IN THE UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF ARKANSAS
FAYETTEVILLE DIVISION

HAROLD BRAZEAL — PLAINTIFF

v. CASE NO. Civ.-12-5201

SCOTT COOPER, M.D. and ORTHOPAEDIC CLINIC, LTD., d/b/a, OZARK ORTHOPAEDIC AND SPORTS MEDICINE CLINIC, LTD., and d/b/a OZARK ORTHOPAEDICS — DEFENDANTS

DEPOSITION OF SCOTT S. COOPER, M.D.

Taken at the offices of Ozark Orthopaedics, 1101 Horsebarn Road, Rogers, Arkansas, on Monday, May 20, 2013, at 2:08 p.m.

APPEARANCES

ON BEHALF OF THE PLAINTIFF:
MR. KENNETH SWINDLE
SWINDLE LAW FIRM
619 West Persimmon Street
Rogers, Arkansas 72756

MR. JAMES E. KEEVER, MD., J.D. (via telephone)
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ON BEHALF OF THE DEFENDANT:
MR. WALTER B. COX
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I N D E X

E X H I B I T S

S T I P U L A T I O N S

The deposition of **DR. SCOTT COOPER** in the above-styled cause was taken before Glenda Woods, CCR, a certified court reporter and notary public within and for Washington County, Arkansas, at Rogers, Arkansas, on Monday, May 20, 2013, pursuant to Federal Rules of Civil Procedure.

P R O C E E D I N G S

Having been called for examination by counsel for the plaintiff, and having been first duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. SWINDLE:

Q Dr. Cooper, could you please state your name for the record?

A Scott S. Cooper, M.D.

Q And have you ever given a deposition before?

A Yes.

Q Could you please tell me how many times you've given a deposition?

A Maybe half a dozen in cases like Work Comp cases, MVAs, things of that nature.

Q Have you ever given a deposition where you're a party?

A No.

Q I'm sure that Mr. Cox has told you but I just want to go over some of the basic rules for all depositions. If I'm

talking, if you would, please let me finish my question even if you anticipate what my question is going to be. That makes it easier for the court reporter if we're not talking over each other, and I'll do the same for you. I'll let you finish your answer even if I anticipate what I think you're going to answer. And if you would, please, make sure that you say "yes" or "no" instead of "uh-huh" or "huh-uh" because that's hard for the court reporter to get down. That creates some ambiguities.

I think Walter and I have somewhat similar styles in this. You know, I'm not here to harass you in any way; I'm just trying to find out what you're going to say at trial. By the time we get to trial, Walter's going to know 99 percent of what I'm going to do and say, and if I'm doing my job, I'm going to know 99 percent of what he and his witness are going to do and say. That's all I'm trying to do today, is try and find out what you're going to say at trial.

It's not a - it's not an endurance examination, you know. I don't expect it to take a real long time but if you need to take a break, just let me know and we'll take a break.

Have you reviewed this Notice of Deposition that we've already discussed?

A Yes.

MR. SWINDLE: And I would like to mark this as Plaintiff's Exhibit 1 to the deposition.

(Whereupon Plaintiff's Deposition Exhibit Number 1 was

marked for identification and entered into the record.)

MR. SWINDLE CONTINUING:

Q And I'd like to go over - you can look at your attorney's copy there, as well, and go over the list of things.

Did you review this Exhibit A, Subpoena Duces Tecum, on the list of things you are supposed -

A Yes.

Q -- to bring with you to the deposition?

A Yes.

Q Do you have the records of Harold Brazeal with you?

A Yes. This is my office chart and these are the x-rays.

MR. SWINDLE: And can I have this to attach to the deposition, Walter?

A (Witness continuing.) Yes.

MR. COX: It's up to you.

MR. SWINDLE: And, Madam Court Reporter, I told you before we got started I didn't think we'd need exhibits and I've already double-crossed myself just a few minutes into the deposition. But if we could mark this as Plaintiff's Exhibit Number 2.

(Whereupon Plaintiff's Deposition Exhibit Number 2 was marked for identification and entered into the record.)

MR. SWINDLE CONTINUING:

Q Dr. Cooper, we requested x-rays. Is that what this CD is on the back?

A Yes.
Q And we requested even things including like correspondence. Is there any correspondence that you know of?
A No.
Q Not that you know of? And we also asked for notes or memorandums regarding your treatment of Harold Brazeal.
Is there anything like that outside of what you've already given to me?
A No.
Q That's included. We've also asked for correspondence to, for example, hospital departments or committees. Anything like that?
A No.
Q We also asked for books, texts, treatises that you're going to rely upon.
Is that in here, or is that something else that you brought?
A Somewhere along the way, maybe about the time I heard about these proceedings, I recall looking at a couple of - one's a surgical exposure book and one's a anatomy book from med school.
Q Can we make a copy of this?
A Sure.
Q So we'll just copy this and then I'll give the original back to you.
MR. SWINDLE: And we can mark this as Exhibit 3, and

we won't attach it. I'll just let the court reporter make a copy of this and leave the original with you.

Is that fine?

A Yes.

(Whereupon Plaintiff's Deposition Exhibit Number 3 was entered into the record, to be marked later.

MR. SWINDLE CONTINUING:

Q Doctor, in your discharge summary, I want to - and you can feel free to refer to anything that you have there.

MR. COX: Ken, before you get to that, you asked for this billing statement, and he has that.

MR. SWINDLE: Okay. We'll attach this as Plaintiff's Exhibit Number 4.

(Whereupon Plaintiff's Deposition Exhibit Number 4 was marked for identification and entered into the record.)

MR. SWINDLE CONTINUING:

Q And, Doctor, you can refer to it. I'm going to be looking for a moment at your discharge summary and if you have that here, you can look at it. As I started out the deposition saying, I'm not here to try and trick you or be mean to you, or anything like that, you know, feel free - this is not a memory examination.

In your discharge summary, I see that you wrote "Nonetheless, as I told them somehow what I did resulted in these complications."

I have it highlighted here if that would help you find that sentence in there.

Do you recall making that statement?

A Well, I dictated that note. I don't remember the specific dictation, but I do have memory somewhere along the way of saying things along those lines.

MR. SWINDLE: We'll mark the discharge summary, Walter, as Plaintiff's Exhibit Number 5.

(Whereupon Plaintiff's Deposition Exhibit Number 5 was marked for identification and entered into the record.)

MR. SWINDLE CONTINUING:

Q Does that mean - from your memory, does that mean you did something in surgery that resulted in a laceration of the - help me out with the pronunciation. Is it popliteal?

A Popliteal.

Q Popliteal. Does that sentence in your memory mean that you did something that resulted in the laceration of the popliteal artery and vein?

