1 NO. 26,836-B

2 SHARON LEE, * IN THE DISTRICT COURT
Plaintiff *
3 *
VS. * 87TH JUDICIAL DISTRICT
4 *
PARKVIEW REGIONAL HOSPITAL, *
5 INC.; PROVINCE HEALTHCARE *
COMPANY; CHARLES RONALD *
6 SMITH, D.O.; ALPHA OMEGA LABS; *
GREG CATON; HERBOLOGICS, LTD. *
7 AND LUMEN FOOD CORP., *
Defendants * OF LIMESTONE COUNTY, TEXAS
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11 ORAL DEPOSITION OF

12 DONALD J. CONEY, M.D.

13 JANUARY 29, 2004

14 VOLUME 1

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17 ORAL DEPOSITION OF DONALD J. CONEY, M.D., produced as a

18 witness at the instance of the Defendants, and duly sworn, was

19 taken in the above-styled and -numbered cause on the 29th day of

20 January, 2004, from 12:48 p.m. to 3:09 p.m., before Wendy

21 Breeland, CSR in and for the State of Texas, reported by machine

22 shorthand, at the Law Offices of Stephen F. Malouf, P.C., 3506

23 Cedar Springs Road, Dallas, Texas, pursuant to the Texas Rules of

24 Civil Procedure and the provisions stated on the record or

25 attached hereto.

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10 ALSO PRESENT:
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1 I N D E X

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1 E X H I B I T L I S T

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1 P R O C E E D I N G S
2 MR. CURNEY: By the Rules.
3 DONALD J. CONEY, M.D.,
4 having been first duly sworn, testified as follows:
5 EXAMINATION
6 BY MR. CURNEY:
7 Q. Good afternoon, Dr. Coney. I'm John Curney, and I
8 represent Parkview Regional Hospital in this case. And you've
9 been designated as an expert witness by Sharon Lee in that
10 particular matter. You're aware of that?
11 A. Yes.
12 Q. I have a feeling this is not your first time on the
13 dance floor with us. Is that fair to say as well?
14 A. That's correct.
15 Q. This is probably going to be about the same as some of
16 the other depositions you've had in the past. I'm going to ask
17 you some questions about some of your opinions and what you
18 reviewed or relied upon in forming those opinions about Ms. Lee's
19 case.
20 When we're answering questions today, I'd like you

21 to do me a favor, and as much as possible, I'd like you to answer

22 the questions that I might ask you based upon a reasonable degree

23 of medical probability. Can you and I have that agreement?

24 A. Yes.

25 Q. And I'd like you also to do me a favor and answer

1 questions based upon a scientific review and analysis of the
2 information you've had as opposed to any kind of subjective
3 reviews or subjective opinions that you might have formed that
4 are not based upon information that is contained within the
5 medical records of Ms. Lee. Can we have that agreement as well?
6 A. Honestly, I couldn't agree to that, because, obviously,
7 some of my objective opinions have a subjective component to
8 them.
9 Q. All right. We'll talk about which of the opinions may
10 have a subjective component to them as we proceed here.
11 So then, in truth, some of the opinions that you
12 have rendered in this case are based upon a subjective analysis
13 as opposed to an objective analysis; is that right?
14 A. Well, no. What I said was I think some of my objective
15 opinions do have a subjective component to them.
16 Q. Fair enough. I've got a copy of your resume, and I'm
17 going to go ahead and --
18 MR. CURNEY: Why don't you just hand me some
19 stickers and I'll do my own marking. Save you the trouble.
20 Q. (BY MR. CURNEY) I'm going to mark a copy of your

21 curriculum vitae as Exhibit 1. And I guess that's a copy of your

22 CV; is that right?

23 A. Yes.

24 (Exhibit Number 1 was marked.)

25 Q. And I think you've got a clean copy of your most recent

1 draft of your report in this particular case; is that right as

2 well?

3 A. Yes.

4 Q. Hand that to me, and we'll go ahead and mark that as

5 Exhibit Number 2.

6 (Exhibit Number 2 was marked.)

7 Q. I'm going to hand you back Exhibit Number 2. And that

8 would be, I guess, the most recent draft of your opinion report

9 in this particular case; is that right?

10 A. Yes, I believe so.

11 MR. MALOUF: Let me make sure that's the right

12 one. Okay. I've got the one on your letterhead. Okay. That's

13 fine.

14 Q. (BY MR. CURNEY) So Exhibit Number 2 is a complete copy

15 of your most recent report in this case; is that right?

16 A. Correct.

17 Q. And you haven't made any changes or alterations to that

18 report since redrafting the same; is that correct as well?

19 A. Correct.

20 Q. And my understanding is that even though the report was

21 dated May 7th, 2003, that that report was actually drafted and

22 prepared by you in August of last year; is that correct?

23 A. I believe that's correct.

24 Q. Okay. So the date may need some correction, but that

25 is your most recent draft; is that right?

1 A. Yes.

2 Q. Dr. Coney, in looking at your resume, I see that you

3 were a UTMB graduate and that you've focused primarily most of

4 your career on Ob/Gyn; is that correct?

5 A. Yes.

6 Q. And what percentage of your practice throughout your

7 career, if any, have you focused on obstetrics as opposed to

8 gynecology?

9 A. Up until April of this year, it was roughly 50/50. In

10 April of this year, I stopped doing obstetrics.

11 Q. So now you're focused primarily on gynecology; is that

12 right?

13 A. Correct.

14 Q. And I also notice that you served some time in the

15 general surgical residency as well; is that right?

16 A. Yes.

17 Q. And do you still practice general surgery outside of

18 gynecology?

