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SUPREME COURT OF VIRGINIA
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IN THE

Supreme Court of Virginia

AT RICHMOND

No. 741108

BETTY J. BLY,

Appellant

V.

JOHN C. RHOADS, M.D.,

Appellee

APPENDIX

EARL H. DAVIS
MARDEN G. DIXON
JACK H. OLENDER
810 - 18th Street, N.W.
Washington, D. C. 20006
(202) 347-9121

TABLE OF CONTENTS

Motion for Judgment	1
Judgment Order	4
Assignments of Error	6
AS TO ISSUE NO. 1:	
Transcript of Evidence, June 26, 1974 Pages 132-141, inclusive	9-18
Transcript of Evidence, June 26, 1974 Pages 148-152, inclusive	19-23
Transcript of Evidence, June 26, 1974 Pages 173-175, inclusive	24-26
Transcript of Evidence, June 26, 1974 Pages 216-228	27-39
Transcript of Evidence, June 26, 1974 Pages 232-240, inclusive	40-48
Transcript of Evidence, June 27, 1974 Pages 75-80, inclusive	49-54
Transcript of Evidence, June 27, 1974 Pages 85-103, inclusive	55-73
Transcript of Evidence, June 27, 1974 Pages 104-107, inclusive	74-77
Transcript of Evidence, June 27, 1974 Pages 132-133, inclusive	78-79
Transcript of Evidence, June 27, 1974 Pages 207-220, inclusive	80-93
Transcript of Evidence, June 27, 1974 Pages 222-224, inclusive	94-96
Transcript of Evidence, June 28, 1974 Pages 5-8, inclusive	97-100
Transcript of Evidence, June 28, 1974 Pages 25-29, inclusive	101-104

AS TO ISSUE NO. 2:

Transcript of Evidence, June 26, 1974 Pages 153-161, inclusive	105-113
Transcript of Evidence, June 26, 1974 Pages 161-171, inclusive	114-123
Transcript of Evidence, June 26, 1974 Pages 175-176	124-125
Transcript of Evidence, June 26, 1974 Page 242	126
Transcript of Evidence, June 26, 1974 Pages 245-246, inclusive	127-128
Transcript of Evidence, June 26, 1974 Page 247	129
Transcript of Evidence, June 27, 1974 Page 40	130
Transcript of Evidence, June 27, 1974 Pages 49-52, inclusive	131-134
Transcript of Evidence, June 27, 1974 Pages 52-59	135-141
Transcript of Evidence, June 27, 1974 Pages 172-207, inclusive	142-177
Transcript of Evidence, June 27, 1974 Pages 220-224, inclusive	178-182
Transcript of Evidence, June 28, 1974 Pages 8-11, inclusive	183-186

AS TO ISSUE NO. 3:

Transcript of Evidence, June 26, 1974 Pages 56-83, inclusive	187-214
Transcript of Evidence, June 26, 1974 Pages 147-148, inclusive	215-216
Transcript of Evidence, June 26, 1974 Pages 240-242	217-219
Transcript of Evidence, June 27, 1974 Pages 60-75, inclusive	220-221

Transcript of Evidence, June 27, 1974
Page 105 222

OTHER MATTERS:

Defendant Dr. Rhoads' Deposition Transcript:
Pages 10-14, inclusive 223-227

Pages 61-62, inclusive 228-229

Dr. Bagley's Deposition Transcript:
Pages 38-39, inclusive 230-231

Pages 92-100, inclusive 232-240

Exhibit 2 241-242

Exhibit 3 243

Exhibit 4 244-272

COMMONWEALTH OF VIRGINIA:

IN THE CIRCUIT COURT OF PRINCE WILLIAM COUNTY

BETTY J. BLY
14602 Eastman Street
Woodbridge, Virginia 22191

Plaintiff

Law No. 55812-L

vs.

JOHN C. RHOADS, M.D.
120 Surveyor Court
Manassas, Virginia 22110

Defendant

MOTION FOR JUDGMENT

COMES NOW the Plaintiff, BETTY J. BLY, and moves this Court for Judgment against Defendant, JOHN C. RHOADS, M.D., in the amount of TWO HUNDRED AND FIFTY THOUSAND DOLLARS ($250,000.00), and as ground therefor, respectfully states as follows:

1. That at all times hereinafter mentioned, Defendant was and still is a physician duly licensed to practice medicine in the Commonwealth of Virginia.

2. That sometime prior to October 28, 1970, Plaintiff had engaged Defendant, as a physician to treat her professionally, and to perform a hysterectomy. Prior to performing the hysterectomy, Defendant advised Plaintiff a hysterectomy was necessary but failed to advise her of any possible risk, complications, or dangers of the operation.

3. That on October 28, 1970, the Defendant performed surgery on Plaintiff and negligently severed tubes leading from the kidney to the bladder, which impaired the functioning of her bladder and kidneys and ureter and required Plaintiff to undergo subsequent surgery for the correction and repair of the said condition.

4. That Defendant's surgical and medical treatment of Plaintiff failed to meet and conform to the usual and customary standards of medical care.

5. That as a direct and proximate result of the negligence of the Defendant aforesaid, the Plaintiff became permanently sick, sore, and disabled, and has suffered, still suffers and will in the future continue to suffer great physical pain, shock, and mental anguish, and has lost amounts of time from her employment and she has incurred great medical and hospital expenses, and her life expectancy has been shortened, all of which has been directly and proximately caused by the negligence of the Defendant herein named, as aforesaid.

WHEREFORE, your Plaintiff respectfully prays that she be awarded a judgment against the Defendant for the amount of TWO HUNDRED AND FIFTY THOUSAND DOLLARS ($250,000.00), plus interest from the date of the injury to Plaintiff, pursuant to 8-223 of Virginia Code of 1950, as amended, plus costs.

Betty J. Bly
BETTY J. BLY
by counsel

Earl H. Davis
EARL H. DAVIS
Counsel for Plaintiff
810 - 18th Street, N. W.
Washington, D. C. 20006
347-9121

JACK H. OLENDER
Of Counsel for Plaintiff
910 - 17th Street, N. W.
Washington, D. C. 20006
296-8984

JURY DEMAND

Plaintiff requests trial by jury as to all issues.

Betty J. Bly
BETTY J. BLY
by counsel

Earl H. Davis
EARL H. DAVIS
Counsel for Plaintiff
810 - 18th Street, N. W.
Washington, D. C. 20006
347-9121

V I R G I N I A:

IN THE CIRCUIT COURT OF PRINCE WILLIAM COUNTY

BETTY J. BLY,	:	
Plaintiff	:	
v.	:	LAW No. 5862
JOHN C. RHOADS, M. D.	:	
Defendant	:	

JUDGMENT ORDER

THIS CASE came before the Court for trial on the merits on Wednesday, June 26, 1974 and the litigants were present in court personally and with their attorneys. Whereupon a panel of 13 jurors was called, sworn and examined by court and counsel on voir dire. The panel being found acceptable to court and counsel each side then struck three and the remaining seven jurors were placed upon their oaths to well and truly try the issues drawn.

After opening statements of counsel the plaintiff began presentation of her evidence through witnesses and by documents and upon certain proffers advanced from time to time and then rested her case.

Whereupon the defendant, by and through his attorney, moved the court to strike the evidence and to grant summary judgment. After due arguments the motion was granted and the case dismissed; wherefore

IT APPEARING TO THE COURT that the defendant's motion to strike the evidence and to enter up summary judgment in favor of the defendant appears to be meritorious and ought to be granted; it is therefore

ADJUDGED AND ORDERED that the defendant's motion to strike

LAW OFFICES
STEINER, BRANDT, JENKINS & O'NEAL
[illegible] SOUTH UTAH STREET
ARLINGTON, VIRGINIA 22201
522-4678

the evidence and for the entry of summary judgment ought to be, and it is hereby, granted, and this case ought to be, and is hereby, dismissed with costs herewith awarded the defendant.

To the foregoing action of the court plaintiff, by and through her attorneys duly notes her exception.

Signed and entered this _____ day of July 1974.

_____
J U D G E

SEEN AND EXCEPTED TO:

EARL H. DAVIS
JACK H. OLENDER
MARDEN G. DIXON

By Earl H. Davis
Earl H. Davis,
Counsel for the Plaintiff

SEEN AND AGREED:

SLENKER, BRANDT, JENNINGS & O'NEAL

By_____
Norman F. Slenker,
Counsel for the Defendant

LAW OFFICES
SLENKER BRANDT,
JENNINGS & O'NEAL
1012 NORTH UTAH STREET
ARLINGTON, VIRGINIA 22201
522-4678

VIRGINIA :

IN THE CIRCUIT COURT OF PRINCE WILLIAM COUNTY

BETTY J. BLY, Plaintiff. vs. JOHN C. RHOADS, M.D., Defendant.	LAW NO. 5862

NOTICE OF APPEAL

TO : JOHN C. RHOADS, M.D., Defendant,
% Norman F. Slenker, Esq.,
Attorney for defendant,
1012 North Utah Street,
Arlington, Virginia 22201

NOTICE IS HEREBY GIVEN, this 12th day of August, 1974, that the plaintiff, Betty J. Bly, by counsel of record, hereby appeals to the Supreme Court of Virginia, from the Judgment Order of the trial Court entered herein on July 13, 1974 granting the defendant' motion to strike the evidence and entering summary judgment for the defendant herein.

Earl H. Davis

Earl H. Davis,
Of counsel for plaintiff,
810-18th Street, N.W.
Washington, D.C. 20006
347-9121
or
5914 Westchester Street,
Alexandria, Virginia, 22310
971-6169

ASSIGNMENTS OF ERROR

1. The trial Court erred in withdrawing the issue of negligence from the jury by granting defendant's motion to strike and in enter ing summary judgment for defendant.

2. The trial Court erred in withdrawing the issue of informed conse from the jury by granting defendant's motion to strike and in enter ing summary judgment for defendant.

3. The trial Court erred in restricting the evidence on the standa of care and in restricting and excluding the testimony of Dr. Louis Gerstley that the defendant violated the minimum standards of any specialist in gynecology.

4. The trial Court erred in restricting and in refusing to admit testimony concerning the medical/hospital staff by-laws and accreditation rules which the defendant had agreed to adhere to for the benefit of the patient.

5. The trial Court erred in the conduct of the trial by its rulings on the evidence, so that the cumulative effect was to preclude the plaintiff from presenting the appropriate relevant credible evidence necessary for a fair trial.

6. The trial Court erred in restricting and excluding the admission of the defendant's prior statements made in his pre-trial deposition which were inconsistent with his trial testimony.

7. The trial Court erred in prohibiting the plaintiff from examining the defendant on the plaintiff's course while in the hospital.

8. The trial Court erred in denying the admission into evidence of the deposition of Dr. Marshall Bagley and in refusing to permit the plaintiff to prove that the defendant, the real party in interes had prior knowledge of the witness' departure from the State, and encouraged and acquiesced in said departure.

9. The trial Court erred in refusing to permit Steven Blood, D.O., to testify as to his care of the plaintiff and its causal relationship to the culpable care of the defendant.

10. The Court erred in failing to grant a blanket order (motion in limine) to block any reference to the Richmond Screening panel's hearing.

STATEMENT RE TRANSCRIPT OF EVIDENCE AND PROCEEDINGS

Plaintiff-appellant states, pursuant to Rule 5:6 of the Rules of the Supreme Court, that the official court-reporter's transcript of the evidence and proceedings in this case, as reported by Deo Reporting, in three (3) seperate volumes, covering the dates June 26 27 and 28, 1974, is being filed simultaneously with the Notice of Appeal and Assignments of Error, with the Clerk of the trial Court.

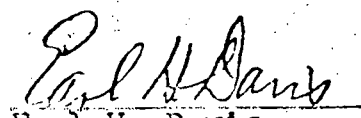
Earl H. Davis

Earl H. Davis,
Of counsel for plaintiff.

ADDITIONAL DESIGNATION OF RECORD

Mr. Clerk :

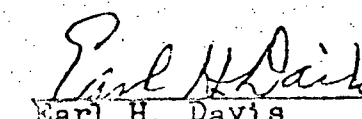
In addition to the official papers designated by Rule 5:8 of the Rules of the Supreme Court, you are instructed to file as part of the Record on Appeal herein, the pre-trial deposition of the defendant, Dr. John C. Rhoads and the deposition of Dr. Marshall Bagley, together with any and all exhibits (whether admitted or rejected).



Earl H. Davis,
Of counsel for plaintiff.

CERTIFICATE OF SERVICE

I hereby certify, this 12th day of August, 1974, that copy of the foregoing and attached Notice of Appeal, Assignments of Error, and Additional Designation of Record, was mailed, this 12th day of August, 1974, by first class mail, postage prepaid, to Norman F. Slenker, Esq., attorney for defendant, 1012 North Utah Street, Arlington, Virginia 22201.



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810-18th Street, N.W.
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or
5914 Westchester Street,
Alexandria, Va. 22310
971-6169

1 predicated my decision to operate on Mrs. Bly and what I
2 did to Mrs. Bly, I believe.
3 BY MR. DIXON:
4 Q Wait a minute.
5 THE COURT: Let's have the Reporter repeat the
6 question.
7 (Thereupon, the Reporter read the question back
8 in open Court.)
9 "Question. Doctor, did you intend to suggest to
10 Mrs. Bly that if the exploration revealed there were no
11 abnormalities in the uterus then you would not remove it?"
12 THE WITNESS: When I talked to her I stated
13 that she had this mass in her abdomen,and the fact she had
14 had previous pelvic pain for a number of years, and the
15 fact that following her discharge from the hospital in
16 September, my diagnosis that was made was that she could
17 have had either pelvic inflammatory disease or
18 endometriosis. Now, these two conditions on occasion
19 predicate that if you remove the tubal ovary you also
20 remove the uterus if there is pathology present in the
21 abdomen.
22 So I told her that there was a possibility,
23 depending on the extent of her disease process, that

DEO REPORTING
931-3434

1 possibly a hysterectomy would have to be carried out at
2 that time.
3 BY MR. DIXON:
4 Q Okay.
5 Let me make sure that I clarify one thing,
6 Doctor. Did you specifically tell her that you intended
7 to remove a normal uterus if she had pelvic inflammatory
8 disease?
9 A I -- I told her that if the extent of the
10 disease was such that it involved the uterus and the
11 tubes and ovaries that a hysterectomy would be carried out.
12 Q Incidentally, Doctor, is there a medical treatment,
13 as opposed to a surgical treatment, for pelvic
14 inflammatory disease?
15 MR. SLENKER: Your Honor, I am going to make an
16 objection to this question because there isn't any theory
17 of recovery advanced by the plaintiff in this case based
18 upon alternative treatments. The two grounds upon which
19 the plaintiff complains are set forth in the motion for
20 judgment. It says nothing about alternative treatments.
21 In other words, there is no claim here that he went the
22 wrong way in treating it. That's not an issue in the case,
23 as revealed by the pleadings. So I think it's immaterial.

DEO REPORTING
931.3434

MR. DIXON: Your Honor, there is an issue of whether she was ever given a proper choice. That is an informed consent issue.

THE COURT: I will overrule your objection, Mr. Slenker.

MR. SLENKER: May I have an exception?

THE COURT: Yes, sir.

BY MR. DIXON:

Q Is there a medical treatment as opposed to a surgical treatment for pelvic inflammatory disease?

A Yes. There are medical and surgical treatments for that disease.

Q Did you attempt any of those treatments with this patient?

A The attempts at conservative management had been previously tried.

Q Now, let me be more specific. Did you recognize treatment with antibiotics as a treatment for pelvic inflammatory disease?

A Yes. That is a modality of treatment for pelvic inflammatory disease.

Q Did you ever attempt to treat Mrs. Bly with antibiotics?

DEC REPORTING
931-3434

1 A No. At that time I felt that Mrs. Bly didn't need
2 antibiotics.
3 Q Did you ever offer her that choice?
4 A I felt that Mrs. Bly had already been treated
5 this way with antibiotics in the service and by other
6 physicians with no appreciable benefit.
7 Q Do you know what antibiotics she received?
8 A She had antibiotics by service doctors.
9 Q Do you know specifically what antibiotics were
10 attempted?
11 A There were some broad spectrum antibiotics. I
12 don't know the specific names, but they had been given to
13 her.
14 Q Do you specifically know which antibiotics she
15 received?
16 A I believe she received broad spectrum antibiotics.
17 Q Doctor, do you know the names of the antibiotics
18 which she received?
19 A I do not. I can refer to them in the record if
20 you care for me to do that.
21 Q Doctor, would you please tell us briefly which
22 antibiotics she received?
23 A She received Achromycin on August 26, 1968. She

1 took -- there was a reference in June of 1968 that she had
2 taken antibiotics with relief of her symptoms. However,
3 the antibiotics were given for a furuncle at that time. So the
4 pelvic symptoms subsided.
5 Q So the antibiotics were successful in treating
6 her pain?
7 A In 1968 she had antibiotics again which offered
8 her temporary relief from her symptoms. But at that time
9 she didn't have masses present. She didn't have tumor
10 present at that time. So she had had previous courses of
11 conservative therapy with antibiotics.
12 Q Incidentally, there are a number of bacteria
13 which are sensitive to one antibiotic and not sensitive to
14 another; isn't that right?
15 A That is true.
16 Q Often you have to try more than one type of
17 antibiotic in order to find an antibiotic that is sensitive
18 to the organism that you are attempting to treat.
19 A That is true.
20 Q Doctor, is there a medical treatment, as opposed
21 to a surgical treatment, for endometriosis?
22 A Yes, there is.
23 Q Did you ever attempt that with Mrs. Bly?

A No, because of the same reasons.

Q Now, Doctor, calling your attention to your preparation of Mrs. Bly for surgery, you did offer her a book which described a hysterectomy; did you not?

A That is correct.

Q Did you ever tell Mrs. Bly about the complications?

THE COURT: Is there any objection to the introduction of this book?

MR. SLENKER: None whatsoever.

THE COURT: All right. Let's have it marked as 6 and received in evidence as 6 at this time.

(A booklet was marked as Plaintiff's Exhibit #6, for identification, and was received into evidence as Plaintiff's Exhibit #6.)

BY MR. DIXON:

Q Doctor, I show you Plaintiff's Exhibit 6 and ask you if that is a copy of the booklet of the type which you gave Mrs. Bly?

A Yes, it is.

Q Okay.

Doctor, other than the material which you found in that book to discuss with Mrs. Bly, did you ever tell Mrs. Bly about the other risks or possible complications

1 from a hysterectomy?

2 A Yes, I did.

3 Q Did you specifically tell Mrs. Bly of the risk

4 that a ureter could be obstructed during the surgery?

5 A I told Mrs. Bly that there could be injury to

6 other organs at the time of her surgery. In addition, I

7 also told her that there could be other complications with

8 regards to her surgery.

9 Q Doctor, I call your attention to your deposition

10 at page 51. At that time the question was asked you,

11 "Okay. Now you have told me that a few minutes ago that

12 you thought you had told her the nature of the operation

13 and so forth. I'd like now to have you just tell me

14 everything that you told her and the same detail that you

15 told her."

16 Wasn't your answer as follows? "I told her that

17 we would do an exploratory operation,and that probably we

18 would remove her uterus, and her left tube and ovary, and

19 this would entail an abdominal operation. And if we took

20 her uterus out she wouldn't have any more children and she

21 wouldn't have any more periods. And we might possibly

22 have --- there was a possibility here, I think, that we

23 might have to take her other ovary out. But I wasn't sure

DEO REPORTING
931-3434

1 of that until we got in there.

2 "But I told her what would happen if she had her

3 womb taken out, and what would happen if the left tube and

4 ovary were taken out, and I gave her that pamphlet that she

5 could read over so that she would understand the situation

6 and the operation."

7 That was your answer so far, was it not, Doctor?

8 Weren't you asked, "Did you tell her anything else at that

9 time that you haven't now told me? Answer. I don't

10 believe so."

11 Was that your answer at that time?

12 A That is what you have there. But that could be

13 misconstrued the way that is stated. But I had -- I had

14 talked to Mrs. Bly on several occasions as to what her

15 operation would be and the complications that could arise

16 from her surgery.

17 Q Did you specifically mention damage to the uterus,

18 sir?

19 A To the uterus?

20 Q Excuse me, to the ureter.

21 A No, I didn't mention that specifically.

22 Q Did you specifically tell Mrs. Bly then there

23 was a risk of up to one to two percent of obstructing a

DEO REPORTING
931.3434

ureter during this form of surgery?

A No, I did not.

Q But this form of surgery does have a risk of up to that percentage rate, does it not?

A Yes, it does.

Q You did tell Mrs. Bly that if her ureter was obstructed that she may have to carry a nephrostomy tube around draining urine out of her side for three months, did you?

A I did not.

Q You didn't tell her it would entail additional time off from work and additional medical losses from that procedure?

A I did not.

Q Now, Mrs. Bly was admitted to the hospital in October on what, the 27th, sir?

A September 27. September 27 -- or no, it was October 27.

Q She came in on the evening before surgery and was operated on the next day; is that right?

A Yes.

Q You reviewed the operative consent form and that said exploratory laparotomy with the word either probable or possible hysterectomy; is that right?

DEO REPORTING
931.3434

A Yes.

Q Her signing that consent form was based on the things that you have already described that you told her?

A Yes.

MR. DIXON: Your Honor, I wonder if I might approach the bench for just a moment with counsel?

(Thereupon, the following proceedings were had at the bench by Court and counsel out of the hearing of the Jury:)

MR. DIXON: Your Honor, I can see that at the rate I am going I am not going to be able to complete the examination of Dr. Rhoads that I had intended to, and I would like the Court's permission to complete a sufficient amount of examination with Dr. Rhoads to where I am satisfied that I have a foundation for calling Dr. Blood, with the right to recall Dr. Rhoads thereafter in order to complete my examination.

I appreciate the situation that what we are doing is breaking up his testimony. We are in a time bind. Dr. Blood is leaving town tonight. I do want to give him an opportunity to testify before he leaves.

MR. SLENKER: I make objection to it, if Your Honor please. All of a sudden we are in a time bind. But

DEO REPORTING
931-3434

1 MR. SLENKER: May I have an exception?

2 THE COURT: All right.

3 BY MR. DIXON:

4 Q Doctor, were you the only operating surgeon in

5 the operating room when you operated on Mrs. Bly?

6 A Yes.

7 Q You didn't have a doctor as an assistant?

8 A No. I had a nurse as an assistant.

9 Q Is a doctor ordinarily more skilled in assisting

10 a physician during the operation because a physician has

11 had more experience and background in surgical procedure?

12 A It depends on the nurse and it depends on the

13 doctor.

14 Q As a usual matter, the doctor has more skill,

15 does he not?

16 A Usually, yes.

17 Q When you operated on Mrs. Bly you performed your

18 exploration by looking into the pelvic cavity; is that

19 right?

20 A That is right.

21 Q You did that to start with?

22 A Yes.

23 Q When you looked into the pelvic cavity, the

DEO REPORTING
931-3434

1 pelvic organs, you found a cyst in the left adnexa; is
2 that right?
3 A That is right.
4 Q This is in the adnexa?
5 A This was in the ovary. It's an ovarian cyst.
6 Q Originally, you thought it was an endometrium,
7 did you not?
8 A I thought by looking at this there was a
9 possibility that could be it.
10 Q The right adnexa was normal?
11 A The right adnexa appeared better off than the
12 left one.
13 Q Did you state the right adnexa was normal?
14 A I believe in my operative report it was normal.
15 Q You stated in your operative report the uterus
16 was normal?
17 A The uterus appeared normal, yes.
18 Q You stated immediately thereafter in your
19 operative report, did you not, that "because of the
20 patient's continued pain and discomfort, we decided that
21 a total hysterectomy and a left salpingo-oophorectomy
22 should be carried out"?
23 A That is correct.

Q Then you proceeded to remove the uterus, the left tube, the left ovary, and the left broad ligament; is that correct?

A Removed the left tube, and ovary, and the uterus, yes.

Q Did you not remove the left broad ligament?

A Well, the tube and ovary are located in the left broad ligament.

Q They are attached to the left broad ligament, are they not?

A That is correct.

Q In this particular case, the enlargement that you had found in the adnexa prior to the surgery was this mass which later turned out to be an ovarian cyst; is that right?

A Well, it turned out to be an ovarian cyst, plus an enlarged adherent ovary to the posterior portion of the uterus.

Q Didn't you state in your operative report that the matter was attached to the left adnexa?

A The mass was in the left adnexa; that's right.

Q This tissue that was removed was sent to the laboratory for a pathologist examination, was it not?

DEO REPORTING
931-3434

A That's correct.

Q The uterus was 75 grams?

A I don't remember what it weighed.

Q Seventy-five grams is the normal weight, is it not?

A I'm not sure. I'd have to check on that. I'm not sure about the normal weight of it.

Q When you observed the uterus in there did it appear to be of normal size?

A The uterus appeared to be normal, but there was an adherent left adnexa to the uterus.

Q Did the uterus appear to be of normal size?

A It appeared to be of normal size, yes.

Q The adnexa consists of the material lateral to the uterus, does it not?

A Yes.

The adnexa is the tube in the ovary.

Q The pathologist's report indicated that the interior of the uterus was normal, did it not?

A Yes.

Q The pathologist's report also indicated that there were some thin delicate fibrous adhesions in the upper part of the body of the posterior aspect of the

uterus, did it not?

MR. SLENKER: Where are you reading from?

THE WITNESS: I have it right here.

BY MR. DIXON:

Q Do you have a copy of the pathologist's report, Doctor?

A I may have it in here. I'm not sure.

Yes. Left tube and ovary are attached, are adherent to the posterior aspect of the body of the uterus by broad thin fibrous adhesions.

Q Thin adhesions can be dissected apart, can they not?

A Yes.

Q It would be possible for you to remove the left tube and ovary and leave the uterus intact, could you not?

MR. SLENKER: I object to what is possible, if Your Honor please. I think anything is possible.

THE COURT: Objection sustained.

BY MR. DIXON:

Q Doctor, weren't you technically capable of dissecting through those thin fibrous adhesions and removing this left tube and ovary?

A Yes.

DEO REPORTING
931-3434

1 A She didn't have an obstetrical problem at
2 that time.
3 Q She was post-operative from the surgery you
4 performed, wasn't she?
5 A Yes. I remained interested in Mrs. Bly
6 throughout that hospital stay.
7 Q You continued to see her on a daily basis, didn't
8 you?
9 A I saw her not on a daily basis after Dr. Bagley
10 took over, but I went to see her maybe every other day I
11 would say.
12 Q That was necessary because of the surgery that
13 she had which you performed, was it not?
14 A Yes. I think by the seventh or eighth day most
15 of the surgery that I had performed on her was fairly
16 well healed up, so Dr. Bagley took over after that.
17 Q Incidently, did you ever have any knowledge
18 prior to Mrs. Bly's case of how much time would be lost
19 from work or how much medical expense would be involved if
20 a ureter was blocked in a patient?
21 A That crossed my mind, yes. The economics is
22 always a part of our profession, too, you know.
23 Q Part of those economics involved the cost of the

DEO REPORTING
931-3434

hospitalization and the medical care that would be necessary if such a complication occurred, would it not?

A Yes.

Q When you called Dr.Bagley in you recommended him as being a competent physician to Mrs. Bly, did you not?

A Yes, I did.

Q Were you familiar with the practices and charges of Dr. Bagley?

A No. I didn't -- I didn't go into those in any detail. I called him in because he is a very competent urologist.

Q Did you ever have occasion to determine how much the doctor's expenses were from Dr. Bagley's treatment?

A No, I didn't.

Q Are you familiar with what the usual and customary charges of urologists are?

A To a certain degree I am, yes.

Q Is an office call of $10.00 a reasonable charge?

MR. SLENKER: Objection, if Your Honor please. I don't think this is the appropriate way to get the

DEO REPORTING
931-3434

1 witness --

2 THE COURT: (Interposing) I will sustain the

3 objection.

4 MR. DIXON: Okay.

5 BY MR. DIXON:

6 Q Doctor, did you have familiarity in 1970 with

7 the obstetrical care and gynecological care in the D. C.

8 area so as to state whether it was a medical community

9 similar to Prince William County insofar as the standards

10 of obstetrical and gynecological care are concerned?

11 A Would you state that again, please?

12 (Thereupon, the Reporter read the preceding

13 question in open court.)

14 THE WITNESS: Yes.

15 BY MR. DIXON:

16 Q Did you find that the obstetrical and gynecologi-

17 cal care of the medical community of the District of

18 Columbia was similar to that of Prince William County?

19 MR. SLENKER: I object, if Your Honor please.

20 The test is what is it here.

21 THE COURT: I think he can testify as to

22 whether or not he found that it was similar to that. Then

23 he may answer his question as to whether or not that is

DEO REPORTING
931-3434

1 It says the impression down at the bottom is
2 infertility, is it not?
3 A Yes.
4 Q Secondary to dysmenorrhea?
5 A Right.
6 Q Then below that is the course of treatment
7 suggested or undertaken by the military physicians, is it
8 not?
9 A Right.
10 Q What are those?
11 A Edrisal. He gave her Edrisal, which is a pain
12 medicine, pain medication, for three months.
13 Q And he also put her on an infertility routine,
14 did he not?
15 A Yes.
16 Q All right, sir.
17 Now, then, the next entries in her hospital
18 record that she brought to you are on the 12th of April,
19 '68 and the 26th of April, 1968, I believe.
20 A Twenty-fifth.
21 Q Sir?
22 A It was the 25th of April.
23 Q Was the 25th of April of '68?

DEO REPORTING
931 3434

A Yes.

Q All right.

Those visits had reference to a furuncle, is it?

A Yes.

Q What is a furuncle?

A It's a boil on the right arm.

Q Is it a form of infection?

A It's a form of infection, that's right.

Q All right.

Where does the infection come from that causes those boils, if we know?

A It usually comes from skin bacteria.

Q Did she receive any antibiotics at the time for the furuncle?

A The first visit she received just compresses and ointment to place on it. And then she was seen again on the 25th of April. And it was incised and drained at that time. And she was given Bacitracin ointment again for the furuncle.

Q Is that medication any kind of an antibiotic?

A It's a local antibiotic.

Q All right.

A In ointment form.

DEO REPORTING
931 3434

Q All right, sir.

Did she then return on the 29th of April, 1968, concerning this furuncle, and, if so, was she then given antibiotics for it?

A Where was that?

Q April 29, 1968. It looks like this (indicating). It should follow right after April 25.

A Oh, here we are.

Q That's it.

A Twenty-nine. The furuncle was draining a small amount. The drain was removed and the patient was developing another one on the left face and lower lip. So a culture was obtained. And she was placed on antibiotics, Tetracycline, 500 milligrams, four times a day,for two days, and then 250 milligrams, four times a day, for six days.

Q Will you tell the members of the Jury how did those dosages of Tetracycline line up with reference to whether it's a stiff jolt, a medium jolt, or a minor dosage?

A Well, the Tetracycline, 500 grams, four times a day, for two days, was a stiff jolt. Then he dropped it down for 60 days at 250 grams-dose a day, which is an

average dose of a drug.

Q All right, sir.

Coming on current now with reference to Mrs. Bly's background, do you see the note of June 11, 1968, from the flight surgeon's office down in Fort Belvoir at Davison Air Field?

A Yes.

Q Read that to the Jury, if you would, please.

A "Recurrent right pelvic pain which does not necessarily correspond with the time of middleschnertz. Middleschnertz means painful ovulation. That means halfway between a period a woman can have pain. This is called middleschnertz, where they ovulate.

"This pain cleared for a time when Mrs. Bly was taking antibiotics for a furuncle. She was said to have a right pelvic mass when hospitalized at Martin Army Hospital, Ft. Benning, Georgia. The patient has had this difficulty for the past three years, with increasing discomfort. Impression at this time was chronic salpingitis." At that time they planned a Gyn, gynecological consult, at that time.

Q Is chronic salpingitis an Ob-Gyn condition?

A Yes.

DEO REPORTING
931-3434

Q Tell the members of the Jury what it is and what it consists of.

A Chronic salpingitis is a chronic inflammation of the fallopian tubes resulting from -- from infection. It's where it changes the anatomy of the tube and they become chronically infected.

Q All right, sir.

Then you see the note of June 19, 1968, where she is evaluated by the gynecological clinic at Fort Belvoir at DeWitt Army Hospital?

A Yes.

Q Read that, please.

A "Twenty-eight year old with a three-year history of recurrent pelvic pain not related to the middle of the month. Dyspareunia" means painful intercourse occurs when she has the pain. "Hospitalized at Fort Bennings with the diagnosis of twisted ovarian cyst. Patient had relief of pain for a time, taking antibiotics for a furuncle. Please evaluate and treat. Provisional diagnosis was right chronic salpingitis."

And the note is a "twenty-eight year old with a history of pelvic pain right lower quadrant is outlined. Pelvic examination: the cervix was clean. Pap was taken.

DEO REPORTING
931-3434

Uterus was second degree retroverted."

Q What does that mean?

A It means it was tilted back. In other words, when it is retroverted the uterus tilts back toward the rectum. It ordinarily is up front toward the abdomen.

Q If it does that is it a normal uterus?

A It can be normal or abnormal.

Q What do you look for in order to determine whether that movement indicates an abnormality or whether it is a normal movement?

A Well, if it's painful to the patient it could be abnormal in its position.

Q All right.

Will you continue on with that note?

A "Normal size and shape. Adnexa, moderate tenderness. The right adnexa, no palpable induration. History and pelvic findings are not completely typical of PID."

Q What is PID?

A Pelvic inflammatory disease which means infection of the tubes and ovaries.

Q All right.

A "Trial antibiotics therapy. Would consider

DEO REPORTING
931-3434

culdoscopy if problem not resolved. Return to the office. Return in two months."

Q All right, sir.

Now, then, on the 25th of August, 1968, she is again at the emergency room, is she not?

A Yes.

Q With a temperature of 100.4 degrees?

A That is correct.

Q Then, on August 26, 1968, she is again at the Gyn clinic, at DeWitt, the gynecologic clinic, at DeWitt, is she not?

A That is correct.

Q On that occasion then they issued their findings, did they not, after receiving a consultation request? My copy has the month off. But it's the 26th of 1968, showing a last menstrual period of 16 August, 1968. Do you have that note?

A Yes.

Q All right.

