ways be related to infection."

Do you agree with that answer?

A. Yes.

Q. He goes on to state how would drainage from an infection appear typically and his answer was, "In most cases it would

be a thick odorous drainage."

Do you agree?

A. No. I don't disagree that it can be but in all cases, no.

Q. In most cases?

A. I don't know the percentage but not all bacteria smells. Not all bacteria creates pus. So the only thing I'll say to that is not in all cases does it create that situation. I have taken a 51, 50 count, but not all wounds that are infected show that.

Q. Dr. Hoepp defines serous fluid as, quote, very clear, thin and watery, close quote.

Do you agree with that definition?

A. No. Serous relates to serum. Serum is the separation of red cells from the rest of the blood and -- but it comes out of there as serous and serous can have a color, cannot always be clear, it can be colored. It can be clear. The thickness varies with what's in it. So

serous is not one -- the only thing serous does mean no blood in it.

Q. Would you agree with me that very clear, thin and watery drainage is usually not the type of drainage that is seen with infection?

A. No, I don't agree with that. Infection and I'll just explain. It's a bacteria that's in that which determines it's infected, not it's cause.

Q. If a wound is probed and there is a determination that there is, quote, no depth to the wound, does that indicate that none of the fluid or drainage has entered a deep space?

A. I don't understand the question because probed by definition is not superficial, means you probe the cavity, so you have a cavity, so it means -- superficial means just that you wouldn't probe, you would swab a superficial wound. And I'm showing you'd swab superficially a cavity, you put a probe into the -- probing means depth. There's a cavity,

a pocket or something in that order.
Q. What was the others word you used?
A. Swab.
Q. So let's assume for a moment that a wound is swabbed and there is no depth to the wound.
A. Correct.
Q. If a wound is swabbed and there is no depth to the wound, does that indicate that none of the drainage or fluid has entered a deep space?
A. In general, I would agree with that.
Q. Now, if no fluid has entered the deep space that would point away from infection?
A. No.
Q. In this case if there was no depth to this wound, would it be possible for the infection to track along the graft to the mid graft level?
A. If there was no depths -- if it was superficial and closed superficial couldn't get to the graft.
Q. Sorry.

A. Couldn't get to the graft.
Q. So if there's no depth to the wound, there's no way that the infection could track down into the graft; correct?
A. Well, yeah, that way but -- this is not the case. But it can track the other way. You can have a graft infected and eventually get a wound infection and track the other way.
Q. That didn't happen here?
A. No.
Q. My question, if there's no depth to the wound there's no way that the bacteria can track down into the saphenous vein?
A. Right. It would have to eat its way down there and create depth, then you get to the graft.
Q. What is seroma?
A. Cavity filled with serum. Like you would have an abscess it's been, you know, open cavity filter with serum. It occurs around moons.
Q. Is that indicative of infection?
A. No. Seroma by definition are not open

to the outside, they basically a cavity filled with serum. They are not infected per se unless they are violated. In most cases they are drained in some cases and then become infected but seroma can be an --

Q. If there's an opening and it starts to coming out?

A. No. That's infected most of the time.

Q. Do you have an opinion as to how long a period of time that mid graft area, ultimately became disrupted, how long it was infected?

A. No.

Q. I take it you have no criticism of the record keeping of Dr. Hoepp or Mr. Massey?

A. No.

Q. Mr. Massey was asked about his procedure, if you will, about examining a wound, and he indicates -- the question is can you describe how you would have examined Mrs. Lepage's wound. His answer was, in regards to this by

observation, by palpation along the wound edge to make sure there was no further opening, checking of all the distal pulses, observing for any signs of infection, that would be the normal course.

Is that a reasonable approach to observation and assessments of a wound?

A. Well, there's a little bit more to assessment to where an assessed patient has a fever.

Q. I'm talking about examination.

A. I understand but a portion of the examination is fine, portion of examination is not for wound infection, checking pulses is not a wound infection evaluation, checking wound seeing swollen seeing red, yes, that's all part of it, as is there a temperature, is there a blood count drainage.

Q. I'm asking. I understand there's a big picture. I'm focusing on one piece which is the actual visual examination

is palpating looking for the opening. Is that what is appropriate?

A. In part, sure. In part, sure.

Q. Asking about wound cultures, what percentage of wound cultures -- let me try to be more specific.

What percentage of wound cultures are going to be contaminated simply by the bacteria in the skin so that you get a false positive? Do you know what I'm asking?