19 A. No, I never have.

20 Q. So your career as a physician has been spent

21 practicing, from that last answer, I take it, primarily in the

22 Ob/Gyn field; is that correct?

23 A. Yes.

24 Q. And you've got several years of experience doing that,

25 and I'm sure you feel like you're well qualified to practice in

1 that area; is that fair?

2 A. Yes.

3 Q. And I think you're board certified as well; is that

4 correct?

5 A. Yes.

6 Q. And I noticed also that you were chief of staff, I

7 think at Medical City here in Dallas; is that correct?

8 A. Yes.

9 Q. And also at -- is it Brookshire?

10 A. Brookhaven.

11 Q. Brookhaven. Sorry. You were chief of staff at

12 Brookhaven Hospital as well; is that right?

13 A. Yes.

14 Q. So you've had an opportunity to practice in an

15 operating room setting on at least one or two occasions during

16 your practice life; is that right?

17 A. Yes.

18 Q. And you're familiar with what goes on in an operating

19 room setting as it relates to interaction between physicians and

20 nurses and technicians within that setting; is that fair to say?

21 A. Yes.

22 Q. You've certainly had your opportunity, I'm sure, to

23 evaluate and review a number of doctors other than yourself in

24 how they interact with nursing staff who are -- you hate to use

25 the word nonprofessionals, but non-Ph.D.s or M.D. professionals;

1 is that right?

2 A. Yes.

3 Q. And you and I can both agree that in many cases, the

4 doctors that are responsible for caring for patients in the

5 operating room setting like to have complete control of what's

6 happening in the operating room; is that fair to say?

7 A. Well, I think they're considered captain of the ships.

8 Any physician who's been in the operating room very long realizes

9 he does not have complete control of the operating room.

10 Q. Well, they like to think that -- at least generally

11 speaking, the physicians like to at least make sure that everyone

12 has the understanding that they're the captain of the ship

13 anyway, to use your phrase?

14 A. That's correct.

15 Q. And the buck stops with the physician regarding care

16 and treatment of that patient; isn't that right?

17 A. Not necessarily.

18 Q. If the physician is instructing hospital personnel

19 within the operating room to perform certain acts or provide

20 certain services or materials, the physician is the person

21 responsible for making those orders; is that also right?

22 A. There are certain duties in an operating room that are

23 totally divided from a physician's responsibility. We do not

24 keep up with the instrumentation, where they're placed. That's

25 the responsibility of the circulating nurse and the scrub nurse,

1 and those are independent and shared responsibilities. But
2 ultimately, in the operating room, the captain of the ship is the
3 physician. There are responsibilities that are obviously the
4 nurse's that are not shared with the physician.
5 Q. Well, let's talk about that real fast. Regarding the
6 care of instrumentation within the operating room environment,
7 the physician is responsible at the end of the day for making
8 sure that he has the appropriate instrumentation in the OR before
9 starting surgery to perform work on a patient; isn't that right?
10 A. I think that's the primary responsibility of the
11 circulator and the scrub nurse. The physician fills out a card.
12 The responsibility of the circulator and the scrub nurse is to
13 look at his card and ensure that that equipment is there and
14 properly prepared for his use.
15 Q. And before the physician starts surgery, he should
16 certainly look at his instrumentation and verify that he's got
17 the proper type and amount of instrumentation to perform that
18 work; isn't that fair to say as well?
19 A. I think practically that does not occur, but
20 technically that would be his responsibility.

21 Q. Okay. And we'll be talking about practical issues and

22 technical issues during your deposition today, because those are

23 going to both come into play --

24 THE REPORTER: Can I get you to slow down, please?

25 Q. (BY MR. CURNEY) -- in this case?

1 MR. CURNEY: No. You've got to do the best you
2 can do, dear. That's how I am. This is going to be a fast day
3 for you. Okay?
4 THE REPORTER: I'm trying to keep up.
5 MR. CURNEY: Well, keep up.
6 Q. (BY MR. CURNEY) When you're dealing with an operating
7 room situation and you're dealing with registered nurses, you've
8 had an opportunity in the past to deal with registered nurses who
9 are degreed, meaning they've got a four-year degree as opposed to
10 a two-year degree; is that right?
11 A. Yes.
12 Q. And you've certainly had an opportunity to interact
13 with all kinds of operating room personnel, technicians, scrub
14 techs, registered nurses with four-year degrees and two-year
15 degrees, during your medical career; is that correct?
16 A. That's correct.
17 Q. And can you and I both agree that as a general rule,
18 the operating room staff personnel who are not physicians
19 generally look to the physicians for guidance regarding how to
20 care and treat any particular patient in an operating room

21 setting?

22 A. Care and treatment of the patient is the responsibility

23 of the physician, I believe, yes, primarily.

24 Q. Now, I've noticed in your curriculum vitae that you

25 have some experience working with some hospitals dealing with

1 hospital administration as well; is that right?

2 A. Correct.

3 Q. And as chief of staff of some of these hospitals, you

4 would have been required to evaluate procedures and policies that

5 are in place at hospitals?

6 A. Yes.

7 Q. And you would have had an opportunity to evaluate those

8 procedures and policies dealing with, for instance, use of

9 medications or use of materials in the hospital setting; is that

10 fair to say as well?

11 A. Yes.

12 Q. And also through your history working with some of your

13 teaching positions on your CV, I'm sure you've had an opportunity

14 in the past to work or at least be around doctors using

15 experimental techniques or materials in surgery; is that fair to

16 say as well?

17 A. You better expand on what you mean by "experimental."

18 Q. Okay. Doctors using new technology not generally

19 available to the medical community.

20 A. No. Most hospitals have a committee that evaluates new

21 medications, new instrumentations. They look at the peer review

22 articles and the literature regarding use of that instrumentation

23 prior to approving its use in any hospital that I've been in.