Would you read that to the members of the Jury?

A "The right ovary is easily palpable today. Approximately four to six centimeters. Tender with cystic consistency. Previous exam it could not be

DEO REPORTING
931-3434

1 outlined. But tenderness is two plus. Trial of
2 Achromycin two tablets four times a day and then one
3 every day because of good response. If recurrent,
4 surgery would appear justified."
5 Q All right, sir.
6 Can you tell the members of the Jury what is
7 cystic consistency? What is the meaning of that within
8 your specialty, sir?
9 A Well, he examined the adnexa and found it to be
10 cystic. That means it is sort of soft. It's like --
11 you can push in on it and it will respond back. It had
12 what we call a cystic feel to it. This is typical of
13 either fluid somewhere. It's fluid in an ovary or
14 probably fluid in a tube. It could represent either one.
15 Q All right.
16 Dr. Rhoads, is that the last of the military
17 records that you have that were brought to you by
18 Mrs. Bly?
19 A Yes.
20 Q Now, then, she first came to your office on
21 the 25th of April of 1970, did she not?
22 A Yes.
23 Q Did she show you or give you any records at all

DEO REPORTING
931-3434

from any military installation or from any physician,any hospital at all, from the period in 1968 up until April of 1970 when she came into your office?

A None that I have a record of.

Q She didn't bring you any of those?

A She brought me these -- just these records that we went over.

Q I know. But those are the only ones she brought you?

A Yes.

Q They bring us up to August of '68?

A Yes.

Q But between August of '68 and April of '70, there were no records brought to you?

A No.

Q All right, sir.

Now, then, will you read to the members of the Jury your handwritten note on the 25th of April, 1970, beginning on the line where that date appears?

MR. OLENDER: I object, Your Honor. I don't think this is proper cross or redirect. These documents are in evidence and speak for themselves. Counsel is aware we have the problem of Dr. Blood who is leaving.

DEO REPORTING
931-3434

THE COURT: Well, I understand that. But I think he has a right to do this. I will overrule your objection.

I might state that under our rules, one particular attorney who handles this and starts with a witness has to handle the witness. You can't have all three. So we will abide by the rules then.

MR. OLENDER: I'm sorry.

THE COURT: That's all right.

BY MR. SLENKER:

Q Go ahead, sir.

A "Chief complaint was discomfort. History of the present illness: the patient has been having pain off and on for eight years in the lower abdomen. It is constant. Her menses are two to five days and every 28 to 30 days. No cramps. Her previous menstrual period was the month before. Her pain is aggravated with movement and aggravated with bowel movements. She has had no loose bowel movements and no blood in her stools.

"The patient was placed on Valium and Darvon Compound 65 by her local medical doctor. Patient was on pills for infection. And she had been off of pills for infection for approximately two weeks. She had had

DEO REPORTING
931-3434

1 painful intercourse for years and does not reach a
2 climax."
3 Q Now, did she at that time indicate the type of
4 infection that she had been receiving the medication for
5 and from whom?
6 A It didn't mention it at that time.
7 Q Do your records reflect how she happened to get
8 to your office in the first place?
9 A She was referred to my office by Dr. Ringler.
10 Q What type of a doctor is Dr. Ringler?
11 A Dr. Ringler is a general practitioner, in
12 Manassas.
13 Q Do you know him?
14 A Yes, I do.
15 Q All right.
16 I believe you read that she was on Valium;
17 Darvon Compound 65 also?
18 A Yes.
19 Q Did she indicate who had prescribed that for her?
20 A She didn't indicate, but I assume it was
21 probably Dr. Ringler.
22 Q All right.
23 Now, have you read us all of the notes from the

1 original part that is in your handwriting?

2 A No. There is more.

3 Q Would you continue on reading it?

4 A "She had a D. and C. eight years ago for heavy

5 menstrual flow. She had chronic pelvic inflammatory

6 disease by doctors. Review of system: she has an

7 itching discharge with an odor to it."

8 Q Where would the discharge be?

9 A It was an itchy vaginal discharge.

10 Q All right, sir.

11 Continue.

12 A "It had an odor to it.

13 "Family history: Eleven years of marriage. And

14 her husband is a test pilot."

15 That's the written part.

16 Q All right.

17 Thereafter, is there a typewritten part?

18 A Yes.

19 Q Will you read that to the members of the Jury?

20 A "Physicial examination: Breasts are normal.

21 Heart and lungs are clear. The abdomen was flat. The

22 liver, spleen and kidneys were not palpated. She has a

23 monilial vaginitis. The uterus was second degree

DEO REPORTING
931-3434

retroverted." It means it was tipped backwards with what we call a first degree descensus. It means the uterus is also dropped down in the vagina somewhat. "It was normal in size. The adnexal structures palpated normally."

"Impression at this time: Psychosomatic disease on the basis of poor family situations. She was given Serax for nervousness, and Mycostatin vaginal suppository which is for a fungus infection of the vagina, and Vioform-Hydrocortisone cream which is also an antifundicidal cream for itching. I told her she needs marital counseling as she has a very unstable situation as well as a financial situation. The patient is under a most emotional circumstance and is in a chronic anxiety state."

Q Is that all of your notes for the first visit in April of 1970?

A Yes.

Q When she left on that occasion can you tell the members of the Jury if you wanted to see her again, and if you did, when?

A I usually tell them if they are treated for a vaginal infection to come back in three weeks for a

DEO REPORTING
931-3434

Q Is a D. and C. considered a surgical procedure?

A Yes.

Q Why so?

A Because the patient is placed under anesthesia and the uterus is then invaded with an instrument called a curette.

Q Does that require authorization from the patient?

A Yes.

Q I show you this page from Plaintiff's Exhibit 1-A that has been admitted into evidence and ask you if that is a copy of the permit given by Mrs. Bly to you authorizing the D. and C.?

(Handing document to witness.)

THE WITNESS: Yes.

BY MR. SLENKER:

Q Do you remember or can you tell the members of the Jury, Dr. Rhoads, approximately how long that particular form has been used with reference to authorizing operations in this area?

MR. DIXON: Your Honor, I object to that. That is immaterial.

THE COURT: What would be the materiality of that?

MR. SLENKER: I think that shows that this type of a permit is one that is in general use around here and has been for several years, if Your Honor please, which shows that permit in that particular form to be the standard of care that prevails in this area.

THE COURT: Does the permit spell out the standard of care? In other words, it's permission signed by her for the operation, is it not?

MR. SLENKER: Yes.

BY MR. SLENKER:

Q All right.

Will you read that permit to the members of the Jury?

A "I, the undersigned, a patient in Prince William Hospital, hereby authorized" --

MR. DIXON: (Interposing) Just a moment, Your Honor. I object to this question. I think the permit will stand for itself. In the interest of time I think it is appropriate for the Jury to read it.

THE COURT: Mr. Slenker, I guess we are going to be here till midnight.

MR. SLENKER: I don't have any other way I can do it. I am trying to accommodate Mr. Dixon.

THE COURT: Is it necessary to read the permit?

MR. SLENKER: Yes, it is, because he is apparently going to bring in the doctor and ask him to assume this, that and the other, and ask the Jury whether or not to support the assumption he will have asked a witness to make. He will have not have had an opportunity to go over these documents at all.

THE COURT: All right. I will overrule the objection.

MR. DIXON: May my exception be noted?

THE COURT: Sure.

THE WITNESS: "I, the undersigned, a patient in Prince William Hospital, hereby authorize Dr. Rhoads and whomever he may designate as his assistant, to administer such treatment as is necessary, and to perform the following operation: D. and C. examination under anesthesia, and a possible laparotomy, and such additional operations or procedures as are considered therapeutically indicated on the basis of the findings during the course of said operation. I also consent to the administration of such anesthetics as are necessary. Any tissue or part surgically removed may be disposed of by the hospital in accordance with the accustomed practice. I also certify

DEO REPORTING
931-3434

that no guarantee or assurance has been made to the results that may be obtained thereby. Authorization must be signed by the patient, or in the case of a minor, or when the patient is physically or mentally incompetent, may be signed by the nearest relative."

BY MR. SLENKER:

Q Now, after the D. and C. was accomplished, was that the time at which there was first a mention of a hysterectomy and a possible need for the extraction of tubes and ovaries with Mrs. Bly?

A Yes.

Q Now, counsel asked you if one to two percent of the cases get obstruction of ureters. That's obstructions from no matter what the causes are. Is that not correct?

A I would imagine.

Q All right.

Are there other risks with reference to this type of surgery, a hysterectomy with the removal of a tube and an ovary?

A Yes.

Q What are some of those?

A There are other risks involved with any

DEO REPORTING
931-3434

1 operation with regards to pelvic structures. With a
2 hysterectomy you can postoperatively get infection which
3 can be severe. You can get hemorrhage at the time of the
4 operation that you are doing or you can get hemorrhage
5 after your operation is finished. You can get trauma to
6 other structures. You can get trauma to bowel or to
7 bladder or any structures around the surgical area. You
8 can have other complications which are more -- or
9 innumerable type complications. You can get pulmonary
10 emboli or blood clots in the lungs. You can get phlebitis
11 in your legs, cardiac arrest on the operating table. You
12 can have an allergic reaction to the anesthetic agent
13 that you get. There are all kinds of complications that
14 one can get when they are undergoing an operation.
15 Q Does the standard of medical care by which you
16 and your other Ob-Gyn specialists are governed here
17 in Prince William County call for you to tell a patient
18 of every single risk?
19 A No. I don't think it -- no. You don't --
20 MR. DIXON: (Interposing) Your Honor, I object
21 to the form of that question. I think that that is
22 immaterial. The standard is what the law requires the
23 doctor to do.

DEO REPORTING
931-3434

THE COURT: Well, I think you have asked him whether or not he advised her of the various risks or whether or not he informed her of the various risks, did you not?

MR. DIXON: Yes. My objection is his discussion about what the standard is that doctors think they should tell the patient rather than what the law says the doctor should tell the patient, and there is a very significant difference between the two.

MR. SLENKER: Your Honor, I asked him what the standard is around here with reference to why you tell them or what you tell them or what risks you tell the patients. I think that is probative.

THE COURT: I will overrule the objection.

MR. DIXON: May my exception be noted?

BY MR. SLENKER:

Q Does the standard of practice prevailing in this area dictate that you tell a patient of every single risk that is possible following surgery or in surgery?

A No. You don't tell the patient every risk.

Q Does the standard --

A (Interposing) The standard doesn't require that you say that.

DEO REPORTING
931-3434

Q Does the standard that prevails in this area have reference to those incidents that may merely be possible, or those risks that may merely be possible, or those to the extent of only one or two percent?

MR. DIXON: Your Honor, may I have a continuing objection to this line of questioning?

THE COURT: All right.

THE WITNESS: You tell the patient what you think are the most common complications. Why tell the patient what complications are rare because you might have a patient like Mrs. Bly who was anxious, upset, worried, had a bad family situation. And you tell her those things and you upset her more. So you tell her -- you tell her the common complications and you go from there.

BY MR. SLENKER:

Q Excuse me, sir. Is the risk of an obstructed ureter considered a significant risk, a nominal risk, or one that very rarely occurs?

A I think an obstructed ureter is rare.

Q How long have you been in practice here in Prince William?

A I've been in practice here eight years.

Q How long have you been out of medical school,

DEO REPORTING
931-3434

let's say?

A I've been out of medical school since '56, 1956.

Q During that period of time have you been involved in Ob-Gyn specialty type work?

A Yes.

Q How many combined obstructed ureters have you either seen or heard about in that period of time?

A I have seen --

MR. DIXON: (Interposing) Your Honor --

THE COURT: (Interposing) Just a moment, Doctor.

MR. DIXON: Your Honor, I object to that. I think that is immaterial.

MR. SLENKER: I think not, if Your Honor please, because counsel asked him about the number of percent, one to two percent of the cases. I am trying to show that so far as his experiences are concerned, out of the thousands of patients he has seen since getting out of medical school, that figure is indeed accurate, or perhaps there is less than the one to two percent.

MR. DIXON: Your Honor, I think that isn't material. I think the real question is what the overall experience is rather than what one individual doctor has

DEO REPORTING
931-3434

1 fortuitously observed or not observed.

2 THE COURT: I am going to sustain the objection,

3 Mr. Slenker.

4 MR. SLENKER: All right. Thank you, Your Honor.

5 BY MR. SLENKER:

6 Q Now, at the time that you talked with Mrs. Bly

7 about the risks of this surgical procedure, did she ask

8 you any questions at all?

9 A No. She never asked me any questions that I

10 could recall.

11 Q All right.

12 Now, counsel asked you a question about whether

13 you got a consultation before the hysterectomy. Will you

14 tell the members of the Jury if the standard of medical

15 care that prevails here in Prince William calls for you to

16 get a consultation from anybody with reference to a patient

17 prior to this type of an operation?

18 A No. We don't have to get consultations. If

19 you are Board certified you don't need a consultation to

20 do a hysterectomy.

21 Q Are you aware of any of the other Ob-Gyn

22 practitioners in Prince William here that are Board

23 certified that do get consultations prior to this type of

1 MR. DIXON: May I have an exception, Your Honor.
2 THE COURT: Surely.
3 BY MR. DIXON:
4 Q Doctor, as a condition of your admission to the
5 staff of the Prince William Hospital, did you agree to
6 adhere to any bylaws of that hospital?
7 THE COURT: Objection sustained.
8 MR. DIXON: May I have an exception.
9 THE COURT: Yes, sir.
10 BY MR. DIXON:
11 Q Doctor, calling your attention back to your
12 decision to perform a hysterectomy on Mrs. Bly, did you
13 make that decision to perform the hysterectomy prior to
14 the surgery?
15 A No. I made the decision at the time of the
16 laparotomy.
17 Q Was that decision to perform the hysterectomy
18 based upon Mrs. Bly's previous history of abdominal pain?
19 MR. SLENKER: Your Honor, I will interpose an
20 objection on the basis that there isn't any theory of
21 recovery here with reference to the need of a hysterectomy.
22 That's not a claim against Dr. Rhoads here that there should
23 not have been a hysterectomy.
MR. DIXON: Your Honor, I think that there are

DEO REPORTING
931-3434

1 two aspects of this. Number one is an issue of uninformed
2 consent with a description of the appropriate risks and
3 alternatives. The other matter goes to the fact that the
4 claimant is making a claim here for an injury to her ureter
5 which would not have occurred if the Doctor had not been
6 negligent in electing to perform a hysterectomy.
7 THE COURT: Objection sustained.
8 MR. DIXON: May I have an exception, Your Honor.
9 THE COURT: Sure.
10 BY MR. DIXON:
11 Q Doctor, in Mrs. Bly's case the performance of
12 the hysterectomy was an elective operation, was it not?
13 A An elective operation, yes.
14 Q This meant that she had no serious disease that
15 required her to have her uterus out; isn't that right?
16 A No. That doesn't mean that.
17 Q Doesn't an elective operation mean that this
18 operation did not have to be performed at the time it was
19 performed?
20 A It didn't have to be performed. It was placed
21 on the schedule because she was having previous problems
22 and she was placed on the operative schedule. There was
23 no emergency about the procedure.

DPC REPORTING
931 3434

Q This procedure could have been performed at some time later rather than at the time it was performed, could it not?

A I think Mrs. Bly was just as anxious to get it all over with at the time I scheduled it.

Q Was this based on your representations to her that she needed the hysterectomy in order to have relief from her discomfort?

A It was based upon her previous history of having had repeated pelvic pain over a long period of time. And I think that she was at the end of the rope as far as her pain goes.

Q Doctor, was this based on your representations to her that this was what she needed?

MR. SLENKER: I object, if Your Honor please. I think it calls for an evaluation of what thoughts she had, what reliance she had. There is no way he would know what her thought processes were.

MR. DIXON: Well, Your Honor, I think the Doctor has a duty to determine what his patient's thought processes are on an elective procedure.

THE COURT: I don't think he can read a mind.

DEO REPORTING
931-3434

1 MR. DIXON: I will withdraw the question. Let me
2 explore that further.
3 BY MR. DIXON:
4 Q Doctor, is it standard practice for a doctor in
5 your specialty who is about to perform a hysterectomy to
6 determine what the wishes of the patient with respect to
7 childbearing happen to be?
8 A Well, yes.
9 Q When one is considering performing a hysterectomy
10 such as this where the indication is for pain, is it standard
11 practice for the doctor to determine how serious the pain is
12 in order to evaluate how strongly she feels about having
13 a hysterectomy?
14 A I think it's important to tell her what the pain
15 is due to and also to determine whether she wants any more
16 children or not. I think that is standard procedure.
17 Q As a matter of fact, you can't read her mind and
18 determine what she is thinking about how serious the pain
19 is, can you?
20 A You can't read her mind, no.
21 Q She's the only one that knows how serious or how
22 debilitating her pain is, isn't she?
23

DEO REPORTING
931.3434

1 A Yes.

2 Q So, when you propose an elective operation for
3 a patient such as this, isn't it customary practice to
4 explain to her what the probable causes of the pain and
5 debilitation are and to explain to the patient what the
6 alternatives are with respect to treatment?

7 A Yes.

8 Q Among these alternatives, with respect to treat-
9 ment, isn't it customary to explain to the patient the
10 significant risks and complications of the surgery so the
11 patient can decide for herself whether those risks and
12 complications are worth the price to have relief from the
13 original complaint?

14 A Yes.

15 Q In the case of a hysterectomy, is it appropriate
16 to explain to the patient the options available for
17 nonsurgical treatment as a part of explaining the risks
18 and proposed advantages of the hysterectomy procedure?

19 A Yes.

20

21 Q Now, in Mrs. Bly's case, did you propose any
alternative therapy to her?

22 A Mrs. Bly had already been through alternative
23 therapy, from the previous history.

DEO REPORTING
931-3434

1 Q Okay. You reviewed that previous history and
2 relied upon that in forming your impression and
3 recommendation for operating on her, did you not?
4 A Yes.
5 MR. SLENKER: If Your Honor please, haven't we
6 been all through this before?
7 THE COURT: Yes. I thought we had.
8 MR. DIXON: Your Honor, we have not been through
9 these various factors which Dr. Rhoads weighed with respect
10 to performing the hysterectomy. This was brought out under
11 Mr. Slenker's examination. I did not go into that at all.
12 This is my first opportunity to ask the Doctor about this
13 previous history.
14 MR. SLENKER: Your Honor, I have, on the very first
15 page, when he started examining Dr. Rhoads yesterday alternative
16 methods of treatment and they were previously tried, which
17 is the same answer that Dr. Rhoads has given now.
18 THE COURT: Mr. Slenker, my notes don't reflect
19 that. I am going to overrule your objection at this time.
20 It was already covered pretty well, I believe.
21 MR. DIXON: Your Honor, I am going to try and
22 expedite this matter.
23

DEO REPORTING
931 3434

1 Q Okay. Now, calling your attention to the year of
2 1966, is there anything in that medical record, or do you
3 have knowledge of anything that indicates that Mrs. Bly
4 had chronic abdominal pain which would indicate a
5 hysterectomy?
6 A In '66?
7 Q Yes.
8 A No. That's the first note. No, I do not.
9 Q Now, in 1967, Mrs. Bly was seen on March 28; isn't
10 that correct?
11 A March 28, yes.
12 Q She was seen for acne; isn't that correct?
13 A That's right.
14 Q That wasn't a female problem. Acne wasn't a
15 female problem that caused abdominal pain to justify
16 hysterectomy, was it?
17 A It was -- acne is a facial lesion.
18 Q Okay. And in August of 1967, Mrs. Bly was also
19 seen, was she not?
20 A Yes.
21 Q I believe that you testified that at that point
22 she received Penicillin; is that correct?
23 A That's correct.

DEO REPORTING
931-3434

Q You described Penicillin as being possibly a broad-spectrum antibiotic?

A Certain synthetic Penicillins are broad-spectrum.

Q But the Penicillin Mrs. Bly got wasn't necessarily one of those broad-spectrum antibiotics, was it?

A I don't know.

Q As a matter of fact, ordinarily, when PEN is written as PEN, that usually refers to Penicillin G or VK, does it not?

A It may be.

Q Those are not the broad-spectrum Penicillins, are they?

A No.

Q As a matter of fact, when Mrs. Bly received that Penicillin, it was not for a female problem, was it?

A No.

Q It was for Tonsillitis, was it not?

A That is correct.

Q Mrs. Bly was subsequently seen in September for the same problem, was she not?

A Yes.

Q Tonsillitis.

DEO REPORTING
931-3434

1 Doctor, my next record indicates that she was
2 seen on the 11th of October, 1967; is that right?
3 A Um-hum.
4 THE COURT: I have 14.
5 MR. DIXON: I am trying to reconcile the notations
6 that I have from the testimony and the medical record, Your
7 Honor. I find that there is some conflict. I'd like to
8 resolve that.
9 BY MR. DIXON:
10 Q Doctor, briefly, wasn't Mrs. Bly seen in 1967 on
11 the 14th of August, something in September, September 17th
12 or something like this, the 11th of October, the 13th of
13 November, and the 14th of November? Isn't that right?
14 A Yes. Fourteenth of November is when she had pain,
15 right.
16 Q When Mrs. Bly was seen on the 14th of November,
17 she had two problems. Number 1 was what was thought to be
18 a kidney infection; isn't that right?
19 A That's what the doctor thought, partly.
20 Q The other was an inflammation of the vagina; is
21 that correct?
22 A He said it was a vaginal discharge.
23 Q Is a kidney infection a cause of abdominal pain

DEO REPORTING
931-3434

1 which would indicate that a hysterectomy would later be
2 justified?
3 A (Nodding.)
4 Q Incidentally, this was a Trichomonas vaginatis
5 again, was it not?
6 A I think so, yes.
7 Q Is Trichomonas vaginitis a cause of abdominal pain
8 which would later indicate the need for a hysterectomy?
9 A No.
10 Q Doctor, my next notation is on the 15th of
11 November. Do you have that? Is that correct? My notes
12 reflect that your next testimony referred to the 15th of
13 November; is that right?
14 A Yes.
15 Q At that time Mrs. Bly was seen with a complaint
16 of abdominal pain?
17 A Yes.
18 Q At that time the diagnostic impression was that
19 she had a ruptured follicular cyst; is that right?
20 A That's right.
21 Q Now that is a cyst on the ovary; isn't it?
22 A Yes.
23 Q A follicular cyst is a relatively common female

DEO REPORTING
931-3434

disorder, is it not?

A Yes.

Q The treatment for follicular cysts is not removing the uterus, is it?

A No.

Q On the 16th of November, 1967, I believe you described that Mrs. Bly went to the Gyn. clinic for consultation; is that right?

A Yes.

Q Did you not testify to the Court that at this time a possible laparotomy was discussed and indicated?

A Yes.

Q This is the laparotomy that you discussed as being similar to the type which you later performed?

A I imagine, yes.

Q Now, this was one day after the diagnosis of a ruptured follicular cyst, isn't that right?

A Yes.

Q So that the indication for the laparotomy was for a different indication than for an abnormality involving the uterus; isn't that correct?

A Yes.

DEO REPORTING
931-3434

1 Q As a matter of fact, later on in the other records,
2 one of the other doctors, rather than recommending a
3 laparotomy, recommends a less serious procedure, does he
4 not, a culdoscopy? I call your attention to the 19th of
5 June, 1968.
6 A A culdoscopy, yes, on the 19th of June.
7 Q Now that's a less serious operation than the
8 laparotomy, isn't it?
9 A Yes, that is usually just a diagnostic procedure.
10 Q That's a procedure where one looks at the tube
11 and the ovary through a special viewing instrument called
12 the culdescope; isn't that right?
13 A Yes.
14 Q It doesn't involve an abdominal incision?
15 A No. That was -- that was for diagnostic purposes.
16 Q Yes. Now, in 1967, Doctor, have I missed anything
17 that we haven't described that would indicate that Mrs. Bly
18 was having abdominal pain that would indicate the need for
19 a hysterectomy?
20 A At that stage, no.
21 Q Okay.
22 Now, calling your attention to 1968, Mrs. Bly
23 was seen on the 27th of February, 1968, was she not?

DEO REPORTING
931-3434

A February 27.

Q Did I say 27?

A You said 28. February 27.

Q Yes. Okay. At that time a gynecological consult was obtained?

A Yes.

Q The impression at that time was that she had a mass in the right adnexa; is that correct?

A That is right.

Q That was thought to be either an ovarian cyst or an adenoma; is that correct?

A I don't know. He said he wanted a Gyn. evaluation at that time.

Q Would you refer to the Gyn. evaluation, sir?

A Twenty-seven of February?

Q That's what my notation indicates.

A Gyn. evaluation was possible ovarian cyst, possible adenoma.

Q An ovarian cyst is similar to the ovarian cyst that we talked about a couple of months previously in November of 1967; is that right?

A It was a -- I don't know whether it was the same or not. But he said it was an ovarian cyst or adenoma.

DEO REPORTING
931-3434

Adenoma is a tumor of the ovary that is not necessarily a cystic tumor of the ovary. It's a solid tumor.

Q When you examined Mrs. Bly when she first came to your office, you did a pelvic examination on her to determine whether she had a mass in her right adnexa, did you not?

A Not only her right adnexa, but both adnexa.

Q Her right adnexa was normal, was it not?

A From what I recall. I didn't find too much on pelvic examination the first time I saw her in my office.

Q Your notations of the various examinations that you performed indicated that each time it was normal, was it not?

A The first time. The second time I examined her I wasn't sure and I thought it would be a good idea to investigate it further.

Q When you examined her under anesthesia, where you had an opportunity to make a good examination, did you regard it as normal?

A No.

Q Didn't you record it in your notes that you thought the right adnexa was normal?

A I recorded that the right adnexa apparently felt

1 normal and the left had a tumor in it.

2 Q Thank you.

3 Now, incidentally, when women have cysts such

4 as ovarian cysts, do these have a tendency to recur and

5 to recur on both sides?

6 A Not necessarily.

7 Q But they can, can they not?

8 A They can.

9 Q When a patient has a history of having masses

10 which occur and then disappear, one should consider very

11 seriously that they may have an ovarian cyst; isn't that

12 right?

13 A If they disappear, yes. You usually wait a

14 menstrual cycle. If they disappear within a menstrual

15 cycle, then you know that you probably have a physiological

16 cyst of the ovary.

17 Q Okay. Now my next notation indicates that

18 Mrs. Bly was seen on the 7th of March, 1968; is that

19 correct?

20 A Yes.

21 Q I have in my notations that she had two complaints.

22 One was right upper quadrant pain; is that right? That is

23 what my notations are that you state.

A Right lower quadrant. Right lower quadrant.

DEO REPORTING
931-3434

Q Okay. My other notation indicates that she was complaining of premenstrual pain; is that correct?

A Yes.

Q Now, when Mrs. Bly came to see you, was she complaining of premenstrual pain?

A She had no premenstrual pain.

Q Now, is it possible that at the time in March of 1968 that Mrs. Bly was complaining of the right lower quadrant pain, that this could have been secondary to a cyst such as she had had on two previous occasions?

A Speculation, but I guess it could be. The ovaries were normal though.

Q Now this was later changed, was it not, because it was shortly after this that Mrs. Bly, in April of 1968, had this boil on her arm, isn't that correct, and she was seen on the 12th of April, the 25th of April, and the 19th of April?

A Yes.

Q During this particular time she received a local antibiotic on the furuncle. That was Bacitracin; isn't that right?

A Um-hum.

Q The Bacitracin wouldn't have any effect on any

DEO REPORTING
931 3434

1 pelvic disease, would it?

2 A Yes.

3 Q She later received tetracycline; is that correct?

4 A Yes.

5 Q Now, I recall on examination from counsel, you

6 said that the original jolt she received was what, a heavy

7 jolt?

8 A Yes. Two grams of tetracycline a day, which is

9 above the norm. Usually it's a gram a day therapy on an

10 ordinary occasion.

11 Q Does the amount of antibiotic which a patient

12 receives depend upon the disease process which the patient

13 has?

14 A I think that you can consider how severe the

15 disease process is and treat it.

16 Q Is the usual amount of tetracycline between

17 one and two grams per day? Wasn't that the standard?

18 A That is the usual dose.

19 Q So that two grams is still within the standard

20 amount that was given; isn't that right?

21 A Yes.

22 Q Now, on the 11th of June, shortly thereafter there

23 was a notation that Mrs. Bly's pelvic pain cleared when

DEO REPORTING
931-3434

1 the antibiotic was given, didn't it?

2 A Where was this now?

3 Q On the 11th of June 1968?

4 A Eleventh of June, yes. It cleared on antibiotics.

5 Q Now, after that Mrs. Bly was seen on the 25th of

6 August; isn't that right?

7 A She was seen on the 19th of June.

8 Q Okay. I'm sorry. I thought I had mentioned that.

9 Okay. So that she was seen on the 11th of June 1968; is

10 that correct?

11 A Yes.

12 Q Then she was seen on the 19th of June. Based on

13 the examination where her pain had cleared with the antibiotic,

14 a diagnosis was made that she had inflammation of the tube;

15 is that right?

16 A That's correct.

17 Q And that inflammation apparently had cleared,

18 had it not?

19 MR. SLENKER: The records didn't say the

20 inflammation cleared.

21 A It says she had a temperature of 100.4 -- no, that

22 was in August. It states on the consultation sheet here

23 "history of pelvic pain, right lower quadrant outlined.

DEO REPORTING
931-3434

1 Tenderness, right adnexa. No palpable induration. History
2 and pelvic findings are not completely typical of PID. Trial
3 antiobiotic therapy. Would consider culdoscopy if problem
4 not resolved. Return in two months."
5 Q That's the only information which you had in
6 order to form an opinion as to whether Mrs. Bly had chronic
7 pelvic pain; is that right?
8 A So far in the record, yes.
9 Q Now, Mrs. Bly was seen on the 25th of August, 1968.
10 At that time she had a four by six centimeter mass in the
11 right ovary; is that right?
12 A Yes, tender mass.
13 Q Incidentally, the conversion from centimeters to
14 inches is that there is one inch for every two and a half
15 centimeters; isn't that right?
16 A That's correct.
17 Q So she had something just under an inch and a half
18 and just over two inches in dimension; is that right?
19 A Um-hum.
20 Q Okay.
21 The notation at that time indicated that she was
22 going to have a trial of Achromycin; is that right?
23 A That is correct.

DEO REPORTING
931-3434

1 Q Achromycin is the same as Tetrocycline; is that
2 right?
3 A It's broad-spectrum.
4 Q It is Tetracycline?
5 A Yes.
6 Q It is a brand name of Tetracycline?
7 A That is correct.
8 Q So, to this point, Tetracycline is the only
9 antibiotic which Mrs. Bly has received for treatment of this
10 pain; is that correct?
11 A That is correct.
12 Q The notation at that time indicates that she had
13 the mass and that they would try a trial of Achromycin;
14 is that correct?
15 A Yes.
16 Q Later on that mass disappeared, didn't it, because
17 you didn't find it.
18 MR. SLENKER: Just a minute. The record there
19 reflects a little something more than what you are referring
20 to. It says, "if recurrent", referring to the pain as well
21 as the cystic mass, "surgery would appear justified."
22 MR. DIXON: Okay. I have no objection to that.
23

DEO REPORTING
931-3434

1 BY MR. DIXON:

2 Q Doctor, in this particular case, do you have any
3 evidence to indicate that at the time you were treating
4 Mrs. Bly she had the recurrence of this mass in her right
5 ovary?

6 MR. SLENKER: Well, Your Honor, I object to the
7 question because there isn't any issue here about it on
8 the right side. The operation is totally on the left.
9 The thrust of his testimony is it's on the left side.

10 MR. DIXON: I am trying to find out when that
11 problem on the left side appeared that was this chronic,
12 unrelenting pain that indicated a hysterectomy was necessary.

13 THE COURT: Is there any evidence with respect
14 to the right side? I haven't heard anything.

15 MR. DIXON: No, there isn't. The point is the
16 Doctor has testified that his justification for recommending
17 the procedure was that she had this chronic abdominal
18 pain. I am trying to find out where this pain was and
19 find out whether this was the pain that was present at the
20 time the surgery was made.

21 MR. SLENKER: I object strenuously, Your Honor,
22 to counsel's representation this was the basis on which
23 the hysterectomy was supposed to have been done. Not at all.

DEO REPORTING
931-3434

1 These records here are the ones she brought to him. He
2 had read them, but then he saw her twice or three times.
3 He made his own evaluation with regard to the left side,
4 not the right side. But she told him, in addition to these
5 records and the history that he took originally on the
6 25th of April, that she had had pelvic discomfort for a
7 long period of time, That's in his records. But the
8 question here has to do with the left side, not the right
9 side.
10 MR. DIXON: Your Honor, if I understand the
11 thrust of the doctor's testimony, he testified that he
12 took into consideration this previous history which the
13 patient had brought to him from the military hospital.
14 THE COURT: That was one of the considerations.
15 That wasn't the only consideration.
16 I think you have a right to question him along
17 those lines. But the way you have stated it, that was
18 the consideration. But there were other considerations
19 that he had taken.
20 MR. DIXON: I don't even know whether we had a
21 question outstanding or not.
22 BY MR. DIXON:
23 Q Doctor, at the time that you saw Mrs. Bly, you had

1 no evidence that she had a mass in the right ovary, did you?
2 A I couldn't tell for sure the first time I examined
3 her. I had a difficult time examining her. And I wasn't
4 sure.
5 Q Now, do you have any military record for after
6 August 25, 1968?
7 A I don't believe we have any more than that. That's
8 it.
9 Q The next time that you have recorded in your history
10 of when Mrs. Bly had problems is from what Mrs. Bly told you
11 and what you recorded in your own notations; is that right?
12 A Yes.
13 Q This is the history which you filled out after
14 you saw Mrs. Bly; is that correct?
15 A That's correct, yes.
16 Q And that particular history, the only history that
17 you had that Mrs. Bly had been on antibiotics was one
18 statement that for a period of time unknown to you, but
19 prior to two weeks prior to when she came to you, she had
20 been on an antibiotic; is that correct?
21 A Yes.
22 Q You didn't know what that antibiotic was?
23 A No.