A. I know what you are asking but the assumption is wrong. All drainage is infected. All open wounds are infected. I think you mean is what can you -- you have cross-contaminants from the skin. Can you show skin contaminants as well, of course, but bacteria goes both ways. Your skin contaminants can be a pathogen. So you can get mixed cultures. I can get a bacteroid disease which is nonsmelling, clear, being my main pathogen. Yet I'll have staff begin growing on there coming from the

skin, then you'll figure out which one is your more virulent, but it's still contaminated still infected.

Q. You had mentioned antibiotics that you believe indicated here to include a broad spectrum staff sensitive antibiotic?

A. Correct.

Q. Are there risks associated with given?

A. Yes.

Q. What?

A. Vancomycin can create autoxicity renal toxicity if very, very high doses are not monitored, true.

Q. Even -- actually that drug even in appropriate doses with appropriate monitoring you can still suffer autoxicity and renal toxicities?

A. Absolutely. Every drug we give has risks and side effects that are weighed against the ultimate problem. I'm not saying the drugs don't have problems. I'm saying I would cover with heavily staff drugs. As I said, the hospital

may have been -- the hospital knows what their staff drugs are, some hospitals, they might not use vancomycin so the hospital might change that to something they know more effective to staff.

Q. In addition to the renal toxicity and autoxicity are there other risks associated with a broad spectrum anti-staff antibiotic?

A. I'm sure the answer is yes. I mean, there are other growths of other bacteria in the body as well.

Q. Now, when you first reviewed this case, you knew that Mrs. Lepage had suffered a mid graft disruption/infection?

A. Correct.

Q. You knew that from the very first piece of paper that you reviewed in this case, which was of the letter that we had marked as Exhibit 2.

A. Yes.

Q. I am going to ask you about the risk of infection for this patient. As of the 26th, can we agree that she was at low

risk of infection on the 26th?
A. No. No.
Q. I know that you believe she had infection because of the drainage and the opening but let me try it this way. As of the 23rd was this patient at low risk for infection?
A. No.
Q. Why not?
A. This is a vascular patient. Vascular patients by definition have decreased blood flow, makes them high risk. She already had an ulcer of the foot. She had ulceration. She is not a low risk for infection. She is a high risk infected patient.
Q. Can we agree that there was no clinical evidence of infection at the time that she was discharged from the hospital on May 9th after her surgery?
A. Of the wound, yes.
Q. And are you familiar with the antibiotic therapy that was provided to this patient preoperatively,

intraoperatively, postoperatively and at discharge?

A. I have read it. I don't know it by heart. I know she was on Cefazolin.

Q. She received Cefazolin, C-E-F-A-Z-O-L-I-N, preoperatively, Keflin solution intraoperatively an Cefazolin intraoperatively Keflex and Cefazolin postoperatively and Keflex at discharge. Was that an appropriate antibiotic therapy for this patient?

A. The answer is yes, not knowing the ultimate bacteria. Yes, it's one of the appropriate regimes. There's no problems with that.

Q. All of the doses and the length of time of those various antibiotics were also appropriate?

A. Also from recollection I have no criticism of the drug or how administered.

Q. Nothing Dr. Hoepp did or failed to do caused this unfortunate infection; true?

A. Correct.

Q. Does the fem-pop bypass procedure in and of itself change blood flow in the lymphatic system which causes swelling of the leg?
A. It's more than lymphatic system, but it causes swelling of the leg, yes.
Q. The swelling of the leg, it can on occasion lead to serous drainage?
A. Correct.
Q. And that is, in fact, a fairly common finding in patients postoperatively?
A. Serous drainage or edema?
Q. Serous drainage.
A. No. No. Wound drainage no swelling. You can see swelling.
Q. I want to go back to your report, Exhibit 4.
A. Yes.
Q. I'm looking on Page 2, the second paragraph. Dr. Hoepp diagnosed Mrs. Lepage with bacterial ulceration. Do you agree with that diagnosis?
A. Yes.
Q. Was it appropriate to place her on Cipro

to see if that would help?
A. Sure.
Q. Which she continued to have pain. Was it appropriate to schedule her for an arteriogram?
A. Absolutely.
Q. As a result of the arteriogram, you would agree surgery is indicated and necessary?
A. Without a doubt.
Q. I think you already told me the surgical technique was just fine.
A. No problem.
Q. Mrs. Lepage received excellent care while in the hospital for her surgery?
A. No problem with care. Care was fine.
Q. Pain control and antibiotic therapy was appropriate?
A. It's just -- I have no problems with any part of the hospitalization, the first or the second hospitalizations at all.
Q. Do most patients have incisional pain following this procedure?
A. Yes.