A Best way to characterize that is just a general statement of the obvious because the injury did occur. I did the knee replacement.

Q Do you feel that there was something that you did that caused the laceration at that popliteal artery and vein in Harold?

A Nothing specific that I know of beyond doing a routine knee

replacement in the way that I always have and since have done.
Q Do you have any reason to believe that the hole was in the artery before the operation?
A I do not.
Q So we agree that there was a hole in the artery after the surgery, right?
A Yes.
Q And we agree that something that you did caused that hole; is that fair?
MR. COX: I'm going to object to the form.
A (Witness continuing.) Well, in the sense that it happened in the knee replacement, yes.
MR. SWINDLE: Walter, I'm going to go now to the original Responses to Interrogatories. We'll mark this Plaintiff's Exhibit Number 6. It's specifically the response to Interrogatory Number 12.
(Whereupon Plaintiff's Deposition Exhibit Number 6 was marked for identification and entered into the record.)
MR. SWINDLE CONTINUING:
Q And I'll pull this out and I'll let you - again, this is not a memory examination. I'm not trying to trick you or anything. I just want to try to figure out what you're going to say at trial.
You say, "I do not contend the complication of surgery experienced by Mr. Brazeal was caused by the negligence of any

person, including myself. Mr. Brazeal experienced a recognized risk and complication of total knee arthroplasty."

Now, that's your response. Did I state that correctly?

A Yes.

Q And you're the one who gave that response; that didn't come from your attorney, right? I mean those are your words?

Is that fair?

A Well, this was a response prepared by my attorney.

Q Right, but you gave him that information, right?

A Right.

Q That's a correct statement of your response, right?

A Right.

Q And again, I'm not trying to trick you. The reason why I'm asking is because by the rules you're supposed to verify the responses. I didn't see a verification from you, so I just want to make sure this really is from you and not from your attorney.

MR. COX: I think the record reflects that I asked you guys if you required his verification, and you all said "not at this time."

MR. SWINDLE: Okay.

MR. SWINDLE CONTINUING:

Q But that's why I'm going through it. I'm not trying to trick you.

How do you define negligence?

MR. COX: That calls for a legal conclusion, and I

object to form. If he can answer, he can answer.

MR. SWINDLE: Well, he used it in his answer so I'm trying to find out -

MR. SWINDLE CONTINUING:

Q Doctor, you used the word negligence in your answer. I want to know, what does that mean to you?

A Negligence would be the occurrence of something of a complication through carelessness, for instance; inappropriate treatment.

Q Would you agree that a surgeon can cause a hole in the popliteal artery and vein during a total knee replacement?

A Yes.

Q Is that a known risk of the total knee surgery?

A Yes.

Q And is that a known complication of the total knee surgery?

A Yes.

Q Are all known risks acceptable risks?

MR. COX: Object to form. Go ahead and answer if you can.

MR. SWINDLE CONTINUING:

Q Let me rephrase that.

If a patient knows about a known risk, does that make it acceptable - an acceptable risk, in your opinion?

MR. COX: Object to form.

A (Witness continuing.) I think that's for the patient to

judge if the risk is acceptable to him.

MR. SWINDLE CONTINUING:

Q A hole in the popliteal artery and vein during a total knee replacement can be caused by surgical error. Would you agree with that?

A Yes.

Q And you would agree that a surgeon doing something that does not display the degree of learning and skill possessed and used with reasonable care by an orthopedic surgeon in good standing in a similar or same medical community would be negligence?

MR. COX: Object to form. Go ahead and answer if you can.

A (Witness continuing.) Can you repeat that?

MR. SWINDLE CONTINUING:

Q Would you agree that if a surgeon caused a hole in the popliteal artery during a total knee replacement, that would be doing something that does not display the degree of learning and skill possessed and used with reasonable care by an orthopedic surgeon in good standing in the same or similar medical community?

MR. COX: Object to form. Answer it if you can.

A (Witness continuing.) Not necessarily.

MR. SWINDLE CONTINUING:

Q Tell me why not.

A Because there are people being people and being complex biological machines, and there are abnormalities of anatomy and pathologies that could result in such an injury during the performance, during the routine standard performance of a knee replacement.

Q Negligence could be something the surgeon did he should not have done. Would you agree with that statement?

MR. COX: Object to form.

A (Witness continuing.) Negligence could be something a surgeon did but should not have done?

MR. SWINDLE CONTINUING:

Q That's correct. Would you agree with that statement?

A That could be.

Q Negligence could be something the surgeon did not do that he should have done. Would you agree with that statement?

A That could be.

Q So negligence can both be acts of commission or acts of omission. Would you agree with that?

A I would say so.

Q Is it your understanding that there can be a laceration, and I stumble over this word every time - is it your understanding there could be a laceration of the popliteal artery and vein during a total knee arthroplasty when the surgeon does not make a surgical error?

A That's correct.

Q What have you learned in your training and experience to explain a laceration of the popliteal artery and vein during total knee surgery without a surgical error to cause the lacerations?

MR. COX: Object to form.

A (Witness continuing.) I think I would have to change the word from laceration to rupture, but an abnormal - a diseased popliteal artery could be more prone to injury, even blunt injury or traction injury, in the performance of knee replacement.

MR. SWINDLE CONTINUING:

Q Do you believe that Harold suffered a rupture, or a laceration, or do you have an opinion?

A I don't know.

Q Can a vessel be lacerated during a total knee arthroplasty?

A Yes.

Q Can you tell me what mechanism would cause the laceration?

A Using the saw to cut the bone could cause a laceration.

Q Anything else?

A Doing dissection behind the knee to free up soft tissue could cause the laceration.

Q Was there any of this dissection in Harold's procedure?

A Minimal amount, comparatively speaking.

Q Anything else that you can think of that would cause a laceration during a total knee or arthroplasty procedure?

A Somewhere in there I saw mentioned placement of retractors. I suppose that's conceivable, although I think that would be an unlikely mechanism.

Q Doctor, you used the term - you said you wanted to change the term from laceration to rupture.

Why is that significant to you?

A Well, the - say - wait, say that again.

Q In my original question on this topic you said - in your answer you said you wanted to change the term from laceration to rupture.

Why was that a significant change to you?

A Well, if the - because it's easier to see a rupture occurring in such a way in a diseased artery in the performance of a knee replacement. But if we use the laceration, I think there are even circumstances imaginable where anatomy was so abnormal in an undectable way that even a laceration could occur.

Q When you said "it's easier to see," would it be correct to say that you meant it's easier to imagine? You're not saying it's easier to physically see the injury.

A Imagine.

Q You listed I think three different things that could cause a laceration: the saw, a dissection, or retractors.