DEO REPORTING
931-3434

1 Q And you didn't know whether that antibiotic would
2 have been treatment of choice for treating any kind of
3 pelvic pain which had been successfully treated previously
4 with antibiotics, did you?
5 A I just know that she was treated with antibiotics
6 for two weeks, apparently.
7 Q Now, Doctor, is it recognized in medicine that
8 many organisms can be susceptible to one antibiotic that
9 later lose their susceptibility to that antibiotic?
10 A That's true.
11 Q Is it true that in clinical practice in this area,
12 that when one antibiotic is not successful, that another
13 one is customarily attempted?
14 A That's true.
15 Q Did you ever attempt to treat Mrs. Bly with any
16 of these antibiotics?
17 A No, I did not.
18 Q Doctor, is it customarily recognized in the
19 medical community that when a patient comes to you for
20 treatment, that the patient often doesn't understand the
21 rationale or the technical aspects of this treatment?
22 MR. SLENKER: I object, if Your Honor please.
23 I don't think that is a question susceptible of answer.

DEO REPORTING
931-3434

1 THE COURT: Objection sustained.

2 BY MR. DIXON:

3 Q Referring to Mrs. Bly specifically, Doctor,

4 did you recognize that she didn't have the medical expertise

5 to appreciate the indications for the hysterectomy and

6 the risk of complication from the surgery or the alternative,

7 without assistance from you?

8 MR. SLENKER: Objection, if Your Honor please.

9 THE COURT: Sustained.

10 BY MR. DIXON:

11 Q Doctor, in your dealings with Mrs. Bly, did you

12 explain to her all of the significant risks of the

13 hysterectomy operation so that she could elect whether

14 the pain that she was suffering was significant enough that

15 she would be willing to undertake these risks?

16 MR. SLENKER: Objection.

17 THE COURT: Objection sustained.

18 MR. DIXON: May I have an exception.

19 THE COURT: Yes, sir, surely.

20 BY MR. DIXON:

21 Q Doctor, did you, in your recommendation to Mrs. Bly

22 to have the hysterectomy, discuss with her the alternatives

23 of cost for the hysterectomy procedure and the hospital

DEO REPORTING
931-3434

1 procedure compared with the cost of a conservative
2 management where no surgery would be undertaken?
3 MR. SLENKER: Objection, if Your Honor please.
4 THE COURT: Sustained.
5 MR. DIXON: May I have an exception to that too,
6 Your Honor.
7 THE COURT: Yes, sir.
8 BY MR. DIXON:
9 Q Doctor, I believe that you referred previously
10 in your testimony to some of the other risks of surgery.
11 As I recall, you testified that there were a number of other
12 risks, including infection; is that right?
13 A Yes.
14 Q Is the probability of an infection which causes
15 an individual to lose four months of work and to require
16 additional multiple hospitalizations a more significant
17 or frequent risk than the frequency of a blockage of the
18 ureter?
19 MR. SLENKER: Objection, if Your Honor please.
20 THE COURT: Sustained.
21 MR. DIXON: May I have an exception.
22 THE COURT: Surely.
23

DEO REPORTING
931-3434

1 BY MR. DIXON:

2 Q Doctor, I believe that you mentioned that another
3 risk of the surgery was the risk of hemorrhage; is that
4 right?

5 A That's correct.

6 Q Is the risk of hemorrhage in a patient the age
7 and health of Mrs. Bly less significant than the risk of
8 blockage of a ureter?

9 MR. SLENKER: Objection.

10 THE COURT: Objection sustained.

11 MR. DIXON: May I have an exception.

12 THE COURT: Surely.

13 BY MR. DIXON:

14 Q Doctor, I believe that you mentioned in your
15 discussion of other risks, the danger of trauma to the
16 bowel or bladder was also present; is that correct?

17 A Yes.

18 Q Is the risk of trauma to the bowel or bladder
19 greater when the surgeon is less experienced than when he
20 is more experienced?

21 MR. SLENKER: Objection.

22 THE COURT: Sustained.

23 MR. DIXON: May I have an exception.

DEO REPORTING
931-3434

1 THE COURT: Yes, sir.

2 BY MR. DIXON:

3 Q Doctor, I believe that in your description of the

4 complications, you mentioned emboli; is that right?

5 A Yes.

6 Q Are emboli a significant risk in a healthy thirty

7 year old female?

8 MR. SLENKER: Objection, if Your Honor please.

9 THE COURT: Sustained.

10 BY MR. DIXON:

11 Q Doctor, what is the customary fee in this

12 community for the performance of a nephrostomy?

13 MR. SLENKER: Objection, if Your Honor please.

14 THE COURT: Objection sustained, at this point.

15 BY MR. DIXON:

16 Q Doctor, you have had some additional training

17 in urology, have you not?

18 A Yes.

19 Q Your hospital privileges would permit you to

20 perform urology at this hospital, would they not?

21 A No. I didn't apply for urological privileges.

22 Q You are qualified to perform them, are you not?

23 A I don't think I would be an expert at urological

DEO REPORTING
931-3434

1 procedures. The extent of my training was three months
2 rotation through a urological service.
3 Q Wasn't the extent of your training six months?
4 A Six. I guess it was six. Three to six months.
5 Q While you were doing that training, did you
6 have occasion to perform any nephrostomies?
7 A No, I did not perform any nephrostomies.
8 Q Did you scrub in while they were being performed?
9 A I imagine I did spend time some time ago.
10 Q Based on that experience and in your working in
11 the medical community, do you know what the customary
12 fee for a nephrostomy is?
13 THE COURT: Objection sustained at this time.
14 Mr. Dixon, how much longer will you be with this
15 witness? It's one o'clock now.
16 MR. DIXON: I honestly can't tell you right now,
17 Your Honor.
18 THE COURT: All right. Let's bring the witness
19 in. We will recess for lunch at this time.
20 Come on in. Stand right inside.
21 Court is going to recess at this time until
22 2 o'clock.
23 Doctor Blood, I want to see you in chambers.

DEO REPORTING
931-3434

1 BY MR. DIXON:

2 Q Doctor, how much was your bill?

3 A $350.

4 Q Thank you.

5 Doctor, that bill of $350 was for your bill

6 commencing with the October 28 hospitalization, was it not?

7 A I assume so.

8 Q (Handing to witness.)

9 A Yes.

10 MR. DIXON: Thank you.

11 That's all.

12 RECROSS EXAMINATION

13 BY MR. SLENKER:

14 Q Doctor Rhoads, will you tell the members of the

15 jury if Mrs. Bly was obliged to have this operation if she

16 didn't want it?

17 A No. She was not obliged to have it.

18 Q What could she have done if she wanted to avoid

19 the operation completely? What could she have done?

20 A She could have refused it. She could have gone

21 to somebody else.

22 Q Did she ever at any time say to you that she

23 didn't want the operation?

DEO REPORTING
931-3434

1 A No.

2 Q As a matter of fact, she signed the permit, did

3 she not?

4 A Yes.

5 Q Now then, I believe that she came to you after

6 she got out of the hospital a number of times and then she

7 didn't show up again?

8 A Yes.

9 Q The last visit, I believe ,according to your records,

10 was the 14th?

11 MR. DIXON: Excuse me, Your Honor. I object to

12 this last line of questioning. That goes beyond the scope

13 of the last examination.

14 MR. SLENKER: He's introduced the bill, Your Honor

15 please, of $350 presumably for the care that she got after-

16 wards. All right. If the bill is in evidence, now I think

17 I am entitled to ask him with reference to the visits and

18 with reference to that particular exhibit.

19 THE COURT: I think so.

20 MR. DIXON: I withdraw the objection.

21 BY MR. SLENKER:

22 Q According to your records, after she got out of

23 the hospital in November, when did she next appear at your

DEO REPORTING
931-3434

1 THE COURT: Surely.

2 MR. DIXON: It would appear to me, your Honor, that
3 the doctor, whether he is believable or not, goes to the
4 weight of the evidence rather than the admissibility.

5 THE COURT: I sustained the objection.

6 BY MR. DIXON:

7 Q Doctor, based on your review of Mrs. Bly's records,
8 did you form an opinion as to whether the nephrostomy which
9 Mrs. Bly was caused to undergo was directly caused by the
10 surgery or the hysterectomy which Mrs. Bly received?

11 THE COURT: Just a moment.

12 MR. SLENKER: Objection, if your Honor please. I
13 don't think that that's a proper question. In any event,
14 the question is whether or not Dr. Rhoads adhered to the
15 standard.

16 THE COURT: You are getting right back to the same
17 issue. I sustain the objection.

18 MR. DIXON: Your Honor, at this time the plaintiff
19 would proffer the damages for the record. As the Court is
20 aware, there have been two separate theories of liability in
21 this case. We would proffer to the Court this witness's
22 testimony on causal relationship of the damages.

23 As the Court is aware, there is an informed consent

1 issue in this case. It appears that the plaintiff would be
2 entitled to this expert medical testimony by a qualified
3 witness on that issue. The Court has already indicated that
4 Dr. Gerstley is eminently qualified.
5 MR. SLENKER: Not as to --
6 THE COURT: (Interposing) We haven't gotten over
7 the first hurdle yet, so I sustain the objection.
8 MR. DIXON: Your Honor, if I understand the Court's
9 ruling, the Court is ruling that there is no finding on
10 liability; is that correct?
11 THE COURT: There is no evidence for the Court at
12 this time with respect to any negligence on the part of the
13 doctor that would make him liable. In other words, I have
14 sustained the objection. That is my position. That is my
15 ruling.
16 MR. DIXON: Your Honor, as I understand the testi-
17 mony there is evidence on the issue of informed consent which
18 has come directly from the mouth of the defendant on what he
19 did and did not tell her. If that evidence is credible, I
20 think the jury has a basis for making a decision on that.
21 The request before the Court is what damages, if any, come from
22 that particular issue.
23 MR. SLENKER: Well, if your Honor please, the only

DEO REPORTING
931-3434

1 evidence is from the defendant. He said what he told her and
2 said that is within the standard.
3 THE COURT: I sustain the objection. I still don't
4 think you have gotten over this first hurdle that you have
5 got to jump, Mr. Dixon, and I sustain the objection.
6 MR. DIXON: May my exception be noted?
7 THE COURT: Yes, sir.
8 MR. DIXON: May we approach the bench for just a
9 moment, your Honor?
10 THE COURT: Yes, sir.
11 (The following proceedings were had at the bench by
12 Court and counsel out of the hearing of the jury.)
13 MR. DIXON: Your Honor, if I correctly interpret
14 the Court's ruling in this matter, the Court is ruling that
15 lay testimony would not be an appropriate basis for liability
16 under the theory of informed consent. If that interpretation
17 is not correct, then we would propose to call Mrs. Bly to ask
18 her about that issue in order to form a credible foundation
19 for Dr. Gerstley to testify on this matter. I appreciate the
20 hour is late.
21 THE COURT: Well, I am not worried about the late
22 hour. In other words, that part doesn't bother me, Mr. Dixon.
23 MR. SLENKER: Well, I think that the informed

DEO REPORTING
931-3434

1 consent, if your Honor please, is a thoery of recovery in a
2 malpractice case the same as any other theory of negligence.
3 Would the jury be allowed to say what the standard is with
4 reference to the information that ought to be disclosed? No.
5 You have got to have an expert.
6 THE COURT: We are getting right back to this same
7 issue. This is the problem. This is my feeling with respect
8 to this. I have the same feeling both ways, Mr. Dixon. As I
9 say, there is no doubt in my mind about this man being quali-
10 fied in his field and so forth. But as I say, it is still my
11 interpretation of the rule as set down by the Supreme Court
12 that the burden is on you to prove, as I have so indicated.
13 I am not going to fill up the record, but this is my feeling.
14 I have sustained the objection, and I would sustain
15 the objection to the testimony of Mrs. Bly along the same
16 lines, because my feeling is that the Court of Appeals has
17 placed this burden on the plaintiff.
18 MR. DAVIS: If your Honor please, I'd like to
19 supplement Mr. Dixon's remarks and point out to the Court in
20 the case of Hunter versus Burroughs, a Virginia case, 1918,
21 it was held that the sixth count of that was sustained on
22 demurrer. It went down to Richmond on appeals and it was
23 affirmed by the Court of Appeals.

DEO REPORTING
931-3434

1 Then in 1972 a case came out of the District of
2 Columbia which went to the United States District Court,
3 Canterbury versus Spence. The U. S. Court of Appeals of the
4 District of Columbia stated the standards are set by law as
5 to the doctrine of informed consent and not set by the medi-
6 cal profession and not what they choose to inform the patient
7 or not inform the patient on. I have the entire volume here
8 of the Canterbury case.
9 THE COURT: I don't believe I am familiar with
10 the Canterbury case. I don't recall.
11 MR. DAVIS: Rehearing was denied and certiorari was
12 denied in December of 1972.
13 MR. DIXON: Your Honor, there are three leading
14 recent informed consent cases. Canterbury versus Spence from
15 the District of Columbia, Cobbs versus Grint, a California
16 case, and a Rhode Island case, I think, of Wilkinson versus
17 Veesee, which are the three most prominent cases which have
18 been widely described in both the medical and legal litera-
19 ture, which hold that it is not necessary to introduce
20 expert testimony on the issue of informed consent. The jury
21 is permitted to make a determination from the facts in the
22 case as to whether or not the patient was advised of the
23 alternatives and the risks of treatment and whether the

DEO REPORTING
931-3434

1 patient gave a consent based upon being informed of these
2 things. In a number of others, and in all three of these
3 cases the courts, especially in a recent trend, have unani-
4 mously held that there is no need for expert medical testi-
5 mony on that topic.
6 MR. SLENKER: That's the minority rule, if your
7 Honor please. The majority rule, by the greater weight of it,
8 is that informed consent is a theory of negligence as a
9 departure from the standard because the failure to inform is
10 a departure from the standard. The jury doesn't know what
11 the standard is. That's why it is of no value, nor does the
12 law here in Virginia establish what shall be told or what
13 shall not be told. That's why there is the necessity of
14 expert testimony on the extent to which it must be made, what
15 must be discussed, and so forth. That comes from the commun-
16 ity in accordance with the standard of medical care that
17 prevails, to the same extent as any other departure, because
18 if there is a failure to inform, that is a departure from
19 the standard. In order to set that standard it has to be set
20 by a preponderance of the evidence like any other theory.
21 That is the vast majority holding in the United States.
22 MR. DIXON: Your Honor, I will grant to Mr. Slenker
23 that there are a number of older cases which held, as Mr.

DEO REPORTING
931-3434

1 Slenker has represented. But I can't agree with Mr. Slenker
2 that this has been the modern trend in the last five years.
3 Mr. Slenker is out of date if he makes that representation
4 with respect to the recent cases.
5 I note that Mr. Slenker hasn't cited any Virginia
6 case in point on this. The Court is well aware Mr. Slenker
7 deals almost exclusively in medical malpractice. I am sure
8 if we had a case in point he would be prepared to represent
9 to the Court as to what that was.
10 MR. SLENKER: Well, I certainly would if I had known
11 we were going to get to the issue this rapidly.
12 THE COURT: I am going to recess until tomorrow
13 morning. We are not going to stay on this. I am going to
14 take these home with me and come back tomorrow morning. You
15 may bring back any particular citations you have. As I say,
16 I am not familiar with this particular case. I haven't read
17 it.
18 MR. DIXON: Your Honor, we do have a problem here.
19 THE COURT: Well, I have informed our friend as to
20 the position of the Court. The only way he can be excused is
21 if counsel wants to excuse him. I figured that is what he
22 wanted, was Mr. Slenker to grant him permission along with
23 your permission.

1 MR. DIXON: I am referring to Dr. Gerstley, who had
2 flown down for today. We have got an airplane for him to go
3 back. We are in a situation where we are going to have to
4 send the airplane back.
5 THE COURT: You mean he came down in a chartered
6 flight or something?
7 MR. DIXON. Oh, yes. We had to bring him down
8 special. He is a very busy man. The airplane is waiting at
9 the airport at this point to take him back.
10 MR. SLENKER: Could I tell you, Mr. Dixon, that
11 there are some patients waiting on Dr. Rhoads also?
12 MR. DIXON: You should have told Dr. Rhoads that
13 when he ligated her ureter.
14 THE COURT: Let's not get into that.
15 MR. DAVIS: I simply want to point out they recite
16 the Butterfield case in the footnote.
17 MR. DIXON: Your Honor, it appears to me at this
18 juncture in the case that if the Court finds that there is no
19 basis for liability, then, of course, we are going to be sub-
20 ject to an adverse ruling. At this point it would appear
21 there would be no jury to the case to permit Dr. Gerstley to
22 testify on the damage issue separate and apart from the lia-
23 bility issue, so that we could permit him to leave. Then, of

1 course, if the liability requirements that the Court sets are
2 not met, then of course the plaintiff will have to take the
3 consequences with the Court's ruling. This would certainly
4 expedite that matter and solve that problem.
5 THE COURT: Well, I am sympathetic with the doctor
6 too. In other words, I have a jury of seven people sitting
7 over there and I am sure they have obligations as well as Dr.
8 Gerstley. This is an unfortunate situation, along with Dr.
9 Blood out there. It's very unfortunate. But at the same
10 time we can go out of our way to try to accommodate doctors.
11 I think everybody knows we make every effort. Mr.
12 Slenker and Mr. Davis will tell you that.
13 There is a limit here. I just don't feel that I
14 can permit him at this time to do this and stay here for him
15 to put on testimony.
16 The question is once this information gets to the
17 jury, how are you going to get it out of their minds once you
18 get it there?
19 MR. DIXON: If we are not able to meet the burden
20 of liability there is not going to be any question of that,
21 your Honor.
22 MR. DAVIS: I would like to leave with your Honor
23 the pertinent copy. I don't have a full photocopy of the

1 Hunter case. But the demurrer was sustained by the Court of
2 Appeals of the Court of Virginia. That was based exclusively
3 on the doctrine of informed consent, even though it was a
4 1918 case.
5 I might say, too, that in the Canterbury case,
6 since it came down in 1972, the Supreme Courts of seven
7 different states have adopted the Canterbury doctrine.
8 MR. SLENKER: Wasn't there a child involved in
9 Canterbury?
10 MR. DAVIS: No, a minor. An F.B.I. fingerprint
11 clerk. My familiarity with this case is because I was coun-
12 sel and battled it all the way up to the Supreme Court. This
13 happened to be a visiting Judge in California sitting on the
14 District Court at the time. He came in to relieve our conges-
15 tion but he created a further one in the Court of Appeals.
16 THE COURT: Well, there are a lot of other points
17 raised in this other than that one particular point. It
18 looks like there was something about --
19 MR. DAVIS: (Interposing) The slip opinion was
20 forty-four pages.
21 THE COURT: And actually forty-four different
22 points.
23 MR. DAVIS: There are three pages of syllabi.

DEO REPORTING
931-3434

1 THE COURT: The aspect of that part of the case
2 with respect to informed consent shouldn't take me too long
3 to read; that aspect of the case with respect to the holding
4 of the Court.
5 MR. DAVIS: But to get the history of it, Judge --
6 MR. DIXON: (Interposing) I think the Court can
7 get a synopsis of it quite rapidly.
8 THE COURT: If I can do that then at least, if I
9 still take the same position after reading this, in other
10 words, certainly the doctor knows where he stands and you
11 would know where you stand as far as the doctor is concerned.
12 MR. DIXON: We would appreciate that, your Honor.
13 THE COURT: And at least I can make a ruling. I
14 have indicated what I feel. But I will do this. I will go
15 ahead and recess here for about another fifteen minutes or so
16 to satisfy myself with respect to the reasoning in this and
17 see if I concur in the reasoning of the case. I will do
18 that much, in other words.
19 MR. DIXON: Thank you very much.
20 THE COURT: And we will find out one way or the
21 other before I make a firm decision.
22 (Thereupon, the following proceedings continued
23 in the hearing of the jury.)

DEO REPORTING
931-3434

1 THE COURT: Members of the jury, as you have seen
2 there has been a point raised with respect to another aspect
3 of the case by counsel that involved Dr. Gerstley. Dr.
4 Gerstley, I understand, needs to get back to Pennsylania and
5 the Court wants to accommodate him if it can.
6 But this particular point is a very important
7 point. I don't want to make a ruling without first reading
8 this and going over a case that's been presented to me on this
9 particular point. It's a case that I'm not familiar with. I
10 just want to see what the reasoning of the Court is and see
11 if I would still take the same position I have taken con-
12 sistently with this.
13 In order to attempt to accommodate the doctor, we
14 find ourselves sometimes getting in trouble. We try to accom-
15 modate these doctors and have done it and always have made a
16 point in accommodating the doctors and sometimes get ourselves
17 in trouble.
18 I promise counsel at least I would peruse this
19 case and see if I feel I can come up with an interpretation
20 and a ruling in respect to that particular motion. So I know
21 it means I am going to hold you here for a few more minutes.
22 But I going to recess at this time to give me an opportunity
23 to go over this particular case.

DEO REPORTING
931-3434

1 So, Doctor, if you will step down, and Court will
2 recess at this time for about fifteen minutes. I will ask
3 you to go to the jury room at this time.
4 (Whereupon, a recess was taken.)
5 THE COURT: Mr. Dixon, after having read the
6 Canterbury case and also the comments there from Hunter ver-
7 sus Burroughs, I will still adhere to my ruling that I made
8 at the bench here with a question of the duty of disclosing,
9 and hold that the same proof that would be required in the
10 malpractice aspect would be the same here with the duty to
11 disclose.
12 In the Canterbury case, it's a very interesting
13 case, but it also states, and I would like to read from that:
14 **********
15 Here they established a precedent , but they had
16 no prior case in the District of Columbia. That is the rule
17 in the District. And it goes on.
18 But it does cite in the footnotes the cases of
19 jurisdictions which are highly respected, such as Massachu-
20 setts having the majority rule, Delaware having the majority
21 rule, and so citing in these cases there that as these cases
22 indicate, the majority rule of the Courts hold that expert
23 testimony is necessary to establish the custom. So I am

1 ruling the same from the bench.

2 I wanted to confirm that insofar as the Hunter case.

3 It deals mainly with the question of allegations, not the

4 proof of allegations. I will maintain the same. I adhere to

5 my ruling at the bench. I did want, at least in all fairness

6 to the parties to deteremine what my ruling will be. But

7 this Court will stick with the majority ruling concensus.

8 MR. DIXON: Your Honor, may we make a proffer?

9 THE COURT: Well, any proffer will have to be out

10 of the presence of the jury here. It is getting rather late

11 at night. How long is it going to take?

12 MR. DIXON: May we approach the bench?

13 (The following proceedings were had at the bench

14 by Court and counsel out of the hearing of the jury.)

15 MR. DIXON: Okay. If I understand the Court's

16 ruling, the Court is ruling that Dr. Gerstley has not been

17 qualified to testify because he is not familiar with the

18 standard of practice in Prince William County as opposed to

19 the standard of practice in a locality similar to Prince

20 William County; is that right?

21 THE COURT: Well, the Court's ruling is based on

22 the fact that there has been no testimony before the Court

23 at this time that the particular alleged negligent action

1 described in his testimony concerning what a Board certified
2 obstetrician does hold himself out to do by the training
3 practices of going to national conventions and reading nation-
4 al journals.
5 We also propose to offer Dr. Gerstley's testify on
6 the standard of practice in an area similar to Washington,
7 D.C., where Dr. Rhoads has testified that he was trained and
8 in the area on which he's based his surgical procedures, as
9 he has already testified in this case.
10 We would also proffer Dr. Gerstley's testimony on
11 the issues of causation inherent as to what relationship the
12 failure to give the patient medical alternatives and the
13 failure to treat the patient properly had upon her subsequent
14 injury. Dr. Gerstley can testify as to the issue of the
15 causation. The nephrostomy was causally related to these
16 other acts of which negligence is alleged. I don't intend
17 by this, of course, to indicate that informed consent is only
18 a negligence issue.
19 We would proffer, of course, that Mrs. Bly separ-
20 ately and independently under the Canterbury case can testify
21 on the issue of what she was told and relate this to what
22 would be a reasonable practice for an individual faced with
23 her circumstance in the absence of medical testimony. So

DEO REPORTING
931-3434

1 what we would do is we would proffer testimony of informed
2 consent both from a lay point of view of Mrs. Bly and from a
3 professional point on the standard of care through Dr.
4 Gerstley.
5 We would also proffer Dr. Gerstley's testimony on
6 the issue of causation and the damages that Mrs. Bly has
7 undergone since the operative procedure on the 28th of October
8 as to the pain and suffering, the medical complications that
9 she has undergone.
10 THE COURT: Do you wish to be heard on that?
11 MR. SLENKER: He is just proffering. You have made
12 your ruling. You have ruled.
13 THE COURT: In other words, do I understand you
14 are asking me now that I would permit you to put this doctor
15 on in the presence of the jury and proffer testimony to
16 testify as to these particular items that you have just indi-
17 cated in your statement to the Court here? His testimony
18 would be in essence what you have just related there?
19 MR. DIXON: If the Court is ruling that we would
20 not be permitted to show these things, then of course there
21 would be no further need to proceed with Dr. Gerstley.
22 THE COURT: I really frankly see no need to proceed
23 any further as far as the proffer of testimony is concerned,

1 because my ruling is the same. This is my feeling there and
2 it's in the record, right or wrong. I feel that I am right.
3 If I didn't I wouldn't say that, Mr. Dixon.
4 Under the circumstances, my ruling would be that
5 I deny the motion to proffer the testimony as long as the
6 testimony would be along the lines that you have indicated.
7 I assume that is what the testimony would be, which is in
8 essense what you have just represented to the Court.
9 MR. DIXON: Yes.
10 THE COURT: So under the circumstances I see no
11 point for staying here any longer. This is my feeling. I
12 would deny the motion.
13 MR. DAVIS: If your Honor please, before adjourning
14 for the day, since I don't believe Mr. Dixon or Mr. Olender
15 are familiar with the Virginia practice, since the proffer
16 would include all the evidence we could offer on the subject,
17 I assume it would be appropriate now for Mr. Slenker to make
18 a motion to strike the evidence. Then it would be tantamount
19 to a directed verdict for giving finality to this case.
20 THE COURT: In other words, assuming that this
21 would be the extent of the proffered testimony of the
22 plaintiff's case, and under the circumstances in order to
23 give it finality , there has got to be some finality before

DEO REPORTING
931-3434

1 result of that, and also the nature and extent of the pain
2 and suffering and subjective damages which she sustained.
3 We would also proffer the testimony of Mr. Paul
4 Gomez who was the employer of Mrs. Bly before the October
5 surgery and was the employer for a period of time thereafter,
6 and was an acquaintance of Mrs. Bly, who will testify as to
7 her work capability before the surgery and afterwards and
8 the change and deterioration in that capacity to work.
9 We would also proffer certain photographs of Mrs.
10 Bly's injuries and the scars which she has.
11 We would proffer the testimony of Mrs. Bly as to
12 her age, the status of her family prior to and subsequent to
13 the operation, her general health prior to and subsequent to
14 the operation. We would proffer her testimony as to the
15 pain, suffering, inconvenience and inability to work and
16 enjoy the fruits of life which occurred during the hospitali-
17 zation in October and subsequent thereto.
18 We would proffer Mrs. Bly's testimony that she
19 absolutely denies being told of any complications by Dr.
20 Rhoads. I call the Court's attention to the fact that this
21 is in conflict with Dr. Rhoads's testimony in this matter.
22 Mrs. Bly will also testify that she was never told of the
23 serious injury to the ureter which was a substantial risk

DEO REPORTING
931-3434

1 which Dr. Rhoads has testified was a risk and the incidence
2 of that risk.
3 Mrs. Bly will testify that Dr. Rhoads told her only
4 she was going to have a scar on her abdomen which could be
5 hidden beneath a bikini. The testimony will be that such a
6 scar was not given, that a different type of incision was
7 made. Dr. Rhoads told her that she would be in the hospital
8 for only seven days and that she would be away from work for
9 between one month and six weeks, and that nothing was said
10 about the possibility of further complications, delays or
11 extensions of hospitalization and extensions of her inability
12 to work.
13 Mrs. Bly will testify and deny that she was offered
14 any options in her treatment. She was not given the options
15 of having antibiotics or any other form of management other
16 than the surgery. She will deny that she was ever asked by
17 Dr. Rhoads about whether she wanted to have the uterus remain
18 so that she could be pregnant if the option was technically
19 available to her.
20 Mr. Bly will testify that she would have elected to
21 have the conservative therapy with antibiotics first if given
22 the choice; that she would not have had the operation at that
23 time had she known all of the potential risks and complications

DEO REPORTING
931-3434

1 of the procedure, and particularly if she had known of an
2 available option to her. Mrs. Bly would also testify that had
3 she been advised of the extensive risks and complications
4 which were possible in this particular surgery that she would
5 have sought another opinion from another physician and would
6 not have had the surgery until a second opinion would have
7 confirmed the necessity for the procedure.
8 She would also testify that if she had been given
9 the choice by Dr. Rhoads she would have chosen the removal of
10 only the tube and ovary and the avoidance of the hysterectomy
11 with its consequent danger to the ureter and the avoidance
12 of the sterilization which occurred because of the hysterec-
13 tomy.
14 Mrs. Bly, as I have previously indicated, will
15 testify as to her emotional and physical state prior to this
16 surgery.
17 In case I didn't make myself clear with respect to
18 the proposal for the removal of the tube and the ovary on that
19 side, Mrs. Bly, if she had been told of the risks of the
20 operation, would have sought a consultation with respect to
21 any procedure if she had been advised of the risks which Dr.
22 Rhoads has testified are inherent in the procedure.
23 Mrs. Bly will testify as to her condition prior to

DEO REPORTING
931-3434

1 the surgery. She will testify as to the pain and suffering
2 and inconvenience, the changes in her ability to work and to
3 cope and to handle life's problems, and her general injuries
4 subsequent to the operative procedure.
5 She will also testify that Dr. Rhoads admitted an
6 obstruction of the tube that connected the kidney with the
7 bladder was caused by something which he did in the operation.
8 She also will testify that the pain that she went to Dr.
9 Rhoads for prior to the operation is still present.
10 We would also propose to offer the testimony of the
11 hospital administrator and his assistant, Mr. Gendrin, with
12 respect to the hospital bills of Mrs. Bly's hospitalization
13 and the reasonableness of those bills. We would also call the
14 hospital administrator to testify as to the number of gyne-
15 cologists who have full staff privileges at the Prince
16 William Hospital here in Manassas.
17 We would also proffer the mortality tables to
18 indicate Mrs. Bly's life expectancy.
19 In addition, we would proffer the testimony of
20 Judy Robinette, a sister of Mrs. Bly, and Jeff Bly, Mrs.
21 Bly's son, with respect to her physical and emotional condi-
22 tion before and after the surgery. This would include testi-
23 mony as to the activities that she was able to do previously

DEO REPORTING
931-3434

1 The law is clear on that topic. So far as Virginia
2 is concerned, it adopts the orthodox law prevailing throughout
3 the country, that judgmental errors are not sufficient upon
4 which to hold a defendant for medical malpractice. There
5 would be no liability.
6 So far as the consultation element is concerned,
7 there is no evidence here in Prince William County that con-
8 sultations are necessary before routine hysterectomies of this
9 type or routine laparotomies of this type. There isn't anybody
10 that said this is a deviation from the standard. So far as
11 assistance during surgery is concerned, there isn't anybody.
12 There isn't any evidence that says this is a deviation from
13 the standard. The only evidence here is that that is the
14 standard.
15 Second of all, as to that particular point, Dr.
16 Rhoads said that there was a nurse there that was helping him
17 who was the assistant. So he had an assistant there, even
18 if you assume this was a departure from the standard that
19 prevails.
20 So, you Honor, I submit that we are still right
21 back where we were.
22 THE COURT: Mr. Dixon, I would still adhere to my
23 decisions that I have made in this matter. Under the

DEO REPORTING
931-3434

1 circumstances I feel that the testimony as submitted and as
2 proffered there, if it were to be submitted and admitted in
3 the record, that we still be at the same position. The Court
4 would have the same position that it has previously expressed.
5 I still am inclined to go along with the majority view in
6 this matter.

7 I might say that in reading the Canterbury case that
8 it is very interesting. I think very interesting thoughts and
9 logic were presented. At the same time, it apparently is not
10 the majority view. I am not inclined to believe it at this
11 time. It may very well be that the Supreme Court of Virginia
12 would say they adopt this particular view in lieu of that
13 view.

14 So under the circumstances the Court will retain
15 its position and make the same ruling as previously made for
16 the record.

17 I understand at this time that the plaintiff would
18 close or rest his case.

19 MR. DAVIS: If your Honor please, although I have
20 heard no formal motion from Mr. Slenker, now that the plain-
21 tiff's case is closed, including the proffer, I think this
22 record should be formalized by immediately assuming that he
23 is making a motion at this time to strike the evidence.

