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CAUSE NO. 2006-CI-09447

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| ROSALYN BROWN | ) | IN THE DISTRICT COURT |
| VS. | ) | |
| BAPTIST HEALTH SERVICES, INC. and/or BAPTIST HEALTH SERVICES, INC., DOING BUSINESS AS ST. LUKE'S BAPTIST HOSPITAL | ) | OF BEXAR COUNTY, TEXAS |
| | ) | 131ST JUDICIAL DISTRICT |

**********

ORAL DEPOSITION OF
BARBARA J. LEVIN, R.N.
FEBRUARY 7, 2008

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THE ORAL DEPOSITION OF BARBARA J. LEVIN, R.N., duly sworn, produced as a witness at the instance of the Defendant, VHS SAN ANTONIO PARTNERS, L.P., DOING BUSINESS AS ST. LUKE'S BAPTIST HOSPITAL, was taken in the above styled and numbered cause on the 7th of FEBRUARY, 2008, from 8:56 a.m. to 10:34 a.m., before Diana Ramos, CSR, RPR, Certified Shorthand Reporter in and for the State of Texas, reported by machine shorthand, at the Apffel Law Firm, 1406-C West Main, League City, Texas, pursuant to the Texas Rules of Civil Procedure and the provisions stated on the record.

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

FOR THE PLAINTIFF, ROSALYN BROWN:

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EXHIBITS

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10-20-07 Letter to E.A. Trey Apffel, III, from David W. Edelstein, M.D.; Attached Correspondence, Medical Records

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11-1-07 Check to Barbara J. Levin from Apffel Law Firm; Attached Invoices, Check

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Handwritten Notes of Barbara J. Levin

(Levin Exhibits 1 through 3 marked.)

THE REPORTER: Stipulations pursuant to the Texas Rules?

MR. ROWE: Please.

BARBARA J. LEVIN, R.N.,

having been first duly sworn, testified as follows:

EXAMINATION (8:56 a.m.)

BY MR. ROWE:

Q. Please state your full name for the record.

A. Barbara J. Levin.

Q. Ms. Levin, my name is Brett Rowe and I represent St. Luke's Baptist in this case. You understand we're on opposite sides of the table here today?

A. Yes.

Q. All right. It's also my understanding that you've done this quite a few times, given a deposition. Is that fair?

A. Yes, I have.

Q. So I don't have to go through all the ground rules about not talking over one another and talking slow so the court reporter can get everything. If you need to take a break at any time, just let me know. All right?

A. Yes.

Q. In looking at your resume, it looks like you have done nurse consulting for 20 years, since 1988?

A. Yes.

Q. What got you started in the business?

A. I was asked to review some medical records related to a pedestrian and a motor vehicle and I was asked specifically to explain all the orthopedic injuries in that case.

Q. Okay. And about how many cases do you think that you've reviewed since 1988?

A. Hundreds.

Q. How many depositions do you think you've given?

A. About 40.

Q. How many times have you been to trial to testify?

A. I think it was seven or eight times.

Q. Ever down here in Texas?

A. For which?

Q. Trials.

A. No.

Q. Whereabouts have those trials been?

A. Massachusetts, Florida, Rhode Island.

Q. I would assume then you've reviewed cases where the care was rendered in Massachusetts, Florida,

Rhode Island and Texas?

A. Yes.

Q. Anyplace else?

A. Yes. Maine, New Hampshire, Connecticut, Virginia, West Virginia, Georgia, Oklahoma.

Q. California?

A. No.

(Brief discussion off the record.)

A. Could I clarify one thing?

Q. (BY MR. ROWE) Sure.

A. When we speak about the hundreds of cases, that is not always an expert.

Q. Okay. What are some of those cases as?

A. Some of those are files that have to do with performing research, attending independent medical exams, attending court mediations, maybe personal injury claims.

Q. Okay. How many of those are malpractice related?

A. A very small percentage of those are malpractice related.

Q. How many malpractice cases do you think you've reviewed?

A. I'm not sure in total. I don't know.

Q. Okay. Do you have any academic appointments?

A. No, I do not.

Q. Tell me about your current employment status. How much are you working hands on as a nurse and how much are you doing nurse consulting in any given week, average?

A. I work at Massachusetts General Hospital and I'm providing direct patient care 28 hours per week. In that role, I also am utilized as the charge nurse. I orient new staff and mentor others as well.

Q. How long has it been that you've been working 28 hours a week over there?

A. Since 1988.

Q. Oh, that long. Okay. Has there ever been a time when you worked less than 28 hours a week?

A. No.

Q. How much time on average do you spend reviewing cases as a nurse consultant?

A. That has actually varied over the years and the last two years has been less. It's -- it used to be maybe ten or 20 hours a week and now I would say average is some -- oftentimes less than ten because I'm working on other projects.

Q. What other projects?

A. I'm working on some publications. I'm working on research. I'm working on presentations as well.

Q. At Mass General, are you working those 28 hours on an orthopedic floor?

A. Yes, I am.

Q. That's the only floor you work?

A. Yes, it is, unless I'm floating to another unit.

Q. Got you. How often do you use abductor pillows?

A. I use them regularly with our patients.

Q. Have you ever had an abductor pillow cause a compression injury to a peroneal nerve?

A. I've cared for patients who have had that occur to them.

Q. Okay. How many or how often is that?

A. Once in a while. They're actually -- they've been patients that have transferred into us from other facilities after their surgery or perhaps they're having their other hip done and this was the result of their first surgery, but it hasn't been the result of our facility of patients that I've cared for.

Q. All right. Do you know that those injuries were caused by an abductor pillow or were they caused by the surgery itself?

A. We had been informed caused by an abductor pillow.

Q. You understand, though, that injuries to the peroneal nerve or damage to the peroneal nerve can occur simply as an inherent risk of the hip replacement surgery. Correct?

A. I'm not sure -- I don't believe that I should be the one to comment on that.

Q. That's -- and that's fair. And let's go ahead and limit your expertise here. You're a nursing expert. Correct?

A. Yes, I am.

Q. You don't give medical diagnoses like a physician. Correct?

A. Correct.

Q. You're not going to be testifying as to what the cause of Ms. Brown's nerve injury was in this case, you're going to leave that to the physicians. Is that fair?

A. That is, although as a nurse caring for patients in -- total hip patients who have abductor pillows, I teach and I -- and I practice that these straps must be loose because it can cause peroneal nerve injury, and we know that.

And I've had patients that have had straps that have been too tight that we've had to loosen that they've had some numbness and tingling and have had --

that things have been fine once the straps have been loosened. So in the nursing sense, I know that the strap can cause a nerve injury.

Q. All right. Do you remember giving a deposition in the Linda Billa case versus Dr. Dunlap August of last year? It was about an abductor pillow injury. Do you remember saying you weren't going to testify about causation?

A. I could -- I probably did --

Q. Okay.

A. -- but I'm saying the nursing part here.

Q. Okay. I hear you. Do you agree that determining the cause of the patient's peroneal nerve injury was outside your area of expertise?