Is that correct?

A Well, the retraction of the tissues, the dislocation of the

knee done, and the knee replacement.
Q So you wouldn't list the physical implement of retractors as something that -
A Oh, no, that, too.
Q Okay.
A But, also, the traction on the vessel -
Q Okay.
A -- in dislocating the knee, as one does.
Q So there's essentially four causes. You're saying the saw, dissection, retractors, and the traction of pulling something apart?
A Uh-huh.
Q Is that a "yes?"
A Yes.
Q And again, I'm not trying to be rude to you but that just makes it hard for the court reporter.
A You're right, I said "uh-huh."
Q And the reason why I'm going through this list of possibilities is because you used this correction. You said you would prefer to use the word rupture.
Would you have the four same possibilities for causing a rupture, or would there be other possibilities?
A No. No other possibilities that I can think of.
Q And would you agree that if the popliteal artery and vein were lacerated by a surgeon during the course of a surgical

error, that would constitute medical negligence?

MR. COX: object to form. Go ahead.

A (Witness continuing.) In the course of a medical error?

MR. SWINDLE CONTINUING:

Q Surgical error.

A In the course of a surgical error -

Q Right. If the vein and the artery were lacerated during the course of a surgical error, would that constitute medical negligence, in your opinion?

A Well, as my attorney stated a minute ago, that's a legal opinion.

Q Do you have an opinion about it?

A If a vessel was lacerated during a medical error, would it be negligence? I don't think so, in my opinion, not necessarily. Although, certainly it could be.

Q What would you consider a surgical error that would constitute medical negligence?

A Lack of awareness of the anatomy, not knowing where the vital structures are.

Q Any other examples you can think of?

A Well, the things that follow from that and doing things in the operation reflecting not knowing where those things are.

Q Fair enough.

Break it down to I guess laymen terms, when I thought about medical negligence I thought about operating on the wrong leg.

A Uh-huh.
Q Would that be medical negligence, in your opinion?
A I think so.
Q To your knowledge, has Harold suffered a permanent injury as a result of the cut of his artery and vein?
A The last time I saw him, my suspicion was, as I said in my office notes, that it may not recover completely and the longer the time went by that it didn't, I didn't think it would.
Q Is that still your opinion today?
A Well, having not seen him in a long time, that seems to be the case.
Q Is it your understanding that Harold suffers a permanent foot drop?
A The last time I saw Mr. Brazeal there was actually some recovery of the nerve that causes extension of the toes and dorsal flexion of the foot, so at that point I thought it was possible that that could improve some. But beyond that, I have no knowledge.
Q Do you recall referring Harold to Dr. Irwin?
A Yes.
Q And do you recall the reason for that referral?
A Well, it was the chronic pain he was having, the neuralgic pain, the nerve related pain.
Q I think I saw somewhere the term "complex regional pain syndrome."

A Right.
Q Is that right?
A Uh-huh.
Q Was that part of the reason for your referral?
A Well, that's a possibility. And, in fact, that's not something that I'm ever the guy that says, yes, this is CRPS. I'll often ask the pain specialist like Dr. Irwin to tell me if they think it is.
Q The pain syndrome was caused by complications of the cut artery and vein during your surgery, would you agree with that?
MR. COX: Object to form.
A (Witness continuing.) I would say the pain syndrome was a result of the complication in surgery.
MR. SWINDLE CONTINUING:
Q Is it typical that patients - is it typical in your experience that patients suffer from complex regional pain syndrome after an arthroplasty procedure?
A No.
Q So just to be clear, you're not saying that the pain that Harold suffers was because of the procedure on his knee but some complication in that surgery; is that fair?
A That's fair.
Q And specifically would that complication be the disruption of his blood flow in the vessels?
A That's right.

Q If Harold is still having serious pain, would you agree that he is likely to have serious pain for the rest of his life?

MR. COX: Object. Speculation. Go ahead and answer it if you can.

A (Witness continuing.) I think that's - I think that's fairly likely, although those things can change over very long periods of time.

(Whereupon Plaintiff's Deposition Exhibit Number 7 was marked for identification and entered into the record.)

MR. SWINDLE: Walter, Number 7 is the supplemental responses.

MR. SWINDLE CONTINUING:

Q Dr. Cooper, again, this is not a memory test. I'm not trying to trick you.

Oh, could I have that one back just for the court reporter?

A This one.

Q Thank you, sir.

I've highlighted part of your answer there. As I started the deposition, I'm just trying to figure out what you're going to tell the jury and so I have a couple of questions just to follow up on your response in that supplemental response on April 26.

You informed us that you expect to testify about your opinion of possible causes of the holes in the artery and vein. I think the words that you used are complications, but I think

that's holes and artery and vein were the complications you're referring to.

Is that fair?

MR. COX: I'm going to object. If you're going to ask him what he said, you ought to read what he said, not your interpretation of it.

MR. SWINDLE: Sure. I'll read it out loud.

MR. SWINDLE CONTINUING:

Q You stated, "I plan to testify as a non-retained expert in my own defense and offer testimony as to the surgery; the findings at surgery; my opinion of the possible causes of complication."

And I'll stop there, Doctor. When you say "complications," are you referring to the holes in the artery and vein?

A Yes.

Q You've had more time to think about it. What do you think caused those holes in the artery and vein of Mr. Brazeal?

A I don't know.

Q Okay.

A Just as I said to Mr. Brazeal and his family, I don't know what caused those.

Q And the reason why I asked is because you state that you plan to testify about your "opinion of the possible causes of the complication."

So again, I'm not trying to trick you. I just want to find

out what you're going to say in front of the jury. What are those possible complications you're going to tell the jury about?

A Well, the things that I outlined: the rupture of diseased artery with the dislocation of the knee done during knee replacement, using the saw to cut the bones, any dissection in the back of the knee. Those are the possible causes.

Q We'll go ahead and mark that as Number 7. I think I've already marked it. I've got it here. Put that right there.

MR. SWINDLE CONTINUING:

Q Dr. Cooper, did you review the Mercy chart in preparation of your deposition?

A Yes, I did.

MR. SWINDLE: I've got a page here, Walter. We'll mark this as Exhibit 8, and it is - says consult notes and I'm trying to help you out, Walter, 12/20/2011, looks like it starts at the bottom of that page, 12/20/2011, and then it goes over to the next page. It says "continued."

(Whereupon Plaintiff's Deposition Exhibit Number 8 was marked for identification and entered into the record.)

MR. SWINDLE CONTINUING:

Q Have I given you - between those two pages, have I given you the full note that you made there?

A This is not a note that I made.

Q That's not your note at the very top?