DEO REPORTING
931-3434

1 THE COURT: I haven't heard anything from him here.
2 I assume that would be the position if plaintiff rests at
3 this point.
4 MR. SLENKER: I thought perhaps they would care
5 to take a nonsuit.
6 THE COURT: I haven't heard counsel say that yet.
7 MR. SLENKER: I don't know that they have considered
8 that.
9 THE COURT: I mean, before I make a ruling, in
10 other words, that is a prerogative that counsel has. Up
11 until such time as the Court has ruled.
12 MR. DAVIS: We are not taking a nonsuit.
13 MR. SLENKER: Then I move on behalf of Dr. Rhoads
14 to strike the evidence, if your Honor please, and to enter
15 summary judgment in his favor.
16 THE COURT: I will grant the motion under those
17 circumstances.
18 MR. DAVIS: Show our exception, your Honor.
19 MR. DIXON: Your Honor, may the record show the
20 exception to the previous ruling with respect to the proffer
21 of evidence which I don't think the Court formalized on the
22 record, denied the proffer.
23 THE COURT: All right. Surely, indeed. As I

DEO REPORTING
931-3434

1 indicated, Mr. Dixon, I think you should save everything.
2 Don't leave anything undone.
3 MR. DIXON: For the record, as I understand the
4 Court's ruling, the proffer was refused; is that right?
5 THE COURT: Yes. In other words, assuming that the
6 testimony would be submitted exactly as that.
7 MR. SLENKER: It was not refused.
8 THE COURT: Based on the proffered testimony, in
9 other words, there wasn't a refusal to permit your proffer.
10 MR. SLENKER: As I understand it also, your Honor,
11 in reaching the conclusion and the ruling on the proffer,
12 your Honor took the evidence as represented by Mr. Dixon at
13 face value.
14 THE COURT: This is what I asked him.
15 MR. SLENKER: That's right. That was stated in the
16 very best light without any cross examination of those wit-
17 nesses had they been tendered.
18 THE COURT: This is the very reason I asked him
19 the question I asked him. It's not a question of refusing
20 the proffer. In other words, the proffer had been made. I
21 accept the proffer and I accept the testimony as proffered.
22 Based on that testimony I would take the same posi-
23 tion. I want to make the record clear now, that I am not

DEO REPORTING
931-3434

1 saying that you cannot proffer this testimony. The Court is
2 not refusing it. The same way with any other proffered testi-
3 mony. It's proffered. It's in the record and it's there. I
4 am certainly not refusing you permission to proffer it.
5 I am certainly assuming that if proffered, it would
6 be exactly as stated by counsel and as such the Court's
7 ruling is based on the testimony as given. That was my rea-
8 son for asking you, in the best interest of your client.
9 MR. DIXON: Yes, your Honor.
10 THE COURT: I think the record is clear.
11 Bring the jury in.
12 (Thereupon, the following proceedings continued in
13 the hearing of the jury.)
14 THE COURT: Members of the jury, you won't have to
15 go back in the box. Just stand right outside the box.
16 In light of the events of this case up to this
17 particular point the Court has made certain rulings and has
18 sustained a motion to strike the plaintiff's evidence, and
19 has entered summary judgment for the defendant in this matter.
20 So your services will no longer be needed in this case.
21 Thank you very much for your services.
22 Court will adjourn at this time.
23

DEO REPORTING
931.3434

1 Q Now, Doctor, when you perform an ordinary
2 hysterectomy without removing a tube and ovary, you
3 ordinarily have to put clamps down beside the uterus in
4 order to separate the tissue before you cut it, do you
5 not?
6 A Yes.
7 Q It's customary and proper surgical practice to
8 stay as close to the uterus as possible so that you avoid
9 the other structures that are present in the pelvis; isn't
10 that right?
11 A That is true.
12 Q Incidentally, in your medical school training, you
13 trained at George Washington University; is that right?
14 A Yes.
15 Q You studied anatomy there as part of your basic
16 course?
17 A That's correct.
18 Q That is where you learned your pelvic anatomy,
19 to learn all of the details of what was found in the
20 pelvis?
21 A That is correct.
22 Q You learned where all of the nerves and arteries
23 and veins and the ureter were located in the pelvis?

DEO REPORTING
931-3434

1 A Yes.

2 Q You knew as you performed the hysterectomy that
3 as you have placed these clamps beside the uterus and cut
4 your way down, that if your clamp went too far to the side
5 you had a danger of clamping the ureter, did you not?

6 A Yes.

7 Q And so it's customary practice to be very
8 careful and keep that clamp very close to the uterus,
9 particularly down around the uterine artery; isn't that
10 right?

11 A That is correct.

12 Q The uterine artery is the place that a great
13 deal of medical literature has described as being the
14 location where the ureter is clamped?

15 A Yes.

16 Q It's generally recognized that one isn't supposed
17 to clamp the ureter during the surgery if he can avoid it;
18 isn't that right?

19 A That is correct.

20 Q Usually when you clamp a ureter you recognize it
21 and can repair it at that time?

22 A Occasionally. You can't say usually. I don't
23 know. You can -- I don't know whether you can suspect it.

DEO REPORTING
931-3434

1 In this operation I did not suspect that I had -- did any
2 damage to the ureter.
3 Q Now, Doctor, when one removes the left broad
4 ligament as well as the uterus, you go further off to the
5 side laterally and closer to the ureter with your clamps,
6 do you not?
7 A No, not necessarily --
8 MR. SLENKER: (Interposing) There hasn't been
9 any evidence here that the broad ligament was taken out.
10 The evidence here is --
11 BY MR. DIXON:
12 Q (Interposing) Doctor, have you testified
13 previously that you took out the broad ligament?
14 A I said the left tube and ovary were removed.
15 They are located in the broad ligament.
16 Q Doctor, have you testified previously that you
17 removed the complete broad left ligament?
18 A I believe that I testified that the left tube
19 and ovary were removed. They are all located in the
20 broad ligament.
21 Q Doctor, calling your attention to your
22 deposition, on page 70, you were asked a question, "Well,
23 you remove a portion of the broad ligament; isn't that true?"

DEO REPORTING
931-3434

1 And your answer was, "Well, you remove -- I think you
2 would remove most all the broad ligament."
3 Didn't you give that answer?
4 A Apparently I did.
5 Q When you remove all the broad ligament that
6 takes your further to the side closer to the ureter; does
7 it not?
8 A Not necessarily.
9 Q Anatomically, does the ureter run either in or
10 adjacent to the broad ligament during its course from the
11 kidneys down to the bladder?
12 A It does.
13 Q Incidentally, in the pelvis, are there areas where
14 you can identify the ureter? You can see it right under
15 this thin membrane, called the peritoneum, can you not?
16 A That is true.
17 Q As you get down closer to the uterine artery
18 there becomes a point where it goes a little deeper where
19 you can't see it right through the peritoneum; isn't that
20 right?
21 A That's right.
22 Q When you are performing more extensive surgery,
23 such as cancer surgery, and you recognize you are going to

DEO REPORTING
931-3434

1 be dissecting out laterally into that area where that
2 ureter is at, you usually take certain precautions to make
3 sure that you don't clamp or cut the ureter, do you not?
4 A Yes.
5 Q Those precautions include inserting a catheter
6 into the ureter in an attempt to help you recognize or
7 identify it?
8 MR. SLENKER: Well, if Your Honor please, I make
9 objection to that also because that is not the type of
10 operation that was being done here. There is no
11 testimony that this is extensive. It is major surgery, to
12 be sure. But there is no evidence that it was extensive
13 as the type of surgery that counsel suggests would involve
14 the insertion of catheters in the ureters. There's been
15 no characterization of this operation other than a simple
16 hysterectomy.
17 MR. DIXON: Well, Your Honor, he has already
18 testified that he's gone beyond the usual hysterectomy,
19 that he's gone laterally. I am trying to elicit what the
20 customary practice is when you cut in the area where you
21 recognize that you have a risk of damaging the ureter.
22 MR. SLENKER: You do that in every hysterectomy.
23 But he is asking now about an operation in the pelvis, if

DEO REPORTING
931-3434

1 Your Honor please. That is much more serious than what
2 this operation been.
3 THE COURT: Aren't you going beyond the scope of
4 the particular operation that is in issue here?
5 MR. DIXON: No, Your Honor. I think this
6 relates directly to it. I think it relates directly to the
7 practice when one recognizes that one is lateral and in the
8 area of the ureter.
9 MR. SLENKER: He hasn't said that he was
10 lateral or that he was in the area of it, as counsel
11 suggests.
12 But his question to which I make objection is
13 that he is characterizing a much more serious and
14 involved operation than this one has been characterized
15 as. It may be that the standard would involve use of
16 the catheters in a more serious operation where there
17 is more pathology than as to the generative elements that
18 he was concerned with at the time of surgery.
19 THE COURT: I think you would have a right to
20 examine with respect to this particular procedure as far
21 as a hysterectomy is concerned, but not going beyond that
22 to a broader type of operation in the pelvic area. This
23 is not the issue here. It is a question of whether or not

DEO REPORTING
931-3434

1 he went beyond the scope of that standard that is used and
2 the procedure that is used as far as a hysterectomy is
3 concerned.
4 I think you are going to have to be confined to
5 a hysterectomy, not just any general pelvic operation that
6 would be of a type different from the hysterectomy.
7 MR. DIXON: Well, Your Honor, we are talking
8 about a hysterectomy of a different type. This is a
9 modified hysterectomy that the doctor performed. It's been
10 modified in such a nature that it has certain aspects which
11 relate to both a usual hysterectomy and a more extended
12 hysterectomy where precautions are taken.
13 THE COURT: I haven't heard any testimony it
14 was beyond it, as far as an extended hysterectomy. There
15 has certainly been no testimony from any other witness
16 so far beyond that.
17 I will have to sustain his objection as going
18 beyond the hysterectomy. If you can develop it through
19 this witness, you can ask him any questions with respect
20 to the particular operation, whether or not in this
21 particular operation he had gone beyond, and did he do
22 these things in performing the hysterectomy.
23 But to say is it normal to do this in another

1 operation, that is an operation of a different type. Now,
2 if it's one and the same operation, and if he will say that,
3 then that is something else.
4 MR. DIXON: May my exception be noted?
5 THE COURT: Surely.
6 BY MR. DIXON:
7 Q Doctor, is it customary practice in operations
8 where you recognize that you are getting close to the
9 ureter and you are going beyond the bounds of the usual
10 hysterectomy to take precautions to identify the ureter
11 by means of a catheter or by dissecting around the
12 ureter so that you are aware of its location?
13 A No. We don't ordinarily catheterize ureters
14 in this type of a hysterectomy because this was not an
15 extensive -- it wasn't an extended radical hysterectomy.
16 Q Doctor, if you know that your clamps are in the
17 area where the ureter might be, do you ordinarily put a
18 catheter in?
19 A No, we don't ordinarily do that in usual
20 hysterectomies.
21 Q Doctor, if you know that you are in the area
22 where the ureter might be, do you dissect around the ureter
23 in order to be sure that it didn't get caught in a clamp or

DEO REPORTING
931-3434

1 a suture?

2 A On occasion, if we think it's indicated, we do.

3 Q That is because you recognize that there is a

4 risk that the ureter may be injured; isn't that right?

5 A That's right.

6 Q When you are talking about the radical

7 hysterectomy for cancer surgery, the precautions which

8 you have described, are those precautions because you

9 recognize that you are close to the area where the

10 ureter goes down?

11 A Yes. You recognize that you are going to be

12 operating in and around the ureter, dissecting very close

13 to it.

14 Q When one removes the left broad ligament, that

15 is a portion of a modified cancer operation, is it not?

16 A When you remove the left tube and ovary, you

17 are getting the broad ligament and the left tube and

18 ovary. You are using them synonymously.

19 Now, there are radical removals of the broad

20 ligament and there are not radical removals of the broad

21 ligament. Now, this was not a radical removal of the

22 broad ligament in the sense that you dissected around the

23 ureter and the base of the broad ligament. So there is a

DEO REPORTING
931-3434

1 distinction that you make there.

2 Q Is it your testimony --

3 A (Interposing) This is a simple removal of the

4 tube and ovary, not a radical removal of the tube and

5 ovary.

6 Q Incidentally, Doctor, with respect to the custom

7 that you have described, you were trained at George

8 Washington University, were you not?

9 A Yes.

10 Q And you did your internship where?

11 A My internship at Garfield Memorial Hospital.

12 Q Where is that?

13 A In Washington, D. C.

14 Q That's in the Washington Metropolitan area?

15 A It used to be. It is no longer in existence.

16 And then -- it's no longer in existence.

17 Q You did your residency in obstetrics and

18 gynecology at George Washington University?

19 A No, at the Washington Hospital Center.

20 Q That is also in Washington, D. C.?

21 A Yes.

22 Q You subsequently had further experience and

23 practice, did you not?

DEO REPORTING
931-3434

1 A Yes.

2 Q Where was that at?

3 A I was in the Air Force for a number of years.

4 Q While you were in the Air Force you worked with

5 doctors that had been trained all over the country?

6 A Yes.

7 Q Doctor, did you find that the customary

8 practices which you are describing are ordinarily performed

9 with a hysterectomy, were the customary practices which

10 you learned while you were in Washington?

11 MR. SLENKER: I object. If Your Honor please,

12 the test in this case, as I understand the law in

13 Virginia, is the test of medical care that prevails here

14 in Prince William County. That is where Dr. Rhoads

15 practices. I don't think there has to be a showing that

16 he is familiar with the standards elsewhere in order for

17 him to practice with the standards that prevail here.

18 MR. DIXON: Your Honor, I think that the rules

19 provide that the doctor's standard is the standard of

20 this locality or similar locality. I think we are entitled

21 to explore what those similar localities are.

22 MR. SLENKER: That might be, Your Honor. But

23 he said throughout the world. Where throughout the world?

DEO REPORTING
931-3434

1 Are those localities, indeed, similar to here where
2 Dr. Rhoads practices? That is the test.
3 THE COURT: I think that is definitely the test.
4 There is no question about that being the test.
5 I assume what you are saying is that the
6 customary standard or procedure in the practice in the
7 District of Columbia were the same as they were here in
8 Prince William County. Is that what you are asking?
9 MR. DIXON: Yes, Your Honor.
10 THE COURT: I will let him answer that question.
11 MR. SLENKER: Well, it's not the test of what it
12 is in Washington, if Your Honor please.
13 THE COURT: No. But, in other words, he will
14 still have to show what the standards are here in Prince
15 William County. He is merely asking him if they are the
16 same standards. He hasn't asked what those standards are.
17 MR. SLENKER: He hasn't asked if Dr. Rhoads
18 knows what those standards are in Washington, D. C. in
19 1970.
20 THE COURT: I think you might ask him that.
21 MR. SLENKER: If he knows what they are. I don't
22 think he practices over there.
23 THE COURT: I don't know. But I think he can ask

DEO REPORTING
931-3434

him that.

MR. DIXON: I'd like to lay a more extensive foundation on that, Your Honor.

BY MR. DIXON:

Q Doctor, after you completed your residency did you immediately stop your medical education?

A No, I did not.

Q You continued on with medical education in order to keep current on matters, did you not?

A That is right.

Q Some of the things that you did included reading journals which are published on a national basis?

A Yes.

Q The standard of practice which you have followed is, in part, based upon the experiences from those journals?

A In part, yes.

Q You also have attended medical conventions and medical meetings in order to keep up in medicine, have you not?

A That's right.

Q You have attended medical meetings in all different parts of the country, have you not?

DEO REPORTING
931-3434

1 A Yes.

2 Q That's the customary practice of doctors in your

3 specialty, is it not?

4 A Yes.

5 Q Doctor, you are a specialty in obstetrics and

6 gynecology, are you not?

7 A Yes.

8 Q You did pass your Boards in order to become a

9 specialist, didn't you?

10 A Yes.

11 Q It's a hard thing to pass your Boards, isn't it?

12 A That is correct.

13 Q In passing your Boards, you took a national test

14 where your performance was compared with doctors from all

15 over the country; isn't that right?

16 A I assume, yes.

17 Q Your performance was expected to be up with those

18 from doctors from all over other parts of the country,

19 were they not?

20 A I assume, yes.

21 Q When you took your Boards, didn't you also have

22 to take an oral examination, Doctor?

23 A Yes.

DEO REPORTING
931-3434

Q That oral examination was not based on what the practice was at Prince William County, was it? It was based on the practice of obsteticians on a nation-wide basis, was it not?

MR. SLENKER: I object to that, if Your Honor please. I think there has got to be some showing that, indeed, what he was asked referred to a standard of practice as distinguished from theoretical or clinical information or medical information or what.

THE COURT: I will sustain the objection.

BY MR. DIXON:

Q Doctor, the doctors which tested you were from other areas of the country, were they not?

A Yes.

Q The books that you studied in preparation for your Boards were books that were written by doctors from all over part of the country, were they not?

A Yes.

Q Since you passed your Boards you haven't stopped keeping track of these practices of obstretrics and gynecology, have you?

A No.

Q Doctor, while you worked in the Air Force you

DEO REPORTING
931-3434

1 worked with physicians who were trained in a number of
2 medical schools and medical centers all over the country,
3 did you not?
4 A Yes.
5 Q You found that the standard of practice of the
6 physicians was about the same, that they were approximately
7 equal in competency?
8 A Yes, most of the time. Yes.
9 Q You found that your skills were on a par with
10 those of physicians from any other area of the country,
11 didn't you?
12 A Yes.
13 Q When patients come to you you don't tell them
14 that you don't practice as good medicine as the doctors
15 in the District of Columbia, do you?
16 MR. SLENKER: Objection, if Your Honor please.
17 THE COURT: Objection sustained.
18 BY MR.DIXON:
19 Q Doctor, isn't the standard of practice of
20 Board-certified specialists in your specialty the same
21 whether you are practicing in Prince William County or
22 practicing in the District of Columbia?
23 MR. SLENKER: Objection, if Your Honor please.

1 That is not the standard.

2 THE COURT: That is not the standard. The

3 objection is sustained.

4 BY MR. DIXON:

5 Q Doctor, the standard of practice of Board-

6 certified specialists such as yourself, was it the same

7 in 1970, whether you were practicing in Prince William

8 County or in the District of Columbia?

9 MR. SLENKER: Objection, if Your Honor please.

10 THE COURT: Sustained.

11 BY MR. DIXON:

12 Q Doctor, in 1970, was the medical community of

13 Prince William County similar to that as the medical

14 community in the District of Columbia?

15 MR. SLENKER: Objection, if Your Honor please.

16 The question is not whether or not it's similar to

17 Washington, D. C. The question is what are the standards

18 here. If you don't know what the standards are here then

19 presumably you have to show what the standards are at some

20 other equivalent community. I think Your Honor can find

21 and judicially take notice that Washington, D. C. is not

22 the same.

23 MR. DIXON: The question goes as to whether they

DEO REPORTING
931-3434

1 are the same.

2 MR. SLENKER: There's been no showing that he

3 knows what they are.

4 THE COURT: I will sustain his objection.

5 BY MR. DIXON:

6 Q Doctor, in 1970, did you attend any medical

7 meetings in the District of Columbia?

8 A Yes.

9 Q Didn't you read medical literature from doctors

10 who are practicing in the District of Columbia?

11 A On occasion.

12 Q Doctor, have you had occasion to engage in

13 professional intercourse in 1970 with doctors who were

14 practicing in Washington, D. C.?

15 A Yes.

16 Q Doctor, didn't you find, based on those

17 observations, that the practice in the field of obstetrics

18 and gynecology was the same in Prince William County as it

19 was in Washington, D. C.?

20 MR. SLENKER: Objection, if Your Honor please,

21 because the answer to that question obviously rests on what

22 those men that he came in contact with, irrespective of

23 what the number is, said to him, which may or may not mean

DEO REPORTING
931-3434

1 what the practice is.

2 THE COURT: I sustain the objection.

3 MR. DIXON: May my exception be noted, Your Honor?

4 THE COURT: Yes, sir.

5 MR. DIXON: May my exception be noted to the

6 previous objections that have been sustained?

7 THE COURT: Surely, absolutely.

8 BY MR. DIXON:

9 Q Doctor, Prince William Hospital is a hospital

10 of how many beds?

11 A One hundred fifty beds.

12 Q How many did it have in 1970?

13 A It had about, I think, 100 beds in 1970, I

14 believe.

15 Q How many doctors were practicing at the hospital

16 in 1970?

17 A I don't know for sure. I'm not exactly sure

18 how many were on the staff at that time.

19 Q Do you have an approximate number, Doctor?

20 A I would say there were probably 50.

21 Q Is that 50 on the active staff?

22 A Gosh, I'm just not entirely sure about that.

23 Q You don't specifically recall now?

DEO REPORTING
931-3434

1 witness --

2 THE COURT: (Interposing) I will sustain the

3 objection.

4 MR. DIXON: Okay.

5 BY MR. DIXON:

6 Q Doctor, did you have familiarity in 1970 with

7 the obstetrical care and gynecological care in the D. C.

8 area so as to state whether it was a medical community

9 similar to Prince William County insofar as the standards

10 of obstetrical and gynecological care are concerned?

11 A Would you state that again, please?

12 (Thereupon, the Reporter read the preceding

13 question in open court.)

14 THE WITNESS: Yes.

15 BY MR. DIXON:

16 Q Did you find that the obstetrical and gynecologi-

17 cal care of the medical community of the District of

18 Columbia was similar to that of Prince William County?

19 MR. SLENKER: I object, if Your Honor please.

20 The test is what is it here.

21 THE COURT: I think he can testify as to

22 whether or not he found that it was similar to that. Then

23 he may answer his question as to whether or not that is

DEO REPORTING
931-3434

similar to the care here.

I will overrule your objection, Mr. Slenker.

THE WITNESS: I think the care is similar.

BY MR. DIXON:

Q In your experience, is the same true for other metropolitan areas, sir?

MR. SLENKER: Objection, if Your Honor please, unless there is some showing he is familiar with other metropolitan areas.

BY MR. DIXON:

Q Doctor, six days after the hysterectomy operation, Mrs. Bly had fever and some flank pain, did she not?

A No. She never complained of flank pain to me, but she had fever.

Q Did she have flank pain, as recorded in the nurses' notes?

A No. She didn't complain to me of flank pain.

Q Did she have flank pain, as recorded in the nurses' notes?

MR. SLENKER: Well, for what day and what time? If Your Honor please, it seems to me like we are backing out of the admissibility of evidence, and I think Your Honor

1 talking about other cases. I'm talking about in this
2 particular case, Mrs. Bly.
3 Q Excuse me, sir. What would be the characteriza-
4 tion that you can give the Jury with reference to the
5 type of operation that this was, so far as Mrs. Bly was
6 concerned?
7 A I think it was just -- it was like any other
8 pelvic procedure that I've done. It wasn't an unusual
9 pelvic procedure.
10 Q Did it involve any cancer consideration?
11 A There was no cancer involved.
12 Q It's major surgery, is it not?
13 A Yes.
14 Q But are there routine or nominal major surgical
15 procedures?
16 A Yes.
17 Q Is this one of them?
18 A I would say that this was one. I didn't think
19 that the -- I thought that there was -- it was a type of
20 condition. I felt that there was no problem handling it.
21 In my judgment at the time, there was no problem handling
22 it.
23 Q Indeed, during the course of the operation, was

1 In other words, sometimes you take a uterus out
2 because of bleeding. That uterus can be normal. But she
3 still -- the pathology report comes back, uterus normal.
4 But that doesn't mean that the patient isn't losing six
5 quarts of blood every time she has a period. If she is
6 having severe cramps, you can still have a normal uterus.
7 Because a uterus is normal doesn't mean it wasn't abnormal
8 in its situation.
9 Q In doing this hysterectomy, the operation,
10 Dr. Rhoads, will you tell the members of the Jury if it
11 was done in accordance with the standards that prevails
12 here in Prince William?
13 A Yes.
14 Q Where did you learn to do this type of surgery?
15 A In my residency training.
16 Q Does this have any special name of technique
17 or anything?
18 A It's called -- it's called a total abdominal
19 hysterectomy. And the technique is the Richardson
20 technique is what we call it.
21 Q Is it the same type of technique that is
22 utilized by other Ob-Gyn surgeons in this area?
23 A Yes.

Q Anything unusual about it?

A No.

Q With reference to the area where you come in closest proximity to the ureter, the left ureter particularly, will you tell the members of the Jury where that is?

A The ureter is about two centimeters lateral to the cervix or the lower part of the womb. This is the closest area that we get to the ureter.

Q Now, when you say it gets that close, do you mean that it runs right down to that point or does it run along parallel with that point?

A No. It runs down to that point. And then it drops down under the broad ligament and goes up into the bladder.

Q Go ahead.

A That is essentially what it does at that point.

Q You knew of this location at the time that you began the hysterectomy, did you not?

A Yes.

Q You knew that at some point during the course of it you were going to come to this point where you were close to the ureter?

DEO REPORTING
931-3434

1 A Yes.

2 Q How do you try to stay away from the ureter, or

3 what do you do during the course of a hysterectomy to

4 accommodate that?

5 A When you are doing a hysterectomy you stay as

6 close to the uterus as you can. In other words, you

7 actually, when you clamp the tissue, you clamp right off

8 the uterus. In other words, you clamp-grasp the uterus

9 and it slides off of it. So you are grasping as close to

10 the uterus as you can. This is what we do to avoid

11 trauma -- or trauma to the ureter.

12 Q Were you taught in medical school that if you

13 did it this way that there would be no involvement of the

14 ureter?

15 A Yes, that you were safe if you followed that

16 technique.

17 Q Approximately how many of these hysterectomies

18 have you done in your time, sir?

19 MR. DIXON: Your Honor, I object to that. I

20 think that is immaterial.

21 THE COURT: Objection sustained.

22 BY MR. SLENKER:

23 Q Have you ever encountered in your own practice

DEO REPORTING
931-3434

1 Q Now, I believe that you testified on direct
2 examination that you were present with Dr. Bagley sometime
3 in February at the time that the ureter was reimplanted?
4 A Yes.
5 Q Did you actually see the point at which there was
6 blockage of this ureter?
7 A Yes. I saw the point of blockage.
8 Q Where was that with reference to the bladder?
9 A It was approximately an inch and a half or so
10 from the entry of the ureter into the bladder.
11 Q How far was it away from where there had been
12 dissection of the uterus?
13 A It was approximately the same -- same distance.
14 Q The same distance?
15 A I think so. It was in the same area.
16 Q You saw the blockage. What was the nature of the
17 blockage, or what was the nature of what you were able to
18 observe there at the operation?
19 A The only thing that we saw there was that there
20 was a massive scar tissue in the area of the blocked ureter.
21 Q Was that located at the distance that you have
22 told us before as being away from the bladder and away from
23 the uterus?

DEO REPORTING
931-3434

Q The past report didn't describe any tissue that was indurated, did it?

A No.

Q Now, Doctor, you've been very helpful in going over the description of the operation with us. You've told us how you keep the clamps very close to the uterus as you go down; is that right?

A Right.

Q That's a part of the normal hysterectomy; isn't that correct?

A Yes.

Q You recognize that if you go lateral to the uterus itself, you are going to be getting over close to the ureters; isn't that right?

A That's right.

Q Isn't it true that it's your present impression that you did not go lateral directly beside the uterus?

A That is correct.

Q That was your intention at the time of surgery?

A That's correct.

Q If you, in fact, had gone lateral to the uterus, then this would have been a departure from the technique which you had attempted to follow?

DEO REPORTING
931.3434

1 A That's correct.

2 Q That would have been a departure from the usual

3 technique?

4 MR. SLENKER: Objection, Your Honor, please,

5 because we are into the area of speculation. He said he

6 went along. He described it. So he says, well if you

7 didn't do that, and there isn't any evidence that he

8 didn't.

9 THE COURT: I will overrule your objection,

10 Mr. Slenker.

11 A Yes. I stayed -- I tried to say as close --

12 in other words, right off the edge of the uterus.

13 BY MR. DIXON:

14 Q In other words, you put that clamp right as

15 tight against the uterus as you could; is that right?

16 A That's true, yes.

17 Q That was necessary to avoid the ureter; is that

18 right?

19 A Right. That's correct.

20 Q If you went lateral to that, because of some

21 clamping problem, or putting a suture in lateral, then

22 that would be a break in the standard technique which you

23 have testified is the customary practice in the community?

DEO REPORTING
931-3434

1 MR. SLENKER: I object to that because there isn't
2 any evidence that that was done, Your Honor. We are in
3 the area of speculation. He's told him what he did. And
4 he said, but if you didn't do that, then you didn't pursue
5 the standard. But there isn't any evidence that he didn't
6 do it.
7 MR. DIXON: Your Honor, this is cross-examination.
8 THE COURT: I will overrule your objection,
9 Mr. Slenker, if he didn't do it. He certainly hasn't
10 stated that he did.
11 MR. SLENKER: That's right, so there isn't any
12 evidence to sustain the hypothesis. I will save an
13 exception, if Your Honor, please.
14 THE COURT: All right. Sure.
15 A What was the question again?
16 THE COURT: Would the reporter repeat it?
17 "Question: If you went lateral to that, because
18 of some clamping problem, or putting a suture in lateral,
19 then that would be a break in the standard technique
20 which you have testified is the customary practice
21 in the community?"
22 A Yes.
23

DEO REPORTING
931-3434

BY MR. DIXON:

Q As a matter of fact, if you had followed the customary practice, then the ureter would not have been clamped; is that right?

MR. SLENKER: Objection, if Your Honor please.

THE COURT: Objection sustained.

BY MR. DIXON:

Q Doctor, if you had followed the customary practice in the community, you would not have removed the entire broad ligament, would you?

A I didn't remove the entire broad ligament.

Q If the entire broad ligament had been removed, would that have been a departure from --

THE COURT: (Interposing) I am going to sustain it. I think you are getting too far afield. You are really getting into the field of speculation.

MR. DIXON: Your Honor, I am perfectly prepared to tie this together and I will proffer to the Court that I shall.

THE COURT: I will sustain the objection at this point. There has been no testimony by this witness that he removed the broad ligament.

DEO REPORTING
931 3434

1 MR. DIXON: Your Honor, may I approach the bench.
2 THE COURT: Sure.
3 (The following proceedings were had at the bench
4 by Court and counsel out of the hearing of the jury.)
5 MR. DIXON: Your Honor, I think this is cross-
6 examination and I think I should be permitted a wide
7 latitude in this. I think that the record is clear from
8 Dr. Rhoads's previous deposition. This is a factual
9 foundation for the area that I am pursuing. And the Court
10 can see it in his deposition.
11 MR. SLENKER: You pursued that on direct
12 examination. You asked him,when you first had the witness,
13 about page 70. You went all through that. I am entitled
14 to ask him about it in order to permit him to explain
15 what the answer was and he has done that. Now I don't
16 understand the thrust of your question. He has denied
17 what you asked, Mr. Dixon.
18 MR. DIXON: Your Honor, I asked him one question
19 about that, the removal of the broad ligament. Now there
20 are two pages here. I was shocked when he originally told
21 me that he had removed the entire broad ligament, but he
22 did. And I went through this. I finally asked him two
23 separate questions. I think I am entitled to bring those up.

DEO REPORTING
931 3434

1 THE COURT: I think you can use this if you want
2 to impeach him, if his testimony was different today.
3 MR. DIXON: The questions I was asking were
4 preliminary questions to that matter. I think I have to
5 ask those in order to --
6 THE COURT: (Interposing) I think you are getting
7 into a lot of area here. Whether or not this jury can sift
8 this out and so-call dissect it, worries me. If you didn't
9 do this and if you didn't do that, there has been no
10 testimony. So, if you have any testimony in that deposition
11 that he has testified contrary to today, then you can
12 certainly attempt to impeach him with that. So I will
13 sustain the objection.
14 MR. DIXON: The objection was to what? As I
15 understood the question, the question is, was removing all
16 of the broad ligament a departure from the standard.
17 THE COURT: That is right. I permitted you to
18 ask him that one question which, frankly, I should have
19 sustained the objection to that because you are getting into
20 the field of speculation. But then when you go ahead to
21 continue to pursue these if, if, if --
22 MR. DIXON: (Interposing) All right. My concern
23 is this. The witness has testified that he customarily

DEO REPORTING
931.3434

1 removed all of the broad ligament. That is his testimony
2 here in these depositions.
3 THE COURT: We are talking about Mrs. Bly's case.
4 MR. DIXON: The questions are within the context
5 of Mrs. Bly's case in his deposition. I think the
6 deposition speaks for itself in that sense.
7 THE COURT: I have sustained his objection. I
8 think we are wasting a lot of time. I have sustained his
9 objection to that line of questioning as to what would
10 happen if he had done this and done that. You may note your
11 exception.
12 MR. DIXON: Your Honor, the question that I am
13 asking is about what the standard is. Now, I didn't ask
14 this witness about any questions about the standards in the
15 community. Mr. Slenker, in his examination, went into the
16 standards and went into what was appropriate.
17 THE COURT: But you start of by if, if, and if.
18 You don't establish a standard that way.
19 MR. DIXON: I am trying to define the standard.
20 MR. SLENKER: Ask him what the standard is.
21 MR. DIXON: I think I am entitled to ask him by
22 cross-examination and leading questions as to the standard.
23 THE COURT: No. I have sustained his objection.

DEO REPORTING
931-3434

1 I will stick with that, Mr. Dixon.

2 (Thereupon, the following proceedings continued

3 in the hearing of the jury.)

4 BY MR. DIXON:

5 Q Doctor, have you previously testified in your

6 deposition, starting on page 69:

7 "Did you also remove the broad ligament?

8 Answer: The broad ligament -- the tube and

9 ovary are in the broad ligament."

10 "In this case the tube and ovary were adherent

11 to the ureters?

12 Answer: Yes."

13 "So you didn't have to remove much of the broad

14 ligament on that side, did you?

15 Answer: Yes. You have to remove the broad

16 ligament. You always do when you take the tube and

17 ovary out."

18 "Approximately how wide a fragment of the broad

19 ligament did you have to remove on this side?

20 Answer: Well, I mean it's hard to say how wide

21 it is. It included the tube and ovary.

22 Question: But the reason why I asked, Doctor,

23 is because the tube and ovary were described as being

1 "adherent to the uterus. So I'm concerned about
2 how much of the broad ligament would have been
3 included if the tube and ovary were right against
4 the uterus.
5 Answer: Well, they are all -- you know, it's
6 all one area where the tube and ovary are inside the
7 broad ligament. And when you remove the tube and
8 ovary, you remove the broad ligament.
9 Question: Is this your usual procedure, to
10 remove all the broad ligament on that side when you
11 remove the tube and ovary?"
12 MR. SLENKER: Now I object there, if Your Honor
13 please, because he asked, "Is this your usual procedure."
14 He just told Your Honor at the bench that this referred
15 to Mrs. Bly's case, not usual and not customary standards.
16 He told you this question had reference particularly to
17 Mrs. Bly's case. It does not by the very use of the
18 language here about a usual procedure, what is customarily
19 done.
20 THE COURT: I am going to permit him though to
21 examine him with respect to his answer to that particular
22 question.
23

DEO REPORTING
931-3434

1 MR. SLENKER: May I have an exception.

2 BY MR. DIXON:

3 Q Your answer is, "Um-hum"; is that correct, sir?

4 A Yes. That is in the deposition.

5 Q Doctor, is that the customary standard to remove

6 all of the broad ligament?

7 MR. SLENKER: Objection, if Your Honor please

8 to what is the customary standard with reference to removal

9 of the broad ligament. Let's keep it to Mrs. Bly's case

10 if we might, sir, to what he removed here, if any part of

11 the ligament.

12 THE COURT: I think that is in line with my former

13 ruling, Mr. Dixon, and I will sustain the objection. The

14 issue here is Mrs. Bly's operation. It's not the customary

15 operation or any other operation. The issue here is her

16 operation, whether it deviated from the norm.