A. That would be a physician's. Correct.

Q. All right. Do you agree that a nerve injury can occur intraoperatively?

A. It can.

Q. Do you agree that charting by exception is a recognized means of charting?

A. Yes.

Q. And y'all use that at Mass General as well. Correct?

A. No, we do not.

Q. Oh, you chart everything?

A. We don't chart by exception.

Q. Okay. But that is recognized in that standard. Correct?

A. That is recognized documentation format.

Q. All right. Foot drop is a known complication of hip replacement surgery?

A. It can be.

Q. Are you still charging 185 an hour for review of records?

A. No, I'm not.

Q. How much?

A. $200.

Q. How much are you charging for deposition time then?

A. I'm here for the day so it's a full day, $2,000.

Q. All right. When you work at Mass General, are you still making $27 an hour?

A. 27, no.

Q. How much are you making at Mass General per hour as a nurse?

A. It's over $70 an hour.

Q. $70 an hour is what they're paying you? Is that what they pay all the nurses there that work on the orthopedic floor?

A. No.

Q. Okay. Are you more than a regular floor nurse then?

A. I'm the clinical scholar for the orthopedic trauma department.

Q. Okay. What do ordinary nurses make on the orthopedic floor; do you know?

A. It depends upon the years of experience.

Q. Okay. Can you give me a range, somebody that starts out?

A. I don't know what the starting pay is.

Q. Okay. At one time was 45 percent of your income derived from legal nurse consulting work?

A. Yes.

Q. Have you ever published on abductor pillows and peroneal nerve injuries?

A. No, I have not.

Q. Have you ever published on orthopedic nursing after hip replacement surgery?

A. In the general sense.

Q. And how so and which article would that be?

A. It isn't specific to hip but more the care of an orthopedic patient.

Q. Okay. How did Trey find out about you to review this case?

A. A colleague of mine had -- somebody that works in his office referred him to me.

Q. And who's that colleague?

A. Janice Ferguson.

MR. ROWE: Janice got everybody for you here.

Q. (BY MR. ROWE) Have you ever worked on cases with Trey before?

A. No, I have not.

Q. Have you ever done work for a witness brokerage service such as Medical Research Consultants?

A. Well, Medical Research Consultants if that's the company that's owned by Doreen Wise.

Q. I'm not sure.

A. Is that her? I had -- if that's the one, I had reviewed a few cases many, many years ago.

Q. Okay. Have you ever worked for Steven Lerner & Associates? He's out in California.

A. No.

Q. Physicians for Quality? He's in San Antonio.

A. No.

Q. Any other groups that hook up nurses and physicians with lawyers?

A. No.

Q. Ever advertise your services as an expert

witness?

A. No.

Q. In the malpractice setting, would you agree that most of your work is done for the plaintiff as opposed to the defendant?

A. I disagree.

Q. Okay. What's your split?

A. 50/50 --

Q. Has it always been --

A. -- just about.

Q. Has it always been 50/50?

A. It's pretty even. Yes, it has been.

Q. Have you ever had to give a deposition in a federal court case?

A. Yes.

Q. Do you have a list of the cases that the federal court makes you create of all the cases you've given depositions in?

A. I used to.

Q. Do you know how -- do you still have that list?

A. I don't.

Q. Have you worked with any other attorneys here in Texas?

A. Yes, I have.

Q. Can you tell me their names?

A. Mr. Branson.

Q. Oh, up in Dallas?

A. Yes.

Q. Who else?

A. And there's one other. I don't remember their name.

Q. Do you remember where they're at?

A. No. It's been a while.

Q. Okay. Ever work with any defense attorneys in Texas?

A. The other attorney is a defense attorney.

Q. Okay. Are you working on any other current cases right now?

A. For whom?

Q. For legal -- or medical malpractice cases. Are you reviewing any other cases right now?

A. I will be. I was contacted to review --

Q. Okay.

A. -- another case.

Q. And not just in Texas but anywhere? Do you have any open medical malpractice cases that you have?

A. I do.

Q. How many?

A. I don't know.

Q. Okay. Less than 12?

A. I'm not sure because I save them and sometimes I don't always obtain notices when things have settled or if they've been dropped.

Q. Okay.

A. So I send letters out so I'm not sure.

Q. Ever reviewed a similar case to this one beside the Billa case?

A. I don't believe so, no.

Q. If we have to go to trial, you'll be charging $2,000 plus the travel expenses to get to San Antonio for trial?

A. Yes.

Q. Let me show you what I've marked as Deposition Exhibit No. 1. Trey was kind enough to give it to me. It's the correspondence between the two of y'all. Just take a quick look through there.

Are you aware of any other correspondence between the two of y'all?

A. That's it.

Q. And I have marked as Deposition Exhibit No. 2 the billing and checks to you. It looks like it's about $5500. Are you aware of any others?

A. This is correct.

Q. Okay. And I've marked as No. 3 a copy of your

report dated October 17, 2007, as well as a CV. Is that your latest report?

A. Yes, that is.

Q. And is your CV up to date?

A. I have an up-to-date one for you.

Q. Oh, that would be great. I'm going to mark your up-to-date one as Exhibit No. 4.

(Levin Exhibit 4 marked.)

Q. (BY MR. ROWE) Is there anything else that needs to be added to Exhibit 4 to bring it up to date to today?

A. I just taught at a patient safety conference last week at Jordan Hospital.

Q. Okay. Have you ever given speeches about abductor pillows?

A. A formal speech?

Q. Uh-huh.

A. No.

Q. And I guess that implies or begs the question you must have done something informally --

A. Yes.

Q. -- at some kind of in-service or something?

A. Correct.

Q. Do you have any written materials from the in-service?

A. No, I do not.
Q. It was just verbal?
A. Yes.
Q. All right.
A. And demonstration.
Q. Okay. And what would have prompted that? Did something happen at Mass General?
A. No.
Q. Okay. Before I jump off into this, can we agree that you're not going -- it's not within your expertise to tell the jury whether it was purely a sciatic injury at the level of the hip that caused this patient's foot drop as opposed to a peroneal injury at the knee? Is that fair?
A. Correct.
Q. All right. Did you see a copy of the notice for your deposition?
A. Yes.
Q. And I've already marked as Exhibit No. 1 all of the correspondence between you and Trey. Correct?
A. Yes.
Q. The medical records you reviewed I think are outlined in your report dated October 17, 2007. Correct?
A. Yes.

Q. Have you done any medical literature search for this case?

A. No.

Q. If you do, will you let Trey know because this is my one and only opportunity to ask you questions and I wouldn't want to be surprised at trial? Okay?

A. Yes.

Q. And you take a lot of notes and so --

A. Yes.

Q. -- what I'm going to do -- I see that you've taken notes for each deposition that you reviewed.

A. Yes.

Q. Rather than go through all of those, I'm just going to have the court reporter with Trey's office make copies of your notes of the depositions if that's good.

A. Yes.

Q. Do you have -- is that more depositions there?

A. Yes.

Q. Can we add them to my stack here?

A. Yes, but I'll need them for the --

Q. Oh, you will?

A. For today, yes.

Q. Okay. Are those notes for depositions or are those records that you have?

A. Depositions.

Q. All right. Did you keep any notes completely apart from just summaries of the depositions that you were reading?

A. Yes.

Q. And where are those?

A. Right here.

Q. On that notepad?

A. Yes.

Q. They're hiding under the clear first page?

A. Yes.

Q. Okay. I'm going to need a copy of that, too.

A. That's fine.

Q. So we've got this stack, we've got that stack and we've got all the notes in there. Any other notes that you would have taken?

A. No. That's --

MR. APFFEL: Just for purposes of the record, can we identify the deposition notes as, for the record, deposition notes --

MR. ROWE: That would be fine.

MR. APFFEL: -- and then her other review notes as review notes?

MR. ROWE: That's fine.

Q. (BY MR. ROWE) These -- the top of each of these notes indicates the deposition that you were

reviewing?

A. That is correct.

Q. Okay. Good. So we'll be able to at least see that. We've got notes for the deposition of the plaintiff, Dr. Pontius, Dr. Johnston-Jones, Dr. Shoumaker -- I promise I'll give them back -- Nurse Dart, or actually a physical therapist, LeClair, Nurse LeClair, Nurse Rhine, R-H-I-N-E, Nurse Arias, A-R-I-A-S, and Nurse Hunter and Virginia Perry. And then --

A. Thank you.

Q. We had a -- is there any title on those notes there?

A. No.

Q. Those are just notes in general about the entire case?

A. From -- just extracted from the medical records, no opinions.

Q. Okay. And we'll just attach all of those as Exhibit 5. All right. And it looks like you reviewed the medical records that Trey's office sent you in the binder. Correct?