A Let's see here, let me -
Q I'm talking about the bottom of the first page and the top of the second page.
A Oh, okay, I see what you're saying.
Q Physician progress -
A Right, right.
Q To me, those notes were hard to read.
A I see.
Q I'm just trying to make sure I have everything.
A Yeah, it was just the label on this progress note.
Q Right.
A This looks like the note that I made when I checked Mr. Brazeal the night after his surgery.
Q Right.
Now is that the entire note as best that you know of?
A Yes.
Q And the reason why I ask is because it's short and there seems to be a lot of abbreviations. I just want to make sure I have everything.
A Sure.
Q Your note says - and tell me if I quote this correctly, "Veins full, but I couldn't feel a pulse except ? faint DP."
A Right.
Q Do you see that?
A Right.

Q Did you put the question mark in that note?
A I did.
Q Could you tell me what that means?
A That means that I thought I might could feel a dorsalis pedis artery.
Q And that's the artery on top of the foot?
A That's the artery on the top of the foot.
Q And then it says "faint DP, but PT strong" and is that word "triphasic?"
A Triphasic, that's right. And what that refers to is the Doppler signal.
Q And would it be - you tell me if I'm misstating this. But would it be fair to say you went in there and you tried to get a pulse, and you got a faint reading with a Doppler machine. Is that correct?
A No. The dorsalis pedis - what I'm saying there is I thought I could feel a dorsalis pedis pulse, maybe.
Q Right. But you didn't use a Doppler machine?
A I must not have on the dorsalis pedis. I didn't - if I did, I didn't put it in there, but I checked the PT - that refers to the posterior tibial pulse.
Q The note reads "No pain. Leg blocked." Is the block talking about the anesthesia?
A Correct.
Q It says "Good spirits." And then it says "VSS."

Could you explain; what does "VSS" mean?

A Vital signs stable.

Q "Foot color good." And then it says "CR nl." What does that mean?

A Capillary refill normal.

Q What significance did that have to you?

A Well, that's a measure of circulation, tissue profusion. You mash down on the tip of the toe, the nail bed, classically, it blanches white, fills back up with blood.

Q And then the next sentence you've talked about that already. And then it says "Case/XR d/w him and family."

I guess that means discuss with him and family. Is that right?

A That's right.

Q What does "Case XR?"

A Case and x-rays.

Q And x-rays?

A Right.

Q Okay.

A In other words, that almost certainly means, because this is what I usually do, I pulled up the x-rays on the computer in the room and showed them to him and the family and discussed the case, told them it went well.

Q Do you remember how long you were feeling for or examining for a pulse?

A I don't. I probably spent a little bit of time trying to do it but I - no, I couldn't tell you minutes or…
Q Would it surprise you if Harold and his family members are going to testify that you spent about 30 minutes looking for a pulse?
A I'd be surprised if it took that long.
Q Is it fair to say that 30 minutes would not be typical?
A Thirty minutes would not be typical.
Q Were you concerned that there was some complication that Harold was experiencing after his surgery?
A At that point, no. If - because no further action was taken and I think the - my strongest confidence that things are fine was that the posterior tibial pulse had such a good signal with the Doppler.
Q Well, you say it was a good signal but in your note didn't you say "faint DP?"
A That's the dorsalis pedis.
Q But you would consider - you're characterizing that as a good reading?
A No, I'm characterizing -
MR. COX: Object to form. You're misstating the testimony.
MR. SWINDLE CONTINUING:
Q Go ahead, Doctor.
A I'm characterizing the posterior tibial pulse with the

Doppler, the triphasic signal.

Q Would it be fair to say that you had some abnormal pulse readings in that examination?

MR. COX: Object to form.

A (Witness continuing.) Oh, in the sense that I couldn't feel it, yes.

MR. SWINDLE CONTINUING:

Q Did that cause you any concern?

A Well, it caused me enough concern to go down the hall to get the Doppler so that I could listen to it and confirm that there was - appeared to be good distal circulation.

Q Would you have considered that a warning sign that there might be something wrong with the vessels?

A Not necessarily because I've seen that before in operated limbs where a pulse that you could feel and then I don't know, you can - swelling around the knee, for instance, and the pulse isn't quite as good palpably.

Q What did you do in response to these abnormal pulses?

MR. COX: Object to form. That assumes that they were abnormal.

A (Witness continuing.) I satisfied myself that his circulation was good.

MR. SWINDLE CONTINUING:

Q How did you do that?

A With the Doppler.

Q Okay. So is the Doppler the only procedure that you used to satisfy yourself?
A The night of surgery, that, capillary refill, and the fact that I could see veins in the exposed part of his foot that had blood in them.
Q Help me out. When you're saying that there was "faint DP," is that a reading from the Doppler or from trying to palpate a pulse?
A Trying to palpate a pulse.
Q And what about the Doppler? What was the reading with that?
A That was - I don't - I didn't document that I checked the dorsalis pedis. I checked the posterior tibial pulse, and it was "strong and triphasic." I'm quoting there.
Q So when it says "strong and triphasic," that is referring to the Doppler; is that right?
A Correct.
Q And at least at that time Mr. Brazeal's leg was still numb, he couldn't move his foot; is that correct?
A Correct.
Q That's what you referred to when you say "Leg blocked."
A Right.
Q Is that right?
A Right.
Q And that is from the - when you say "leg blocked," that

would be from the anesthesia, right?
A That's right.
Q And the anesthesia that you used - I think it's called - is it Naropin? Is that the anesthesia? Naropin? Doesn't sound familiar?
A No, those aren't drugs that I use. Anesthesiologists or nurse anesthetists use those drugs.
Q So you don't know what anesthesia was used?
A Well, I know he had a popliteal block and a femoral nerve block.
Q Well, would the anesthesia used be significant for your examination after the surgery?
MR. COX: Object to form.
A (Witness continuing.) Yes, it would be significant, but it's what we do as part of our protocol with joint replacements because the patients wake up pain free much of the time when the blocks are completely effective like this one appeared to be.
Q Different anesthesia drugs or medications have different effects; is that fair to say?
A Yes.
Q Didn't you think it would be significant that night to find out what anesthesia he was on?
MR. COX: Object to form.
A (Witness continuing.) I knew he had been blocked. I knew his nerves had been blocked.

MR. SWINDLE CONTINUING:

Q But you didn't find it - you didn't think that it was significant to find out that night what anesthesia he was on?

A What agent was used?

Q Right.

A What drug?

Q Right.

A No.

Q What was your schedule the next morning?

A I was in the office.

Q In this office on Horsebarn Road?

A That's right.

Q Do you know how long this Naropin agent lasts?

MR. COX: Object to form.