17 MR. DIXON: Well, Your Honor, I think that the

18 thrust of the doctor's previous testimony is to the

19 fact that he did remove all of the broad ligament in

20 Mrs. Bly's case. If there is a conflict, I think that is

21 for the jury to resolve.

22 THE COURT: I permitted you to examine, in other

23 words, along the lines of the questions and answers asked

DEO REPORTING
931-3434

in that deposition just a few moments ago. When you say it is customary, we get right back to the same thing that it is customary. We are talking about a custom. The question here in this particular situation is, did he in this particular operation deviate from the norm.

MR. DIXON: Your Honor, the only way I can determine whether the doctor deviated from the norm is by dissecting out what the standards of the norm are and find out whether the doctor adhered to them. That requires two parts: One, determining what the standard is; and, two, determining what he did. I thought my question was directed to that part one.

THE COURT: I sustain his objection.

MR. DIXON: May my exception be noted.

THE COURT: Yes, sir.

BY MR. DIXON:

Q Doctor, I believe that you had previously testified that with respect to the blockage of this ureter and subsequent complications, this was outside of the field of obstetrics and gynecology; is that right?

A Yes. I think that a blockage of a kidney or ureter, the handling of it is done by a urologist.

DEO REPORTING
931-3434

1 DIRECT EXAMINATION

2 BY MR. DIXON:

3 Q Would you state your name and address, sir?

4 A My name is Dr. Louis S. Gerstley, III.

5 Address -- home or office?

6 Q Both.

7 A Home address, 900 Homestead Road, Jenkintown,

8 Pennsylvania. Office address, Cedarbrook Hill Apartments,

9 CM-23, Wyncote, Pennsylvania 19095.

10 Q Thank you sir. What is your occupation?

11 A I am an obstetrician and gynecologist.

12 Q How long have you had that occupation?

13 A I have been in the specialty in private practice

14 for eighteen years. Before that I had three years additional

15 training as a resident.

16 Q Now, would you tell us what your premedical

17 education and your medical education have consisted of, sir?

18 A My premedical education was at Harvard University.

19 My medical education was at the University of Pennsylvania.

20 Q By medical education, you are referring to

21 how many years of work?

22 A Four years of medical school, one year of internship

23 at the hospital of the University of Pennsylvania, and three

DEO REPORTING
931-3434

1 years of residency at Temple Hospital in Philadelphia.

2 Q That was completed when, sir?

3 A 1956.

4 Q Did that qualify you at that time for Board

5 certification, sir?

6 A When you finish your residency, you are what

7 is called Board eligible.

8 Q What does that mean?

9 A That means you have completed an approved

10 residency training program. And you -- at that point

11 in history, we were not allowed to take our Boards until

12 three years after we had completed our training. You

13 had to have three years of private practice with the

14 cases to submit to the Boards. And then you took your

15 Board examinations. And if you passed them, you were

16 then Board certified.

17 Q Did you subsequently take those examinations, sir?

18 A I did.

19 Q Are you now Board certified?

20 A I am.

21 Q Have you had any hospital affiliations since

22 completing your residency, sir?

23 A Yes, I have.

DEO REPORTING
931-3434

1 Q Can you tell us what those affiliations have
2 consisted of?
3 A My private practice has been at the Abington
4 Memorial Hospital in Abington, Pennsylvania, and the
5 Albert Einstein Medical Center, Northern Division, in
6 Philadelphia. And at one point, I was Chief -- first,
7 Assistant Chief, and then later Chief of Clinics at
8 Philadelphia General Hospital, which was charitable-type
9 work, educational-type.
10 Q How long have you had these hospital appointments?
11 A At Abington and Einstein, I joined the staff
12 in July of 1956. I also started at Philadelphia General
13 in 1956. I left Philadelphia General in 1967.
14 Q As a part of your responsibilities at the
15 hospital, did you have any medical staff responsibilities,
16 sir?
17 A What do you mean?
18 Q Let me be more specific. Did you ever work as
19 as an officer on a committee of the medical staff?
20 A Oh yes, many.
21 Q What is the medical staff?
22 A The medical staff is made up of the physicians
23 who practice at a hospital.

DEO REPORTING
931-3434

1 Q What kind of committees do the hospitals have?

2 A Oh, I've been --

3 MR. SLENKER: (Interposing) I object to the

4 materiality and the relevancy of this.

5 MR. DIXON: Your Honor, this goes into the

6 qualifications of this Doctor, the experience that he's had.

7 This question goes into his relations and observations

8 with other physicians.

9 MR. SLENKER: That may be, but the medical staff

10 at Einstein or at Abington is immaterial.

11 THE COURT: I think he can testify what he

12 observed. I will overrule the objection.

13 MR. DIXON: Thank you.

14 THE WITNESS: Am I to answer that question?

15 BY MR. DIXON:

16 Q Yes.

17 A The medical records committee which peruses

18 medical records to see if they are up to snuff; tissue

19 committees, which review the cases that are done where

20 there is a discrepancy between what the doctor sends to

21 a pathology laboratory and the tissue that is submitted.

22 For instance, if a man says -- submitted to pathology,

23 acute appendicitis and an appendix and it is a normal

DEO REPORTING
931-3434

1 appendix, this would go to the tissue committee to find
2 out why indeed the operation was done and pass on its
3 justification and verification.
4 Then I have been on utilization committees which
5 determine whether or not a patient belongs in a hospital.
6 I have been on obstetrical review committees, gynecological
7 review committees, paranatal review committees where we
8 review cases to see if they are in the purview of these
9 areas.
10 It's part of the physician's maintaing good
11 control over other physicians to make sure the practice
12 of medicine is always kept up to its best possible level.
13 I am trying to think what other committees.
14 Well, I think that is a pretty fair representative.
15 Q With respect to the tissue review committee,
16 was one of those responsibilities with respect to that
17 committee the obligation to review reports of pathology
18 specimens from the gynecology department?
19 A Yes.
20 Q Did that include the evaluation of pathology
21 reports on the female structures known as the uterus,
22 the tubes and the ovaries?
23

DEO REPORTING
931-3434

1 A Yes.

2 Q What was your job with respect to those particular
3 studies?

4 A Well, the hospital at which I did -- sat on
5 the tissue committee for the longest -- I think I was on
6 the Einstein Tissue Committee for something close to ten
7 or twelve years. We had a practice of referring -- all
8 hysterectomies were referred to the tissue committee for
9 evaluation on every single patient who had a hysterectomy.
10 The whole case was sent always to the tissue committee
11 to determine if the case was indeed justified.

12 Q Now, Doctor, do you have any medical licensures,
13 sir?

14 A Yes. I am licensed in the State of Pennsylvania.

15 Q Have you had any academic appointments?

16 A Yes. I am Clinical Associate Professor of
17 Obstetrics and Gynecology at Temple University Hospital.

18 Q What is a Clinical Professor?

19 A A Clinical Professor is one who is basically not
20 full time in the academic levels of medicine. I am a
21 full time private practitioner. Temple University sends
22 their medical students up to the hospital where I am engaged
23 in teaching them at Einstein Northern.

DEO REPORTING
931-3434

1 We teach the students so that they give me
2 professorial rank at the parent hospital so that it
3 enters the catalogue and indicates that these students are
4 coming to a then qualified staff member.
5 Q What is the level of training of the students
6 which you teach as a result of this academic appointment,
7 sir?
8 A All levels.
9 Q Now, could you --
10 A (Interposing) First year, second year, third
11 year, fourth year students.
12 Q These are medical students?
13 A Yes.
14 Q Do you also have occasion to teach or train
15 interns?
16 A And residents at the hospital. They are not
17 Temple interns and residents. They are our own hospital
18 interns and residents.
19 The interns who rotate through our service, this
20 is coming to a close because the internship program throughout
21 the United States is coming to a close. The residents who
22 are in our program, I am Director of Resident Training
23 at Einstein, not at Abington.

DEO REPORTING
931-3434

1 Q What is an intern as opposed to a resident?

2 A An intern is somebody taking special training,

3 one year out of medical school. A residency was --

4 an internship was supposed to have been a fairly broad

5 covering of all the phases of medicine.

6 We used to have what we called rotating internships.

7 These have gradually disappeared over the last decade

8 or so, and have been headed toward what we call straight

9 internships where you take an internship in a particular

10 specialty. And because this has come to be such a common

11 occurrence, it was sort of felt why spend an extra year.

12 We want to make more doctors. And they now go on almost

13 directly out of medical school into residency.

14 And they will be beginning the first year of

15 internship with the first year of residency, the idea being

16 that you get part of your internship in the fourth year

17 of medical school now and part of your internship is

18 sort of absorbed in the first year of residency as we do

19 away with rotating internships.

20 Q What is a resident?

21 A A resident is a physician who is taking training

22 in a given specialty, specialty level training in a given

23 specialty.

DEO REPORTING
931-3434

1 Q The residency of your training is in the area
2 of obstetrics and gynecology?
3 A Obstetrics and Gynecology, yes.
4 Q That includes both areas?
5 A Yes.
6 Q Can you tell us when you commenced training?
7 A When I commenced?
8 Q Yes.
9 A As soon as I entered private practice.
10 Q Have your residents and interns gone out in
11 private practice on their own?
12 A Oh yes.
13 Q Can you tell us what kinds of geographical
14 localities these interns and residents have gone to?
15 A Up and down the length of the country, sir,
16 urban centers, teaching centers, local communities, almost
17 any place you could name.
18 At -- let's see. At Philadelphia General, we had
19 four residents a year. At Abington, at that point, one,
20 and at Einstein, two or three residents a year. So that
21 would be seven, eight residents a year times eighteen years,
22 approximately would give you the total number of residents.
23

DEO REPORTING
931-3434

1 And these are spread out to 126, if my memory serves me,--
2 no -- 144 residents that have gone to places that
3 144 doctors might go to practice.
4 Q Have you had occasion to keep in contact with
5 any of these doctors who have left your program?
6 A Some of them. Not all of them. Yes.
7 Q Have you had occasion to associate with other
8 obstetricians and gynecologists who practice this specialty
9 since the completion of your training?
10 A Oh, certainly.
11 Q Can you tell us how you kept in contact with
12 other doctors, sir?
13 A Well, through going to the specialty board
14 meetings. The American College of Ob-Gyn. meets annually
15 in various parts of the United States. And then, in
16 addition, in Philadelphia we have something called the
17 Obstetrician Society of Philadelphia, which is the
18 second oldest professional society of its kind in the
19 United States. And we have a number of obstetricians
20 and gynecologists who are drawn through the entire area,
21 not just Philadelphia but upstate Pennsylvania, New Jersey,
22 Delaware, who come to these meetings that are held once
23 a month, eight months out of the year.

1 Q As a result of this experience, Doctor, have
2 you had occasion to become familiar with the standard of
3 practice in the field of obstetrics and gynecology of
4 Board certified specialists in the United States?
5 A Yes.
6 Q Have you formed any opinions as to the variations
7 in the standard of practice within the various areas of
8 the United States?
9 A Most of the physicians whom I know and where I
10 have seen have pretty much one level of practice. It's
11 kept fairly standard by the fact that there is just one
12 set of Board certifying organization within our specialty.
13 Everybody who wishes to be certified in our specialty
14 goes to Chicago where the American Board of Ob-Gyn. is
15 and everybody gets certified there. And they grade
16 everybody on a single level of practice.
17 There isn't -- we don't make a man a specialist
18 in a different level of education or knowledge or ability
19 because he practices here or he practices there. He either
20 passes the Boards or he doesn't pass the Boards.
21 Q Now, when a doctor takes these Board examinations,
22 is he tested by other physicians?
23 A Yes, he is.

1 Q Where do these doctors who perform the testing
2 come from?
3 A All over the country, again. The Board Examiners
4 are made up usually of outstanding men, men with fine
5 reputations in the field, many times professors, heads of
6 departments, but they can come fairly widely scattered
7 throughout the country.
8 Q Do some of these individuals also come from small
9 towns?
10 A Yes.
11 Q Now, calling your attention to the case of
12 Mrs. Betty Bly, have you had occasion to review the medical
13 records of Mrs. Bly's admission to Prince William Hospital
14 in September of 1970 and her admission to the hospital
15 in October of 1970, wherein she was discharged in November
16 of 1970?
17 A Yes, I have.
18 MR. DIXON: Your Honor, I am going to offer this
19 man for his qualifications at this time prior to asking him
20 a hypothetical question in order that counsel may object
21 or voir dire the witness.
22 THE COURT: Do you wish to voir dire the witness?
23 MR. SLENKER: No. I believe at this time, Your

1 Honor, I will wait for the hypothetical question.

2 THE COURT: All right, sir.

3 Doctor, after he has posed his hypothetical

4 question, please don't answer until the Court has ruled

5 on the objection he is going to raise.

6 THE WITNESS: Yes, Your Honor.

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1 BY MR. DIXON:

2 Q Doctor, I want you to assume that Mrs. Betty Bly
3 went to military doctors during the years 1966 through 1968.
4 During the course of those years she was treated in October,
5 1966, for a non-gynecological infection with tetracycline;
6 and that on the 6th of December, 1966, she had a pap smear
7 which was read as having trichomonas in the smear; that Mrs.
8 Bly in August of 1967 was treated for a non-gynecological
9 problem in which she received penicillin by mouth. And again
10 in September, 1967, Mrs. Bly was treated with penicillin.

11 I want you to assume further that on the 14th day of
12 November, 1967, Mrs. Bly was treated for complaints of dysuria
13 and hematuria and that the subsequent treating doctor, Dr.
14 Rhoads, read in the record that this complaint was related in
15 that record to a kidney infection and vaginitis which was
16 attributed to trichomonas.

17 In November of 1967, Mrs. Bly was treated, according to
18 the military records, for what was described as a suspected
19 ruptured follicular cyst; and that on the 17th of November,
20 1967, a right adnexa mass was determined.

21 I want you further to assume that on the 27th of
22 February, 1968, Mrs. Bly again was treated because of a mass
23 in the right adnexa which, according to the treating physician

1 at that time may have been either an ovarian cyst or an
2 adnoma.
3 I want you to further assume that on March 7, 1968,
4 Mrs. Bly had right lower quadrant pain and pain which was
5 described a premenstrual pain, according to the military
6 records; that a consideration was made to the question of
7 dysmenorrhea with infertility and secondary to the "dysmenor-
8 rhea"; that at that time Mrs. Bly was treated with a prepara-
9 tion called Edrisal.
10 I want you further to assume that in April of 1968
11 Mrs. Bly was treated for a boil on her right arm, a furuncle,
12 with tetracycline in an amount of first two grams per day and
13 then later a decreasing amount of this antibiotic; and that
14 on June 11, 1968, during the following month the medical
15 report indicated that the pain cleared. By the pain I am
16 referring to the pain in her right lower quadrant when she
17 was treated with the antibiotic for the furuncle.
18 I want you to further assume that the medical record
19 of the 19th of June, 1968, contained a reference to possible
20 right chronic salpingitis and a uterus that was retroflexed.
21 I want you to further assume that on the 25th of
22 August, 1968, Mrs. Bly was seen in a military GYN clinic
23 where an examination was described as including a right ovary

1 which was enlarged to a size of four by six centimeters. And
2 at that time a trial of achromycin, an antibiotic, was recom-
3 mended. The description of the adnexa at that time was
4 described as a cystic adnexa.
5 I want you to further assume that Mrs. Bly there-
6 after was treated by other doctors whose histories were not
7 available to Dr. John Rhoads, but that Mrs. Bly came to Dr.
8 Rhoads with the history which I have just described to you.
9 Doctor, I want you to assume that when Mrs. Bly came
10 to Dr. Rhoads, Dr. Rhoads recorded a history that Mrs. Bly was
11 having pain off and on for eight years in the lower abdomen,
12 a constant pain. The menses were every two to five days, about
13 twenty eight to thirty days. She had had no cramps. Her
14 previous menstrual period was in March. Now this was April
15 25; that the pain was described in the record as being aggra-
16 vated with movement and aggravated with bowel movements. She
17 does have occasional loose bowel movements. There was no
18 blood in her stools. She is on Valium and Darvon Compound
19 65. She had been on an unknown antibiotic but had been off
20 the antibiotic for two weeks.
21 Mrs. Bly further gave a history of dyspareunia,
22 that is painful intercourse, for a number of years, and does
23 not reach climax.

DEO REPORTING
931-3434

1 Dr. Rhoads further recorded the additional past
2 history that she had had a D and C eight years ago for heavy
3 menstrual flow. And some doctors had told her that she had
4 a diagnosis of chronic pelvic inflammatory disease in the past.
5 The review of the symtoms indicated that she had an
6 itchy vaginal discharge with an odor to it. She was married
7 for eleven years. Her husband was a test pilot. That was in
8 the family history.
9 The physical examination indicated that the breasts
10 were normal and the heart and lungs were clear. The abdomen
11 was flat. The liver, the spleen, and the kidneys were not
12 palpable. The patient was thought to have a monilial vagin-
13 itis. The uterus was described as second degree retroverted
14 with first degree descensus, but normal in size. The adnexal
15 structures palpated normally.
16 Impression at this time was, "Psychosomatic disease
17 on the basis of poor family situation." She was given Serax
18 capsules fifteen milligrams three times a day for nervousness
19 and Mycostatin vaginal suppositories and Vioform-Hydrocorti-
20 sone cream for her monilial vaginitis and vulvitis.
21 She was told that she needed some marital counsel-
22 ing as she has had a very unstable family situation as well
23 as financial situation, according to the records, and that

DEO REPORTING
931-3434

1 the patient is "under a most emotional circumstance and is
2 in a chronic anxiety state."
3 Let me ask you to further assume that Mrs. Bly
4 returned on the 15th of November, 1970, and Dr. Rhoads made
5 the following notation. Examination essentially as it was
6 before. She was told that a D and C and examination under
7 anesthesia will be carried out. She was given Flygyl and
8 Vioform-Hydrocortisone cream and Mycrostatin vaginal supposi-
9 tories for mixed vaginitis. She still has emotional problems;
10 however, she feels that her family situation is much better
11 than it was before. She still continued to have her pain;
12 that the D and C and examination under anesthesia doesn't
13 reveal anything. The doctor notes, "Will follow her conserva-
14 tively for another few months and if it still continues a
15 pelvic laparotomy will be performed."
16 Docotor, I want you to further assume that in
17 September of 1970 Mrs. Bly was admitted to the Prince William
18 Hospital in Manassas, Virginia, where she had a dilatation and
19 curettage. That is a D and C. Her physical examination was
20 described by the doctor at discharge as essentially normal,
21 except for a pelvic exam which revealed the uterus to be
22 slightly enlarged, second degree retroverted. Her right
23 adnexa palpated normally. The left adnexa was enlarged and a

DEO REPORTING
931-3434

1 cyst about three to four centimeters in diameter was pal-
2 pated, according to the discharge summary.
3 The doctors' impression as recorded at discharge
4 from the hospital was "Pelvic endometriosis or chronic
5 inflammatory pelvic disease."
6 MR. SLENKER: Exactly what were you reading from
7 there?
8 MR. DIXON: The discharge summary.
9 Mrs. Bly was discharged from the hospital shortly
10 after the D and C. The pathologist's report carried the
11 diagnosis of "endometrium secretory phase, disease C,
12 benign." The pathologist makes the notation that no evidence
13 of any malignant neoplasm is present in his report.
14 After this visit to the hospital Mrs. Bly again
15 saw Dr. Rhoads on approximately October 7, 1970, where Dr.
16 Rhoads made the notation, "Returns again. Still has her
17 mass in the left lower quadrant. Still tender. Will do a
18 pelvic laparotomy on her as soon as can be scheduled."
19 Let me ask you to assume that Mrs. Bly was told at
20 this time she needed a pelvic laparotomy and that a hysterec-
21 tomy was a possibility which she should contemplate because
22 it may be required.
23 Let me ask you to further assume that prior to the

DEO REPORTING
931-3434

1 September 1970 visit to the hospital, Mrs. Bly had inquired
2 of Dr. Rhoads about the possibility of having further child-
3 ren. At this time she was thirty years old and had one child,
4 and that between the time of the September hospitalization
5 and the time that Mrs. Bly was admitted to the hospital on
6 October 28, there was no further discussion about whether
7 Mrs. Bly wanted to have children if she were given this
8 option.

9 Let me ask you to assume that Mrs. Bly was not
10 given any option as to the possible forms of therapy that
11 might be undertaken; that no inquiry was made as to whether
12 she desired a hysterectomy, if she could have a lesser pro-
13 cedure such as a mere removal of the pelvic mass which was
14 described at the physical examination.

15 Let me ask you to assume that Mrs. Bly was not told
16 of the risks of the surgical procedure, that is, the compli-
17 cations which were an inherent part of the procedure except
18 as to the booklet, "After Hysterectomy, What?" plaintiff's
19 Exhibit #6; and that Mrs. Bly was told that there was a
20 possibility of complications from the surgery. But these
21 were not spelled out as to either their nature or their
22 extent.

23 Let me ask you to assume that Mrs. Bly was

DEO REPORTING
931-3434

1 hospitalized at Prince William Hospital on the 27th of
2 October, 1970. On the following day Mrs. Bly went to the
3 operating room for the proposed exploration. At that time
4 the doctors operating noted that procedure was as described
5 in the medical records which you have read.
6 I call your attention to the description of the
7 internal organs. "There was a cyst in the left adnexa,
8 probably an endrometrioma. The right adnexa appeared normal.
9 The uterus was normal," and that the doctor made the follow-
10 ing statement. "Because of the patient's continued pain and
11 discomfort we decided that a total hysterectomy and left
12 salpingo-oophorectomy should be carried out." The term "we"
13 was used, but there was no other doctor in the operating
14 room at this time to assist in the procedure that was carried
15 out.
16 Let me ask you to assume that as the operative
17 reports describe, that a hysterectomy was performed and that
18 the doctor performed a hysterectomy and removed the left tube
19 and ovary and the doctor also removed the left broad ligament
20 Let me ask you further to assume the facts con-
21 tained in the pathologist's report of the surgical specimen
22 which was submitted to the pathologist and the portions of
23 that report include the following:

DEO REPORTING
931.3434

"One container under A consisted of a complete uterus with attached left uterine tube and ovary. The overall appearance is the left tube and ovary are attached or adherent to the lower portion of the posterior aspect of the body of the uterus by broad, thin fibrous adhesions. The fimbriated ends of the uterine tube are unidentifiable. Most of the left uterine tube is adherent to the surface of the ovary. There also appears to be some thin, delicate fibrous adhesions in the upper part of the body of the posterior aspect of the uterus. The uterus has a weight of about 75 grams and approximate dimensions are 7.5 by 5.0 by 3.5 centimeters. The uterus has a vaginal cuff in the axis of five to seven o'clock, this being as much as 1.8 centimeters. Division of the cervix reveals a Nabothian cyst about a hald centimeter in diameter. The endmyometrium is about two centimeters in thickness. The endometrium is about one millimeter in thickness. The left ovary is about three centimeters in diameter and has a rounded shape and is fluctuant. On dividing it, it has a cystic space of practically the full width. The lining is pinkish-gray glistening tissue. The cyst contains a moderate amount of light tan fluid. The cyst wall has a thickness of about two millimeters. The internal surface appears to be organized

DEO REPORTING
931-3434

1 fibrinous material. No obvious structures are present. The
2 terminal portion of the uterine tube is obviously dilated.
3 The area is about two centimeters in diameter. The diameter
4 of the uterine tube is about seven to eight millimeters."
5 Incidentially, let me ask you to assume that there
6 was no hystrosalpingogram or tests performed prior to the
7 patient's admission for this surgery or prior to this
8 surgery. Let me ask you --
9 MR. SLENKER: (Interposing) What was that again?
10 MR. DIXON: There was no hystrosalpingogram.
11 BY MR. DIXON:
12 Q Let me ask you to assume the facts contained in
13 the remainder of the pathologist's report which included the
14 diagnosis of complete uterus, mininal chronic cervicitis,
15 endometrium secretory phase, fibrous adhesions, posterior
16 aspect of the body of the uterus to the left tube and ovary,
17 one Nabothian cyst. The path report described the ovary as
18 ovary with old corpus luteum cyst. The left uterine tube
19 was described as left uterine tube with hydrosalpinx and
20 chronic inflammation and adhesions to the uterus.
21 THE COURT: There has been a request for a recess
22 at this time. The Court will recess for about five minutes.
23 (Whereupon, a short recess was taken.)

DEO REPORTING
931-3434

1 THE COURT: All right. Are you ready, Mr. Dixon?

2 MR. DIXON: Yes.

3 THE COURT: Do you recall your stopping-off point

4 there?

5 MR. DIXON: Yes.

6 BY MR. DIXON:

7 Q Doctor, let me ask you to assume further that the

8 post-operative course after the hysterectomy and removal of

9 the tube and ovary were described by Dr. Rhoads as being

10 complicated by fever of unknown origin. Because of this

11 fever and the fact that the left adnexal mass was quite

12 adherent to the pelvic wall, it was felt that an IVP would

13 be indicated. Also, cultures of her urine were taken. The

14 cultures revealed no growth in twenty-four hours. An IVP

15 done on 11/3/70 revealed a non-functioning left kidney.

16 Following this finding, Dr. Bagley was called for

17 consultation on this particular problem. He attempted a

18 retrograde pyelogram which was unsuccessful. After this

19 unsuccessful attempt a left nephrostomy was performed on the

20 3rd of November, 1970, and a number 3 Foley catheter was

21 placed in the pelvic area of the calycel system of the left

22 kidney. This area was then drained.

23 Following the nephrostomy the patient's course was

DEO REPORTING
931.3434

1 uneventful. She developed a low infection in the nephros-
2 tomy incision about three days prior to her discharge. Her
3 addominal incision healed well. However, a day prior to her
4 discharge a small amount of drainage was noted in the lower
5 part of the incision. And this was felt to be just an accum-
6 ulation of serosanguineous material in the incision.
7 On the date of discharge she was doing well. And
8 thereafter the patient was advised to return to the offices
9 of Dr. Rhoads, her gynecologist, and Dr. Bagley, her urolo-
10 gist.
11 Doctor, let me ask you further to assume that Dr.
12 Rhoads is a fine physician, well trained in the field of
13 obstetrics and gynecology at George Washington University in
14 Washington, D. C., and that he also received his training in
15 obstetrics and gynecology in the Washington, D. C. Metropoli-
16 tan Area, that he is Board certified in the field of obstet-
17 rics and gynecology, and that he keeps current on medical
18 techniques by attending national conventions and reading
19 journals which have national distribution.
20 Let me ask you to assume that the surgical procedure
21 which Dr. Rhoads followed was a procedure which he had learned
22 during his training in the Washington, D. C. area during his
23 residency.

DEO REPORTING
931-3434

1 Doctor, based upon these facts, do you have an
2 opinion as to whether the care of Dr. Rhoads in caring for
3 Mrs. Bly met the appropriate standard of a Board certified
4 obstetrician with the experience and background which I have
5 just described to you, who is practicing in Prince William
6 County, Virginia, in the City of Manassas or a similar
7 locality in the year 1970?
8 MR. SLENKER: If your Honor please, I make objec-
9 tion to the question on the basis that there has not been
10 an appropriate foundation laid through this witness that
11 would put him in a position to answer this question. The
12 question, as it's put to him, does not call for a relevant
13 and material answer, according to the rule of evidence in
14 malpractice cases formulated here in Virginia.
15 THE COURT: Mr. Dixon?
16 MR. DIXON: Your Honor, I don't think that Mr.
17 Slenker is specifying an objection that I can even respond
18 to at this particular point.
19 THE COURT: In what respects are the shortcomings,
20 Mr. Slenker?
21 MR. SLENKER: Well, first of all, the witness
22 hasn't said that he's familiar with the standard, the appro-
23 priate standard. The question refers, in the final

1 analysis, to standards with reference to a Board Certified
2 man, which is not the test in any Virginia case of malprac-
3 tice.
4 The test really is what is the standard that pre-
5 vails in Prince William County, whether this witness knows
6 the standard, whether he's been in a position to know the
7 standard, whether under the hypothetical question that is
8 assumed here, if he does know those standards, if it falls
9 below the standard, above the standard, or at the standard.
10 There hasn't been any showing that this doctor has even been
11 to Prince William County except for today or is familiar at
12 all with Prince William County, which is the only area that
13 John Rhoads practices in. Those are the omissions.
14 MR. DIXON: Your Honor, I don't think that the
15 Virginia rule requires that the doctor be familiar with
16 practice specifically in Prince William County. I think
17 that the Virginia cases, and I am ready to cite three of
18 them to you if the Court would desire, require that this be
19 on the basis of a similar locality. The doctor has testified
20 previously that the standard of practice is similar in this
21 respect.
22 THE COURT: Let me have the citation of the cases
23 that you are referring to.

DEO REPORTING
931-3434

1 MR. DIXON: Yes, sir. (Indicating.)

2 THE COURT: Do you have further copies of those

3 particular cases at this time?

4 MR. DIXON: No, your Honor.

5 THE COURT: I would like to glance at these parti-

6 cular cases. Do you have them to have photocopies? This is

7 Whitfield vs. Whittaker Memorial Hospital, 169 S.E. 2nd, 210

8 Virginia. This recites the Reed vs. Church case.

9 The Court is going to take about a ten minute

10 recess. It's been some time since I have read them. I

11 can't seem, for some reason or another, to recall the termi-

12 nology of the language. Counsel does not have a photocopy

13 of the cases. The Court is going to recess for about ten

14 minutes.

15 (Whereupon, a recess was taken.)

16 THE COURT: Mr. Dixon, after having gone over this

17 case and refreshed my memory with respect to the content of

18 th4se cases, and reviewing the particular hypothetical ques-

19 tion as posed to the doctor, I am going to sustain the ob-

20 jection.

21 I think the objection is well taken for two

22 reasons: number one, with respect to the form of the ques-

23 tion; and number two, with respect to the question of there

DEO REPORTING
931-3434

1 has been no evidence before this Court concerning the devia-
2 tion from the normal practice in this area or in a similar
3 area.
4 With all due respect to Dr. Gerstley, I don't think
5 there is any question about the doctor being very eminently
6 qualified to practice. But I think the issue involved here
7 is whether or not Dr. Rhoads has deviated from the normal
8 practice of similar physicians under like conditions in this
9 area of Prince William County or a similar area such as
10 Prince William County.
11 I think I can take judicial notice of the fact that
12 Dr. Gerstley is practicing in Pennsylvania. He hasn't said
13 that the custom and practice in Pennsylvania is the same as
14 the custom and practice in Prince William County. For those
15 reasons I am going to sustain his objection.
16 MR. DIXON: May my exception be noted, your Honor?
17 THE COURT: Yes, sir.
18 BY MR. DIXON:
19 Q Doctor, calling your attention to the practice of
20 medicine in Manassas, Virginia, and in Prince William County,
21 let me ask you to assume that at that time the practice of
22 medicine by a Board certified obstetrician -gynecologist
23 consisted of practice in a --

DEO REPORTING
931-3434

1 MR. SLENKER: (Interposing) Well, now, I am going
2 to object to this question if your Honor please, because he
3 is asking him to assume. Now he's going to proceed, appar-
4 ently, to tell the doctor what he thinks the standard of
5 practice is here. That's an improper question to be pro-
6 pounded.
7 The purpose of an expert witness is one that knows
8 the standard and can tell what the standard is and can
9 evaluate that.
10 THE COURT: Let's let him ask the question first,
11 Mr. Slenker. I will ask the doctor to refrain from answering
12 until I have had a chance to rule.
13 BY MR. DIXON:
14 Q Let me ask you to assume, Doctor, this hospital is
15 a small community hospital and had approximately one hundred
16 beds or possibly one hundred fifty. The record isn't clear
17 on that; and that there were approximately fifty doctors on
18 the attending staff at that time.
19 Let me ask you to assume that Manassas, Virginia,
20 is within a period of driving time of less than one hour from
21 the Metropolitan area of Washington, D. C., where there are
22 large major medical facilities there, including two medical
23 schools and a number of large medical centers.