Q. How long does it tend to last, variable?
A. Pain is very real. I have patients, big incision, no pain. Also depends on diabetics, less pain because less pain sensation. So if you have a diabetic, they may have no pain whatsoever.
Q. In your experience have you had patients who have had fem-pop bypass who start to experience some pain in their incisions as they become more active?
A. Yes. Yes. That does happen. That does happen with every incision in most cases.
Q. I'm going to shift gears a little bit. Some questions about your background. You discussed with us briefly that you had done some worker's compensation and liability evaluations in the early 1980s.
A. Yes. I still do some liability evaluations, IMEs to this date, but, yes, I started that years ago.
Q. In your CV you have both Barnert Memorial Hospital and Pascack Valley

Hospital 1982 to the present. Am I correct in understanding that you obtained privileges at both those facilities in 1982?

A. Correct.

Q. There were two hospitals where you were not successful in obtaining those privileges?

A. Englewood and St. Joseph's in Paterson. Just one hospital closed. I think it's on there.

Q. Kennedy?

A. Kennedy, right.

Q. Now, am I correct in understanding that you are Board Certified in surgery?

A. Correct.

Q. And you passed the written examination on your third attempt?

A. Correct, and the board exam, the oral on first.

Q. You failed the first and second attempt at the written examination?

A. Correct.

Q. Am I correct in understanding that you

do not qualify for a certificate in vascular surgery because you did not complete a fellowship?

A. Yes.

Q. And I am aware of the disciplinary proceeding that was brought against you in New Jersey and then subsequently in New York related to New Jersey?

A. Right, and the Appellate decision there was no wrong doing.

Q. I know all about that. There was some reference in the deposition of yours, one of the issues there was a fee dispute, some testimony about that fee dispute is still pending. Has that been resolved?

A. Well, no, that finally -- I got disgusted with their issues and brought them before the Judge, and in New Jersey they have the right to tell the Judge we have no issue at this time, and the Judge tells them if you have an issue, you bring it up with me before you bring it up with anybody else, and that's been

eight years ago. And I haven't heard anything of it. So they haven't resolved it, but in order for them to resolve it, it has to be brought before the Judge.

The answer is they don't resolve issues. There's no issue that's resolved. The fact is, as far as I'm concerned, there's no issue. If there was an issue they'd have to tell the Judge, and it's eight years, so if they bring it up before I die, maybe we'll get it resolved. I can't resolve it even going to the Court, so that was brought in a deposition saying just to cover all bases. As far as I'm concerned there is no issues.

Q. I want to ask you about the areas in which you have offered expert testimony in the past in terms of medical disciplines.

A. Sure.

Q. You have offered criticisms in terms of violations in the standard of care in

general surgery cases.
A. Correct.
Q. Vascular?
A. Correct.
Q. Obstetrics?
A. Only when general surgery is involved with it.
Q. Obstetrical cases involving surgery?
A. When there's crossovers to certain things, obstetricians may do surgical procedures that I do, and that I may get involved with.
Q. Failure to diagnose breast cancer?
A. Yes.
Q. Neurology?
A. From what, neurology to general surgery and preservations of the nerve, not on diagnosis of neurological injuries.
Q. Emergency medicine?
A. Yes, also relate to surgical patients.
Q. Failure to diagnose breast cancer for malignancy?
A. Yes.
Q. Orthopedic surgery?

A. Not unless general surgery issues are involved, I don't get involved in saying a fracture is handled wrong, but there's an occasion where there may be an arterial injury related to an orthopedic injury.
Q. Gunshot wound?
A. Yes, that's general.
Q. Have you testified in a case about the negligence of an obstetrician during labor and delivery resulting in the need for caesarian section?
A. Not to my recollection.
Q. I'm trying to determine what other disciplines you may have offered expert testimony in. We've covered several. How about oncology?
A. Not oncology as to medications. I don't believe I have -- what I'm saying, everything would have to be related to surgery. I have -- there are general practitioners who do surgery, remove lesions, have problems. The discipline of the doctor is not the issue what he

does. If he does -- I do general vascular surgery in relation to it, so if a physician does that, then he falls within my realm of possibility.