A (Witness continuing.) What I can say is that when our anesthesiologists do these peripheral blocks, which they do a lot of, I see the effects last 24 hours not rarely, and even occasionally a little longer than that.

MR. SWINDLE CONTINUING:

Q So would you expect Harold's leg to still be blocked by this anesthesia the night of the 20th?

A Yes.

Q What about by noon on the 21st?

A By noon of the 21st it could still be blocked, but it could also still be completely worn off by then. I would expect it to

be wearing off somewhere in that time range.
Q Why did you not check Harold's leg on the morning of the 21st?
MR. COX: Object to form. That assumes he didn't check it.
A (Witness continuing.) The morning -
MR. SWINDLE CONTINUING:
Q Of the 21st.
A -- of the 21st. Because I had satisfied myself that his leg was fine when I checked him, and I checked him the night of surgery, and my routine is - I typically round in the evening rather than early in the morning.
Q And I'm assuming everything that happened is in the records, and your attorney was making the objection that my assumption may not be correct.
If you would have checked him on the morning of the 21st, would you expect that to be in the records?
A I would expect it to.
Q And there's nothing in the records showing that you checked him on the morning of the 21st. Would you agree with that?
A I would.
Q Had you checked - if you would have checked Harold's leg on the morning of the 21st and it was still numb, would that have alerted you to a problem?
A First thing early that morning?

Q Yes.
A I don't think so. I think his surgery was, if I'm not mistaken, around noon so it would not be a surprise if the block was still in effect.
Q So if you would have checked him, for example, eight o'clock in the morning, which would have been about twenty hours later and his leg was still blocked or numb, that would not have alerted you to a problem?
A Not necessarily. Those blocks will last longer than that sometimes. They don't always. That's fairly variable, but it's not unusual for them to last that long.

MR. COX: Ken, I just want to make an objection for the record. You've been asking him a lot of questions about things that should or shouldn't have been done, and your own expert hasn't been critical of that so I just want to make an objection to that line of questioning because your own expert didn't offer those criticisms.

MR. SWINDLE: I understand.

MR. SWINDLE CONTINUING:

Q And I'm just trying to find out exactly what you're going to say at trial, especially because you're going to be testifying as what you say a non-retained expert.

If you would have checked Harold's leg the morning of the 21st and found altered pulses, would that have alerted you to a problem?

A Yes, if there was a difference from the night before.
Q Why did you not make it a point to go in and check for his pulses the morning of the 21st?
A I answered that a minute ago. I was satisfied that there was not a circulation problem at that time.
Q And what would have an earlier operation to restore circulation, what benefit would that have been to Harold?
A Well, it could have conceivably resulted in a more complete recovery of function.
Q Would it have been likely to be more completely - what word did you use - return to function? Would it be more likely than not?
A Well, it always depends on the timing but, yeah, earlier is generally better.
Q And that would have resulted in earlier relief of a compartment syndrome; is that right?
A Right.
Q And again, Doctor, all I have to go by is your records so if the records are incorrect in anything, please tell me. But from what I saw, you did not go to the hospital on the 21st until a nurse called you; is that correct?
A That's correct.
Q And you didn't call the nurses that morning to check on Harold, right?
A Not that I recall.

Q Do you have any criticisms of how the nurses cared for Harold?
A Oh, I do not at all.
Q Were the nurses responsive to your orders?
A Yes.
Q I want to go back to this - and if we're re-tilling the same ground, I apologize. But earlier you said you preferred to use the word rupture over laceration, and so that's why I want to ask you again do you agree or disagree that there was a hole in both the artery and the vein of Harold?
A I do not disagree.
Q I want to show you what I've printed off the Internet and you can mark this as Plaintiff's Exhibit 8.
Do you recognize that document?
A Not that particular version but - in fact, I'm not sure I've looked at this one at all with these cutting jigs. These are not the cutting guides that I use.
Q And for the record, it's entitled the "Genesis II Anterior Cut First Surgical Technique."
Well, help me out on what you used. Are there different companies that make these? Do you use something from a different company, or what do you use?
A No, this is the company, but these are different cutting jigs, newer ones, and I use the ones that I trained with. They're kind of the ones that are more the traditional type

technique. Let me go through this.

MR. SWINDLE: Let me mark this correction to Plaintiff's Exhibit 9.

(Whereupon Plaintiff's Deposition Exhibit Number 9 was marked for identification and entered into the record.)

MR. SWINDLE CONTINUING:

Q Let me let you look through it because I don't have the older one that you said that you use. Let me ask you, is that the same surgical technique that you used in Harold's surgery, or is there something radically different about that document I just showed you?

A These are the same implants, okay. Let me see - yeah, these are - they're all different cutting jigs from what I use.

Q Would you - do you have anything in your possession that is similar as far as like a brochure of what you use?

A I don't know if I still do.

Q Fair enough.

A I may be, but I'd have to look through some old stuff.

Q Fair enough.

A I read it a jillion times but none in the last few years.

Q Let me go through some possibilities with you, and you may have already answered this. But do you agree it's possible to cut the artery and the vein with the saw while doing the cut on the tibia or the shin bone?

A The way I do that, that's virtually impossible.

Q Would you please explain why?
A The way I do it, and certainly it's not unique to me, but I dislocate - after the femur cuts are made, I dislocate the tibia out from under the femur, so the knee is bent like this - this isn't going to translate well verbally. I use what's called a PCL retractor, posterior cruciate ligament retractor. It's this wide metal thing. It's about as wide as my hand there, with the handle up here, going up the femur, and it has these two prongs, each of which is roughly the width of my finger; flatter, rounded edges. You don't put sharp stuff in there. All right. So this PCL retractor, these two prongs go on either side of the posterior cruciate ligament. I preserve the PCL when I do a knee replacement. Some people do; some people don't.

So this is now - those prongs are now on either side of the PCL pushing the tibia out from under the femur. Okay? So these prongs are like that, up hard against the bone on either side of the PCL. Okay? Like that. That's not a bad approximation of the tibial plateau as far as the size goes. And so it stuck out like that.

Then the tibia is cut off more or less flat, perpendicular to the floor in both planes, more or less. Some on a little bit of a slope, generally.

Q So why would that make it impossible to cut the artery?
A Well, the prongs of the PCL retractor, okay, for one thing, the saw blade, which is roughly an inch wide, is physically

stopped from going back there where the vessels are. Not only that, between those two prongs is the PCL which if you're going that way, you're going to have to take out the PCL.

Q Right.

A Till you injure the vessels and you can imagine, well, could you get over there, get over there and go in at an angle, well, that's conceivable but you wouldn't do that.

Q In your opinion, is it possible to cut the artery when you're cutting the femur or the thigh bone?