DEO REPORTING
931-3434

1 Now, Doctor, calling your attention to those
2 assumptions, can you describe to the Court and to the jury
3 what experience you have had in observing the standard of
4 medical practice of Board certified obstretician-gynecologists
5 who practice in a similar locality?
6 MR. SLENKER: Well, if your Honor please, I think
7 we are back now, are we not, to the same thrust of the ob-
8 jection to the main hypothetical that was put to him. How
9 can one --
10 THE COURT: (Interposing) I don't know how you
11 can compare. If he's never been in Prince William County,
12 never practiced in Prince William County, never been ac-
13 quainted with the practice of Prince William County, how is
14 he going to compare with Washington, D. C. or any other
15 local area?
16 Our Supreme Court, unfortunately, has made the
17 rule. I didn't make the rule. The doctors who testified in
18 each of those cases there were doctors who were familiar with
19 the practice in the locale. There was testimony that there
20 was a deviation from the practice in the locale.
21 I think that the word "similar local community";
22 we are speaking about Prince William and the customary
23 practice of physicians here in Prince William County. As I

1 say, with all due respect to Dr. Gerstley, I don't have any
2 question in my mind about him being eminently qualified as
3 an expert in his field. We have an issue involved here, and
4 the point involved here is the custom and practice in Prince
5 William County.
6 MR. DIXON: Your Honor, may I respectfully take
7 exception to that. As I understand the Virginia cases, the
8 courts have held that it isn't a question of that locality,
9 which happens to be Prince William County, but it is either
10 that locality or a similar locality. I call the Court's
11 attention to the Hemway vs. Martinez case.
12 THE COURT: I have read that. I think the same
13 terminology used in these cases was cited by Mr. Olender
14 which was given to me--similar localities. But we are
15 speaking about the custom and practice. In other words, I
16 don't think the Court could take judicial notice that some-
17 one who has not had experience and knows about the custom
18 and practice of Prince William County can compare it with any
19 other area at this time, to say it is similar. How would
20 he know there is a similarity if he knows nothing about the
21 custom and practice?
22 MR. DIXON: Your Honor, as I understand the rule,
23 it isn't a question of whether a practice is similar to that

1 in Prince William County. It is a question of whether he is
2 familiar with a practice in a locality similar to Prince
3 William.
4 THE COURT: I don't interpret the cases that way.
5 MR. DIXON: As I read the Huntly case, that is a
6 situation wherein an ophthalmologist from New York was
7 permitted to testify in Charleston, West Virginia.
8 THE COURT: I am thinking about the rule in
9 Virginia. My understanding of the rule in Virginia is just
10 as I have stated. I don't think the fact it is in West
11 Virginia is necessary for Virginia. We have cases in Virginia.
12 It is my opinion this is the issue involved here.
13 We are speaking about the custom and practice in the community.
14 Our Supreme Court speaks to that or similar communities.
15 Right at this time there is no evidence before the
16 Court that Dr. Gerstley has ever practiced in Prince William
17 County. I don't see how he can testify if he has never
18 practiced in Prince William. I sustain the objection.
19 MR. DIXON: Your Honor, may I be heard on one
20 other matter?
21 THE COURT: Yes, sir.
22 MR. DIXON: As I understood Dr. Rhoads's testimony
23 under examination by his counsel, he testified that the

DEO REPORTING
931-3434

1 performance of this procedure was in accordance with what
2 he had learned in his residency, which was in Washington,
3 D. C., which is a much larger metropolitan area. That was
4 what Dr. Rhoads testified to us. I think that this estab-
5 lishes quite clearly the standard of practice that he
6 learned and he was adhering to. I think by the doctor's own
7 testimony he was stating by implication his practice here in
8 Prince William County was the same ~~as the same~~ as that which
9 he learned in Washington, D. C. I think that if that is the
10 case we are entitled to explore this particular area.
11 THE COURT: I don't agree with that, Mr. Dixon.
12 In the first place, as I say, my recollection of his testi-
13 mony is that he complied with the custom and practice of
14 Prince William County. That is all I have heard so far
15 throughout this case. Until such time as there is a physi-
16 cian put on the stand that is going to testify along the lines
17 there has been some deviation, I will be in a position to
18 sustain the objection to these questions. That is my ruling.
19 MR. DIXON: Your Honor, as I understand it, the
20 dilemma this is putting the plaintiff in is there are six
21 obstetricians in the county.
22 THE COURT: There might be six in Prince William
23 County, but there are numbers in Fairfax County and Arlington

DEO REPORTING
931-3434

1 County. I understand that the burden is upon the plaintiff
2 to prove his case, not upon the defendant. This is the prob-
3 lem. It's an ominous burden but at the same time that is
4 the ruling of law involved. That is my ruling, Mr. Dixon.
5 I don't see any point to pursue it any further at this time.
6 MR. DIXON: May I respectfully except to the ruling?
7 THE COURT: Surely.
8 BY MR. DIXON:
9 Q Doctor, have you ever practiced in Prince William
10 County?
11 A I have not.
12 Q Have you had occasion to practice in any similar
13 localities?
14 A Well, I am not that familiar with Prince William
15 County as such. But the area in which I practice, for
16 instance, the Abington area, is a small suburban community
17 and has pretty much the same level of practice. The level
18 of practice, as far I can find, seems to be pretty much the
19 same throughout rural areas.
20 MR. SLENKER: I object.
21 THE COURT: Objection is sustained. I instruct the
22 jury to disregard the answer.
23 MR. DIXON: May my exception be noted, your Honor?

1 THE COURT: Surely.

2 MR. DIXON: It would appear to me, your Honor, that
3 the doctor, whether he is believable or not, goes to the
4 weight of the evidence rather than the admissibility.

5 THE COURT: I sustained the objection.

6 BY MR. DIXON:

7 Q Doctor, based on your review of Mrs. Bly's records,
8 did you form an opinion as to whether the nephrostomy which
9 Mrs. Bly was caused to undergo was directly caused by the
10 surgery or the hysterectomy which Mrs. Bly received?

11 THE COURT: Just a moment.

12 MR. SLENKER: Objection, if your Honor please. I
13 don't think that that's a proper question. In any event,
14 the question is whether or not Dr. Rhoads adhered to the
15 standard.

16 THE COURT: You are getting right back to the same
17 issue. I sustain the objection.

18 MR. DIXON: Your Honor, at this time the plaintiff
19 would proffer the damages for the record. As the Court is
20 aware, there have been two separate theories of liability in
21 this case. We would proffer to the Court this witness's
22 testimony on causal relationship of the damages.

23 As the Court is aware, there is an informed consent

1 ruling the same from the bench.

2 I wanted to confirm that insofar as the Hunter case.

3 It deals mainly with the question of allegations, not the

4 proof of allegations. I will maintain the same. I adhere to

5 my ruling at the bench. I did want, at least in all fairness

6 to the parties to deteremine what my ruling will be. But

7 this Court will stick with the majority ruling concensus.

8 MR. DIXON: Your Honor, may we make a proffer?

9 THE COURT: Well, any proffer will have to be out

10 of the presence of the jury here. It is getting rather late

11 at night. How long is it going to take?

12 MR. DIXON: May we approach the bench?

13 (The following proceedings were had at the bench

14 by Court and counsel out of the hearing of the jury.)

15 MR. DIXON: Okay. If I understand the Court's

16 ruling, the Court is ruling that Dr. Gerstley has not been

17 qualified to testify because he is not familiar with the

18 standard of practice in Prince William County as opposed to

19 the standard of practice in a locality similar to Prince

20 William County; is that right?

21 THE COURT: Well, the Court's ruling is based on

22 the fact that there has been no testimony before the Court

23 at this time that the particular alleged negligent action

DEO REPORTING
931-3434

1 on the part of the doctor was in violation of the standard
2 of practice as set forth in and as practiced in Prince William
3 County or a county similar to that. The fact of Dr. Gerstley
4 not having practiced in Prince William County, I don't know
5 how he could testify what the standard procedures are in
6 Prince William County, not being familar with the practice
7 in Prince William County. This is the basis for my ruling.
8 MR. DIXON: Your Honor, we would proffer that Dr.
9 Gerstley is prepared to testify on both the standard of care
10 in negligent treatment and the standard of care in informed
11 consent of a patient of the proposed treatment; and that Dr.
12 Gerstley is prepared to testify as to his qualifications and
13 experience and capacity to testify, and capacity to observe
14 and relate to the Court the standard of practice of a Board
15 certified obstetrician-gynecogologist who practices in a
16 rural area of a similar nature to Prince William County but
17 not Prince William County.
18 If the Court is holding that the doctor can be
19 familiar only with the Prince William County location, of
20 course Dr. Gerstley can't testify to that. But the doctor
21 can testify as to the standard of practice in a similar
22 small rural type of community which is the region from which
23 he's from. And of course with the limitations that have been

DEO REPORTING
931-3434

1 described in his testimony concerning what a Board certified
2 obstetrician does hold himself out to do by the training
3 practices of going to national conventions and reading nation-
4 al journals.
5 We also propose to offer Dr. Gerstley's testify on
6 the standard of practice in an area similar to Washington,
7 D.C., where Dr. Rhoads has testified that he was trained and
8 in the area on which he's based his surgical procedures, as
9 he has already testified in this case.
10 We would also proffer Dr. Gerstley's testimony on
11 the issues of causation inherent as to what relationship the
12 failure to give the patient medical alternatives and the
13 failure to treat the patient properly had upon her subsequent
14 injury. Dr. Gerstley can testify as to the issue of the
15 causation. The nephrostomy was causally related to these
16 other acts of which negligence is alleged. I don't intend
17 by this, of course, to indicate that informed consent is only
18 a negligence issue.
19 We would proffer, of course, that Mrs. Bly separ-
20 ately and independently under the Canterbury case can testify
21 on the issue of what she was told and relate this to what
22 would be a reasonable practice for an individual faced with
23 her circumstance in the absence of medical testimony. So

DEO REPORTING
931-3434

1 what we would do is we would proffer testimony of informed
2 consent both from a lay point of view of Mrs. Bly and from a
3 professional point on the standard of care through Dr.
4 Gerstley.
5 We would also proffer Dr. Gerstley's testimony on
6 the issue of causation and the damages that Mrs. Bly has
7 undergone since the operative procedure on the 28th of October
8 as to the pain and suffering, the medical complications that
9 she has undergone.
10 THE COURT: Do you wish to be heard on that?
11 MR. SLENKER: He is just proffering. You have made
12 your ruling. You have ruled.
13 THE COURT: In other words, do I understand you
14 are asking me now that I would permit you to put this doctor
15 on in the presence of the jury and proffer testimony to
16 testify as to these particular items that you have just indi-
17 cated in your statement to the Court here? His testimony
18 would be in essence what you have just related there?
19 MR. DIXON: If the Court is ruling that we would
20 not be permitted to show these things, then of course there
21 would be no further need to proceed with Dr. Gerstley.
22 THE COURT: I really frankly see no need to proceed
23 any further as far as the proffer of testimony is concerned,

1 because my ruling is the same. This is my feeling there and
2 it's in the record, right or wrong. I feel that I am right.
3 If I didn't I wouldn't say that, Mr. Dixon.
4 Under the circumstances, my ruling would be that
5 I deny the motion to proffer the testimony as long as the
6 testimony would be along the lines that you have indicated.
7 I assume that is what the testimony would be, which is in
8 essense what you have just represented to the Court.
9 MR. DIXON: Yes.
10 THE COURT: So under the circumstances I see no
11 point for staying here any longer. This is my feeling. I
12 would deny the motion.
13 MR. DAVIS: If your Honor please, before adjourning
14 for the day, since I don't believe Mr. Dixon or Mr. Olender
15 are familiar with the Virginia practice, since the proffer
16 would include all the evidence we could offer on the subject,
17 I assume it would be appropriate now for Mr. Slenker to make
18 a motion to strike the evidence. Then it would be tantamount
19 to a directed verdict for giving finality to this case.
20 THE COURT: In other words, assuming that this
21 would be the extent of the proffered testimony of the
22 plaintiff's case, and under the circumstances in order to
23 give it finality , there has got to be some finality before

DEO REPORTING
931-3434

1 the surgery. She will testify as to the pain and suffering
2 and inconvenience, the changes in her ability to work and to
3 cope and to handle life's problems, and her general injuries
4 subsequent to the operative procedure.
5 She will also testify that Dr. Rhoads admitted an
6 obstruction of the tube that connected the kidney with the
7 bladder was caused by something which he did in the operation.
8 She also will testify that the pain that she went to Dr.
9 Rhoads for prior to the operation is still present.
10 We would also propose to offer the testimony of the
11 hospital administrator and his assistant, Mr. Gendrin, with
12 respect to the hospital bills of Mrs. Bly's hospitalization
13 and the reasonableness of those bills. We would also call the
14 hospital administrator to testify as to the number of gyne-
15 cologists who have full staff privileges at the Prince
16 William Hospital here in Manassas.
17 We would also proffer the mortality tables to
18 indicate Mrs. Bly's life expectancy.
19 In addition, we would proffer the testimony of
20 Judy Robinette, a sister of Mrs. Bly, and Jeff Bly, Mrs.
21 Bly's son, with respect to her physical and emotional condi-
22 tion before and after the surgery. This would include testi-
23 mony as to the activities that she was able to do previously

DEO REPORTING
931-3434

1 that she was unable to do subsequently, such as horseback
2 riding, swimming, judo activities, activities with her boy in
3 the Scouts and so forth.
4 Judy Robinette will also testify that Dr. Rhoads
5 stated to her shortly after the obstruction of the ureter was
6 discovered that he stated that something went wrong during
7 the operation and the tube from the bladder to the kidney was
8 cut, and that Dr. Rhoads was going to have assistance of a
9 kidney doctor or urologist and that Mrs. Bly would probably
10 need additional surgery.
11 We would also proffer the testimony of Dr. Bartone,
12 who is a Ph.D doctor rather than a medical doctor, who was an
13 instructor at the George Washington University Medical School,
14 and who taught medical students their basic anatomy, and
15 taught the medical students the anatomical relationships of
16 the pelvis, including the structures of the uterus, the
17 ureter, the tube, ovary, broad ligament, and the other
18 matters which the Court has heard previous testimony on.
19 As I previously mentioned, your Honor, we would
20 offer the life expectancy tables. Mrs. Bly is now at the age
21 of thirty-four. The Code tables provide the life expectancy
22 of 42.3 years.
23 Your Honor, we would also proffer the Directory of

1 Medical Specialists to be identified to medical witnesses.
2 This is a book published for the American Board of Medical
3 Specialists and for the Board of Specialists in Obstetrics
4 and Gynecology of which Dr. Rhoads is a member, which indi-
5 cates the number of Board certified specialists which are
6 available in Prince William County to testify as to the stand-
7 ard of care, indicating the very small number which are
8 available.
9 I call the Court's attention to the fact that the
10 directory indicates that there are four specialists listed in
11 the current directory. One of those is Dr. Rhoads. Another
12 is a physician who is listed as an associate of Dr. Rhoads.
13 The other two doctors are associated in physical close prox-
14 imity to Dr. Rhoads's office.
15 We would also offer your Honor the bills which Mrs.
16 Bly has expended in her care subsequent to the operation
17 through her and, through the medical witnesses to authenticate
18 them to indicate they are necessary and the reasonableness of
19 those bills.
20 In order to be specific, your Honor, with respect to
21 the other special damages we would proffer Mrs. Bly's testi-
22 mony on her work history and on the loss of wages that she has
23 suffered since the hysterectomy operation.

DEO REPORTING
931-3434

1 That concludes the proffer, your Honor.

2 THE COURT: Mr. Dixon, from this juncture of the
3 proceeding, in other words, I understand in essence this would
4 be the balance of your testimony in the case. Is that right?
5 That is on the issues of malpractice alleged on the part of
6 Dr. Rhoads as well as informed consent. Is that right?

7 MR. DIXON: Yes, your Honor.

8 THE COURT: Mr. Slenker, I would like you to tell
9 me why I should not permit this particular testimony to be
10 heard at this time.

11 MR. Slenker: If your Honor please, with respect to
12 the items of testimony that were first mentioned, that con-
13 cerning hospital records, Dr. Rhoads, Dr. Blood and Dr.
14 Gerstley, I think your Honor has previously ruled upon that
15 testimony. Within the framework of the proffer I hear
16 nothing new that has not been encountered before, brought to
17 your Honor's attention, indeed, some of it brought to the
18 jury's attention. Your Honor has ruled upon those before.
19 So that, I think, is a rehash of what has gone on before in
20 this trial.

21 As to the remaining items, it occurs to me that
22 they have reference to damages. Perhaps not all of them but
23 most of them as represented by counsel would go to the damage

DEO REPORTING
931-3434

MR. DIXON: Yes, sir. I note an exception.

MR. SLENKER: If Your Honor please, I think one of the first hospitalizations, the first group that is there is the September 22 confinement which has to do with a D. and C. We don't have any objection to those at all coming in because she was under the care of Dr. Rhoads exclusively.

THE COURT: Why don't counsel get together during the lunch recess? I would certainly exclude any report from Dr. Bagley since he is not here to testify.

MR. SLENKER: Thank you.

THE COURT: Do you want to call another witness at this time?

MR. DIXON: We would like to call the hospital administrator.

Whereupon,

E. L. DERRING,

was called as a witness for and on behalf of the plaintiff and, having been previously duly sworn, was examined and testified as follows:

DIRECT EXAMINATION

BY MR. DIXON:

Q Would you state your name and address, sir?

DEO REPORTING
931-3434

1 A E. L. Derring, 8708 Barnet Street, Manassas,
2 Virginia.
3 Q What is your occupation?
4 A Hospital administrator.
5 Q Are you the administrator of the Prince William
6 County Hospital?
7 A It's Prince William Hospital.
8 Q Prince William Hospital?
9 A That is correct.
10 THE COURT: How do you spell the last name, sir?
11 THE WITNESS: D-e-r-r-i-n-g.
12 BY MR. DIXON:
13 Q How long have you been so employed, sir?
14 A In this position?
15 Q Yes.
16 A Approximately eight years.
17 Q Has that been continuously to this present date?
18 A I beg your pardon.
19 Q Has that been without interruption?
20 A Yes.
21 Q What are your duties as the administrator at the
22 hospital?
23 A Well, I am the chief executive at the hospital.

1 Q As the chief executive, are you familiar with
2 the medical staff bylaws of that hospital, sir?
3 A Yes.
4 Q Can you tell us what the medical staff bylaws
5 are?
6 MR. SLENKER: I object, if Your Honor please, to
7 the evidence on the basis of relevancy and materiality.
8 There is no issue here that involves the hospital in any
9 respect; no issue in this case with regard to the bylaws
10 of the medical staff of the hospital or of the hospital
11 itself in any regard.
12 THE COURT: What would be the relevancy of this?
13 MR. DIXON: May we approach the bench?
14 (The following proceedings were had at the bench
15 by Court and counsel out of the hearing of the Jury:)
16 MR. DIXON: Your Honor, the medical staff bylaws
17 provide certain requirements that the doctors must conform
18 to in their practice at this hospital. Those practices
19 are required by the Committee on Accreditation. They are
20 propounded for the protection of the patient. The doctor,
21 by agreeing to join that staff, has agreed to adhere to
22 those bylaws.
23 If those bylaws provide certain standards that

DEO REPORTING
931-3434

1 the doctor is expected to adhere to, which could have some
2 bearing on the care of this case, then I would propose
3 that they would certainly be relevant as indicating the
4 standard that the doctor should have followed.
5 MR. SLENKER: I object, if Your Honor please,
6 to the immediate question and to any future reference or
7 any reference at all to any rules from any organization,
8 whether it be an accreditation bureau or what have you.
9 Certainly whatever that bureau might say with reference to
10 how something is to be done or why something is to be done
11 could not influence or supercede or preempt at all the
12 law that prevails in the Commonwealth on duties that are
13 encumbent upon individuals, be they hospitals, be they
14 professional people, or just the citizenry. The question
15 here is whether or not a standard of care was met by a
16 physician.
17 THE COURT: In other words, they have a set of
18 rules here that says they will all comply with these and
19 none of the doctors in the area complied on any of them.
20 Does the hospital set the standard?
21 MR. DIXON: The hospital has certain standards
22 that the doctors agree to adhere to. This is one reason
23 why hospitals are accredited, so that the patient knows

DEO REPORTING
931-3434

1 that when he goes to an accredited hospital these people
2 are indicating that they are going to follow a certain
3 high quality standard of medical care. This protects the
4 patient from an inferior level of care.
5 The patient has a right to rely on that. She
6 goes to an accredited hospital. The hospital takes
7 insurance money based upon that representation that they
8 are following accreditation practices. The patient relies
9 on that.
10 These people hang a big sign in their corridors
11 that says that we are accredited. And it indicates that
12 they are holding themselves out to a certain level of
13 care.
14 THE COURT: But that's not the issue here. The
15 issue here is whether or not this doctor violated the
16 standard practice by doctors in like circumstances in
17 this area.
18 The fact that the hospital had those rules and
19 regulations I don't think is material. It's not the issue
20 here. I mean, the hospital has all kinds of rules and
21 regulations. And the fact that the patients rely on it,
22 it's not a fact of reliance by the patient. It's a
23 question of whether --

1 MR. DIXON: (Interposing) The question is
2 what are those standards that the doctor agreed to adhere
3 to?
4 THE COURT: Well, the fact that the hospital has
5 the standards doesn't mean that that is practiced by all
6 the doctors here. I think the burden is on you to prove
7 by competent medical testimony that this doctor didn't
8 comply with those standards in this area.
9 MR. DIXON: But I think that this is evidence on
10 what that standard is. I don't think that only a doctor's
11 testimony as to what the standard of practice is is the
12 only relevant testimony of this. I think that collateral
13 factors which also indicate a standard are also admissible
14 on this and can be corroborated by a doctor's testimony of
15 what the appropriate standard of practice is.
16 Of course, when you get down to a dispute over
17 whether doctors do adhere to a certain standard of
18 practice or not, I think that the medical staff bylaws
19 which the doctors have agreed to conform to are relevant
20 evidence on which doctor is telling the truth, which
21 doctor is credible on this issue.
22 THE COURT: I am going to sustain his objection.
23 MR. SLENKER: Thank you, Your Honor.

DEO REPORTING
931-3434

(Thereupon, the following proceedings continued in the hearing of the Jury:)

MR. DIXON: I think that the objection has been made, Your Honor.

THE COURT: All right. I sustained his objection.

MR. DIXON: May my exception be noted?

THE COURT: Yes. Surely.

MR. DIXON: I would like to make a proffer to the Court. We would proffer the medical staff bylaws of the hospital.

MR. SLENKER: Your Honor, this is improper. You have sustained the objection. I thought the proffer had been made at the bench conference after which Your Honor sustained the objection. For counsel now to announce his proffer is improper because Your Honor has said that this is not appropriate evidence here, and for him to make a proffer, it's going before the Jury.

THE COURT: I would have to excuse the Jury and have him proffer it out of the presence of the Jury. In other words, you can't very well do it in the presence of the Jury. If you want to proffer it for the record I will excuse the Jury and let it go in the record that way.

1 (The following proceedings were had at the bench
2 by Court and counsel out of the hearing of the Jury:)
3 MR. DIXON: Your Honor, I would like to proffer
4 to this Court the testimony that Dr. Rhoads has agreed in
5 his acceptance of staff privileges at this hospital to
6 adhere to the standards and regulations and bylaws of this
7 hospital.
8 MR. SLENKER: Your Honor, can we take this up
9 some place else? He's talking loud enough that the Jury
10 is going to hear him anyhow.
11 THE COURT: I will excuse this Jury at this time,
12 right now. I may as well excuse them for lunch because
13 it's only about five or six minutes. I will excuse them.
14 If you want to proffer this testimony, I mean I will
15 permit you to proffer it out of the presence of the Jury
16 if you want to have it in the record.
17 MR. DIXON: Well, one of our problems, Your
18 Honor, is we still have a witness here on the stand. I
19 don't know what the limits of the Court's ruling is going
20 to be as to what it will permit me to do or not.
21 THE COURT: I am going to keep him here. It may
22 shorten our lunch hour, but I am going to let the Jury go
23 at this time. There is no point having them sit here and

DEO REPORTING
931-3434

1 then coming back. I am telling them to go at this time.

2 It shouldn't take too long to proffer whatever

3 standards you want to proffer for the record. What I will

4 do is after the proffer is made, if you don't have any

5 other questions of this man, well, then maybe he can be

6 excused, although -- I mean, did you have additional

7 testimony that should go before the Jury other than the

8 standards?

9 MR. DIXON: Yes.

10 THE COURT: Well, if you do that then, in other

11 words, we may as well recess now until 2:00 o'clock. Let

12 him come back with everybody else. I will give everybody

13 about an additional 15 minutes, that you can just proffer

14 and have them back in the Jury Room if you do have

15 additional testimony because I don't want to go up, say, to

16 quarter of 2:00 or something like that and have the Jury

17 coming back here and sitting.

18 So I will recess at this time for the lunch

19 hour. I will have them come back at 2:15. We will come

20 back with this witness at 2:00 o'clock. We will have the

21 witness back at 2:00 o'clock and the Jury back at 2:15.

22 MR. DAVIS: Your Honor, I would like to call to

23 the attention of the Court that there has been a number of

1 decisions in other jurisdictions on this matter of the
2 accreditation standards and there has been a number of
3 Courts which have permitted the accreditation standards to
4 be used as against the doctor. I am sure the Court is
5 familiar with the famous Darlin case, in Illinois, which
6 led the way. In that case, it did state that accreditation
7 standards were admissible as indicating the standards
8 practiced. A number of Courts have followed it since then.
9 MR. SLENKER: That was a case against the
10 hospital.
11 MR. DIXON: I agree.
12 MR. SLENKER: Not a doctor. And there wasn't any
13 objection interposed either. You ought to tell that to the
14 Court.
15 MR. DIXON: Except that the Court in its
16 language --
17 THE COURT: (Interposing) I have made my ruling
18 on that. I am going to recess. Let the Jury go until
19 2:15. I will have this witness come back at 2:00 to
20 proffer his testimony.
21 (Thereupon, the following proceedings continued
22 in the hearing of the Jury:)
23 THE COURT: Members of the Jury, I am going to

1 recess at this time. If you would report back at 2:00
2 o'clock, Mr. Derring. We will have the Jury come back at
3 2:15. Report to the Jury Room. Don't come back to the
4 courtroom. We will be taking certain testimony we want to
5 proffer for the record that shouldn't go to the Jury at
6 this time.
7 During the course of the trial don't discuss the
8 case. Don't let anyone discuss it in your presence. You
9 are excused now until 2:15.
10 Mr. Derring, return back at 2:00 o'clock sharp.
11 Counsel, return back at 2:00 o'clock.
12 I might suggest to counsel to get back a few
13 minutes before, and you might go over the medical records.
14 Court will recess at this time until 2:00 o'clock then.
15 (Whereupon, at 1:00 o'clock p.m., the hearing was
16 recessed to reconvene at 2:00 o'clock p.m.)
17 - - -
18
19
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1 AFTERNOON SESSION (2:12 p.m.)

2 (The following proceedings were had by Court and
3 counsel out of the hearing of the Jury:)

4 THE COURT: Are you gentlemen ready at this time?

5 MR. DIXON: Yes, sir.

6 MR. SLENKER: Yes, sir.

7 MR DIXON: Your Honor, at this time I would
8 proffer to the Court certain statements from Dr. Rhoads'
9 deposition. On page 13, line 10 --

10 MR. SLENKER: (Interposing) I object, if Your
11 Honor please. I understand it's a proffer. But I thought
12 that the materials that the proffer was to come from was
13 with regard to the rules --

14 THE COURT: (Interposing) The standard.

15 MR. SLENKER: Joint accreditation through this
16 witness, Mr. Derring.

17 MR. DIXON: Your Honor, this is a foundation for
18 that proffer. Dr. Rhoads has already testified that he's
19 been willing to and agreeable to abide by those rules and
20 regulations of the hospital. This is in his deposition.

21 I further proffer to the Court that Dr. Gerstley
22 will testify that it is the practice in the community to
23 adhere to the hospital regulations and bylaws when a

1 physician has privileges in that hospital.

2 THE COURT: Well, this particular proffer that

3 you are making now is from a deposition or --

4 MR. DIXON: (Interposing) The deposition of the

5 defendant.

6 THE COURT: The deposition of the defendant?

7 MR. DIXON: Yes.

8 THE COURT: I will permit that.

9 MR. SLENKER: May the record reflect in that

10 connection, if Your Honor please, that Dr. Rhoads is here

11 in Court. The deposition counsel refers to was a

12 discovery deposition which was taken in accordance with

13 notice by counsel for the plaintiff.

14 THE COURT: I understand this is laying a

15 foundation for the testimony to be introduced.

16 MR. DIXON: Dr. Rhoads' deposition, page 13,

17 line 10, "Question. Okay. What hospitals have you been

18 accepted as a staff member to? Answer. To Prince William

19 County Hospital. Question. Is this the only one?

20 Answer. And also Doctors, Northern Virginia Doctors.

21 Question. Any others? Answer. No others."

22 To page 65 of the Doctor's deposition,

23 commencing with line 22, "When you applied for hospital

1 privileges, did you have to agree to abide by the hospital
2 rules and regulations?" Beginning on the top of page 66,
3 "Answer. Yes."
4 "Is that hospital accredited by the Joint
5 Commission on Accreditation of Hospitals? Answer. Yes, it
6 is. Question. And I presume that they make you sign some
7 kind of paper when you are accepted to the staff saying
8 that you will agree to abide by the regulations, isn't
9 that right? Answer. I don't think so. You don't have to
10 sign, as far as I know, I didn't sign any papers. Question.
11 Did you have to sign an application form? Answer. We have
12 an application form, yes. Question. Do you know on the
13 bottom of that application form there is a statement above
14 your signature that requires that you agree to adhere to
15 the hospital rules and regulations? Answer. I'm sure that
16 there is. However, I'm not -- I can't recall that, you
17 know. Question. At any rate, you are willing to abide
18 by them? Answer. Yes. Question. You would be willing to
19 abide by the accreditation rules or whatever that the
20 hospital had to adhere to? Answer. Yes."
21 Your Honor, without going into the witness'
22 testimony further, I would like to renew my offer to take
23 his testimony at this particular time, if the Court

DEO REPORTING
931-3434

1 responded favorably to this, rather than to inquire further
2 of the witness on the stand.
3 THE COURT: I sustained the objection.
4 Whereupon,
5 E. L. DERRING,
6 resumed the witness stand, having been previously duly
7 sworn, and was further examined and testified as follows:
8 DIRECT EXAMINATION (Resumed)
9 BY MR. DIXON:
10 Q Mr. Derring, is it?
11 A Yes.
12 Q Calling your attention to the medical staff
13 bylaws of the Prince William Hospital, is every doctor who
14 applies for hospital privileges there required to read,
15 understand, and agree to adhere to those rules, sir?
16 A They are supposed to be given a copy.
17 Q When are they given such a copy?
18 A At the time that their letter of acceptance,
19 which is approved by the Board, is done.
20 Q Are the doctors, in their application and in the
21 bylaws, put on notice that they are expected to adhere to
22 these bylaws, sir?
23 A Well, yes.

DEO REPORTING
931.3434

1 Q How are they put on notice?

2 A By receiving it.

3 Q If a doctor refuses to adhere to these bylaws

4 are his hospital privileges terminated or changed?

5 A We haven't had that problem. I can't answer

6 your question.

7 Q If attention is called to the fact a doctor is

8 not adhering to these medical bylaws does the hospital take

9 any action or have any procedure for having the doctor

10 thereafter adhere to these bylaws?

11 A The medical staff has its own organization which

12 this goes through.

13 Q Does the medical staff, through this

14 organization, enforce these medical bylaws, sir?

15 A I think that they do to the best of their

16 ability.

17 Q They are expected to; is that right?

18 A Yes.

19 Q Incidentally, in the receiving of hospital

20 accreditation by your hospital, does your hospital hold

21 itself out to the public as being accredited?

22 A Yes, it certainly does.

23 Q Does it hold itself out to insurance companies

DEO REPORTING
931.3434

1 who won't pay bills unless that hospital has the
2 accreditation?
3 A Well, I don't know -- I don't know what you are
4 implying there. Many insurance companies will pay the bill
5 whether we are accredited or not.
6 We do this because we want to meet the high
7 standards. The accreditation is something you apply for.
8 It's not something you have to have.
9 Q Are there some insurance companies that don't
10 pay unless the hospital is accredited?
11 A Well, are you speaking of Medicare?
12 Q No. I'm talking about any medical insurance.
13 A I am not aware this is true.
14 Q You don't know whether that is true or not?
15 A I don't know whether that is true, no.
16 Q How frequently is your hospital accredited, sir?
17 A Well, it was every three years. In the last
18 several years it has gone to every two years for full
19 accreditation which we have received.
20 Q When was the last notice of accreditation which
21 your hospital received prior to October 28 of 1970, sir?
22 A Well, I have to look up the record.
23 We were surveyed on May 22, 1969, a three-year

DEO REPORTING
931-3434

1 period. And we received -- I received the letter of
2 accreditation for three years on June 16, 1969.
3 Q Is the purpose of accreditation to insure better
4 medical care and hospital care for the patient?
5 A That is correct.
6 (A letter, dated June 13, 1969,
7 was marked as Plaintiff's
Exhibit #2, for identification.)
8 BY MR. DIXON:
9 Q Now, calling your attention to Plaintiff's
10 Exhibit No. 2, could you identify that, sir?
11 A This is the letter notifying us of our
12 accreditation for three years, signed by Dr. Porterfield,
13 who is the director on the Joint Commission on
14 Accreditation of Hospitals.
15 Q Now, if the part of that accreditation survey --
16 THE COURT: (Interposing) Excuse me,
17 Mr. Dixon. You said Plaintiff's Exhibit No. 2. Has that
18 been marked?
19 MR. DIXON: Yes, that has been marked, sir.
20 THE COURT: For identification?
21 MR. DIXON: Yes.
22 THE COURT: All right. Number 2. What is that?
23 MR. DIXON: Your Honor, this purports to be a

DEO REPORTING
931-3434

1 letter dated June 16, 1969 from the Joint Commission on
2 Accreditation of Hospitals.
3 THE WITNESS: No. The letter is dated, I
4 believe, June 13, 1969. We have it marked as received on
5 June 16, 1969.
6 THE COURT: The letter of June 13? This is from
7 the Commissioner?
8 THE WITNESS: Yes. That is correct, sir.
9 BY MR. DIXON:
10 Q Doctor, at the time you received that letter
11 did the Commission make any recommendations to you with
12 respect to changes?
13 A Yes, they did. They made four recommendations
14 which is outstanding for most hospitals to receive so few.
15 Q Did you take any steps to implement those
16 changes that were recommended by the hospital?
17 A Yes. We do in time because they check these
18 when they come back.
19 Q Let me call your attention to recommendation
20 number two. Would you read that, sir?
21 A Certainly.
22 "The operating surgeon should have a qualified
23 medical assistant in all operations with unusual hazards."

DEO REPORTING
931-3434

1 Q Doctor, did your --

2 A (Interposing) Excuse me. But it's Mister.

3 It's not Doctor.

4 Q I'm sorry, sir.

5 Did your hospital take any steps to implement

6 that recommendation?

7 A Yes, sir. O.R. was notified of this. Each

8 department was notified of the particular recommendations.

9 And I'm sure that the surgeons were notified in there also.

10 Q Did Dr. Rhoads receive notification of that?

11 A They didn't receive it individually, no.

12 Q Was this passed through the medical staff so

13 that --

14 A (Interposing) Well, as far as I can remember.

15 I'm sure it was, but I can't say that.

16 Q Did you have a procedure or policy within the

17 hospital for communicating this to the medical staff?

18 A Well, this is communicated to the O.R. and the

19 O.R. supervisor. And then she communicates this.

20 Q To the best of your knowledge, was this

21 communicated directly or indirectly to each member of the

22 staff?