Q. So, again, I understand, surgical related matters?

A. Right.

Q. They involve several. They have involved several disciplines, we've covered a few, emergency medicine, obstetrics?

A. Again, I don't remember the issue and the case, and I don't think it was the obstetric issue I made comments on. It was some related issue done at the time.

Q. Family practice?

A. Yes.

Q. Internal medicine?

A. Again, if it's surgical related issues, yes.

Q. Pediatrics?

A. Not to my knowledge. Not to my knowledge.

Q. Cardiology?

A. Not to my knowledge.
Q. Plastic surgery?
A. Not to my recollection, but there may have been plastic surgeons who did general surgery.
Q. Oral surgeons?
A. Possible. Possibly.
Q. In the New Jersey disciplinary action matter, did you pay a $700 fine?
A. No, I paid costs. That was the cost of their expert. There's no fine.
Q. You have advertised your services as a physician in local papers, shoppers local magazines?
A. Sure. Over the years, sure.
Q. The New Jersey disciplinary action, you did accept reprimand?
A. For doing nothing wrong.
Q. But you did accept the reprimand?
A. Without violation, without liability, within violating those statutes, standards or codes, yes.
Q. There's a special certificate created by the American Board of Surgery for a

competency in the field of vascular surgery.

A. Yes, we discussed that.

Q. You do not have that certificate?

A. Right.

Q. Have you ever been the chief of surgery at any hospital?

A. No.

Q. Have you ever served as an editor of a peer review journal?

A. No.

Q. Have you ever been an officer in any of the vascular or general surgical societies?

A. No.

Q. One of the cases that you were a defendant in is the Jerome Bell (Ph) case. Do you recall that?

A. Yes.

Q. What was the outcome of that case?

A. That was a settled case.

Q. What did that involve?

A. Lady who have a laparoscopic cholecystotomy, I went into the hospital

and had a transmission of 100 units.

Q. I apologize, I think I may have asked you this. I did. I did. I remember.

(Whereupon, a brief recess was taken.)

Q. As part of the Consent Order with the State of New Jersey, you agreed to a plan for monitoring X-rays.

A. We had trainer and we had our radiologist review the techniques and give an in-service and basically looked at the X-rays. I think there were 40 or something for the year. He wrote a report, that was the end of it.

Q. You agreed to that plan?

A. Yes.

Q. By doing so, the board agreed not to pursue license suspension issues against you?

A. They agreed, basically the resolution is as it states, only requirement we agreed upon, and they -- that was it. That was the resolution of the whole case. There was no mention of any other issues other

than the X-rays and the Consent Order.
Q. The statements you agree truthfully?
A. True and accurate at the time and circumstances. There is no admission in that statement that I did or said anything inappropriate at the time, so it's not a statement that I said things wrong, statement was I did nothing wrong. That's what they said in the Consent Order, that they agreed.
Q. There is a sentence in the consent agreement that says, quote, a consideration of settlement of the charges of the complaint after completion of Discovery and prior to trial respondent, which is you, acknowledges the following as true. Then it goes on to list several paragraphs.
A. Right. As I said, if you read the statements in there, they are true, and a lot of statements are something/something else, and that was the language in that report was to

satisfy both parties. I did not agree with some of the language. They didn't agree with some of the language I used. It was accepted by both parties. There was nothing wrong.

Q. Let me ask a full question and see if you can answer it.

A. Okay.

Q. The Consent Order, Page 2, contains a statement, quote, in consideration of settlement of the charges of the complaint after completion of Discovery and prior to trial, respondent acknowledges the following as true. And it lists Paragraphs 1 through 5.

And, am I correct in understanding that you do, in fact, acknowledge those Paragraphs 1 through 5 as true?

A. Yes. Those statements were made.

MR. LANNEY: Those are all the questions I have. Thank you.

MR. SUCHECKI: No questions.

(Whereupon, the deposition

is concluded at 12:15 p.m.)

AGENCY CERTIFICATE

We hereby certify that a Notary Public, in and for the State of New Jersey, duly commissioned and qualified to administer oaths, swore in STEPHEN I. BECKER, M.D., witness.

We further certify that the foregoing deposition was taken stenographically by a representative of our firm in the presence of counsel and reduced to typewriting under our direction, and the foregoing is a true and accurate transcript of the testimony.

We further certify that we are neither of counsel nor attorney to either of the parties to said suit, nor are we an employee of either party to said suit, nor are we interested in the outcome of said cause.

Witness my hand as Notary Public

this 24 day of November, 2004.

Braxton Reporting

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