24 Q. And when you're in that particular setting, if a

25 physician wants to use a new material or a new technique within a

1 hospital setting, there is usually a chain of command that he
2 should go through with regard to use of that material or that
3 technique; is that fair to say?
4 A. Better stated than I did, that's correct.
5 Q. All right. And the chain of command that he should go
6 through is he should certainly approach hospital administration
7 regarding those materials before he brings them into the hospital
8 to use them; is that fair to say as well?
9 A. Beyond question.
10 Q. All right. And in this case, I'm sure you've had an
11 opportunity to review some of the records in this case dealing
12 with Dr. Smith's use of the H3O; is that fair to say as well?
13 A. Yes.
14 Q. And does it appear, based on your review, that
15 Dr. Smith in this case went through that chain of command before
16 using the H3O in his practice?
17 A. He did not go through a chain of command.
18 Q. And is that something that's generally taught to
19 physicians in medical school, as far as how to conduct themselves
20 in their practice?

21 A. Actually, that's one he primary learns after he's out

22 of medical school and as he has joined the hospital staff.

23 That's part of the introduction to the hospital, the rules and

24 regulations, protocols in the hospital.

25 Q. And with regard to this particular case, my

1 understanding is you're critical of Dr. Smith for not going
2 through that chain of command; is that right?
3 A. Yes.
4 Q. And you're critical of him for not having done testing
5 on the H3O scientifically to verify whether or not it provided
6 his patients with a positive benefit for its use; is that fair to
7 say as well?
8 A. Or at least be aware of peer review investigation of
9 that medication prior to using it, yes. I don't think it's
10 necessary that he personally performed it, but it should have
11 been performed, he should have been aware of it and substantiated
12 it's safe to use it.
13 Q. What I'm seeing in your report is that you think that
14 somebody should have done some review of that medication or that
15 substance before it was utilized by him in the hospital setting
16 or on his patients; is that right?
17 A. Beyond question.
18 Q. And you've, of course, seen his deposition, I presume;
19 is that right?
20 A. Yes.

21 Q. And you've seen information in his deposition about his

22 own personal use and testing of the material; is that right as

23 well?

24 A. He presented anecdotal use of it. He in no way did any

25 testing on it.

1 MR. DUMAS: Objection, nonresponsive.
2 Q. (BY MR. CURNEY) My understanding, when I was at his
3 deposition, is that he says he used the substance in his office
4 and tested it on himself and his family members before using it
5 on patients. Do you remember that?
6 A. I remember that. From a medical standpoint, the
7 technical response to your question is he did not test it. That
8 is an anecdotal use, nonscientific and not considered testing in
9 the medical community.
10 Q. Okay.
11 MR. DUMAS: I'm going to object as nonresponsive.
12 Q. (BY MR. CURNEY) With regard to his nonanecdotal
13 testing of the material, you would have expected that he would
14 have put the material through some type of scientific analysis,
15 using the scientific method, before approaching hospital
16 administration regarding its use; is that right?
17 A. Or else been aware of peer reviewed testing of the
18 material, that's correct.
19 Q. And the peer review testing that you would have
20 expected them to use is that same type of scientific analysis

21 regarding the material's use or the benefits that you might

22 derive from its use or the problems that its use may cause; is

23 that right?

24 A. Yes.

25 Q. And you and I can, I'm sure, understand and agree that

1 until some type of scientific review and analysis of the
2 substance had been performed, that it would be speculative on
3 anyone's part to determine whether or not this material used in a
4 medical setting with human beings could be causative of any type
5 of problems associated with injury to patients upon whom it's
6 used?
7 A. That's too long a question. Can you shorten it and go
8 back over it again?
9 Q. Yes, sir, I'll try. You and I can both agree that --
10 I'll shorten it up -- that you've seen no information with regard
11 to the H3O that indicates scientific testing of the H3O regarding
12 its use on laboratory animals has been conducted?
13 A. That's correct.
14 Q. And you've seen no evidence, from a scientific
15 perspective, that the use of H3O has been tested regarding its
16 use on human beings?
17 A. That's correct.
18 Q. And you've seen no scientific testing with regard to
19 the use of H3O on an anatomical -- I hate to use the phrase
20 "unit," but I'm going to use "unit" --

21 A. Model.

22 Q. -- model, that could use either people or animals,

23 wherein the H3O has been evaluated by the scientific community

24 and that it is causing damages to those patients or those models;

25 is that right?

1 A. That's correct.

2 Q. And so with regard to your opinions in this case that

3 the use of the H3O may have caused adhesions or other problems,

4 that's based upon -- I assume, that's part of your subjective

5 component to your objective review that you were talking to me

6 about before; is that fair to say?

7 A. No, that's not fair to say.

8 Q. Okay. We'll come to that in a minute then. It's fair

9 to say that with regard to the use of the H3O with regard to this

10 particular case, that you yourself have not performed any kind of

11 scientific testing to determine the effect of the H3O in its use

12 on a human being intra-abdominally; is that right?

13 A. That's correct.

14 Q. And you've done no scientific testing to determine the

15 effect of H3O intra-abdominally in its use on other models, such

16 as animals or the like; is that right?

17 A. Me personally?

18 Q. You personally.

19 A. I have not.

20 Q. And I think you told me before that you haven't seen

21 any kind of scientific testing or evaluation regarding the H3O

22 having been utilized under those circumstances and the outcome;

23 is that right?

24 A. As the H3O as a specific compound. Obviously, what I'm

25 going to be referring to -- so we won't proceed with a

1 misconception -- is the content of the H3O is sulfuric acid,

2 eight percent solution. And my observations and conclusions are

3 based on my knowledge of eight percent or – of that acid,

4 sulfuric acid.

5 Q. Fair enough. Have you seen scientific testing that

6 indicates to you that the use of an eight percent solution of

7 sulfuric acid and water has been tested or analyzed

8 scientifically on humans intra-abdominally?