23 A To the best of my knowledge, indirectly.

DEO REPORTING
931-3434

1 Q Now, was this recommendation a recommendation
2 that was based on some other standard of the Hospital
3 Accreditation Committee?
4 A I'm sure they have a reason for this.
5 Q Was the reason for that particular recommendation
6 to improve the medical care of patients who were
7 hospitalized?
8 A All of the recommendations are.
9 Q Okay.
10 Now, calling your attention --
11 MR. SLENKER: (Interposing) Your Honor, may I
12 say I have not expressed any objection to these because
13 it's in the nature of a proffer?
14 THE COURT: That's right. This is what I
15 understand.
16 MR. SLENKER: But I would like, if I might, sir,
17 for the record to reflect that I don't go along with this
18 at all. I go along with a proffer. But with regard to the
19 form of the questions that are being asked and, indeed,
20 the substance of the questions that are being asked, I
21 think that they are objectionable even within the proffer.
22 So I hope I have not waived those. I would like to
23 preserve --

1 THE COURT: (Interposing) I will let the record
2 show that you are not waiving any objection to this; that
3 you object to the whole presentation of this particular
4 testimony and line of questioning.
5 MR. SLENKER: Yes, I do, if I can preserve that.
6 (A certificate of accreditation
7 was marked as Plaintiff's
Exhibit #3, for identification.)
8 BY MR. DIXON:
9 Q Sir, I call your attention to Plaintiff's
10 Exhibit No. 3 and ask if you can identify that?
11 THE COURT: What is No. 3 that has been marked
12 for identification?
13 THE WITNESS: Do you want me to answer that,
14 Judge?
15 THE COURT: Counsel can answer that.
16 MR. DIXON: Your Honor, this purports to be the
17 certificate of accreditation at this hospital.
18 BY MR. DIXON:
19 Q Is that right, sir?
20 A Yes.
21 Q Is this publicly displayed at your hospital?
22 A Yes, it is.
23

DEO REPORTING
931-3434

(A list of bylaws was marked as Plaintiff's Exhibit #4, for identification.)

BY MR. DIXON:

Q Now, I call your attention to Plaintiff's Exhibit No. 4, which purports to be the Prince William Hospital Medical Staff bylaws, sir; is that right?

A That is correct.

Q Were these bylaws in effect in 1970?

A They are dated and approved as of January 21, 1970.

Q These are the hospital bylaws which you have previously referred to, sir?

A Yes, at this time. They have been changed since this time.

MR.SLENKER: Excuse me, Mr. Dixon. Are those the hospital bylaws or the medical staff bylaws?

MR. DIXON: Let's clarify that.

BY MR. DIXON:

Q Sir, can you differentiate the medical staff bylaws --

A (Interposing) Well, the medical staff bylaws are the bylaws for the organizational structure for the medical staff and the rules and regulations by which they are governed. The hospital bylaws are the bylaws of the

DEO REPORTING
931-3434

1 corporation just like you would have in any other
2 corporation.
3 THE COURT: Do we have the corporate bylaws
4 or the medical staff bylaws?
5 THE WITNESS: The medical staff bylaws.
6 THE COURT: Is that right?
7 MR. DIXON: Yes, Your Honor.
8 BY MR. DIXON:
9 Q These are the bylaws that the medical staff has
10 agreed to abide by; is that right?
11 A That's right.
12 Q This is in a normal meeting that doctors have
13 agreed they are going to adhere to these bylaws?
14 A That's correct.
15 MR. DIXON: Let me ask one other preliminary
16 question while I am looking here, Your Honor.
17 BY MR. DIXON:
18 Q Sir, calling your attention to the recommendations
19 of the Joint Commission on Accreditation of Hospitals that
20 you previously described in Plaintiff's Exhibit No. 2,
21 referring to "The operating surgeon should have a qualified
22 medical assistant in all operations with unusual hazards,"
23 was that procedure adopted by the medical staff?

DEO REPORTING
931-3434

1 A Was that procedure adopted by the medical
2 staff?
3 Q Yes. Or was that recommendation adopted by the
4 medical staff?
5 A It's already in their bylaws, yes, but not
6 worded that way. It's worded differently in the bylaws.
7 MR. DIXON: I'm sorry, Your Honor. I am not as
8 familiar with these as I should be. I haven't had an
9 opportunity to go through them in the detail that I
10 desired.
11 BY MR. DIXON:
12 Q Doctor, I call your attention to Rule number 17
13 on page 23 of the medical staff bylaws, which is
14 Plaintiff's Exhibit No. 4. This provides as follows:
15 "Except in an emergency, consultations are required in the
16 following cases." And then it lists number 2, obscure
17 diagnosis, and number 3, major obstetrical surgery and
18 first cesarean sections; is that correct?
19 A That's right.
20 Q That was adopted by the medical staff?
21 A That's right. If it's in those bylaws, it is.
22 MR. DIXON: Your Honor, I would renew my proffer.
23 I think that this gentleman has testified that the medical

DEO REPORTING
931-3434

1 staff has adopted these things and has agreed to adhere to
2 them. I think that meets the requirements of the rule.
3 I would call the Court's attention to the
4 re-statement of Section 295-A which provides that even when
5 a matter does meet the customary practice of the
6 community, if it's negligence and even though it meets the
7 customary practice, that liability still can be found. I
8 think these particular provisions spell out the standard
9 of the doctors that are practicing at this hospital. I
10 don't think that 295-A is necessarily applicable, although
11 this man has testified that these are standards which are
12 provided for the protection and benefit of the patients.
13 I think under this rationale the witness' testimony would
14 be admissible.
15 THE COURT: Mr. Slenker, do you wish to respond?
16 MR. SLENKER: I do, indeed, Your Honor.
17 First of all, Your Honor has ruled on the point
18 in issue.
19 THE COURT: Well, he's renewed his motion at this
20 time based on the testimony that has been given.
21 MR. SLENKER: Well, I think that the testimony
22 that is before the Court at this time, and neither from the
23 lips of Mr. Derring nor the documents here, does not change

DEO REPORTING
931-3434

1 the position I expressed earlier that we are not
2 concerned with standards as may be promulgated by some
3 commission some place made up of people that are not
4 doctors, that are not familiar with the standards that are
5 in the community, and, as a matter of fact, could not
6 address themselves to the way in which you practice
7 medicine. That's the first point.
8 The second point is if you are dealing with a
9 hospital and its liability perhaps and the way in which it
10 does things or requires things to be done within the
11 hospital, if the hospital was the defendant in the case
12 there might be some materiality, but certainly not in the
13 case at hand where we are dealing with an Ob-Gyn defendant.
14 The test that he has to meet and the duties that are
15 incumbent upon him are specified by the law generally
16 prevailing in the Commonwealth.
17 I think to understand it completely one has only
18 to envision that perhaps a commission is formulated. And
19 they say, well, the doctors, they don't have to use clean
20 instruments. They can use table knives when they are going
21 to operate. Under the theory that was advanced by
22 Mr. Dixon that would be sufficient. You could show that.
23 And yet that would fly right in the face of all the

DEO REPORTING
931-3434

1 sterile conditions and so forth that the medical
2 profession and that the law of Virginia say must exist.
3 So we are not concerned here with what are
4 written standards promulgated or imposed or undertaken
5 voluntarily by an institution in order to have an
6 accreditation of some sort when an accreditation isn't
7 necessary to operation as a matter of fact as the witness
8 has said.
9 So here it seems like we are getting very far
10 afield from the case that we have here with reference to
11 the charges made against the defendant in the lawsuit.
12 Certainly the standards, no matter who promulgates them,
13 cannot preempt the law of Virginia.
14 MR. DIXON: May I address myself to that, Your
15 Honor?
16 THE COURT: Yes.
17 MR. DIXON: I can foresee some value in
18 Mr. Slenker's statement that no committee some place else
19 can tell a doctor how to practice medicine. But this
20 problem is a problem that a doctor wrote as a member of
21 the staff that has adopted these as standards and has
22 agreed to abide by these. These are not the standards now
23 of some other committee located some place else. These are

DEO REPORTING
931-3434

1 cross-examine the doctor. I want you to cover him up to
2 that point. Then there won't be any question about trying
3 to be fair to both sides. Then we will call the doctor.
4 Doctor, we will get you in here just as soon as
5 we can.
6 (Thereupon, the following proceedings continued
7 in the hearing of the Jury:)
8 BY MR. DIXON:
9 Q Doctor, prior to taking Mrs. Bly into the
10 operating room for the surgery, did you ever obtain a
11 consultation from another doctor concerning the necessity
12 for this operation?
13 A No, I did not.
14 Q While you were in the operating room were you
15 the only doctor present in the operating room?
16 MR. SLENKER: I object to this question, if
17 Your Honor please, on the basis that there isn't any
18 claim asserted here that there was not a consultation
19 obtained as a part of the failure to meet the standard
20 that Dr. Rhoads is accused of. There isn't any claim here
21 about him not having an assistant.
22 THE COURT: I will overrule the objection,
23 Mr. Slenker.

DEO REPORTING
931-3434

MR. SLENKER: May I have an exception?

THE COURT: All right.

BY MR. DIXON:

Q Doctor, were you the only operating surgeon in the operating room when you operated on Mrs. Bly?

A Yes.

Q You didn't have a doctor as an assistant?

A No. I had a nurse as an assistant.

Q Is a doctor ordinarily more skilled in assisting a physician during the operation because a physician has had more experience and background in surgical procedure?

A It depends on the nurse and it depends on the doctor.

Q As a usual matter, the doctor has more skill, does he not?

A Usually, yes.

Q When you operated on Mrs. Bly you performed your exploration by looking into the pelvic cavity; is that right?

A That is right.

Q You did that to start with?

A Yes.

Q When you looked into the pelvic cavity, the

DEO REPORTING
931-3434

1 fortuitously observed or not observed.

2 THE COURT: I am going to sustain the objection,

3 Mr. Slenker.

4 MR. SLENKER: All right. Thank you, Your Honor.

5 BY MR. SLENKER:

6 Q Now, at the time that you talked with Mrs. Bly

7 about the risks of this surgical procedure, did she ask

8 you any questions at all?

9 A No. She never asked me any questions that I

10 could recall.

11 Q All right.

12 Now, counsel asked you a question about whether

13 you got a consultation before the hysterectomy. Will you

14 tell the members of the Jury if the standard of medical

15 care that prevails here in Prince William calls for you to

16 get a consultation from anybody with reference to a patient

17 prior to this type of an operation?

18 A No. We don't have to get consultations. If

19 you are Board certified you don't need a consultation to

20 do a hysterectomy.

21 Q Are you aware of any of the other Ob-Gyn

22 practitioners in Prince William here that are Board

23 certified that do get consultations prior to this type of

DEO REPORTING
931-3434

1 surgery?

2 A No, none that I know of.

3 Q Now, counsel asked you also with reference to

4 whether or not you had an assistant at surgery. I

5 believe your response was that you had a nurse assistant?

6 A Yes.

7 Q To what extent was the nurse assisting you?

8 Tell the members of the Jury what she was doing.

9 A The nurse merely helps the doctor with exposure.

10 She will sponge where you need -- in other words, you need

11 a sponge to get the blood out of the way. She'll sponge

12 that for you and so on. But she doesn't do any of the

13 operating. She just assists.

14 Q Will you tell the members of the Jury if the

15 standard of medical care that prevails here in Prince

16 William requires that you have a physician assistant with

17 you in the room at the time of surgery?

18 A No. You don't have to have a physician

19 assistant.

20 Q All right.

21 In this type of a hysterectomy --

22 A (Interposing) Now, in this particular type --

23 I'm talking about this particular case, now. I'm not

DEO REPORTING
931-3434

1 talking about other cases. I'm talking about in this
2 particular case, Mrs. Bly.
3 Q Excuse me, sir. What would be the characteriza-
4 tion that you can give the Jury with reference to the
5 type of operation that this was, so far as Mrs. Bly was
6 concerned?
7 A I think it was just -- it was like any other
8 pelvic procedure that I've done. It wasn't an unusual
9 pelvic procedure.
10 Q Did it involve any cancer consideration?
11 A There was no cancer involved.
12 Q It's major surgery, is it not?
13 A Yes.
14 Q But are there routine or nominal major surgical
15 procedures?
16 A Yes.
17 Q Is this one of them?
18 A I would say that this was one. I didn't think
19 that the -- I thought that there was -- it was a type of
20 condition. I felt that there was no problem handling it.
21 In my judgment at the time, there was no problem handling
22 it.
23 Q Indeed, during the course of the operation, was

DEO REPORTING
931-3434

1 Q Is that true even when a blockage is caused by
2 an obstetrical or gynecological procedure?
3 MR. SLENKER: I object, Your Honor, please.
4 There isn't the slightest bit of evidence that --
5 THE COURT: (Interposing) Objection sustained.
6 BY MR. DIXON:
7 Q Doctor, in Mrs. Bly's case, is the most probable
8 cause, the blockage of Mrs. Bly's ureter, the hysterectomy
9 procedure which you performed?
10 MR. SLENKER: Now, I object, if Your Honor please.
11 I think that is --
12 THE COURT: (Interposing) That is an improper
13 form. I will sustain the objection.
14 BY MR. DIXON:
15 Q Doctor, calling attention to your professional
16 qualifications and training, you studied the anatomy of
17 the ureter and the genitourinary system during your
18 training, did you not?
19 MR. SLENKER: I object, if Your Honor please.
20 I didn't go into his qualifications and what he studied at
21 the time he was in school in my examination. I think he is
22 limited now to covering the matters that I covered in my
23 examination.

DEO REPORTING
931.3434

1 MR. DIXON: May I have an exception, Your Honor.
2 THE COURT: Surely.
3 BY MR. DIXON:
4 Q Doctor, as a condition of your admission to the
5 staff of the Prince William Hospital, did you agree to
6 adhere to any bylaws of that hospital?
7 THE COURT: Objection sustained.
8 MR. DIXON: May I have an exception.
9 THE COURT: Yes, sir.
10 BY MR. DIXON:
11 Q Doctor, calling your attention back to your
12 decision to perform a hysterectomy on Mrs. Bly, did you
13 make that decision to perform the hysterectomy prior to
14 the surgery?
15 A No. I made the decision at the time of the
16 laparotomy.
17 Q Was that decision to perform the hysterectomy
18 based upon Mrs. Bly's previous history of abdominal pain?
19 MR. SLENKER: Your Honor, I will interpose an
20 objection on the basis that there isn't any theory of
21 recovery here with reference to the need of a hysterectomy.
22 That's not a claim against Dr. Rhoads here that there should
23 not have been a hysterectomy.
MR. DIXON: Your Honor, I think that there are

1 BY MR. DIXON:

2 Q Doctor, I believe that you mentioned that another
3 risk of the surgery was the risk of hemorrhage; is that
4 right?

5 A That's correct.

6 Q Is the risk of hemorrhage in a patient the age
7 and health of Mrs. Bly less significant than the risk of
8 blockage of a ureter?

9 MR. SLENKER: Objection.

10 THE COURT: Objection sustained.

11 MR. DIXON: May I have an exception.

12 THE COURT: Surely.

13 BY MR. DIXON:

14 Q Doctor, I believe that you mentioned in your
15 discussion of other risks, the danger of trauma to the
16 bowel or bladder was also present; is that correct?

17 A Yes.

18 Q Is the risk of trauma to the bowel or bladder
19 greater when the surgeon is less experienced than when he
20 is more experienced?

21 MR. SLENKER: Objection.

22 THE COURT: Sustained.

23 MR. DIXON: May I have an exception.

DEO REPORTING
931-3434

1 Q Can you identify them for us, please?

2 A Oh, yes. Dr. Roger O'Donnell. Dr. Jurgenson,

3 Dr. Ray Enos.

4 Q How is that spelled?

5 A R-a-y E-n-o-s.

6 Dr. Raymond Chin. Dr. Eugene Milstead, to name a

7 few.

8 Q Can you think of any others right now?

9 A Right now I can't think of anything.

10 Q Are these people that you just described all on

11 the staff as opposed to being other physicians in training

12 who were over you?

13 A No, they were on the staff. They were staff

14 obstetricians and gynecologists.

15 Q Can you identify who your supervising staff

16 consisted of when you were in your residency?

17 A At the hospital center?

18 Q Yes.

19 A They were Dr. Samuel Dodeck, Dr. Keith Cromer

20 were the chiefs at that time. We had many other -- the

21 doctors that I had previously mentioned all transferred

22 that service over to the hospital center, and in addition

23 there were other doctors, Dr. Frazier, D. K. Frazier,

DEO REPORTING
931-3434

1 William Tenenblatt, Tenenblatt, Dr. Buzz Parker, several
2 others. I can't recall all their names now but that is just
3 a few of them.
4 Q Were any of these people regarded as national
5 authorities in any field of obstetrics or gynecology?
6 A I think so.
7 Q Were any of the physicians that you mentioned
8 either from your internship or residency?
9 A I think so. Dr. Dodeck, Samuel, and Dr. Keith
10 Cromer.
11 Q Any others?
12 A I believe that's all.
13 Q What were these people prominent in? What was
14 their particular field that they earned national prominence
15 in?
16 A Dr. Samuel Dodeck in obstetrics and Dr. Cromer in
17 gynecology.
18 Q Now do you regard him as being -- are they still
19 alive?
20 A Yes, they are both still living.
21 Q Are they still regarded as authorities in the field?
22 A I believe so.
23 Q When did you complete your residency?

DEO REPORTING
931-3434

1 A At the Washington Hospital Center.

2 Q When?

3 A Gee, '61, I believe.

4 Q Did that residency consist of so many years of

5 obstetrics and so many years of gynecology, and if so, what

6 was the breakdown of this training?

7 A Well, they had one -- there were three years of

8 ob-gyn and there was one year of a rotating residency

9 program which included a six-month program in general

10 surgery and a six-month program in urology.

11 Q And was this last portion necessary for you to

12 complete your Boards?

13 A It was a program set up by the hospital center as

14 a four-year program. You really didn't need the last year

15 to complete your Boards.

16 Q This was additional, more specialized training for

17 a physician in your specialty, was it not?

18 A This is correct.

19 Q Incidentally, what Boards are you certified by,

20 sir?

21 A Ob-Gyn, American College of Obstetrics and

22 Gynecology.

23 Q So that you're --

DEO REPORTING
931-3434

1 A (Interposing) Board certified.

2 Q (Continuing) -- by the American Board of Obstetrics

3 and Gynecology and you're also a member of the American

4 College of Obstetrics and Gynecology, is that correct?

5 A Yes, that's correct.

6 Q Are you also Boarded by the American College of

7 Surgeons?

8 A I don't need to belong to the American College

9 of Surgeons.

10 Q Okay. What hospitals have you been accepted as

11 a staff member to?

12 A To Prince William County Hospital.

13 Q Is this the only one?

14 A And also Doctors, Northern Virginia Doctors.

15 Q Any others?

16 A No others.

17 Q Okay. Incidentally, I presume that you subscribe

18 to either the Journal of the American Board or American

19 College of Obstetrics and Gynecology?

20 A I do.

21 Q I presume that those journals are part of your

22 program for continuing medical education for staying current

23 in the field?

DEO REPORTING
931-3434

1 A That is true.

2 Q Do you ordinarily rely on these things to keep

3 current and understand what the best medical care of

4 treatment is, is that correct?

5 A That is true.

6 Q Do you subscribe to any other medical journals?

7 A Well, I subscribe to a number of medical journals

8 in addition to the OB-GYN which is our green journal.

9 OB-GYN Survey, which is published by Johns Hopkins

10 University School of Medicine. Also the American, the

11 Clinics of OB-GYN that is published by the Hebner

12 Publishing Company.

13 Q Any others?

14 A That's it.

15 Q Okay. Do you rely on these journals that you have

16 just described the same way as you rely on the other

17 journals that you have described to me?

18 A Yes.

19 Q Okay. Calling your attention to your obstetrical

20 and gynecological training and by this I'm talking about not

21 only your residency but your internship and training as a

22 medical student and your other training up until the time

23 that you went out into practice on your own, did you ever

DEO REPORTING
931-3434

1 Q During that period of time while you were in the
2 Air Force, did you practice obstetrics and gynecology
3 exclusively?
4 A Yes.
5 Q Incidentally, I notice that you have a tendency
6 to be very helpful and to answer my questions before I
7 complete them.
8 A I'm sorry; I apologize.
9 Q Well, the only reason I tell you that, I might
10 change the form at the end of the question.
11 A Okay.
12 Q So that you would be better of to wait until I
13 finish so that I don't change that so that I won't mislead
14 you.
15 A I'm sorry. I didn't know I was doing that. I
16 apologize.
17 Q While you were in your Air Force experience I
18 gathered that you worked with physicians who trained in a
19 number of medical schools and medical centers all over the
20 country, is that right?
21 A Yes, sir.
22 Q Did you find that the standard of practice of
23 physicians was about the same; that they are all

DEO REPORTING
931-3434

1 approximately equal in competency?

2 A I believe so.

3 Q Do you also have occasion now that you're out in

4 private practice to attend national meetings?

5 A Oh, yes.

6 Q Obstetricians and gynecologists?

7 A Yes.

8 Q Do you find that your skills are on a par with

9 those of physicians from any other area of the country?

10 A I believe so.

11 Q Incidentally, when you saw Mrs. Bly at her

12 hospital examination on her admission, physical examination,

13 you described that she had an enlarged uterus, did you not?

14 A When was this now? When was this?

15 Q Let me call your attention to your physical

16 examination when Mrs. Bly came into the hospital for the

17 exploratory --

18 A (Interposing) I don't have the hospital record.

19 MR. SIENKER: Here is the hospital record. Why

20 don't you take this?

21 THE WITNESS: No. I said -- I didn't say the

22 uterus was enlarged. I said the left adnexa was enlarged.

23

DEO REPORTING
931-3434

1 A The peritoneum is anteriorally and it's usually
2 picked up next to the peritoneum.
3 Q The ureter is next to this thin membrane called
4 the peritoneum; is that right?
5 A Yes.
6 Q And you can usually see the outline of this
7 peritoneum in the ureter?
8 A Yes.
9 Q Did you attempt to trace the ureter down after
10 that?
11 A I did.
12 Q Can you tell me what you did?
13 A I dissected the ureter downward until I could
14 dissect no further into a mass of scar tissue.
15 Q How long did it take you to do that dissection
16 from the time that you picked it up at the iliac vessels
17 until you terminated it at the edge of the scar tissue?
18 A I don't recall specifically.
19 Q Can you give me your best estimate?
20 A Fifteen, twenty minutes.
21 Q And how long a distance was that?
22 A Five to six centimeters.
23 Q Did you ever make any attempt to ascertain what the

DEO REPORTING
931-3434

cause of this scar tissue was?

A Cause?

Q Yes.

A No. Other than her prior surgery.

Q Did you determine whether there was scar tissue of the same type on the opposite side?

A I did not.

Q Did you make any attempt to ascertain whether the scar tissue was caused by infection?

MR. SCANLON: I think it's the same question. You can go ahead and answer.

A I didn't. There was no evidence.

BY MR. DIXON:

Q Did you make any attempt to determine the age of the scar tissue as of the time that you saw it?

A It appeared to be matured scar tissue.

Q Can you define what you mean by mature?

A Quite dense scar tissue.

MR. SCANLON: Dense?

THE WITNESS: Dense.

BY MR. DIXON:

Q Can you define what you mean by dense?

A Heavy, firm scar tissue.

DEO REPORTING
911 1434

1 BY MR. DIXON:

2 Q Doctor, have you had any conversation with Dr.
3 Rhoads concerning the cause of Mrs. Bly's ureteral
4 obstruction?

5 MR. SCANLON: I think the witness already answered
6 that question. Go ahead and answer it one more time.

7 A I have had conversation with Dr. Rhoads in which
8 I have indicated I couldn't, I have no knowledge of what
9 obstructed the ureter.

10 Q Did you ever have any discussion with Dr. Rhoads
11 in which you discussed the various possibilities?

12 A No.

13 Q Of the various possible causes of this obstruction?

14 A No.

15 Q Now, as a physician treating Mrs. Bly, did you
16 regard this as a complete mystery where you have no idea
17 what the possible cause of the ureteral obstruction could be?

18 MR. SCANLON: I don't think he has to state --
19 would you read that question again? I don't think he has to
20 give his mental impressions.

21 MR. DIXON: I think this Doctor was treating this
22 patient. I want to know what his mental impressions were of
23 his diagnosis, when he treated her.

DEO REPORTING
931-3434

1 MR. SCANLON: What his mental impressions of his
2 diagnosis were when he treated her? I think he testified
3 to that about two and a half hours.
4 MR. DIXON: I don't think he has.
5 MR. SCANLON: I think he has.
6 BY MR. DIXON:
7 Q Dr. Bagley, at the time that you treated Mrs.
8 Bly, did you form a mental impression as to the possible
9 causes of Mrs. Bly's ureteral obstruction?
10 A I'm sure that I mentally went over the differential
11 diagnosis.
12 Q Can you tell me what that differential diagnosis
13 was that you went over mentally?
14 MR. SCANLON: I think the witness already answered
15 he doesn't have any opinion as to the cause. I don't think
16 his mental impressions are admissible or relevant.
17 MR. DIXON: This is a discovery deposition.
18 MR. SCANLON: I am aware of that, Mr. Dixon.
19 MR. DIXON: I think that pursuing this matter may
20 lead to material which would be relevant.
21 MR. SCANLON: I think it's speculative.
22 MR. DIXON: I grant you it may be speculative. But
23 I would like to know what it is in order to determine whether

DEO REPORTING
931-3434

1 it is speculative.

2 MR. SCANLON: The Doctor can give us his

3 evaluation of his mental impressions, first of all. Do you

4 have any — can you say with any reasonable degree of

5 medical certainty what your impressions were, or if they

6 have any degree of medical certainty? Let's put it that way;

7 or were they pure conjecture, speculation?

8 THE WITNESS: They would be speculation.

9 BY MR. DIXON:

10 Q Doctor, when you made these mental considerations,

11 differential diagnosis is part of your ordinary treatment

12 routine; is it not?

13 A Yes.

14 Q And the differential diagnosis that you went

15 through in Mrs. Bly's case consisted of what?

16 MR. SCANLON: I don't think he made any differential

17 diagnosis. He said first of all he didn't have any opinions

18 as to the cause of the condition and then going to his

19 mental impressions, he said it was purely speculative. And

20 so I don't think, see how you can go beyond that and label

21 it as a differential diagnosis.

22 MR. OLENDER: If you would listen to your own

23 client —

DEO REPORTING
931-3434

1 MR. SCANLON: (Interposing) I am listening to my
2 own client.
3 MR. OLENDER: You would have heard him testify
4 that he did form a differential diagnosis.
5 MR. SCANLON: That was a word that you put into
6 his mouth.
7 MR. OLENDER: It's obvious to anybody that —
8 MR. SCANLON: (Interposing) It's not obvious to
9 anybody at all.
10 MR. OLENDER: It's obvious to anybody that you
11 are merely attempting to protect St. Paul, the defendant in
12 this case.
13 MR. SCANLON: I object to that and that remark
14 ought to be stricken.
15 MR. OLENDER: Your objections have nothing to do
16 with protecting Dr. Bagley.
17 MR. SCANLON: That's the only person I'm interested
18 in.
19 MR. OLENDER: You are obstructing the questioning
20 of Dr. Bagley.
21 MR. SCANLON: I'm not obstructing anything at all.
22 I'm trying to terminate it. I think we have been going long
23 enough. But you're going round and around and dealing in

DEO REPORTING
931-3434

1 semantics. You have to ask the question the right way,
2 whether it's a deposition or whether it's the trial.
3 MR. DIXON: I think, Mr. Scanlon, that this is a
4 discovery matter and I think I am entitled to ask questions
5 that may lead to the pursuit of material which may be
6 admissible at trial. I am attempting to do that and you are
7 attempting to suppress that.
8 MR. SCANLON: I'm not attempting to suppress that
9 at all, in the slightest.
10 MR. DIXON: I think your interest is quite obvious
11 in this matter.
12 MR. SCANLON: I think your interest in this matter
13 is quite obvious also.
14 MR. DIXON: I am willing to reveal my interest.
15 I wish you would do the same.
16 MR. SCANLON: I am revealing my interest is to
17 protect Dr. Bagley and protect him from any further
18 harassment. I think this is getting burdensome.
19 MR. OLENDER: Could he please answer the question?
20 MR. SCANLON: What is the question?
21 MR. OLENDER: The question is what was his
22 differential diagnosis.
23 MR. SCANLON: I think you ought to ask the question

DEO REPORTING
931-3434

1 if he made a differential diagnosis.

2 MR. OLENDER: He already answered that he did.

3 MR. SCANLON: I don't believe that he did. Go

4 ahead, Doctor.

5 THE WITNESS: A differential diagnosis of an

6 obstructed ureter would include the possibilities of

7 obstruction not related to the patient's previous surgery

8 such as a stone, edema. Other possibilities in a

9 differential diagnosis would be surgical trauma.

10 BY MR. DIXON:

11 Q Is that all that you considered, Doctor?

12 A There is not much more that could obstruct the

13 ureter.

14 Q So, that is your answer, yes?

15 A That's my answer.

16 Q Within the consideration of a stone, did you ever

17 evaluate Mrs. Bly to ascertain whether she had a stone?

18 A There was no evidence of a stone on the intravenous

19 pyelogram.

20 Q With respect to the evaluation of edema, edema

21 could be caused by surgical trauma, could it not?

22 A It can.

23 Q Did you ascertain whether the obstruction in

DEO REPORTING
931.3434

1 Mrs. Bly's case was the edema?

2 A In the question of surgical edema, dye and/or

3 the catheter would have passed beyond that point at the time

4 of the cystoscopy.

5 Q So that you therefore included, I gather, that

6 edema was not the cause of the obstruction; is that right?

7 A I did not feel it was the cause.

8 Q Did you attempt to evaluate mentally the various

9 causes of surgical obstruction which would have led to Mrs.

10 Bly's ureteral obstruction?

11 A The various possibilities, the answer is yes.

12 Q Can you tell me —

13 A (Interposing) The various possibilities would be

14 direct trauma to the ureter by clamping, ligating, suturing

15 or cutting the ureter, transecting.

16 Q If Mrs. Bly's ureter had been cut, would you have

17 expected to have found different findings than you found in

18 Mrs. Bly's case?

19 A I would have.

20 Q Now, in Mrs. Bly's case, did you find anything to

21 rule out the presence of a clamped ureter?

22 A I have no way of telling.

23 Q In Mrs. Bly's case, did you find anything to rule

DEO REPORTING
931-3434

1 out the possibility that the ureter was ligated?

2 A Again I have no way of knowing.

3 Q And in Mrs. Bly's case, did you find anything to

4 rule out the possibility that the ureter had been sutured?

5 A Again I have no way of knowing.

6 Q Incidently, in those areas of the pelvis where the

7 only thing that overlies the ureter is the thin peritoneum

8 membrane, can you ordinarily ascertain the position of the

9 ureter from within the peritoneal cavity?

10 A In a thin individual, yes.

11 Q Was Mrs. Bly relatively a thin individual?

12 A She was.

13 Q After Mrs. Bly's surgery, did you have any

14 conversation with her concerning what had happened, what

15 caused her problem?

16 A Any conversation I would have had with her would

17 have been similar to what we are talking. I didn't know

18 what the cause of her blocked ureter was.

19 Q So that your answer is yes, you did have a

20 conversation?

21 A I did have a conversation.

22 Q And that was immediately after the surgery on Mrs.

23 Bly and her husband was present?

DEO REPORTING
931.3434

A This would have initially been with her husband.

Q And when did that take place?

A November the 3rd.

Q And can you tell me what you told Mrs. Bly's husband?

A That the left ureter was blocked. I could not pass a catheter and that I would have to do drainage in terms of a nephrostomy above the blockage.

Q Did you ever tell Mrs. Bly or her husband that the ureter was blocked during Mrs. Bly's surgery for her hysterectomy?

A Not to my knowledge.

Q Could you have so told them?

MR. SCANLON: I object to that. Go ahead and answer.

A I don't know that it was blocked during her surgery.

BY MR. DIXON:

Q But the question was could you have told either Mrs. Bly or her husband that the ureter was blocked during surgery for the hysterectomy?

A I'm not sure that I have an answer for that. You're asking could I. Sure I could.

Q Did you ever have any conversation with Dr. Rhoads

DEO REPORTING
931-3434

JOINT COMMISSION ON
ACCREDITATION OF HOSPITALS

645 N. MICHIGAN AVE., CHICAGO, ILLINOIS 60611, TEL. 642-6061
JOHN D. PORTERFIELD, M.D., Director

MEMBER ORGANIZATIONS
AMERICAN COLLEGE OF PHYSICIANS
AMERICAN COLLEGE OF SURGEONS
AMERICAN HOSPITAL ASSOCIATION
AMERICAN MEDICAL ASSOCIATION

JUN 1 0 1969

RECEIVED
JUN 16 1969
PRINCE WILLIAM HOSPITAL

Mr. E. L. Derring
Administrator
Prince William Hospital
1060 Sudley Road
Post Office Box 110
Manassas, Virginia, 22110

Dear Mr. Derring:

The Board of Commissioners of the Joint Commission on Accreditation of Hospitals has approved the recommendation that your hospital be accredited for a period of three years or until a subsequent survey is conducted. This is the result of the evaluation of the hospital survey conducted on the date and by the field representative indicated below.

Attached are the recommendations for the improvement of the quality of patient care based on the findings of the survey. These warrant your attention and should be put into effect before the next visit of a representative of the Commission.

Copies of this letter with the recommendations have been sent to the chief of staff and president of the governing board of your hospital. Since this report is confidential on the part of the Commission, the release of its contents is a matter for your mutual consideration and decision. Any publicity emanating from this report must of necessity come from your authorized spokesman.

Your hospital is entitled to a Certificate of Accreditation. To be certain that our information is correct, we ask that you please complete and return the enclosed form.

If any question should arise relating to this letter or to the accreditation status of your hospital, please communicate with Otto Arndal, M.D., Assistant Director, Hospital Accreditation Program, Joint Commission on Accreditation of Hospitals.

The Commission wishes to commend you for maintaining standards deserving of accreditation and for your constant effort to improve the quality of patient care. Please be assured of our interest and of our willingness to be of all possible help to you.

Sincerely yours,

John D. Porterfield MD

John D. Porterfield, M.D.
Director

Refused

EXHIBIT NO. 2 (pl
PL(✓ DEF( ) COM( )
CASE NO. 5862
DATE 6/26 19 74
JUDGE: Bley vs. Rhoade

cc: Mr. W. Caton Merchant, Jr., President of the Governing Board
J. Paul Wampler, M.D., Chief of Staff

SURVEYOR: LOUIS J. FUHRMANN, M.D.
DATE OF SURVEY: MAY 22, 1969

PRINCE WILLIAM HOSPITAL
MANASSAS, VIRGINIA

DATE OF SURVEY	SURVEYOR	REVIEWER
MAY 22, 1969	LOUIS J. FUHRMANN, M. D.	Earl F. Weir, M. D.