A. Yes.

Q. You reviewed some discovery answers that I filed -- that my office filed. Correct?

A. Yes.

Q. And the only thing I haven't seen are in the green folders. What's in there?

A. Well, this had my CV in it.

Q. Okay.

A. And this was --

Q. The notice?

A. -- the notice.

Q. Okay.

A. And this is the correspondence.

Q. Which we already have copies of?

A. Right. And your expert reports.

Q. Okay. That will work. Have you spoken with anybody besides Trey about this case?

A. No, I have not.

Q. All right. You've never spoken with the plaintiff, you've never spoken with the treating physicians involved, any of the experts?

A. No.

Q. Is the first time you met Trey this morning?

A. Yes.

Q. Over breakfast?

A. Yes.

Q. Did you share the contents of your report with Trey before finalizing it? And I'm talking about the October 17, 2007, report.

A. Well, we spoke beforehand because I wanted to make sure that the format was proper for what your state requires.

Q. Okay. Did he suggest any changes that needed to be made to the report?

A. No.

Q. Do you anticipate doing any more work on this case?

A. I guess it depends if it's going to trial or if there's something in addition that you need me to review.

Q. Okay. Is your report a fair summary of your opinions?

A. Yes, it is.

Q. Do you need to make any changes to your report at this time?

A. Yes.

Q. You do? Okay. Tell me the change you need to make.

A. There were a couple of dates in the medical records that -- a couple of pages that didn't have dates so my -- so my criticism -- let me just find it. My criticism of them not documenting the medications would not be correct --

Q. Okay.

A. -- because I found the page that had the medications documented.

Q. All right. Even so, even if you hadn't found that, did the medications cause the foot drop in this patient?

A. No.

Q. Okay. Did failing to document medications cause the foot drop in this patient?

A. I found them and they were documented.

Q. Okay. But even if they weren't documented, do you agree with me that failing to document medications didn't cause this foot drop?

A. It didn't cause, but it goes along with the nursing process in documenting the treatment that you're giving a patient.

Q. I hear you. You understand, though, that this isn't just about breaches of the standard of care but it's also breaches of the standard of care that caused the injury in this case?

A. Yes.

Q. All right.

MR. APFFEL: Was that the only other -- was that the only change?

A. And the intake and output, that was the other -- I found a sheet that has the intake and output

on it and I hadn't -- I was able to figure out the date on it from the handwriting.

Q. (BY MR. ROWE) All right. And, again, the I's and O's didn't cause the failing -- even if you couldn't have found that, the failing to document I's and O's didn't cause this patient's foot drop. Is that correct?

A. That's correct.

Q. Have you had an opportunity to review all the information you need for your report to be complete?

A. Yes.

Q. Let me start with the consent form. You routinely as a nurse get consent forms signed for surgery. Correct?

Maybe not on the orthopedic floor then. Those are going to be the surgical nurses?

A. No. Actually in our facility the physicians obtain the consents.

Q. Are you aware in other states that nurses are allowed to get the consents after the physician gives informed consent?

A. Yes.

Q. Have you ever seen the Texas Medical Disclosure Panel's List A procedures that require disclosure? Do you have any idea what I'm talking about?

A. No.

Q. Do you have any role in getting consent from the patient before hip replacement surgery?

A. My only role is to make sure there is a consent.

Q. Okay. In Massachusetts, does that consent include the inherent risks to the procedure?

A. Can you repeat that?

Q. Sure. In Massachusetts, does the consent form that the patient signs before hip replacement surgery include the inherent risks to that procedure?

A. Yes.

Q. Are you aware that an inherent risk of hip replacement surgery is impaired function such as foot drop?

A. Yes.

Q. Is that something that appears on the Massachusetts form?

A. The physicians actually fill out the form and they -- and they write in it so it's not a -- it's not a pre-typed form.

Q. Oh, it's not a standard form?

A. No.

Q. Do you have anything to do with filling the form out before the physician gives informed consent?

A. No.

Q. Is the physician in Massachusetts required to fill out the form himself or can the nurse fill it out for him?

A. The practice is on my unit, we do not complete any procedure -- or consent forms at all.

Q. Okay.

A. Our role is specifically to make sure the doctor hasn't been -- has been informed if a patient doesn't have a consent and also the anesthesiologist as well.

Q. Okay. You understand what an inherent risk is of a procedure?

A. A risk that can occur as a result of the procedure.

Q. And one that can't necessarily be avoided. Is that fair?

A. Okay.

Q. I don't want to put words in your mouth. Is that your understanding?

A. It is. I don't do consents but...

Q. But you do understand that an inherent risk of hip replacement surgery includes nerve injuries and foot drop. Is that fair?

A. It can.

Q. And that can happen even when everybody acts reasonably in the care of a patient. Fair?

A. It can.

Q. In this case, are you aware of the anesthesia that was provided to this patient?

A. Yes.

Q. And was she receiving a block?

A. Yes.

Q. And on an orthopedic floor, you all would know what the effects of a block would be. Correct?

A. Yes.

Q. And what are those?

A. It depends on what kind of block it is, if it's a short-acting block or a long-acting block.

Q. Do you know in this case if it was short-acting or long-acting?

A. I had a hard time reading what medication was used to know if it was short-acting or long-acting.

Q. The anesthetic record is a little I guess difficult to read is the nice way to put it. So you can't tell us how long you would have expected that block to work. Is that fair?

A. That is correct.

Q. And while that block is working, you're going to expect to have changes. You're going to expect the

patient not to feel pain in that extremity. Correct?

A. I can't necessarily agree with that because when a patient comes up to the floor postoperatively, we do a full neurovascular assessment. We do a full assessment head to toe and we would find out at that time comparing both legs what the assessment is.

If the patient at that time does not have any sensation or motion, then I would be contacting the physician to ask him how long would he expect this to go on for.

Q. What's the purpose of the block?

A. To help diminish pain --

Q. Postoperatively?

A. -- postoperatively. Correct.

Q. So if it's working effectively, it's going to reduce the pain. Correct?

A. Yes.

Q. All right. In this case, are you also aware that Dr. Pontius placed the abductor pillow in the operating room?

A. That is correct.

Q. Do you believe that it was changed at any time after that from the way that he placed it?

A. Yes.

Q. Was that when the sequential compression

devices were placed?

A. Yes.

Q. And those are placed underneath of the abductor pillow. Correct?

A. Correct.

Q. And are you aware that Dr. Pontius probably saw the patient in the PACU?

A. Yes.

Q. And are you aware of any of his findings which would indicate that she had any peroneal nerve injury or even a sciatic nerve injury at the time that he saw the patient in the PACU?

A. No. He did not state that.

Q. Okay. Will you agree with me that if this was a sciatic nerve injury at the level of the hip, then it was immaterial how tight the strap was on the abductor pillow with respect to the peroneal nerve injury?

A. I disagree.

Q. Have you read Dr. Roman's report dated December 7, 2007, the neurologist? He's one of my experts. It's going to be under my expert reports.

A. I did.

Q. The conclusion indicates, "Since the foot drop was caused by a lesion of the sciatic nerve upstream in the hip at the time of the total hip replacement, the

discussion about an alleged compression of the peroneal nerve by a strap of the abductor pillow in the immediate postoperative period is irrelevant to the causation of the injury." Do you disagree with that?

A. I'm not a physician to address what the causation issues are here, but as a nurse and knowing that what we teach and what we practice is to be certain that the strap is not too tight to cause a peroneal nerve injury --

Q. Fair to say then that you're --

A. The strap was very tight.

Q. And how do you know that?

A. Dr. Pontius had stated that he found the patient with a strap that was too tight and stated that there were problems.

Q. And did you read Dr. Pontius's deposition where he indicated that he felt this was a peroneal nerve injury as opposed -- a sciatic nerve injury as opposed to a peroneal nerve injury?