9 A. I have not personally read the articles. They are

10 referenced in, I believe, Dr. Snodgrass and possibly

11 Dr. Armstrong's. I'm familiar, in a broad sense, from medical

12 school of the effect of acids on animal and human tissue.

13 In my own experience in practicing medicine some

14 35 or 40 years, I am aware of the effect of acids on human skin

15 and have seen the results of it. So my teaching, based on

16 chemistry all the way through medical school, I'm aware of the

17 effect of acids on human tissue. My own experience in seeing

18 patients injured with acids, I am familiar with and have dealt

19 with.

20 Q. With regard to the substance that we're talking about

21 in this case -- and that would be the H3O or the sulfuric acid

22 component to it -- you've done no testing to determine the effect

23 that that sulfuric acid component would have on its ability to

24 create adhesions with regard to its use intra-abdominally; is

25 that fair to say as well?

1 A. I have not done that specific testing, no.

2 Q. And have you seen any kind of literature, in forming

3 your opinions in this case, other than Dr. Snodgrass's report,

4 that indicates to you that the use of the H3O with that sulfuric

5 acid component, in fact, can cause adhesions with regard to its

6 use intra-abdominally?

7 A. I am familiar with the literature in the obstetrical

8 and gynecological field that does indicate the effect of acids

9 specifically on adhesion formation and upon injury to the bowel.

10 This is discussed extensively in the laparoscopic

11 branch of gynecological surgery, because oftentimes the solutions

12 that are used there in an electrical field can produce an

13 acid-type response and cause adhesions and damages to the bowels.

14 Q. With regard to Ms. Lee's care, you did review the

15 physical information and her background information before

16 rendering your opinions in this case; is that right?

17 A. I'm sorry?

18 Q. Sure. I'll do it again. With regard to Ms. Lee, you

19 did review her prior physical examination information prior to

20 rendering your opinions in this case, I assume; is that right?

21 A. Yes.

22 Q. And you and I can both agree that she had a propensity

23 towards adhesion formation prior to Dr. Smith's initial surgery

24 on her at Parkview; is that right?

25 A. I would disagree with that. She had a minimal amount

1 of adhesions at his first surgery. She had had three previous
2 abdominal surgeries. That would imply to a physician who
3 operates frequently that her propensity for adhesion formation
4 was minimal.
5 The only site she had adhesions when he did her
6 hysterectomy was around her -- I believe it was her right ovary.
7 And that -- after somebody who's had a tubal ligation and two
8 C-sections, that's minimal adhesions.
9 Q. So you disagree with an opinion that says that Ms. Lee
10 would have had a propensity towards formation of adhesions prior
11 to the time of this surgery; is that right?
12 A. I'm saying you've got clinical proof that specifically
13 she was a minimal adhesion formation, secondary to three previous
14 surgeries, having no adhesions to her anterior abdominal wall,
15 none to her intestines, and only adhesions around her right
16 ovary. And I guarantee you that's a minimal propensity for
17 adhesions in a patient, she demonstrated personally, which you
18 can't argue with what she did before.
19 Q. The best person to testify about what the adhesions
20 looked like and regarding her propensity for formation of

21 adhesions as a result of those first three surgeries would be the

22 doctor who was actually doing the lysis of the adhesions; is that

23 fair to say as well?

24 A. Not necessarily. You can read what he wrote at the

25 time, prior to a lawsuit, and reach conclusions. She had no

1 adhesions to her anterior abdominal wall, none from her
2 intestines. That's in Dr. Smith's own writing. She only had
3 adhesions around her right ovary.
4 Q. Do you recall Dr. Smith opining in his medical report,
5 regarding the surgery on Ms. Lee, that he performed a lysis of
6 dense adhesions around her ovary?
7 A. Yes.
8 Q. Okay. And when you use the phrase "dense adhesions,"
9 what do you take that to mean?
10 A. That around her ovary she had dense adhesions.
11 Q. And that seems to indicate that she had some adhesion
12 formation that occurred prior to that partial hysterectomy; is
13 that right?
14 A. Yes.
15 Q. And adhesion formation would have occurred as a result
16 of a surgery that had been performed on her in the past; is that
17 also right?
18 A. Not necessarily. Probably so.
19 Q. Within a reasonable degree of medical probability in
20 this case, it would be fair to say objectively that that adhesion

21 probably formed as a result of a prior surgery?

22 A. Yes.

23 Q. With regard to Ms. Lee's condition prior to surgery,

24 you're aware of the fact that, I think you told me earlier, that

25 she had three prior surgeries intra-abdominally; is that correct?

1 A. Yes.

2 Q. She had a tubal ligation, I think is one of them; is

3 that correct?

4 A. Yes.

5 Q. And she also had two C-sections?

6 A. Yes.

7 Q. Is that your understanding as well?

8 A. Yes.

9 Q. And in one of the C-sections, there's an indication

10 that she may have had a ruptured uterus. Are you aware of that

11 as well?

12 A. I think that was referred to as a possible indication

13 for doing the second surgery, and I've read nothing anywhere that

14 would indicate that she actually had a ruptured uterus.

15 Q. Well, I don't think that any of those medical records

16 were found or made available regarding the fact that she may have

17 had a ruptured uterus.

18 But either event, you have not seen records

19 indicating what was actually found during that surgery; is that

20 right?

21 A. That's correct.

22 Q. So any opinions that you might have as to what may have

23 occurred or not occurred regarding those prior surgeries would be

24 just based upon having to speculate, to a degree, as to what may

25 have occurred during those prior surgeries; is that right?