A That's possible, too. But there the vessels are generally at their closest to the bones is on back of the tibia and there's - well, no one is casual behind the knee. But there's a little bit of leeway. On the other hand, you know, it's pretty much done - you're cutting through those cutting jigs similar to that on the femur, and you just cut until you get through the bone and stop. And the knee is flexed up which lets the vessels be as far away as possible anyway.

Q Do you agree that it's possible to cut into the artery or vein with the tip of the retractor?

A That's possible. That just doesn't seem very likely because of the retractors I use. There are pointed tip spiked retractors, which I do not nor have I ever used in these operations.

Q I think earlier you talked about the rounded tips, the protractors going in I think behind the tibia. Is that what you

were referring to?
A That's correct.
Q Could you please explain exactly what does your training and experience include for this type of surgery, the arthroplasty surgery? I assume that you learned something in medical school; is that correct?
A Not much.
Q Not much about this surgery in medical school?
A Lots in residency.
Q You practiced it in residency.
Is there some type of examination that you take to become certified as a orthopedic surgeon?
A American Board of Orthopedic - excuse me - American Board of Orthopedic Surgery.
Q Would you have to show a knowledge of this surgery to pass that examination?
A Not specifically this surgery beyond the - when you first take it, the first time you take it is right at the end of residency before you start practice, and it's a long written test. Everybody goes to Chicago and takes it. It's a I want to say all day. I can't remember. That was a long time ago. And so in that sense, in a didactic taking a written test sense, yes, that's - knee replacement being such a common orthopedic operation is thoroughly covered in that test.
Q As part of your training and your experience is the

possibility of cutting a vein or an artery part of the learning that you have as a risk to avoid?

A I'd say yes, that's a very general statement in that - yeah.

Q Well, to be more specific, as part of your training, were you taught to be careful about not cutting the vein or the artery with the saw?

A Yes. I had to be because I know that.

Q And were you taught to be careful, as part of your training, not to puncture a vessel with a retractor?

A Yes. Those are lessons that were a long time ago, and do I remember specific lessons about that, it's just part of it.

Q Right.

That's just part of what any competent orthopedic surgeon doing the surgery would know. Is that fair to say?

MR. COX: I object to form. Go ahead and answer it if you can.

A (Witness continuing.) How to place your retractor safely and how to avoid vascular injuries?

MR. SWINDLE CONTINUING:

Q Yes.

A As best we can, yes.

Q And were you taught that vessels should not be cut if the saw is used properly?

A That specific point, no.

Q Were you taught that the saw should never penetrate more than a millimeter beyond the bone where the - when making the tibial cut?
A Was I taught that?
Q Right.
A No. Specifically a millimeter, no.
Q What were you taught about how far it should penetrate?
A As little as possible. You cut the bone and stop.
Q Would it be the same thing when making the posterior - I think you called it femoral cut. Would it be the same thing?
A Yes.
Q Same training? No specific training about a millimeter?
A I don't remember a specific training about a millimeter.
Q Were you taught that a vessel should not be injured if the retractor is used properly?
A I don't remember being taught that, specifically.
Q Were you taught to keep the retractor on the bony edge of the back of the tibia?
A Yes. What I can say is I do knee replacements the way I was taught, between 22 and 17 years ago.
Q That you know of, has the training changed for that procedure in the last 17 years?
A Not that I know of, other than with minimally invasive systems, which I don't use.
Q And attorneys have to go to continuing legal education

seminars. I assume doctors do, as well, right?
A Uh-huh.
Q And you've gone to continuing orthopedic seminars; is that correct?
A That's correct.
Q You guys have to do that every year?
A Well, we have requirements of a certain number of hours, both by the state and by our board.
Q And at least that you're aware of, the training for the procedure that you did on Harold has not changed in the last 17 years; is that correct?
A No, not from the way I do it.
Q Were you taught that if a retractor went deeper than the bony edge of the tibia, it might put the vessels at risk?
A I don't remember being taught that, specifically. That kind of falls under the category of general knowledge of anatomy.
Q And you finished your residency I think I saw in 1997?
A Ninety-six.
Q Ninety-six?
And you're familiar, obviously, with the Journal of Arthroplasty?
A I'm familiar with the Journal of Arthroplasty. I do not subscribe.
Q Have you done any research on the injuries to the popliteal

vessels since Harold's surgery?
A I have not.
Q In your operative note, and I have it here somewhere. I think this is it. Yeah, here it is. On the last page of the operative note near the top, you say, "The tibia was subluxed by the PCL retractor."
A Right.
Q What does PCL mean?
A Posterior cruciate ligament.
Q Go ahead.
A Well, that's what you call that retractor that I was describing a minute ago.
Q And you use a retractor to displace the tibia forward when making the tibial cut; you agree with that?
A Yes.
Q And a retractor goes just beyond the level of the knee joint; you would agree with that?
A Yes.
Q And that would be about where the level of the dye stopped in the arteriogram; would you agree with that?
A No.
Q Where did the dye stop?
A Proximal to that point.
Q When you say "proximal," does that mean above it, or below it, or -

A Above.
Q Above. Do you know how far above?
A Oh, just looking at it, it could be - I haven't measured it, but it could be as far as three centimeters or so, and I'm referring to the dye in the vessel.
Q Right.
I think we're up to Exhibit Number 10.
(Whereupon Plaintiff's Deposition Exhibit Number 10 was marked for identification and entered into the record.)
MR. SWINDLE CONTINUING:
Q Let me show you this article, Doctor. But you said you do not subscribe to that journal; is that correct?
A I do not.
Q And that's a 1999 article entitled "Injury to" - and is it popliteal?
A Popliteal.
Q I struggle with that every time I see it.
A That's how most of us say it.
Q "Injury to the Popliteal Artery and Its Anatomic Location in Total Knee Arthroplasty."
Are you familiar with this article at all?
A I'm not.
Q You've never seen it?
A I don't recall seeing this article at all.
Q You would agree that a retractor can poke a hole in the

popliteal artery or the popliteal vein; is that correct?

MR. COX: I object to form. Go ahead.

A (Witness continuing.) It's possible, but it's hard to imagine with the ones that I use.

MR. SWINDLE CONTINUING:

Q If you could, Doctor, and you and your attorney can look over on page 805. Just turn the page on that and there's several - and could you explain what those pictures are? I mean just generally.

Are they arteriograms, as far as you can tell?

A They look like lateral view arteriograms.

Q And would you agree that they show the retractor displacing the popliteal artery?

A Let's see - it appears that they do.

Q And that retractor could poke a hole in the artery and vein; would you agree with that?

A Well, if it was a retractor with some sharpness to it, that's imaginable.