A. I believe that he felt that there were two injuries, that there was a sciatic nerve injury and there was also a peroneal nerve injury.

Q. Did you read his affidavit where it indicates -- he says, "An intraoperative cause is the most probable cause of this patient's injury"?

A. I did see that. And he also stated, "It's my opinion that there was a separate incident of damage harm to the nerve in the thigh area as well," and he talks about there was a separate occurrence at the knee, the common peroneal area caused by tethered swelling pressure from the strap placing the pressure on the nerve.

Q. The SCD that was underneath of the abductor pillow, that has an alarm on it. Correct?

A. There is an alarm on the SCD. I'll let you ask me before I speak too much.

Q. Well, no. It does have an alarm. Correct?

A. There is an alarm.

Q. How does the alarm work?

A. The alarm can work for a couple of reasons. The alarm can work if something is too loose or if they're -- the boots are on too tight as well.

Q. And you don't want the boots on too tight because they can cause a compression injury. Right?

A. They can.

Q. Would you expect an alarm to sound from the SCD if the abductor strap pillow -- abductor pillow strap was too tight on the SCD?

A. Not necessarily, no.

Q. Why not?

A. Because it depends how tight those SCD's are around the leg to then know how much give there will be underneath as they're having air being inserted and depressing.

And when you have the abductor pillow strap on, it's only touching one part of the SCD. It's not going all the way around to compress it. That then would make it high pressure for the other areas.

Q. Okay.

A. So I -- we've seen this and the alarms are not going off.

Q. I'm not following you here. Why would not the SCD -- if you're telling me that the strap from the pillow is too tight -- and that strap is on the SCD. Correct?

A. Yes.

Q. If that strap is too tight -- does the strap go all the way around the leg?

A. No, it does not.

Q. It attaches in the pillow so it goes -- it makes a U around the leg. Correct?

A. Correct, yes.

Q. All right. But if you're saying that that strap is so tight that it's going to cause a compression injury and that strap is on the SCD, why would it not be

compressing the SCD such that the alarm would go off?

A. Because it's displacing the air to the other -- to the other parts of the SCD. The pressure is actually on -- on one specific area, and that's where the peroneal nerve is is at the fibular head, so it's that pressure.

You're not having pressure on the inside where your abductor pillow is. There's plenty of area for the SCD to inflate and deflate. The times that we'll see the pressure alarm go off will be if the -- if there's no place for the boot to expand to, the SCD to expand to.

And when you have a strap that's only going around that area and if the SCD's are loose enough, you'll have plenty of room for that air to be displaced.

Q. All right. Are you aware of any literature discussing the interplay between an abductor pillow and an SCD and a peroneal nerve injury?

A. An inner plate? Did you say inner plate?

MR. APFFEL: Interplay.

Q. (BY MR. ROWE) Interplay.

A. Oh, interplay. I'm sorry. I can't cite a specific source, but I am aware of literature talking about placement of all of those to avoid pressure on the

peroneal nerve.

Q. All right. Have you ever seen this happen?

A. I have seen the straps be too tight and a patient is having some numbness and tingling and we've loosened the straps, but not a foot drop.

Q. Okay. So at Mass General, you have had abductor pillow straps that were too tight?

A. Yes.

Q. In those cases, were SCD's also applied?

A. I -- I'm not sure if in every one. I don't know.

Q. All right. Have you ever seen a case where an SCD was applied and an abductor pillow strap was too tight and a peroneal nerve injury occurred? Have you personally ever seen one?

A. No, I have not.

Q. Okay. Are you aware of any peer-reviewed journal article that discusses that, use of an SCD and an abductor pillow strap causing a peroneal nerve injury?

A. I'm not sure.

Q. If you come up with any, you need to let Trey know so that I can be forewarned before we go to trial. Is that fair?

A. Yes.

Q. Of the cases where you had abductor pillow straps too tight, the peroneal nerve injury resolved. Correct?

A. Yes, it did.

Q. It did not result in a foot drop?

A. Correct.

Q. Do you know how tight these abductor pillow straps need to be to cause a compression injury? Do they need to be higher than the systolic blood pressure or do you have any idea?

A. I don't know.

Q. How tight is too tight; do you know?

A. To put it in measurable terms, the straps if they're pulling in -- I guess everyone's anatomy is a little different, too, but if they're pulling in and you're putting your hand there and it's tight -- I don't know how to describe measurable numbers to you, but you know when you're putting your hand in the strap on the outer part of the leg, not on the inner part or not on the top either because there is -- there is room there.

Q. Okay. So it's not an exact science?

A. It's not an exact science, but placement of the strap; and if it's tight, all you need is some pressure over that peroneal nerve to cause an injury such as, you know, if I can say, a CPM machine. You

have to be careful with the leg because the knob can rub against where the peroneal nerve is and you can have a peroneal nerve injury from pressure just from that knob --

Q. All right.

A. -- so it's pressure.

Q. Do you know that an injury is a result of the amount of pressure applied and the duration of the pressure applied?

A. Do I know what? I'm sorry?

Q. Do you know that that's what causes a peroneal nerve injury, the amount of pressure applied and the duration that that amount of pressure is applied?

A. Yes, that could be.

Q. Okay. Can you describe the mechanism of injury to the peroneal nerve as a result of an abductor pillow strap or is that causation, that's best left to the physicians?

A. Well, actually as a nurse we know to avoid having the strap be too tight because what it does is it compresses the peroneal nerve so it's the act of compression.

Q. Okay. Does that compression reduce blood flow to that nerve? What exactly is the mechanism of injury to the peroneal nerve?

A. It's not blood flow to the foot. You'd still expect to see a pink foot, capillary refill return. It's when you compress a nerve, then you end up having decreased sensation. You may start out with numbness and tingling and then soon have no sensation to that area where the nerve goes to.

Q. At the site of the nerve injury, is the injury to the nerve because it's not getting adequate blood flow or what is the mechanism of injury in that peroneal nerve; do you know? Or is that best left to a neurologist?

A. I'll leave that to the neurologist.

Q. All right. Are you aware that a nerve doesn't have to be completely damaged for it to have -- or that a nerve can have partial downstream damage as opposed to full damage, the sciatic nerve breaks off into the peroneal and the tibial nerves?

A. Correct.

Q. You can have an injury of the sciatic nerve at the hip that only affects the peroneal distribution as opposed to the peroneal and the tibial. Did you know that?

A. In this case, I'm not -- I'm not sure about that because we have so many people who are stating that there are two separate injuries here and one being

specifically due to compression of the peroneal nerve.

Q. All right. You agree you're not a neurologist. Correct?

A. Correct.

Q. You don't do EMG's and nerve conduction studies?

A. Correct.

Q. Would you defer to those people that did the EMG's and nerve conduction studies with respect to the -- where the damage was on this nerve?

A. Yes.

Q. Okay. You're looking at me like you want to take a break.

A. Oh, no, no. I just was sort of looking around.

Q. You're not going to differentiate the damage caused as a result of the sciatic nerve injury at the hip versus the damage caused by an alleged injury at the peroneal nerve behind the knee, are you?

A. Well, if asked, I can talk about the nursing implications of such.

Q. Correct. You can talk to me about standard of care for nursing and how you believe they breached it. Correct?

A. Yes.

Q. But you're not going to talk about causation with respect to what caused the foot drop, whether it was sciatic nerve at the hip or peroneal nerve at the knee. Is that fair?

A. Well, from a nursing standpoint, talking about the impact of having an abductor pillow strap that's too tight --

Q. All right.

A. -- and that's still nursing.

Q. All right. Can you tell me what percentage of her foot drop is caused by the sciatic nerve injury at the hip versus an alleged peroneal nerve injury at the knee?