1 A. No. It's based on my clinical experience of dealing
2 with a uterine rupture. That's a catastrophic event that's
3 remembered by everyone involved in it. And I think, beyond
4 question, had Ms. Lee had her uterine ruptured, the clinical
5 circumstances surrounding that would have caused her to remember
6 beyond doubt that she had had a uterine rupture.
7 I think the indications were that because of some
8 fetal distress, she might have had a uterine rupture because she
9 had a previous C-section. And that's based on my experience
10 clinically in obstetrics and with uterine ruptures.
11 Q. Well, when we took her deposition, she didn't know
12 either. You know that?
13 A. That's what I'm saying. And that's extremely strong
14 evidence that she did not have a uterine rupture.
15 Q. With regard to your other review of Ms. Lee's medical
16 records, did you have an opportunity to review the records from
17 Parkview Regional Hospital?
18 A. Yes.
19 Q. And you had an opportunity to review, I assume, the
20 records from Palestine Regional Medical Center as well; is that

21 right?

22 A. Yes.

23 Q. And did you also review the records with regard to the

24 care and treatment she received in Corpus Christi?

25 A. Yes.

1 Q. And have you reviewed any other medical records of hers
2 other than from those three different medical providers?
3 A. Not that I recall.
4 Q. The records from the Parkview Regional Hospital surgery
5 were the records that related to Dr. Smith's first surgery and
6 the removal of a cyst; is that correct?
7 A. Removal of an ovary.
8 Q. Removal of her ovary and a removal of a cyst as well?
9 A. Within the ovary, right.
10 Q. Okay. Well, do you remember seeing the record in there
11 where Dr. Lewis also removed a ganglion cyst?
12 A. Oh, okay. The ganglion cyst, yes.
13 Q. Okay. She actually had two operative procedures at
14 Parkview?
15 A. Yes. Dr. Lewis did that one.
16 Q. That's correct. And then you saw the one from
17 Palestine where they performed an operative procedure in there to
18 release adhesions as well there; is that right?
19 A. Yes.
20 Q. And you also saw the records related to the operative

21 procedure she had in Corpus Christi regarding removal of some of

22 the staples?

23 A. Yes.

24 Q. Is that also correct?

25 A. Yes.

1 Q. All right. I'm going to backtrack with the Corpus
2 Christi procedure first.
3 You haven't rendered an opinion in this case, nor
4 did I see anything in a report form, that you felt that the
5 stapling issue was caused by use of the H3O; is that fair to say?
6 A. That's fair to say.
7 Q. Okay. And you will not be rendering an opinion at
8 trial in this case as to whether or not Dr. Smith's use of the
9 staples with regard to his surgical services provided to
10 Ms. Smith (sic) was either proper or improper under the
11 circumstances of this case; is that fair to say as well?
12 A. I think it's proper to use staples, and I think
13 probably he might have gone a little bit low, but that's a
14 recognized complication of the use of staples, and it's certainly
15 not below the standard of care, in my opinion. That makes it
16 easier.
17 Q. That makes it easy for me. That eliminates one of the
18 issues we have in this case.
19 Also in my review of your report, I do note that
20 you're critical of his use of the H3O, you used the phrase

21 intra-abdominally and also topically; is that right?

22 A. Yes.

23 Q. Now, the information that you have regarding its use

24 intra-abdominally, from whom did you receive that information?

25 A. From the records and the depositions.

1 Q. All right. Do you know whether or not, as you sit here
2 today, Dr. Smith actually used the H3O as an intra-abdominal
3 irrigant?
4 A. I believe I have evidence that will substantiate that,
5 and that in all degree of medical probability, he did, yes.
6 Q. And I'll let Dr. Smith's lawyer talk to you about that
7 evidence in a minute.
8 Now, you also have noted and have seen in the
9 Parkview records where Dr. Smith instructed the nursing personnel
10 to use the H3O topically; is that correct?
11 A. Yes.
12 Q. Now, after the subcutaneous tissue is closed in a
13 surgical procedure and you've closed the skin, use of the topical
14 solution should not have played a role with regard to any
15 intra-abdominal problems that Ms. Lee was having at that point in
16 time. Do you agree with that?
17 A. No.
18 Q. Do you think that the use of the solution topically
19 could have also created or caused problems regarding her
20 intra-abdominal adhesions?

21 A. Yes.

22 Q. Okay. And what information do you have in the medical

23 records that indicates to you that the use of the solution

24 topically would have also created a problem intra-abdominally?

25 A. The -- when you make an incision and you close it,

1 there is a period of time prior to actual sealing of the
2 peritoneum, the fascia, and the layers from the skin into the
3 abdominal cavity.
4 It's my understanding that the solution was
5 applied actually while she was in the operating room, and it
6 certainly could have been a source of leakage into the abdomen,
7 because at that time it's just not sealed.
8 Q. You're aware of the testimony in this case to date that
9 Dr. Smith provided that he used the H3O subcutaneously only; is
10 that right?
11 MR. MALOUF: Objection, form.
12 A. No, I disagree with that.
13 Q. (BY MR. CURNEY) You think --
14 A. That is not what his testimony is, in my opinion.
15 Q. And you think that Dr. Smith used this as an
16 intra-abdominal irrigant?
17 A. I think that I have several things that would indicate
18 that he did, yes.
19 Q. Now, what you don't know is you don't know what type of
20 volume he used as the irrigant; is that right?

21 A. That's correct.

22 Q. Nor, I'm assuming, have you performed any kind of tests

23 to determine what the pH level of the irrigant that he used was

24 on Ms. Smith; is that right as well?

25 A. Actually, he stated in his first deposition that he

1 made it to a pH of 1.8.

2 MR. CURNEY: Object as nonresponsive.

3 Q. (BY MR. CURNEY) My first question is: You didn't

4 determine what it was first; is that right?