RECOMMENDATIONS AND COMMENTS

1. The dietitian should record her comments in the medical records of patients on therapeutic diets.

2. The operating surgeon should have a qualified medical assistant in all operations with unusual hazards.

3. A post anesthetic follow-up note should be recorded by the anesthesiologist or the anesthetist.

4. Emergency room records should contain more clinical information as well as a statement of instructions given to the patient about essential follow-up care.

Reference is made to the enclosed "Standards for Hospital Accreditation".

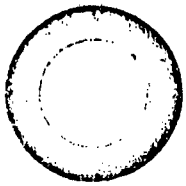
RATING BY BOARD OF COMMISSIONERS: ACCREDITATION FOR THREE YEARS.

k

American College of Physicians

American College of Surgeons

American Hospital Association


American Medical Association

THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

has accredited

PRINCE WILLIAM HOSPITAL
MANASSAS, VIRGINIA

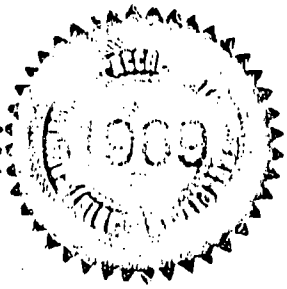
which has been surveyed and meets the standard for hospitals of The Joint Commission on Accreditation of Hospitals.

For providing high quality medical and hospital care in all services and for maintaining as its primary objective the safety and welfare of the patient, this certificate of accreditation is granted by the authority of the Joint Commission on Accreditation of Hospitals

Richard A. Kern Chairman

John D. Porterfield Director

November 16, 1966



Refused

...ION NO. 3 (Ed)
...(✓ DEF( ) COM( )
...ASE NO. 5862
...DATE 6/26 1974
JUDGE: Only US. Rhoades

PRINCE WILLIAM HOSPITAL

MEDICAL STAFF BYLAWS

Refused

EXHIBIT NO. 4 (Rd).
PL(✓ DEF( ) COM( )
CASE NO. 5862
DATE 6/26 1974
JUDGE:
Coley vs Richard

BYLAWS

Rules and Regulations of

The Medical and Dental Staff of Prince William Hospital

Date Adopted January 21, 1970.

PREAMBLE

Recognizing that the medical staff is responsible for the quality of medical care in the hospital and must accept and assume this responsibility, subject to the ultimate authority of the hospital governing body, and that the best interests of the patient are protected by concerted effort, the physicians practicing in Prince William Hospital hereby organize themselves in conformity with the Bylaws, Rules and Regulations hereinafter stated.

For the purpose of these bylaws the word medical staff shall be interpreted to include all physicians and dentists who are privileged to attend patients in the Prince William Hospital.

Whenever the term governing body appears, it shall be interpreted to refer to the Board of Directors.

ARTICLE I

Name

The name of this organization shall be the "Medical Staff of Prince William Hospital"

ARTICLE II

Purpose

The purpose of this organization shall be:

1. To insure that all patients admitted to the hospital or treated in the outpatient department receive the best possible care;

2. To provide a means whereby problems of a medico-administrative nature may be discussed by the medical staff with the governing body and the administration;

3. To initiate and maintain rules and regulations for governing the medical staff;

4. To provide education and to maintain educational standards.

ARTICLE III

Membership

Section 1. Qualifications

The applicant for membership on the medical staff shall be a graduate of an approved medical school or an approved dental school, legally licensed to practice in the Commonwealth of Virginia, a member of his local medical or local dental society and practicing within a reasonable distance of this hospital.

Section 2. Application for Membership

Application for membership on the medical staff shall be presented on the prescribed form to the administrator of the hospital and shall state the qualifications and references of the applicant; it shall signify his agreement to abide by the bylaws, rules and regulations of the medical staff; it shall state specifically the area in which he wishes to practice and privileges desired.

Section 3. Terms of Appointment

Subsection 1. Appointments shall be made by the governing body of the hospital after recommendation of the medical staff. They shall be for the period of one year, [illegible] in December.

Subsection 2. In no case shall the governing body take action on application, refuse to renew an appointment, or cancel an appointment previously made without conference with the medical staff.

Subsection 3. Appointment to the medical staff shall confer on the appointee only such privileges as may hereinafter be provided.

Section 4. Ethics and Ethical Relationships

The Principles of Medical Ethics as adopted or amended by the American Medical Association shall govern the professional conduct of the members of the medical staff. Specifically, all members of the medical staff shall pledge themselves that they will not receive from or pay to another physician, either directly or indirectly, any part of a fee received for professional services.

Section 5. Procedure of Appointment

Subsection 1. Application for membership on the medical staff shall be presented on a prescribed form, to the administrator of the hospital. It shall state the qualifications and references of the applicant and such other information as may be required. The applicant shall also signify his intention as may be required. The applicant shall also signify his intention to abide by the bylaws, rules and regulations of the medical staff and by the decisions of the executive committee. The administrator shall transmit the application to the secretary of the medical staff.

Subsection 2. The secretary shall present the application to the credentials committee in time for consideration at its next meeting.

Subsection 3. The credentials committee shall investigate the character, qualifications and standing of the applicant. It shall submit a report of findings to the executive committee as soon as possible, in all cases within 60 days, recommending that the applicant be accepted, deferred or rejected. If acceptance is recommended, the credentials committee shall suggest the staff category, department and section, rank and privilege to be assigned. All proposed recommendations for new appointments shall be submitted by the executive committee to the medical staff for approval at a regular medical

staff meeting. Where recommendation to defer action is made by the medical staff, it must be followed by one to accept or reject the applicant at the next meeting of the medical staff.

Subsection 4. On receipt of the report of the executive committee, the medical staff shall immediately recommend to the governing body that the application be accepted, deferred or rejected and, if accepted, what privileges to be granted.

Subsection 5. The recommendation of the medical staff shall be transmitted to the governing body of the hospital through the administrator.

Subsection 6. The governing body shall either accept the recommendation of the medical staff or shall refer it back for further consideration stating the reasons for such action.

Subsection 7. When final action has been taken by the governing body, the administrator of the hospital shall be authorized to transmit this decision to the candidate for membership and, if he is accepted, to secure his signed agreement to be governed by these bylaws, rules and regulations.

Subsection 8.

Paragraph I. The credentials committee shall review the work and participation of the members of the medical staff annually and submit to the executive committee its recommendations for reappointment. These recommendations shall include designation of rank, privileges, and service for each physician reappointed.

Paragraph II. The executive committee shall present these recommendations for annual reappointment to the medical staff at its annual meeting.

Paragraph III. These recommendations shall be acted upon by the governing body in its December meeting.

Section 6. Appeals

Subsection 1. In any case where the medical staff and/or the governing body do not recommend reappointment, where reduction in rank is recommended, or where the executive

committee recommends punitive or corrective measures, th[illegible] shall notify the physician concerned. He shall be given an opportunity to appear before an appeals committee, comprised of five physicians:

(a) two physicians chosen by the member appealing
(b) two physicians appointed by the executive committee; and
(c) one physician selected by the four physicians previously selected.

Subsection 2. This appeals committee shall be considered a special committee under Article VII, Section 2, Subsection 9.

Subsection 3. The chairman shall be the physician selected by the four previous physicians; he shall report the proceedings of the committee meetings to the executive committee.

Subsection 4. The executive committee shall report to the medical staff at its next meeting, regular or called.

Subsection 5. The executive committee shall notify the physician concerned of the particulars of the decision. If these are acceptable to the physician, the administrator shall carry the report to the governing body. If the decision is unacceptable, the physician shall have the right of appeal to the joint conference committee, and the credentials committee meeting in joint session, called at the request of the executive committee. The report of the joint conference committee shall be sent to the governing body.

Subsection 6. Until such time as final disposition is made, the privileges of the physician concerned shall be temporarily suspended or his reduction in rank temporarily recognized. He shall abide by any other conditions imposed by the executive committee and noted by the medical staff.

Section 7. Emergency and Temporary Privileges

Subsection 1. Regardless of his departmental or staff status, in case of emergency the physician attending the patient shall be expected to do all in his power to save the

life of the patient, including the calling of such consultation as may be available. For the purpose of this section an emergency is defined as a condition in which the life of the patient is in immediate danger and which any delay in administering treatment would increase the danger.

Subsection 2. The administrator of the hospital, after conference with the chief of staff, shall have the authority to grant temporary privileges to a physician who is not a member of the medical staff. The chief of staff shall give authoritative opinion as to the competence, licensure, and ethical standing of the physician concerned and shall have direct supervision over such physician in the exercise of the privileges granted.

Subsection 3. Temporary privileges shall be valid only to such extent designated by the administrator in consultation with the chief of staff. This physician shall be required to complete the prescribed membership application form within the 30 days of such consultation. Otherwise, he is denied privileges in the hospital until he is accepted as a member of the medical staff. This may be waived at the discretion of the executive committee.

ARTICLE IV

Categories of the Medical Staff

Section 1. The Medical Staff

The Medical Staff may be divided into honorary, consulting, active, associate and courtesy groups.

Subsection 1. The Honorary Medical Staff

The honorary medical staff shall consist of physicians who are not active in the hospital and who are honored by emeritus positions. These may be physicians who have retired from active hospital service; or physicians of outstanding reputation not necessarily resident in the community.

The honorary staff is not eligible to vote or hold office, ordinarily does not admit patients, and shall have no assigned duties.

Subsection 2. The consulting medical staff shall consist of physicians of recognized professional ability who are active in the hospital or who have signified willingness to accept such appointment.

Paragraph I. The duties of the members of the consulting medical staff shall be to give their services, without charge, in the care of service patients on request of any member of the active medical staff. In other cases in which consultation is required by the rules of the hospital, these services may be given without charge.

Paragraph II. Membership on the consulting medical staff does not preclude membership on the active staff.

Paragraph III. A member of the consulting staff cannot vote or hold office unless he is also a member of the active staff.

Subsection 3. The Active Medical Staff

Paragraph I. The active medical staff shall consist of physicians resident in the community who have been selected to transact all business of the medical staff. They shall attend service patients in the hospital. Service patients shall be assigned to them. Only members of the active medical staff shall be eligible to hold office and to vote.

Paragraph II. Insofar as it is possible, vacancies shall be filled by promotion of members of the associate medical staff who have signified a desire to become more active in the work of the hospital.

Paragraph III. Members of the active medical staff shall be required to attend medical staff meetings as provided in Article VII of these bylaws.

Paragraph IV. Upon recommendation of the committee chairman and chief of staff, and approval of the executive committee, a member of the active staff who has not fulfilled his hospital staff obligations as set forth in these bylaws and rules and regulations may be reassigned from the active staff status to the courtesy staff. Final approval of such reassignment shall be made by a majority vote of the active staff at a meeting in which a quorum is present. This reassignment shall be approved by the governing body.

Paragraph V. Changes in staff assignments as prescribed by rules and regulations do not need approval of the medical staff.

Subsection 4. The Associate Staff

Paragraph I. The associate staff shall consist of new members of the staff or members of the courtesy staff who manifest an interest in the various hospital services.

Paragraph II. They shall be appointed and assigned to duties in the same manner as provided for the active medical staff. They shall be eligible for promotion to the active staff after demonstration of one year of satisfactory service. This recommendation to active staff status will be made by the credentials committee annually. This committee will notify members in writing if eligible for appointment to active staff. In order to be assigned to the active staff, the eligible associate or courtesy member must request this by letter to the chairman of the credentials committee. The member should indicate by letter to the chairman of the credentials committee his desire to become an active member.

Paragraph III. They may also act on all committees except the executive committee and the credentials committee.

Paragraph IV. The associate medical staff is not eligible to vote or hold office.

Subsection 5. The Courtesy Medical Staff

Paragraph I. The courtesy staff shall consist of those physicians otherwise eligible as herein provided for staff membership who do not desire active staff responsibility, but who shall be privileged to admit and to attend private patients.

Paragraph II. Members of the courtesy staff shall not be eligible to vote or to hold office. They shall have no assigned responsibilities for free patients or for teaching.

Paragraph III. Members of the courtesy staff shall be eligible for promotion to the active staff after two (2) years of satisfactory service and provided a vacancy on the active staff exists.

ARTICLE V

Departmental Categories for Staff Assignment

Section 1. Departments

Subsection 1. Departments of the medical staff shall be as follows: medicine, surgery, obstetrics and gynecology, general practice, radiology, pathology, pediatrics and anesthesia.

Subsection 2. Members of the medical staff shall not be required to be exclusive specialists. It is expected that they will be well skilled in the particular branch of medicine to which they are assigned, and their attendance of free patients will be limited to those assigned to that service and that a large proportion of their private practice shall fall in that specialty.

Subsection 3. The responsibilities of the general practitioners shall be limited to administration and educational. Its members shall have the privileges in other clinical services as recommended by the credentials committee and approved by the governing body. They shall be subject to the rules of the services in which they have privileges

and like all other members shall be under the jurisdiction of the committee chairman concerned.

Subsection 4. Patients admitted for dental-oral surgery shall be admitted to the services of a physician of the medical staff. An adequate history and physical shall be done by the physician on admission of the patient. This physician shall be responsible for evaluation and guidance of the patients' general medical problems while hospitalized.

ARTICLE VI

Committee Organization Function & Structure

Section 1. If any given department is considered too small to require monthly meetings, such requirement may be waived by the executive committee. Members of such departments, however, must attend meetings of other departments as described in Article VIII, Section 4, Subsection 1. If meetings of the department are not held, then attendance at general staff meetings will fulfill the obligation of attendance.

Subsection 1. Until such time as departments are large enough to have regular meetings, department functions will be carried on by special and standing committees who will meet monthly and report to the executive committee. Committee duties will be those outlined under Article VII.

Section 2. Assignment to Departments

The credentials committee will recommend to the executive committee of the medical staff the departmental assignments of the medical staff.

ARTICLE VII

Officers and Committees

Section 1. Officers

The officers of the medical staff shall be President, President- elect, Vice President and Secretary. These shall be elected at the December meeting. Their

term of office shall begin on January 1 of the next year.

Subsection 1. The President shall call and preside at all meetings of the Medical Staff except as otherwise provided in the by-laws. He shall be a member ex-officio of all committees and he shall have general supervision over all professional work of the hospital.

Paragraph I. He shall serve a term of office of two consecutive years, and shall not be eligible to succeed himself.

Subsection II. The President-elect shall be elected one year before his term as President. His duties shall consist of those provided in the by-laws and those assigned to him by the President.

Subsection III. The Vice President shall serve a one-year term and shall not succeed himself. He shall assume all duties of the President in the President's absence.

Subsection IV. The Secretary shall serve a one-year term and shall not succeed himself. He shall keep accurate and complete minutes of all meetings, call meetings on order of the president, attend to all correspondence and perform such other duties as ordinarily pertain to his office. If there are funds to be accounted for, he shall also act as treasurer.

Section 2. Committees

Subsection 1. Committees of the medical staff shall be standing or special. Standing committees shall meet monthly. All committees other than the executive committee shall be appointed by the president.

Subsection 2. The Executive Committee shall be made up of five (5) members, consisting of the President, Vice President, Secretary, President-elect or immediate Past President, and a member at large. The President shall be Chairman.

Paragraph I. The immediate Past President shall serve a one-year term, this to follow his term as President, and to coincide with the first year of the two-year presidential term. The President-elect's term of office will coincide with the second year of the two-year presidential term. A member at large shall be nominated by the Nominating Committee and elected by the Medical Staff at its annual meeting. He shall serve a one-year term, and shall be eligible to succeed himself.

Paragraph II. The duties of the executive committee shall be:

1. To act on any professional policy matters;
2. To act in any advisory capacity to the hospital administrator in any matters pertaining to professional services within the hospital;
3. To cooperate with the hospital administrator in securing proper execution of the approved professional policies of the hospital and in the observance of all rules and regulations relating thereto;
4. To meet monthly, and to present the minutes of these meetings to the full medical staff at their monthly meeting;
5. To meet with the administrator at the call of either the committee or the administrator, and to consider any and all administrative-professional problems as they may arise, and/or to clear any such administrative matters or proposals contemplated to be presented later to either the medical staff or the executive committee of the hospital as the same might relate to the mutual interests, welfare, or concern of either or both groups;

6. To review monthly all committee reports.

7. To investigate any breach of ethics that may be observed by this committee, or reported to it by any member of the medical staff;

8. To review records of any member of the medical staff submitted by the medical records committee;

9. To keep the medical staff abreast of the accreditation program and keep members of the medical staff informed of the accreditation status of the hospital.

Paragraph III. The executive committee shall have the power to impose corrective and/or punitive disciplinary measures on a member or members of the medical staff in order to insure high and generally accepted standards of medical care for hospital patients.

Paragraph IV. These disciplinary measures shall not be imposed until approved by a majority of the medical staff in attendance at the next regular meeting.

Paragraph V. The appeals process as outlined in Article III, Section 6, shall be available to members subjected to action of the executive committee and medical staff, as outlined in Paragraph II and III above.

Subsection 3. The medical records committee shall consist of at least three (3) members of the active medical staff.

Paragraph I. The duties of the medical records committee shall be:

1. To supervise and appraise the quality of the medical records, and

2. To insure their maintenance at the required standard.

Paragraph II. This committee shall meet at least once a month and submit to the executive committee a report in writing which will be made a part of the permanent record.

Subsection 4. The credentials committee shall consist of three (3) members of the active staff.

Paragraph I. Its duties shall be:

1. To investigate the credentials of all applicants for membership, and,

2. To make recommendations in conformity with Article III, Section 5 of these by-laws.

Subsection 5. The joint conference committee shall be composed of the President and Vice-President, and two (2) members of the governing body, appointed by the chairman of the governing body. The Administrator of the hospital shall serve as secretary of this committee. Another member of the medical staff may be appointed by the President of the Medical Staff, and another member appointed by the Board, by mutual agreement.

Subsection 6. The tissue committee shall be made up of at least three (3) members of the medical staff - usually the pathologist should sit as a member of the committee or ex-officio.

Paragraph I. The duties of the tissue committee shall be to study and report to the staff, or to the executive committee of the staff, on the agreement or disagreement among the preoperative, postoperative and pathological diagnoses, and on whether the surgical procedures undertaken in the hospital were justified or not. This study will also include those procedures in which no tissue was removed.

Paragraph II. The report to the executive committee shall be in writing on at least a monthly basis.

Subsection 7. The morbidity and mortality committee shall consist of three (3) members of the medical staff.

Paragraph I. Its duties shall be to review monthly all cases of deaths, excessive morbidity and those cases involving apparent mismanagement or lack of proper consultation. This committee shall be empowered to call consultants from the various

services serv.

Paragraph II. This committee will report in writing to the executive committee which committee will make appropriate action and such reports to become a part of the records of the medical staff.

Subsection 8. The utilization committee shall consist of the two (2) past presidents of the medical staff, with the immediate past president being chairman, representative of administration, the Public Health Director, and additional persons as may be called for special purposes. In the event the physician members are unable or unwilling to serve, the president of the medical staff shall appoint their replacements.

Paragraph I. This committee shall be empowered to:

1) Set up guidelines for good hospital utilization;

2) Develop additional means of collecting data for study as it becomes necessary;

3) Provide for immediate review of suspected instances of poor utilization;

4) Recommend to the executive committee of the medical staff areas of hospital work that may need special projects to strengthen its program;

5) Cooperate with administration through the executive committee; and

6) Treat as confidential all facts gathered.

Subsection 9. Until departments are large enough to have departmental meetings, the supervision of these departments shall be carried out by standing committees.

Paragraph I. The members shall be appointed by the president of the medical staff.

Paragraph II. These committees shall meet monthly and report to the executive committee.

Paragraph III. The duties of these committees shall involve formulation of rules and policies insuring high professional standards; there shall be supervision and review to insure the continuation of these standards.

Subsection 10. An infections committee shall be appointed by the president of the medical staff. Its duties will be to set up procedures to detect all hospital-acquired infections and to review these cases. The committee shall report to the executive committee; it may make recommendations for improving bacteriological control in the hospital.

Subsection 11. Special committees may be constituted from time to time.

Paragraph I. They may be appointed by the chief of staff or upon motion and approval by the medical staff.

Paragraph II. Their duties shall be set forth when formed. These will ordinarily involve a specific purpose with no on-going characteristics.

Paragraph III. The committee chairman will be appointed by the chief of staff; he will report in writing to the executive committee.

Paragraph IV. The special committee will be dissolved when its purpose has been accomplished.

ARTICLE VIII

General Staff Meetings

Section 1. The Annual Meeting

The annual meeting of the staff shall be the last meeting before the end of the fiscal year of the hospital. At this meeting the retiring officers and committees shall make such reports as may be desirable, officers for the ensuing year shall be elected and recommendations for appointment to the various categories of the medical staff and assignment of privileges and departments shall be made.

Section 2. Regular Meetings

Subsection 1. Regular meetings of the medical staff shall be held monthly.

Subsection 2. Additional item or items may be added to the agenda under "new business" by unanimous vote of those members present.

Section 3. Special Meetings

Special meetings of the medical staff may be called at any time by the president and shall be called at the request of the governing body, the executive committee, or by any members representing 10% of the active medical staff. At any special meeting no business shall be transacted except that stated in the notice calling the meeting. Sufficient notice of any meeting shall be a notice posted on the bulletin board in the staff room at least 72 hours before the time set for the meetings, or telephone contact to the member at his office by the secretary of the medical staff at least 72 hours prior to the time of such meeting.

Section 4. Attendance at Meetings

Subsection 1. Each active staff member shall attend at least 50 percent of all staff meetings. A member may be excused by the executive committee for just cause. Absence from more than one-half of the regular meetings for the year, unless excused by the executive committee for just cause such as sickness or absence from the community, shall be considered as resignation from the active medical staff and shall automatically place the absentee on the associate medical staff.

Subsection 2. All members of the associate medical staff shall be expected to attend meetings with the same regularity as members of the active medical staff.

Subsection 3. Members removed from active status because of absenteeism may be reinstated to active status by simple letter request provided that a vacancy on the active staff exists, and that the member has fulfilled his meeting requirements for the previous calendar year.

Subsection 4. Members of the honorary, consulting, and courtesy categories of the medical staff shall not be required to attend meetings. It is expected, however, that they will attend and participate in these meetings unless unavoidably prevented from doing so.

is to be presented for discussion at any meeting, shall be notified and shall be required to be present. Failure to attend on receipt of such notice shall involve the penalty, in case of a member of the consulting or active staff, of reverting to the associate or courtesy staff; and, in the case of a member of the courtesy staff, of forfeiting his staff membership. If a member is not present when his case is to be discussed, it shall be presented nonetheless. A member may request postponement of his case for sufficient cause. In no case shall postponement be beyond the next regular meeting.

Section 5. Quorum

Thirty percent of the active medical staff shall constitute a quorum.

Section 6. Agenda

Subsection 1. The agenda at any regular meeting shall be:

A. Business

1. Call to order.
2. Reading of the minutes of the last regular and of all special meetings.
3. Unfinished business.
4. Communications
5. New business.

B. Medical

6. Review of patients in the hospital with special reference to diagnosis, treatment and delayed recoveries; selected cases discharged since the last conference with special consideration of selected deaths, unimproved cases, infection, complications, errors in diagnoses, and results of treatment; and analyses of clinical reports of various departments.

7. Reports of committees.

8. Discussions and recommendations for improvement of the professional work of the hospital.

9. Adjournment.

Subsection 2. The agenda at special meetings shall be:

1. Reading of the notice calling the meeting.

2. Discussion of business for which the meeting was called.

3. Adjournment.

ARTICLE IX
Rules and Regulations

The medical staff shall adopt such rules and regulations as may be necessary for the proper conduct of its work. Such rules and regulations shall be a part of these bylaws, except that they may be amended at any regular meeting, following presentation at a previous meeting, by a majority of those present. A copy of such proposed amendments shall be placed on the bulletin board in the doctors' lounge as soon as possible following its presentation, to remain there until it is acted upon. Such amendments shall become effective when approved by the governing body.

ARTICLE X
Amendments

These bylaws may be amended after notice given at any regular meeting of the medical staff. Such notice shall be referred to a special committee which shall report at the next regular meeting. Approval by two-thirds of the total membership of the active medical staff shall be necessary for adoption of amendments to the bylaws. A copy of such proposed amendments shall be placed on the bulletin board in the doctor's lounge as soon as possible following its presentation, to remain there until it is acted upon. Amendments so made shall be effective when approved by the governing body.

Adoption

These bylaws, together with the appended rules and regulations, shall be adopted at any meeting of the active staff following a thirty-day notification period. They shall replace any previous bylaws, rules and regulations and shall become effective when approved by the governing body of the hospital. They shall, when adopted and approved, be equally binding on the governing body and the medical staff.

RULES AND REGULATIONS

1. The meetings of the medical staff shall be held as provided in Article VII of the bylaws.

2. Except in emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated and the consent of the administrator or his delegate secured. In case of emergency the provisional diagnosis shall be stated as soon after admission as possible.

3. Physicians admitting private patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatever, or to assure protection of other patients from self harm.

4. All charity patients shall be attended by members of the active staff and shall be assigned to the service concerned in the treatment of the disease which necessitated admission or in rotation if there is no service division. Pay patients shall be attended by their own private physician. In the case of a pay patient applying for admission, who has no attending physician, he shall be assigned to the members of the active staff on service in rotation. Physicians who are assigned patients shall be informed at that time whether they are admitted as charity or pay patients.

5. Laboratories shall be provided in the hospital to insure as complete service as possible. Examinations which cannot be made in the hospital shall be referred to any out-

established rate.

6. Standing orders shall be formulated by conference between the medical staff and the administrator. They can be changed only by mutual consent of the medical staff and administrator, and the latter shall notify all personnel concerned. These orders shall be signed by the attending physician.

7. All orders for treatment shall be in writing. An order shall be considered to be in writing if dictated to a graduate nurse or other authorized persons and signed by the attending physician. Orders dictated over the telephone shall be signed by the person to whom dictated with the name of the physician per his or her own name. At his next visit, the attending physician shall sign such orders.

8. Drugs used shall be those listed in the United States Pharmacopeia, National Formulary, New and Non-official Remedies, British Pharmacopeia, or Canadian Formulary, with the exception of drugs for bonafide clinical investigations. Exceptions to this rule shall be well justified. Unless specifically stated on the order sheet, the attending physician will order for narcotics, sulfanamides, antibiotics, barbiturates and sedatives will expire in 48 hours and the order must be rewritten if drugs are to be continued. Orders for anticoagulations are to be written daily.

9. The attending physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall include identification date; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory, x-ray and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note; follow-up and autopsy report when available. No medical record shall be filed until it is complete, except on order of medical records committee.

10. A complete history and physical examination shall in all cases be written within 24 hours after admission of the patient. Patients who are readmitted within 3 weeks after discharge for the same condition shall require only an interval note. Daily progress notes are expected on all charts. Progress notes every 3 days are required.

11. When such history and physical examinations are not recorded before the time stated for operation, the operation shall be cancelled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient.

12. All records are the property of the hospital and shall not be taken away without permission of the administrator. In case of readmission of a patient, all previous records shall be available for the use of the attending physician. This shall apply whether the patient be service or pay, and whether he be attended by the same physician or another.

13. Except in cases of emergency, patients admitted for surgery under general anesthesia shall be admitted not later than 4 o'clock in the afternoon preceding surgery. In the case of tonsillectomies, adenoidectomies and eye muscle cases, however, admittance may be delayed until a reasonable hour in advance of surgery, that is the same day of surgery, but only provided that necessary laboratory work is done and physical examination made within 24 hours immediately preceding such surgery.

14. All operations performed shall be fully described on the records by the attending surgeon. All tissues removed at operations shall be sent to the hospital pathologist unless the operating surgeon obtains competent pathological examinations elsewhere. The requisition accompanying removed tissue sent to the pathologist shall indicate preoperative and post-operative diagnosis, and this requisition shall be signed by the operating surgeon. If pathological diagnosis reveal abnormal variance from clinical diagnosis, these situations shall be brought to the attention of the tissue committee.

15. The operating surgeon shall obtain an assistant [illegible] judgement, the procedure requires it, or if the rules of the department require assistance in a given procedure. The operating surgeon should notify the patient of the use of an assistant. The assistant must bill the patient separately. Surgeons are expected to help their fellow surgeons if requested to do so.

16. Operating surgeons shall be in their respective operating rooms and ready to commence operating at the time scheduled, and in no case will the operating room be held longer than 15 minutes after the time scheduled for the operation to begin.

17. Except in an emergency, consultations are required in the following cases:

1. Poor risk, surgical;
2. Obscure diagnosis;
3. Major obstetrical surgery and first cesarean sections;
4. Any operation that may interrupt a known, suspected or possible pregnancy, especially curettages;
5. Sterilization.

In addition to consultation, the executive committee's approval must be obtained for Item Number 5. The consultant shall make his recommendations in every case, such opinion to be recorded on the chart preoperatively.

18. Tubal ligations, vasectomies, or other methods of sterilization shall be performed only in accordance with the laws of the Commonwealth of Virginia. Excessive performance of sterilization procedures shall be brought to the attention of the tissue committee.

19. Therapeutic abortions shall be limited to those cases in which there are definite medico-pathologic indications, and all requests for such procedures shall be reviewed by the executive committee of the medical staff. The request of the attending physician

for review of a case in which he believes an abortion is indicated shall be accompanied by a complete medical record, including history, indications, and consultations reports. All approved procedures must have attached to the chart a release signed by the patient and spouse or responsible individual.

20. In those cases in which a known, suspected or possible pregnancy is a factor, the operation of dilatation and curettage shall be performed only when abortion is incomplete as substantiated by the recovery of parts of the products of conception. In cases of inevitable abortion, accompanied by hemorrage in an amount sufficient to constitute a definite and immediate threat to the patient's life, these cases shall be handled operatively only after consultation with a recognized obstetrician, gynecologist, or surgeon. In addition to all the provisions above, the tissue committee shall review each month all case records of abortions.

21. In all other cases where a rule of the hospital requires consultation, the consultant shall give his services without charge if the patient is unable to pay for them.

22. Each member of the medical staff not resident in the immediate vicinity shall name a member of the medical staff who is a resident in the immediate vicinity, and who may be called to attend patients in an emergency. In case of failure to name such associate, the administrator of the hospital shall have authority to call any member of the staff when necessary.

23. Patients shall be discharged only on written order of the attending physician. Telephone orders shall be accepted in accordance with Rule Number 7. At the time of discharge, the attending physician shall see that the record is complete, state his final diagnosis, and sign the record.

24. After discharge, records should be completed within 10 to 15 days. The medical records committee, with the approval of the executive committee, shall take such steps

as are necessary to enforce this rule. At the time of the annual review of privileges, any physician having records incomplete for more than six months prior to that time shall not be reappointed, but must reapply for privileges by letter. This will be considered in the same way as an initial application.

25. Due to the nature of the patient-doctor relationship, the notice of an institutional death should not be given by any representative of the hospital to the nearest of kin, but should be given directly to the attending physician. He shall, in turn, notify the family of the deceased person and shall simultaneously endeavor to obtain autopsy permission. No autopsy shall be performed without written consent from the next of kin.

26. No member of the staff shall give to or receive from another physician any part of the fee received from a patient. It is recommended that all physicians render separate accounts and issue separate receipts.

27. The medical staff discussions at meetings held as provided for under Number 1 of these rules and regulations shall constitute a thorough review and analysis of the clinical work done in the hospital, including consideration of deaths, unimproved cases, infections, complications, errors in diagnosis and results of treatment from among significant cases in the hospital at the time of the meeting and significant cases discharged since the last meeting; and analysis of clinical reports from each department and reports of committees of the active medical staff.

28. The hospital shall admit patients suffering from all types of disease except the following:

a. communicable diseases;

b. psychiatric cases, uncomplicated;

c. alcoholic cases; uncomplicated.

Above cases of patients may be admitted if facilities for proper care are available. Patients may be treated only by physicians who have submitted proper credentials and have been duly appointed to membership on the medical staff.

29. Except in emergency cases, direct responsibility shall rest upon the attending surgeon to ascertain that proper operative authority has been obtained before proceeding with an operation. In emergency cases involving surgery, however, the welfare of the patient shall not be jeopardized in this process. The general guardian is necessary an operative permit in all cases involving minors.

30. Medical Staff Disaster Assignments. All physicians shall be assigned to posts, either in the hospital or in the auxiliary hospital, or in mobile casualty stations, and it is their responsibility to report to their assigned stations. No physicians will perform any duties other than those assigned. The chief of the Disaster Emergency Medical and Surgical Services in the hospital and the administrator of the hospital will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the hospital to another or evacuation from hospital premises, the Chief of the Medical and Surgical Services during the disaster will authorize the movement of patients by direction of the administrator of the hospital and chief of staff. All policies concerning patient care will be a joint responsibility of the chief of the Medical and Surgical Services and/or the chief of staff and the administrator of the hospital, in their absence, the deputy chief and alternate in administration, and next in line of authority respectively. All physicians on the medical staff of the hospital specifically agree to relinquish direction of the professional care of their patients, service and private, to the chief of the staff of the Disaster Emergency Medical and Surgical Services in cases of such emergency.

31. Recognizing that patients charts are the property of the hospital, authority is hereby given by members of the medical staff to the hospital to release pertinent information from patients charts to other physicians and/or insurance companies, blue cross associations, and any other recognized persons or agencies, provided however, authorization is signed by the patient. In the instance of a request appearing to be unusual in character, the attending physician shall be contacted. The right of direct inspection of patients' charts shall not be given to any third party, unless specific permission is obtained from each patient in each instance where direct inspection is thought to be necessary.

32. The responsibility for the professional care of the patient is solely that of the attending physician of that patient. The chief of service or the President of the Medical Staff has neither responsibility nor liability to any patient solely by virtue of his position.

33. It is the responsibility of the Governing Board of the hospital to ascertain that its employees are properly trained and capable of performing their duties.

34. These rules and regulations shall become effective when adopted by the active staff at a regular meeting, and approved by the Governing Board.

Dated: January 21, 1970

APPROVALS

Gunter F. Hahn M.D.
Chief of Staff

Joseph J. Bolugari M.D.
Secretary-Treasurer

Thomas Merchant K.
President - Board of Directors

Marguerite W. Putnam
Secretary - Board of Directors