A. No, I cannot.

Q. All right. Neither could Dr. Edelstein. I just wanted to make sure neither one of y'all were going to be telling me.

From your reading of the information, do you agree that there was an injury to the sciatic nerve at the level of the hip where the operation occurred?

A. According to a variety of physicians, they have believed that to be so as one of the injuries.

Q. All right. Based upon the information that we have about the block that this patient received for postoperative pain control, based upon a known injury to

the sciatic nerve at the level of the hip, based upon the fact that we have a nursing note at 8:00 a.m. the next morning indicating that there was complication of the surgery, can you tell me at what time a nurse or the patient should have been aware of changes in the peroneal nerve distribution? Can you tell me what time that should have occurred?

A. Well, the first assessment would have provided a foundation to know where Ms. Brown is at and that would be upon her admission to the unit from the recovery room.

Q. Okay.

A. So a full assessment would be done to determine what is she able to do and what is she unable to do.

Q. And what time was that?

A. I believe she arrived on the floor at 1705. 1705.

Q. Any indication there that she had any complication with her sciatic nerve or peroneal nerve?

A. No.

Q. All right. Would you expect her to be able to complain of problems that would indicate a complication with the sciatic nerve or peroneal nerve based upon the fact that she had a block and she was on pain

medication?

A. Maybe, maybe not. I don't know the duration that the blocks would last.

Q. Okay. Can you tell me -- from 5:00 p.m. until we have a note at 8:00 a.m. the next morning that there was a complication with either the sciatic nerve or the peroneal nerve, can you tell me at what time that there should have been documentation or should have been observation of a sciatic nerve or peroneal nerve? And then I'm going to ask you how you can tell what time.

A. I would state that evening on the 14th that if things were abnormal -- unfortunately, there's no postoperative note to define what the patient was able to do or not able to do.

But if things were abnormal, then you would be following that patient on a regular -- doing regular assessments on that patient every hour to determine if the patient's able to move the foot, do they have full sensation. And if by four hours later there's nothing that's returned, initiate a call again to the physician to find out, you know, why hasn't this patient regained sensation or movement and/or notify him.

Q. Okay. That's not exactly what I was asking.

A. I understand that.

Q. What I'm asking is, can you tell me or tell the jury at what time overnight this patient's foot drop should have been identified? And then I'm going to ask you, what evidence do you have of that?

A. The changes, which sensation then goes with the foot drop, should have been identified in the evening if regular assessments would have been done. Unfortunately, there is no documentation to state that anything was abnormal on the evening or the night shifts.

Q. Okay. At what time do you think these things should have been identified and why do you think it would have been in the evening?

A. I would state by 10:00 o'clock before the night shift --

Q. Okay.

A. -- comes in. Approximately 10:00 o'clock. And why? Because you've had a period of time the patient was out of the operating room. There's that amount of time, eight hours -- let me make sure of the time. So almost eight hours postsurgery there should be some type of recovery with sensation and movement of that leg.

Q. All right. Any indication at that time that there was a foot drop developing?

A. There's no documentation of that.

Q. All right. When were the SCD's applied?

A. 8:00 p.m.

Q. And when the SCD's were applied, the abductor pillow straps necessarily had to be removed. Correct?

A. Yes, they did.

Q. At the time that the abductor straps were removed and the SCD's were applied, is there any indication that the nurses charted anything irregular about that leg?

A. No, they did not.

Q. And charting by exception means that that means it was normal. Correct?

A. Charting by exception means that things have not changed since the last time you documented.

Q. All right. Do you believe that the injury to the -- you believe there was an injury to the peroneal nerve. Correct?

A. Yes.

Q. Caused by the abductor strap. Right?

A. Yes.

Q. Was it apparent at 8:00 p.m. when the SCD's were applied?

A. I don't know what time. I don't know.

Q. Okay. Was the injury to the peroneal nerve,

did it occur before 8:00 p.m. when the SCD's were applied?

A. I don't believe so.

Q. Why not?

A. Because Dr. Pontius specifically applied the straps very loosely with the nurse.

Q. Okay. And then he asked that they be -- then again, nurses are trained to apply the straps loosely. Correct?

A. They should be.

Q. Okay.

A. It doesn't always happen.

Q. Sure. The doctor should apply the straps loosely. Correct?

A. They should. He made a specific point of having that documented.

Q. Do they always apply the straps loosely, physicians?

A. I don't know what they all do.

Q. Okay. You're going to give the nurse the benefit of the doubt that she would have complied with her training and applied the straps loosely?

A. Which nurse?

Q. The nurse that applied the abductor pillow at 8:00 p.m. when the SCD's had to be applied.

A. I don't know that to be so.

Q. Okay. Are you going to tell the jury that a peroneal nerve injury can develop and cause foot drop within two hours if the abductor pillow was reapplied at 8:00 p.m. and you say that at 10:00 p.m. they should have identified problems in the sciatic or peroneal nerve?

A. You would see problems. Changes would develop, change in sensation, motor.

Q. Any indications that this patient ever complained of sensory or motor deficits from 10:00 p.m. -- are you now saying that the care rendered before 10:00 p.m. is okay?

A. I can't specifically state because there isn't a lot documented in there.

Q. All right. Do you believe that -- before 10:00 p.m. when the SCD's were applied and the abductor pillow strap had to be removed, do you believe that anything before 10:00 p.m. caused the peroneal nerve injury you allege occurred?

A. Prior to 10:00 p.m. -- I'll have you repeat that. I'm sorry.

Q. No problem. We agree at 10:00 p.m. the SCD's were applied so the abductor pillow straps had to have been removed. Correct?

A. At 8:00 p.m.

Q. At 8:00 p.m. How did I get 10:00 p.m.? Oh, that's when you say it should have been discovered.

A. At 8:00 p.m.

Q. At 8:00 p.m. Do you have any criticisms of any of the care before 8:00 p.m. that would have caused a peroneal nerve injury? Did the abductor strap cause a peroneal nerve injury before 8:00 p.m.?

A. I don't know.

Q. Okay. Why don't you know?

A. The nurse from 3:00 to 7:00 didn't document a note and so they didn't do a baseline assessment -- neurovascular assessment of the patient to know where we're starting at.

Q. Okay. If -- you assumed that a nurse would have to remove the abductor pillow strap at 8:00 p.m. to apply the SCD's. Correct?

A. Correct.

Q. If they would have seen something untoward, something unusual, you would expect them to document that. Correct?

A. Yes.

Q. Is there anything in the chart that indicates that they saw anything unusual when they removed the abductor pillow strap at 8:00 p.m. to apply the SCD's?

A. No.

Q. Okay. Are you going to say there was something unusual at 8:00 p.m. that just wasn't documented?

A. No. I don't know that.

Q. Okay. So then do you believe anything before 8:00 p.m. caused a peroneal nerve injury or did it occur thereafter? I'm just trying to limit the time we're going to argue about it today.

A. I understand that. It's difficult to state because there is lack of documentation in there.

Q. All right. Will you defer to the nurse who was caring for this patient and assume that with charting by exception they would have charted something at 8:00 p.m. when they took off the abductor pillow straps if they had seen something they should have documented?

A. I really can't defer to her because she states that everything was normal through the night, plantar and dorsiflexion, and you don't go from being totally normal to all of a sudden having no sensation and no movement and a foot drop. It just -- it just doesn't happen just like that. It evolves over time.

Q. And you believe it's a progressive injury?

A. Yes.

Q. What would explain a more sudden change in sensation and motor function would be the fact that the patient's coming out of the block and becoming less obtunded after surgery. Is that fair?

A. Well, the patient's not obtunded on the floor. They're alert and oriented when they come to the floor.

Q. All right. They do have a block, though?

A. Yes.

Q. And they are on pain medications. Correct?

A. Yes.

Q. So you expect that the block and the pain medications are going to deaden the patient's pain. Correct? That's the purpose?