Q What about if it was a retractor with the rounded edges like you say you use?

A Well, the one that I use, remember it's the rounded edges; not only that, the prongs on it are not right in the midline, they're medial and lateral, a little bit wide enough so that the PCL can be - PCL is about a centimeter - so that the PCL can be in-between those so that the PCL is not damaged or disturbed.

Q Okay.
A So, right, it's not - I think this is referring to a single prong retractor.
Q So is it your testimony that a single prong retractor with a flat edge is more likely to cause an injury to the vessel than a double prong retractor with rounded edges, which is what you used?
MR. COX: Object to form.
MR. SWINDLE CONTINUING:
Q Is that a correct statement of your testimony?
A Well, what I said was a sharp retractor.
Q Okay.
A Yeah.
Q So a single sharp retractor is more likely to cause an injury than a double pronged round retractor?
A That's speculation, having never given that concept a thought, but I would say so, probably.
Q And we can - if you can hand that back to me. And, Doctor, all of these are going to be exhibits to your deposition, which you'll have. I'm just trying to keep everything in order for the court reporter here.
When an artery is injured, does spasm occur?
A A spasm can occur when an artery is injured.
Q Is it something that you would expect to occur?
A I'm not a vascular surgeon, but I would say in most cases

probably so.
Q Were you taught that spasm in a cut artery could make it difficult to be certain, at least from an arteriogram, the exact location of the cut?
A I wasn't taught that.
Q Would you agree with that statement or disagree?
A Well, it depends on what degree of precision you're using. Arteriograms are used routinely to generally localize the location of - I say routinely - location of an arterial injury.
Q Would the spasm make it difficult within let's say a few centimeters? Could it make a few centimeters difference?
A I suppose it could. I wouldn't think it would be very likely but, again, we're out of my area of expertise.
Q Fair enough.
In Harold's case or his situation, there was a large collection of blood in the soft tissues in the area of the cut; would you agree with that?
A Yes.
Q And that had been bleeding for almost 24 hours at the time of the arteriogram; would you agree with that?
MR. COX: Object to form.
A (Witness continuing.) I suppose so.
MR. SWINDLE CONTINUING:
Q And the bleeding had pretty much stopped because of the pressure from the surrounding collection of blood and the blood

clot; would you agree with that?
A I don't know the answer to that because there was contrast that leaked out of the vessel, so it wouldn't be accurate to say that the bleeding had stopped, and I don't know how to characterize "pretty much."
Q What happens to blood when it's next to an area of injured tissue and not flowing?
A Well, it clots.
Q And after repairing an artery that has been cut, a surgeon routinely runs a catheter up and down the artery; would you agree with that?
A Yes.
Q And what is the purpose of doing that?
A Well, it's to remove any thrombus or clot that's gone distal in the vessel.
Q You would expect there to be clots in the movement of Harold's cut artery; would you agree with that?
A Probably so.
Q And that would show as an area of non-feeling on the arteriogram; would you agree with that?
A Well, only if it was completely blocked.
Q Was it completely blocked in Harold?
A I don't know.
Q Are you going to testify that the artery could not have been cut at the level of the proximal tibial cut?

A I'm going to testify that it's hard for me to imagine that happening.
Q Why is that?
A Because of what I described with regards to the PCL retractor.
Q Okay.
A I also think the arteriogram more likely than not shows the approximate level of disruption of flow. That's my opinion. Again, not a radiologist, not a vascular surgeon.
Q And where does that arteriogram - where does it show that you're referring to?
A That was what I referred to a little while ago as maybe three centimeters or so above about where the tibial cut is.
Q Are you going to tell a jury that the blood flow could not have been terminated by the arterial spasm?
A I'm not going to tell them it could not have been.
Q You're just going to tell them it's not likely?
A That's correct.
Q Are you going to tell the jury that the blood flow could not have been terminated by a clot?
A No.
Q Are you going to say that Harold's vessels could not have been cut by your saw?
A I'm not going to say they could not have been cut by the saw.

Q And if his vessels were cut by your saw, would you agree that would be negligence on your part?

MR. COX: Object to form.

A (Witness continuing.) I wouldn't agree to that.

MR. SWINDLE CONTINUING:

Q Please tell me why not.

A Because in the performance of a routine knee replacement, as I explained much earlier this afternoon, there can be such pathology and anatomic abnormalities that make it unavoidable with regular meticulous due caution as I practice.

Q What factors were there present in Harold's situation that would make it non-negligent for you to cut his vein, if that happened?

MR. COX: I object to form. You're asking him to speculate.

A (Witness continuing.) Well, there is evidence that he did have arterial disease; surgical evidence and angiographic evidence.

MR. SWINDLE CONTINUING:

Q Have you heard of other surgeons cutting a patient's vein or artery during an arthroplasty procedure?

A I have "heard of," yes.

Q Are you going to tell the jury that a surgeon cutting a patient's vein or artery during an arthroplasty procedure is not negligent because other surgeons have done it?

MR. COX: I'm going to object to form. Go ahead.

A (Witness continuing.) I don't think I would say that.

MR. SWINDLE CONTINUING:

Q Is the fact that other surgeons have cut a vessel during the arthroplasty procedure something that makes the cutting of a vessel during the procedure a known risk?

MR. COX: Object to form.

A (Witness continuing.) I suppose that's one of the factors that makes it a known risk.

MR. SWINDLE CONTINUING:

Q In your opinion, does the making of an injury - excuse me. In your opinion, does making an injury from a complication a known risk turn the injury from the complication into an acceptable risk?

MR. COX: Object to form. Asked and answered, also.

A (Witness continuing.) Can you ask that again?

MR. SWINDLE CONTINUING:

Q Sure.

In your opinion - let me try to restate it and state it better.

In your opinion, does making the patient aware of a complication such as an injury that's possible from a procedure turn that known risk into an acceptable risk?

A That's actually a decision that the patient makes.

Q If the patient makes the decision to proceed, does that

make it an acceptable risk, in your opinion?
A If the patient has decided it's an acceptable risk, then - and knowing that it's a very uncommon thing, then I suppose I would answer that question yes.
MR. SWINDLE: I think we're up to Number 11. Mark this as Number 11.
(Whereupon Plaintiff's Deposition Exhibit Number 11 was marked for identification and entered into the record.)
MR. SWINDLE CONTINUING:
Q Can you identify this, Doctor?
A That's a pre-surgical consent to surgery form from Mercy Medical Center.
Q I know it's small handwriting. I'm not trying to trick you. You can look at a larger blowup if your attorney has one. That's what I have. I think you're probably pretty familiar with those forms; is that correct?
A Oh, yes.
Q Did you cover the things listed on that form with Harold before the surgery?
A I did and what I covered more specifically is documented in the pre-surgical history and physical.
Q Did the consent form cover the possibility that Harold might suffer a cut to his vessels?
A I'm sure it does, but I'm going to need to find a bigger form.