5 A. No, I did not.

6 Q. So anything that you would have with regard to his

7 actual use of the H3O would be based upon testimony that you

8 received from Dr. Smith; is that right?

9 A. Well, from the depositions that have been taken in this

10 case, I think that Dr. Armstrong and Dr. -- I can't remember his

11 name, I'm sorry -- is it Jacob?

12 Q. Homer Jacobs is my expert.

13 A. Yes, I understand that.

14 Q. Okay.

15 A. And he did not do a pH determination. There was

16 another pH determination done. But I'll just say, from the

17 records and the depositions that have been taken, including

18 Dr. Smith's.

19 Q. All right. So any information that you have in this

20 case with regard to evaluating the pH level of the solution that

21 was used, by your opinion intra-abdominally on Ms. Lee, would be

22 based upon your review of other individuals' work?

23 A. That's correct.

24 Q. Is that correct?

25 A. Yes.

1 Q. You have done no independent work on your own to
2 determine what the pH levels would have been with regard to the
3 use of the H3O in its diluted form on Ms. Lee, as testified to by
4 Dr. Smith?
5 A. That's correct.
6 Q. Now, a solution that has -- I think you told me it was
7 a 1.1 pH; is that correct?
8 MR. DUMAS: Objection, form.
9 A. 1.8.
10 Q. (BY MR. CURNEY) 1.8 pH. Would that be an acidic
11 solution or a basic solution?
12 A. Acidic.
13 Q. And that would be a mildly acidic solution, correct?
14 A. No. Neutrality is a pH of 7. Anything above 7 is
15 basic; anything below that is acidic.
16 Q. Have you done any kind of testing to determine, in this
17 case, scientifically, what a solution with a pH of 1.8 would do
18 to a human model when used intra-abdominally?
19 A. To circumvent this, I've done no testing at all,
20 period, on any solutions used -- well, the H3O in this case.

21 I've done no personal experience. My opinions are based on

22 review of the medical records and the depositions, plus my past

23 experience and education and training.

24 Q. The education and training that you would have had

25 regarding the use of acidic solutions intra-abdominally on

1 patients, is that information that you've gained during your
2 medical school educational background experience, or is that
3 something that you've accumulated throughout your ongoing career?
4 A. I think it would be cumulative. You know, I first took
5 chemistry in high school, actually. So it would be a cumulative
6 type thing.
7 Q. Now, you haven't been offered in this case and I'm
8 assuming that you're not telling us that you are an expert on the
9 chemistry aspects of the use of H3O?
10 A. You're exactly right. I'll stay a long way away from
11 that.
12 Q. Okay. And you haven't been offered in this case and
13 I'm assuming again for purposes of your testimony in this case
14 and opinions in this case that you're not going to render expert
15 opinions as to the analysis of this type of solution in a
16 laboratory setting?
17 A. Correct.
18 Q. And so --
19 A. My only comments would be that I've read what they said
20 and I'm accepting them as experts in the field. I'm certainly

21 not an expert.

22 Q. So your opinions, to that degree, are based upon your

23 review and acceptance of other information that was developed by

24 other individuals that you were not responsible for supervising?

25 A. That's correct.

1 Q. Responsibility in the operating room, are you aware of
2 whether or not Parkview Regional Hospital had policies and
3 procedures in place with regard to the use of medications or
4 substances within the confines of the hospital?
5 A. Yes.
6 Q. And they did have those policies and procedures in
7 place; is that right?
8 A. Yes.
9 Q. And did you find any errors that you believed, with
10 regard to the way that they had drafted their policies and
11 procedures, that would have provided an individual practicing
12 medicine within the confines of the hospital with any indication
13 that there was some vagueness or ambiguity to the instructions?
14 A. I have not critically read those policies and
15 procedures.
16 Q. And so with regard to this case, you're not going to be
17 rendering an opinion in this particular matter whether or not the
18 Parkview Regional Hospital policies and procedures in and of
19 themselves were appropriate under the circumstances; is that
20 right?

21 A. I think prior to trial, it would be my responsibility

22 to go read those more accurately, and I'll do so.

23 Q. But as you sit here today, you have not done that?

24 A. That's correct.

25 Q. And so what I'll do, Dr. Coney, is if for some reason

1 this case doesn't get settled and we have to go to trial, I'm
2 going to ask that if you decide to go back and do that additional
3 work, that you notify Mr. Malouf that you're doing that, so that
4 we'll have an opportunity to talk to you, or at least I will if I
5 need to, before you testify at trial. Will you do that?
6 A. I will.
7 Q. Now, also with regard to this case, you've not been
8 designated, nor have you rendered opinions related to the
9 standard of care to be exercised by nurses working at the
10 hospital; is that right?
11 A. I thought I did criticize the nurses. Did I not?
12 MR. MALOUF: It's right here, I think.
13 A. Yeah, nursing personnel, that's on Page 3 of my letter.
14 And I think also included in some of the criticisms of the
15 hospital would be, though not stated a direct criticism of nurses
16 for not carrying out hospital policy that would be their
17 responsibility to -- for instance, it is the responsibility of
18 the nurses in surgery to make sure that the hospital policies
19 of -- for instance, allowing this medication into the operating
20 room, they're the ones there, they would be the ones that would

21 have to be responsible for not allowing it in.

22 Q. With regard to looking at your CV, I did not see on

23 your CV where you have, in the past, conducted any kind of

24 training or teaching exercises dealing with training nurses on

25 what the standard of care is in an operating room environment; is

1 that fair to say?

2 A. No, it's not. I have done that. I just didn't include

3 it in my CV.

4 Q. All right. Well, I got to deal with what I've seen on

5 your CV, unfortunately, Dr. Coney.