A. Yes, although she wasn't using any pain medication initially.

Q. Okay. She's just status post hip and she didn't have any pain medication?

A. She had it, but she didn't -- I believe she wasn't using it right away.

Q. Okay. A peroneal nerve injury will cause pain. Correct?

A. It can.

Q. All right. Where does it cause pain?

A. It can cause pain at the site and it can cause pain going down the leg.

Q. Okay. You indicated the patient was not on pain medications. Why then would she not have complained of pain behind the knee with the peroneal nerve -- where you allege the peroneal nerve was being compressed by the abductor strap or down the leg?

A. They don't necessary -- they don't always have pain.

Q. Okay.

A. They could have the numbness that has -- that has occurred.

Q. Okay. Do you see any indication in the record that she complained of pain or numbness overnight until 8:00 a.m. when the nurse documented it?

A. No. Only in her deposition.

Q. All right. Let me go back to 8:00 p.m. Do you think the strap that Dr. Pontius put on was too tight until 8:00 p.m.?

A. No.

Q. All right. We have now gotten rid of everything before 8:00 p.m., is that fair, because that did not cause a peroneal nerve injury?

A. Unless the nurse upon turning redid the straps.

Q. Okay. Are you aware of any evidence whatsoever for the jury to presume or assume that that

occurred before 8:00 p.m.?

A. No, I don't know that.

Q. Okay. That would just be a guess?

A. Yes.

Q. Okay. Do you believe the nurse that applied the SCD's and then reapplied the abductor strap pillow -- or the abductor pillow strap applied it too tightly at 8:00 p.m.?

A. Yes.

Q. And what evidence do you have of that?

A. It could have been 8:00 p.m. or sometime during her shift. The evidence that I have is that at 8:00 a.m. there was numbness and there was foot drop and Dr. Pontius found the strap too tight, found that there were problems with this situation with the nursing staff, that he spoke with the nurse and went to the nursing supervisor to speak about it.

Q. Okay.

A. To prevent it from ever happening again.

Q. All right. Are you aware that the discharge summary written by Dr. Pontius indicates that they first thought this was a peroneal nerve injury and subsequently developed to be a sciatic nerve injury?

I don't have -- actually I have a page number, 24, if y'all's are the same as mine. It's the

discharge summary.

A. When was it dictated?

Q. October 27, 2004. Yes, it was six months after.

A. Right.

Q. When he would have even known more about what had happened to this patient. Correct?

A. When you're reflecting back, this is six months later, but at that time he's at the bedside and he himself found the straps much too tight that he took action about that.

Q. Correct.

A. And he was upset about that.

Q. Okay. But the point is that after he's had time to review more information, probably including EMG's and nerve conduction studies, he writes they first thought it was a peroneal nerve injury but subsequently it developed to be a sciatic nerve injury?

A. He did write that.

Q. All right. And then the next sentence he writes in his discharge summary is, "The perioperative care as well as the postoperative care was evaluated and felt that the sciatic nerve injury occurred intraoperatively through an unknown mechanism."

A. That's what he wrote.

Q. All right. Do you have any basis to disagree with Dr. Pontius's opinion of the cause of this patient's foot drop being the sciatic nerve as opposed to what they first thought was a peroneal nerve injury?

A. Well, he's also subsequently testified that he felt that there were two separate incidents, and that was even a little later reflecting back in time. So he's stating that there's two separate incidents as well as other treating physicians felt that there were two different incidents that occurred --

Q. All right.

A. -- so sciatic and also due to the abductor strap.

Q. Did you read his -- in his deposition where the abductor strap was just a possibility of an injury?

A. Could you tell me which page it is?

Q. Yeah. I'm looking in his deposition. It looks like Page 97. He indicates at the time he loosened the strap he thought she just had a peroneal nerve injury. Subsequent to that, it turned out she had a sciatic nerve injury.

She's seen Dr. Shoumaker. He thinks it's a sciatic nerve injury and the peroneal branch is just a part of that. Maybe the thing with the pillow was spurious.

And then on Page 101, he indicates external compression by the abductor pillow in his mind is a possibility and he's not saying that it was a probability.

MR. APFFEL: Objection. Form.

MR. ROWE: That was kind of rambling. I'll sustain that objection.

Q. (BY MR. ROWE) Do you have any expertise that would allow you to disagree with Dr. Pontius's opinions as to the cause of the injury in this case? Let me just put it that way.

A. I just found something in there. I'm sorry. Ask me again.

Q. Sure. Do you have any expertise which would allow you to disagree with Dr. Pontius's opinion as to the cause of this patient's injury?

A. No, I don't have expertise. I'm reading what he's stating in the deposition --

Q. Okay.

A. -- throughout the deposition and that if he felt that it was a -- if there was more of a complete deficit -- if it was totally from the sciatic nerve, he would have expected to find the tibial nerve to be more dense and more weak, and then afterwards states that he feels it's two separate incidents.

MR. ROWE: All right. I'll have to object to the nonresponsive portion --

A. Sorry.

MR. ROWE: -- of that.

Q. (BY MR. ROWE) That's okay. Do you know that a nerve doesn't have to be totally damaged; it could be partially damaged?

A. Yes.

Q. And in this case, the sciatic nerve branches out into the peroneal and tibial nerves. Correct?

A. Yes.

Q. And there may just happen to be a stretch injury that affects the peroneal nerve portion of the sciatic nerve at the hip. Correct?

A. That's a hard one if your injury is way up high and you have the -- you have the branching of the -- of the nerves to just have one segment versus both.

Q. But you're aware that there are distributions of the tibial nerve that were affected in this patient. Correct?

A. And resolved immediately.

Q. Okay. But they were affected. Correct?

A. Yes.

Q. All right. So that indicates a higher level

injury as opposed to at the knee where the peroneal nerve branches off. Correct?

A. Yes.

Q. All right. Let's go back to 8:00 p.m. when the abductor pillow strap was reapplied after the SCD's were applied. Can you tell me -- do you have any experience or expertise as to how long it takes for a permanent foot drop to develop caused by an abductor strap -- abductor pillow strap?

A. No. I just know generally nerve injury and length of time.

Q. Okay. And it also depends upon the amount of pressure as well. Correct?

A. Yes.

Q. All right. So can you tell me and the jury what time after 8:00 p.m. there was sufficient pressure and sufficient duration to cause a permanent foot drop?

A. I don't know specifically what time, but we would -- the nurses should be doing regular neurovascular assessments to find things are returned to normal after surgery.

Q. Okay. I hear you about the standard and the breach that you want to talk to me about, but I want to find out in reality in Ms. Brown's case at what time during the night was the injury to the nerve such that

it should have been discovered; can you tell me?

A. I would still state around 10:00 p.m. to know -- to learn if things had returned to normal or they're not normal to then move on from there.

Q. All right. Can you tell me that had you been there and done a neurovascular exam at 10:00 p.m. that it would have been abnormal just two hours after the abductor pillow strap was applied?

A. It could have been with the sensation.

Q. Okay. Could have been isn't the same as probability. What I need to find out is what time -- I'm hoping you just tell me you can't tell me because then I'm going to ask you what evidence you have of it.

Can you tell me, based upon probabilities, at what time there should have been evidence of compromise of the sciatic nerve or the peroneal nerve sometime between 8:00 p.m. and 8:00 a.m. when it's documented by the nurse?

MR. APFFEL: Objection. Form.

Q. (BY MR. ROWE) You can answer that.

A. Prior to 8:00 a.m.

Q. Okay. And you can't tell me how far prior to 8:00 a.m. Is that fair?

A. Correct.

Q. All right. So you can't tell me that if the

neurovascular exam had been done at 10:00 p.m. that it would have shown compromise to the sciatic and peroneal nerve. Is that fair?

MR. ROWE: You asked one too many questions, Trey. That's what it is.