Q Sure.

MR. SWINDLE: Do you have a bigger form, Walter?

A (Witness continuing.) Nerve or blood vessel damage.

MR. SWINDLE CONTINUING:

Q And that would, in your opinion, cover the possibility of Harold's vessels being cut?

A Well, that's a surgical permit. I think the documentation of the discussion is better in terms of "covering."

Q Did you discuss with Harold the possibility of loss of blood flow that could result in - I think it's called Compartment Regional Pain Syndrome?

A I did not discuss that with him specifically, but as it's documented in the chart, blood vessel and nerve damage which can result in permanent numbness, weakness, pain, or even limb loss.

Q Does the consent form cover the possibility that Harold's vessels might be cut negligently?

A I don't think so.

Q Do you believe that a patient can consent to negligent treatment?

A Well, they could consent to negligent treatment. I don't think they would consent.

Q And if you would have cut the artery and vein on Harold's leg, would that be negligence, in your opinion?

MR. COX: Object to form.

A (Witness continuing.) We've been over that a few times,

and I don't think it's necessarily so.

MR. SWINDLE CONTINUING:

Q If you operated on the wrong leg, would that be negligence, in your opinion?

MR. COX: Asked and answered, Ken. You've asked him that before. He's told you yes.

MR. SWINDLE CONTINUING:

Q And operating on a wrong leg is a known risk and complication of total knee surgery; would you agree?

A Yeah, but it's not one that I talk to patients about.

Q But it does occur; wouldn't you agree?

A Unfortunately, it does. Quite rarely.

Q Would you be surprised if the - have you ever heard of the Joint Commission Center for Transforming Healthcare?

A Yeah, I think that's the - not that specifically, but I'm familiar with the Joint Commission of Hospital Accreditation.

Q Would you be surprised that they reported in 2012 that wrong site surgery occurs 40 times a week in the United States?

A I would be surprised. That's a bigger number than I would think.

Q My exhibits are getting smaller. That means we're getting close to done.

MR. SWINDLE: We'll mark this as Plaintiff's Exhibit 11, Walter. This is - I keep forgetting to ask for things back. I'm bad about that.

Plaintiff's Exhibit 12. Thank you, Madam Court Reporter.

(Whereupon Plaintiff's Deposition Exhibit Number 12 was marked for identification and entered into the record.)

MR. SWINDLE CONTINUING:

Q Which is entitled "Facts About Wrong Site Surgery." I don't have any questions about it. It'll be attached to your deposition. You can read it.

MR. COX: May I ask what that has to do with this lawsuit?

MR. SWINDLE: Maybe nothing. We'll see.

MR. COX: We're not talking about wrong site surgery here.

MR. SWINDLE: Well, we're talking about what you can and can't consent to; at least that's what you were talking about in one of your pleadings.

MR. SWINDLE CONTINUING:

Q Doctor, do you remember your visit, and I'm about done, Doctor. Do you remember your visit to Harold's room after the arterial surgery the next day?

A I do.

Q Do you remember telling Harold's family and friends that you had cut Harold's artery or vein?

A No, I don't remember saying that.

Q Did you know that Harold is going to have those family and friends at trial to testify about what you told them?

A Well, I would assume. I'm - is there - do you know where in the chart is there a - do I have a progress note in there?
Q I don't know off the top of my head. Progress note talking about what you said to their family?
A Yeah, what I said to them after the surgery.
Q I don't know.
A Because that's going to be more reliable than my memory these many months later.
Q Fair enough.
But you did know that they have been listed as witnesses, or did you?
A I don't think I did.
Q Let me ask you this, Doctor. If you had run a red light and crashed into Harold, would you take responsibility for his harms and losses?
MR. COX: I'm going to object to that. That's totally improper.
MR. SWINDLE: I think it is completely impr - completely proper.
MR. SWINDLE CONTINUING:
Q Do you understand the question, Dr. Cooper?
A If I ran a red light -
Q And you crashed into Harold, would you take responsibility for his harms and losses from that crash?
MR. COX: Object to the form.

A (Witness continuing.) I suppose so.
MR. SWINDLE CONTINUING:
Q Have you read Harold's deposition?
A I have.
Q Do you understand that Harold is not angry; he just thinks you made a mistake like running a red light?
A I understand that.
Q Can you accept the idea that a surgeon can make a human mistake or a surgical error that unnecessarily harms patients?
A Can a surgeon make a human mistake or unnecessary error that causes patients - a surgeon can do that.
Q You understand that Harold wishes you no harm; he just wants compensation for his injuries?
A I understand.

MR. SWINDLE: No other questions, Walter. I would request the opportunity to consult with my co-counsel just for a minute because he might have something else.

Could we go off the record?

MR. COX: Before we go off the record, I want to object to his asking questions.

MR. SWINDLE: No, I'm going to ask all the questions, but he might prompt my memory about something, but I think we are done if we can just have one minute off the record.

MR. COX: Sure.

(Off the record.)

MR. SWINDLE: Do you have any redirect?

MR. COX: I have no questions at this time.

MR. SWINDLE: Okay, we'll be done.

(Whereupon Deposition was concluded at 3:32 p.m.)

C E R T I F I C A T E

STATE OF ARKANSAS)
) SS
COUNTY OF WASHINGTON)

I, GLENDA WOODS, a Notary Public and Certified Court Reporter in and for the aforesaid county and state, do hereby certify that the witness, **DR. SCOTT S. COOPER**, was duly sworn by me prior to the taking of testimony as to the truth of the matters attested to and contained therein; that the testimony of said witness was taken by me by voice writing, and was thereafter reduced to typewritten form by me or under my direction and supervision; and that the foregoing transcript is a true and accurate record of the testimony given to the best of my understanding and ability.

I FURTHER CERTIFY, that I am neither counsel for, related to, nor employed by any of the parties to the action in which this proceeding was taken; and, further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, nor financially interested, or otherwise, in the outcome of this action; and that I have no contract with the parties, attorneys, or persons with an interest in the action that affects or has a substantial tendency to affect impartiality, that requires me to relinquish control of an original deposition transcript or copies of the transcript before it is certified and delivered to the custodial attorney, or that requires me to provide any service not made available to all parties to the action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office this the 3rd day of June, 2013.

GLENDA HAWLEY WOODS
Washington County
My Commission Expires
June 1, 2014

GLENDA WOODS
Certified Court Reporter and
Notary Public
Arkansas License No. 413