6 A. I understand.

7 Q. And in either event, there's nothing on your CV that

8 was provided to us in this case that indicates that you've had

9 that kind of experience in the past; is that fair to say?

10 A. It's not on my CV, that's correct.

11 Q. And also on your CV, I did not see information in there

12 where you were responsible for conducting any kind of training

13 classes or analysis of nursing activities as they deal with

14 supervision of physicians in their practice; is that right?

15 A. The nurses supervising the physician?

16 Q. Yes, sir.

17 A. I think my CV, if you look at it, would include

18 positions that entail peer review not only of physicians, but of

19 nursing personnel in the hospital. Being on a board of a

20 hospital -- and I'm sure you understand – certainly entails a

21 review of nurses' practices and procedures; some of the hospital

22 committees would include that. But, no, there's not a committee

23 that would say your responsibility is to review -- the nurse to

24 supervise a physician in an operating room.

25 Q. Going back to your captain of the ship opinion in this

1 case, it is clear in this case that within an operating room
2 scenario, that the physician who's responsible for that patient
3 care is responsible for all aspects of the patient care, the buck
4 stops with him?
5 A. Well, it is a shared responsibility. Specifically
6 addressing this case, that a nurse in the operating room,
7 circulator or scrub nurse, if she is aware of the fact that a
8 physician inappropriately brings in a medication, such as H3O,
9 and starts to use it on a patient, it is their responsibility and
10 duty to stop its use; if necessary, enact the chain of command to
11 make sure it doesn't get used. So they have a shared
12 responsibility in caring for the patient to make sure that the
13 patient was treated safely and appropriately.
14 MR. CURNEY: Okay. Object to part of the answer
15 as nonresponsive.
16 Q. (BY MR. CURNEY) Within that operating room confine, in
17 the room itself, while surgery is being performed, you told me
18 earlier that the physician was the captain of the ship, right?
19 A. Yes.
20 Q. And as the captain of the ship, discussions regarding

21 care and treatment of his patient is his responsibility, is it

22 not?

23 A. Well, within the confines that I just described. There

24 are shared responsibilities with nurses and physicians. It's

25 more obvious in obstetrics. If a nurse reads a fetal monitor

1 strip that indicates the baby's in really bad trouble, it's her
2 responsibility to do appropriate measures to resuscitate the
3 infant.
4 Specifically in this case, the use of H3O on a
5 patient and a medication that they're unaware of, don't know what
6 it might do to the patient, her intestines, it's their
7 responsibility to object to it. Even though the physician is the
8 commander of the ship, he's in charge, if that nurse feels like
9 that what he's doing endangers the patient, she has a
10 responsibility to go above him and enact the chain of command.
11 MR. CURNEY: I guess I need to object to the part
12 of the answer as nonresponsive.
13 Q. (BY MR. CURNEY) In the physician's role as captain of
14 the ship, can you and I agree that -- we're in the practical word
15 now instead of the theoretical world -- that in the practical
16 world, that the physician is the individual who is going to be
17 providing orders to nursing staff and personnel in the operating
18 room regarding what they are to do; is that fair to say?
19 A. Yes.
20 Q. And in the practical world, the nursing staff and the

21 technical staff are looking to the physician for guidance

22 regarding how to care and treat a patient; is that right?

23 A. Yes, but they also have the responsibility to make sure

24 that that care is appropriate.

25 Q. Okay. We're in the practical world now. And in the

1 practical world, can you and I both agree that where a nurse
2 disagrees with a physician's care and treatment plan regarding a
3 patient, that the physician, generally speaking, will use his
4 best efforts to either coerce or inform the nurse that they are
5 to follow his directions as opposed to working on their own?
6 MR. DUMAS: Objection, form.
7 A. In my experience, in the years in administrative
8 capacities, I am aware of innumerable instances where nurses
9 refuse to give medications ordered by physicians; they refuse to
10 perform certain nursing procedures ordered by physicians. So as
11 a general rule, the physician issues the orders, but the nurse
12 has the responsibility to know that they're appropriate orders
13 and to recognize inappropriate orders, and if they are
14 inappropriate orders or medication, to not do them.
15 Q. I took the deposition of the Plaintiff's expert on
16 nursing a week and a half or two weeks ago. Have you reviewed
17 her deposition?
18 A. What's her name?
19 MR. MALOUF: Dr. Stevenson.
20 Q. (BY MR. CURNEY) Dr. Stevenson.

21 A. No.

22 Q. Okay. I asked her that same kind of question. And she

23 told me she thought it was incumbent on the nurse or the surgical

24 tech to make a reasonable inquiry of the doctor as to what it was

25 he was doing. Do you agree with that?

1 A. Yes.

2 Q. And assuming that the nurse made reasonable inquiry of

3 the doctor and he provided her with a response that seems

4 satisfactory at the time the response is provided, is it your

5 position here that the nursing staff or the technical staff needs

6 to do more than questioning the doctor regarding his use of a

7 substance with which they are not familiar?

8 A. Yes.

9 Q. And in this case, you're aware of the fact that the

10 Parkview Regional Hospital personnel who were working with regard

11 to Ms. Lee have testified that they did question Dr. Smith

12 regarding what he was using; is that right?

13 A. I recall one nurse. I actually recall two nurses

14 saying they didn't.

15 Q. And you're aware of the fact that Dr. Smith provided

16 the operating room staff with an explanation as to what it was he

17 was using the H3O for; is that right?

18 A. No, I don't agree with that.

19 Q. You don't agree with that?

20 A. No.

21 Q. You're not familiar with the testimony in the case that

22 has been provided in this matter that Dr. Smith did, in fact,

23 explain to the personnel why he was using the H3O and what it

24 was?