A. There's two different so-called theories here.

Q. (BY MR. ROWE) Okay.

MR. APFFEL: Now you did it.

MR. ROWE: Now I really did it.

Q. (BY MR. ROWE) Let me -- let me do what a lawyer's not supposed to do and ask you, what do you mean?

A. If you're stating the injury is both intraop and having to do with a nerve block --

Q. You mean the abductor pillow strap?

A. No. The nerve blocks itself, that they were still -- if the nerve blocks were still working at the time when the patient came to the floor, then this documentation would reflect the changes in the neurovascular assessment, the changes in sensation, the changes in movement, and there isn't anything documenting -- documented in here.

And if those changes were there, then you would be monitoring that patient closely to find out when does that return.

Q. Okay.

A. If everything truly was normal and there was plantar and dorsiflexion upon admission to the floor, then monitoring and seeing that there are changes, that's very important to document later when you find that there's decreased sensation and movement and then eventually the foot drop.

Q. Okay. Do you know how injury to the sciatic nerve occurs during hip replacement surgery?

A. Sometimes due to the procedure itself and the proximity to the sciatic nerve.

Q. Okay. Have you seen patients that developed foot drop where abductor pills weren't even used post hip replacement surgery?

A. No, I have not.

Q. But you're aware that that occurs?

A. Yes.

Q. Okay. Agree with me that if the injury occurred intraoperatively caused by the surgery itself that there was nothing anybody could have done to have avoided the foot drop thereafter?

MR. APFFEL: Objection. Form.

A. It depends on the patient and it depends upon the cause. If there were a blood accumulation, I know they can bring them back to the operating room if there

were something such as that.

Q. (BY MR. ROWE) Okay. Are you aware of any hematoma development in this case?

A. No.

Q. Are you aware that the injury can be caused by a stretch injury of the -- of the sciatic nerve as they're positioning the leg?

A. Yes.

Q. If that occurred intraoperatively and the injury was done there in the OR suite while the patient was on the table, are you aware of anything that the nurses can do to prevent a foot drop from later developing as a result of that stretch injury in the operation?

A. No.

Q. So basically the die is cast in the operating room with respect to the outcome, correct, in that instance?

A. Well, if so, then we would see changes upon admission to the floor.

Q. Okay. But the answer to that question that I've asked, though, is yes?

A. Is the die cast? Possibly.

Q. Okay. Why wouldn't it be probably if the injury occurred in the operating room by a stretch of

the sciatic nerve?

A. Then you would see, as Dr. Pontius said -- I think he -- he didn't say more of a global effect, but more of an effect on the tibial nerve as well as the peroneal nerve. You would have seen more of an effect.

Q. All right. I don't want to belabor that point, but you'll agree with me that sometime before 8:00 a.m. you believe there should have been signs and symptoms of a sciatic or peroneal nerve injury; you just can't tell me at exactly what time. Is that fair?

A. Yes.

Q. Okay. The next logical step with that is had there been a neurovascular exam done -- let's pick a time -- at midnight, you can't tell me that there would have been signs and symptoms of a sciatic or peroneal nerve injury at midnight, is that fair, going back eight hours?

A. Right.

Q. Okay. Or any other time. Is that fair?

A. Prior to 8:00 a.m.

Q. All right. Have you ever been in the OR during hip replacement surgery?

A. Many, many years ago.

Q. Is that like 20 years ago?

A. No.

Q. How long?

A. Seven, eight years ago.

Q. Okay.

MR. APFFEL: That's like yesterday.

Q. (BY MR. ROWE) Do you know how long a hip replacement surgery usually takes?

A. A few hours.

Q. Do you know anything about a two-incision hip replacement surgery?

A. A minimally invasive procedure. We have a physician that actually was performing them at our facility.

Q. Is he no longer there or is he no longer doing the procedure?

A. He's still there and he's been doing more, I think, some research lately.

Q. Is there any problem with the minimally invasive surgery that caused him to stop?

A. No.

Q. I'm not going to go over all that with you.

MR. APFFEL: See, the sunshine has an effect on him, too.

MR. ROWE: I usually just like to get to the point.

Q. (BY MR. ROWE) All right. You're spared of

all that.

MR. APFFEL: Barbara, you need a break or anything? You doing okay?

MR. ROWE: Yeah. Go ahead and -- let's take a break.

THE WITNESS: Okay.

(Recess from 10:11 a.m. to 10:22 a.m.)

Q. (BY MR. ROWE) We took a quick break. I may as well ask you about your merit review panel work. Tell me about that.

A. I sit on a tribunal panel in various areas in Massachusetts. When contacted, I review medical records prior to the date that we actually hear them and I sit on a panel with a judge and an attorney and myself and we listen to a brief synopsis of the cases and determine if we feel there is enough merit to then grant them a trial date.

Q. Is that in conjunction with the nursing board in Massachusetts?

A. No.

Q. The medical board with respect to physicians?

A. No.

Q. Okay. Help me out.

A. It's not in conjunction with any boards. We are a review panel. So when there are nursing cases,

oftentimes there will be a nurse who sits on that panel --

Q. Okay.

A. -- such as myself.

Q. Do you sit on panels for physicians?

A. No, I do not.

Q. Okay. Are there lay people that also sit on those panels?

A. No.

Q. So your involvement is for review of nursing cases where nursing negligence has been alleged?

A. Yes.

Q. In Massachusetts, do they sue the individual nurse or do they sue the institution that they work for?

A. It can be both.

Q. Okay. And the end result of your review is a determination whether the nurse can be sued or not sued?

A. Whether or not we feel the case has enough merit, enough grounds that we feel there were enough breaches to then grant them a trial date.

Q. Okay. What if you don't grant them a trial date? What happens?

A. Then we notify them and let them know that we are -- we don't feel there's enough merit.

Q. Okay. Do they get to still bring a lawsuit or

no?

A. If they post a bond, they can overturn the tribunal decision.

Q. Does the jury get to know what the tribunal decision was? I'm asking way too much, I know.

A. Not that I'm aware of.

Q. Okay.

A. I know some states actually have panel hearings that the jury does hear that. I don't believe that's so in Massachusetts --

Q. Okay.

A. -- but I don't know that as a fact.

Q. All right. Those were all legal questions anyway. I was just interested.

In looking at your October 17, 2007, report, I indicate -- or I see that you have a number of criticisms of the nurses. I don't really want to talk about ones that do not directly relate to causing a peroneal nerve injury. Okay? Can we separate them out?

A. Yes.

Q. The failure to document on an MAR, the failure to document I's and O's that we've already discussed didn't cause a peroneal nerve injury. What I would like for you to tell me are, what are your criticisms of the nurses that caused or contributed to what you believe

was a peroneal nerve injury? Can you do that?

A. Yes.

Q. Okay.

A. Failure to do a postoperative assessment and writing a note, failure to do a nursing care plan, failing to perform neurovascular assessments as described in my report.

Q. Is that a good summary or is there more?

A. Failing to communicate changes -- appreciate changes in a neurovascular assessment and then communicating those changes --

Q. Okay.

A. -- and failing to act as a patient advocate.

Q. That's a catch-all all the time. Okay.

A. And failing to utilize the nursing process. That sort of goes with all of those.

Q. That's a nice broad general one, too. Okay. Let's talk about the postop assessment now. You're talking about a note when the patient is received on the orthopedic floor. Correct?

A. Correct.

Q. And that would have been at 5:00 p.m. Correct?

A. Yes.

Q. And you've already agreed that you don't

believe the injury occurred before 8:00 p.m. when the SCD's were applied and the abductor pillow straps were reapplied. Correct?

A. Right.

Q. Okay. So will you agree with me that a postop note at 5:00 p.m., whether it's written down or not written down physically, did not cause the peroneal nerve injury in this case?

A. No, I can't agree with that because you need to have a foundation -- a foundation of the norm or abnorm to know how you're going to follow through and assess and identify any issues that are going on. Is there a normal assessment at that time or is there an abnormal assessment at that time?

Q. Okay. What do you believe the assessment would have been at that time had you been there and done a postop assessment? Would it have been normal?

A. I don't know because the patient had blocks so I don't know if the patient had full sensation and movement at that time or not.

Q. Okay. So fair to say that you can't tell the jury more likely than not had a postop assessment done -- been done to your satisfaction that it would have changed anything in this case?

A. No. It could have changed because if you're

identifying the abnorm, then you would be following through to when it becomes normal or notifying a physician earlier that there's an abnormal examination.

Q. All right. Let's step back. Forget about the note. Had you been standing there at 5:00 p.m., more likely than not, probability, would the exam have been normal or would it not have been normal?

A. As I said, I don't know because of the block. I don't know how long the block was lasting for.

Q. Fair to say that you can't say, based upon probability, that it would have been abnormal at 5:00 p.m. Is that fair?

A. Correct.

Q. Okay. Let's go to the care plan. When the -- when should the care plan have been done or what do you believe was wrong with it?

A. There isn't a care plan.

Q. Okay. And how would a care plan have changed anything in this case?

A. A care plan helps identify the types of issues. It's a problem-oriented list. And according to their policy, they utilize problem-oriented lists and notes to determine types of care to be delivered.

Q. Okay. A care plan is just the documentation of issues that a patient has. Is that fair?

A. It's also the thought process of what problems does the patient have.

Q. Okay.

A. Then follow through and find out when they resolve or not resolve.

Q. Okay. You would expect a nurse on an orthopedic floor to understand that there are issues with respect to sciatic and peroneal nerve injuries, post hip replacement surgery. Correct?

A. It would actually on a problem list have to do with potential change in neurovascular assessment.

Q. Okay. You would expect a nurse to know that whether they write it down on a care plan or not. Fair?

A. They should know it, but they may not know it.

Q. Okay. You would expect that a reasonable nurse would -- that works on an orthopedic floor would know that changes to neurovascular status of a patient should be identified. Is that fair?

A. They should.

Q. Okay. The neurovascular assessments -- all we know is that sometime before 8:00 a.m. you believe the neurovascular assessment would have identified a problem. Correct?

A. Yes.

Q. But we can't tell what time that is. Correct?

A. We do not know specifically what time, correct.

Q. Okay. You also indicate that at the time a neurovascular change occurs it should be communicated to the physician. Correct?

A. Yes.

Q. Do you have any criticism of the nurse that communicated with Dr. Pontius at 8:00 a.m. when he discovered that there was a change in the patient's neurovascular condition?

A. No.

Q. Okay. And then the catch-all ones, the advocate and the nursing process. I know a nurse should be a patient advocate and I know that they should communicate changes in conditions to a physician, but is there anything more specific with respect to Ms. Brown's case that you believe the nurses should have done apart from assessing the patient, identifying the changes in neurovascular condition and communicating it with Dr. Pontius?

A. And reassessing the patient to find out if there's an improvement or if the condition's gotten worse.

Q. Sure. Do you have any criticisms of the nurses after 8:00 a.m. when they told Dr. Pontius,

"We've got a change here. Will you come take care of this patient?" Do you have any criticisms of the nurses after that?

A. No, I don't.

Q. We've limited our time here now.

A. Can I add one thing?

Q. Sure.

A. And it is a criticism because I wonder about -- when we were talking about knowledge base before, the nurse on the night shift, Virginia Perry, she stated -- this was on the 15th, the night shift -- that there was plantar and dorsiflexion, but there couldn't have been dorsiflexion because there was zero over five EHL and there's foot drop, so I wonder about the quality of the assessments that are being done if she feels that there's a -- this patient can dorsiflex.

Q. Okay. Is that the night of the 15th so we're talking about the next day --

A. That night. No. The 15th at night.

Q. Okay.

A. The night -- the next night. It's just to show what type -- my criticism is I wonder about the quality of the assessments if she feels that there is -- this patient can dorsiflex.

Q. Okay. Surgery was on the 14th?

A. Uh-huh.

Q. Is that a "yes"?

A. Yes.

Q. Okay. You were talking about the nurse that was on duty the night of the 15th?

A. Correct.

Q. After the foot drop has already been identified?

A. Right.

Q. Okay. Her error in documentation or even error in understanding didn't cause the foot drop. Will you agree with me?

A. Exactly.

Q. Okay.

A. I agree.

Q. But it was still wrong?

A. Correct.

Q. Okay. Shy didn't care for this patient earlier than that shift, did she?

A. No.

Q. Okay. Have you understood all my questions today?

A. Yes.

Q. Have I been kind and courteous to you?

A. Yes.

Q. The court reporter is going to type this up and you're going to be given an opportunity to make any changes to it. Do so at that time.

MR. ROWE: And I'll reserve the rest of my questions for trial.

THE WITNESS: Thank you.

MR. APFFEL: We will reserve our questions till trial.

(Deposition concluded at 10:34 a.m.)

(Levin Exhibit 5 marked.)

CHANGES AND SIGNATURE

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I, BARBARA J. LEVIN, R.N., have read the foregoing deposition and hereby affix my signature that same is true and correct, except as noted above.

_____
BARBARA J. LEVIN, R.N.

THE STATE OF TEXAS )
COUNTY OF _____ )

Before me, _____, on this day personally appeared BARBARA J. LEVIN, R.N., known to me (or proved to me under oath or through _____) (description of identity card or other document) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that they executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, _____.

_____
NOTARY PUBLIC IN AND FOR
THE STATE OF TEXAS

CAUSE NO. 2006-CI-09447

ROSALYN BROWN ) IN THE DISTRICT COURT
)
VS. )
)
BAPTIST HEALTH SERVICES, ) OF BEXAR COUNTY, TEXAS
INC. and/or BAPTIST HEALTH )
SERVICES, INC., DOING )
BUSINESS AS ST. LUKE'S )
BAPTIST HOSPITAL ) 131ST JUDICIAL DISTRICT

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REPORTER'S CERTIFICATION
ORAL DEPOSITION OF BARBARA J. LEVIN, R.N.
FEBRUARY 7, 2008

I, Diana Ramos, Certified Shorthand Reporter in and for the State of Texas, hereby certify to the following:

That the witness, BARBARA J. LEVIN, R.N., was duly sworn by the officer and that the transcript of the oral deposition is a true record of the testimony given by the witness;

That the deposition transcript was submitted on _____ to the witness or to the attorney for the witness for examination, signature, and return to me by _____;

That the amount of time used by each party at the deposition is as follows:

Mr. Brett B. Rowe - 1 Hour, 27 Minutes

That pursuant to information given to the deposition officer at the time said testimony was taken, the following includes counsel for all parties of record:

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I further certify that I am neither counsel for, related to, nor employed by any of the parties or attorneys in the action in which this proceeding was taken, and further that I am not financially or otherwise interested in the outcome of the action.

Further certification requirements pursuant to Rule 203 of TRCP will be certified to after they have occurred.

Certified to by me this 13th day of February, 2008.

_____

Diana Ramos, CSR, RPR
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FURTHER CERTIFICATION UNDER RULE 203 TRCP

The original deposition was/was not returned to the deposition officer on _____;

If returned, the attached Changes and Signature page contains any changes and the reasons therefor;

If returned, the original deposition was delivered to _____, Custodial Attorney;

That $_____ is the deposition officer's charges to the DEFENDANT, VHS SAN ANTONIO PARTNERS, L.P., DOING BUSINESS AS ST. LUKE'S BAPTIST HOSPITAL, for preparing the original deposition transcript and any copies of exhibits;

That the deposition was delivered in accordance with Rule 203.3, and that a copy of this certificate was served on all parties shown herein and filed with the Clerk.

Certified to by me this _____ day of _____, 2008.

_____

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