25 A. Over and above that, I'm exactly familiar with what he

1 said, that this is a high oxygen type solution, which it was not.
2 Consequently, if the nurse is not responsible with it, and in
3 this case, the explanation he gave was erroneous and
4 ill-informed, they have the responsibility to primarily protect
5 the patient before they administer that medication that's not in
6 their formulary, to find out if it is a good medication and is
7 indeed what he says it is.
8 Q. Well, we know in this case that the nursing staff, in
9 fact, did not administer the medication. Dr. Smith did that,
10 didn't he? Do you remember reading in his deposition where he
11 said he used it intra-abdominally as an irrigant? Do you
12 remember that?
13 MR. DUMAS: Objection, form.
14 A. Well, now you're saying he did use it
15 intra-abdominally.
16 Q. (BY MR. CURNEY) Well, that he said he used it on
17 Ms. Lee?
18 A. Yeah.
19 Q. That Dr. Smith was responsible for using the H3O on
20 Ms. Lee, you're aware of that testimony?

21 A. I'm aware that he said that. My interpretation of that

22 testimony was that he had ordered the medication. The further

23 depositions indicate that the nurses certainly administered it to

24 the -- externally to the incision. And I don't have any idea if

25 they had done so intra-abdominally or not.

1 Q. That was my mistake for not being more careful about
2 being specific.
3 In the operating room setting, you're aware of the
4 fact that Dr. Smith has testified he was responsible for
5 administering the H3O on Ms. Lee? I'll ask the question that
6 way. You're aware of that?
7 A. Yes.
8 Q. And you're aware of the fact that in the hospital
9 aftercare setting, that he ordered nurses to use it topically on
10 Ms. Lee, correct?
11 A. Yes.
12 Q. And the nurses soaked, I guess, 4-by-4 gauzes and wiped
13 it on her surgical wound; is that correct?
14 A. Or applied it to her surgical wound, yes.
15 Q. Okay. And that's the only way that it was used
16 topically, as far as you can tell from the medical records; is
17 that right?
18 A. I'm not sure about the application in the operating
19 room. On the way to the recovery room as they were applying the
20 original bandage to the incision.

21 Q. In the operating room setting, is the physician the

22 captain of the ship with regard to prescription of medications to

23 be used on his patients?

24 A. He and the anesthesiologist.

25 Q. And in the operating room setting, is the physician

1 responsible for determining which types of nonprescriptive
2 medical supplies to be used on a patient?
3 A. Practically, no; theoretically, yes. And in reality,
4 the use of some medications, again, the nurses still have the
5 responsibility to make sure it's an appropriate medication. They
6 should be aware of what medications they're giving. That's part
7 of their nursing code. It's part of the hospital rules and
8 regulations.
9 Just because a physician says that you can give
10 strychnine to a patient, for a nurse to go ahead and give the
11 strychnine to a patient is a breach of her responsibility, a
12 breach in her standard of care. The same thing applies, in my
13 opinion, to the H3O.
14 MR. CURNEY: Object to the part of the answer as
15 nonresponsive.
16 Q. (BY MR. CURNEY) One of the issues that I have in this
17 case that I'm looking at is use of nonprescriptive medical
18 supplies in an operating room setting.
19 And in my discussions with Dr. Jacobs, he has told
20 me that doctors, on occasion, have brought in different types of,

21 for instance, sutures for use on patients. Have you ever done

22 that?

23 A. I haven't. I'm aware of it being done. It's done only

24 after that particular type of suture has been evaluated in peer

25 reviewed articles and approved by the committees in the hospital.

1 In other words, somebody can't just walk in and say I've got this
2 great suture I'm going to walk in and use. It has to go through
3 the channels of the hospital.
4 Q. And with regard to that use of the suture material,
5 Dr. Jacobs says that in his career, on occasion, like you're
6 aware of, that doctors would bring that material into an
7 operating room setting and use it, and that nurses would comment
8 that they have never seen that in use before. Are you aware of
9 that happening?
10 A. For a physician to bring it in without going through
11 the appropriate committees and protocols for a hospital is a
12 breach in the standard of care and a breach in the nurse's
13 standard of care if they allow it to be done. I mean, those
14 rules are set there to protect the patient. If it might have
15 been done, it was done so as a breach in the standards of care.
16 Q. That really wasn't my question. My question was
17 whether you were aware that doctors, during your practice life,
18 have used, in particular, suture material in situations which
19 nursing personnel were not familiar with the suture material
20 being used? You've certainly heard of that?

21 A. They've used suture material that's been approved for

22 use in the operating room in that particular hospital that the

23 nurses might not be aware of.

24 Q. And if the nurses are not aware of the type or kind of

25 suture material being used, they would have an obligation, in

1 your opinion, to question the doctor regarding the suture
2 material; is that right?
3 A. They would have an obligation by JCAH, by the protocols
4 of the hospital. My opinion doesn't matter. But they are
5 required by the rules and regulations of the hospital where they
6 work and by JCAH to make inquiries of anything that they use or
7 administer, prior to the use of it.
8 Q. Okay. Who should they make that inquiry to first?
9 A. Start with the nurse in charge of the operating --
10 well, the physician, ask him, "Is this approved?" If he says "I
11 don't know," ask the operating room supervisor, who would then go
12 up the chain of command.
13 Q. And assuming that the physician tells them or provides
14 them with a response that appears to be satisfactory regarding
15 its use, is it your feeling that the nurses have an obligation to
16 stop the physician in his tracks and go up the chain of command
17 if they have any question in their mind about whether or not the
18 substance that he's using on the patients is not approved or
19 improper?
20 A. That's correct.

21 Q. And how are they supposed to go about stopping a

22 physician in his tracks?

23 A. Say, Stop, this is not approved, I'm not going to use

24 it, I'm not going to give it to you.

25 Q. And in the practical world, it's your experience that

1 the doctors are going to listen to nurses under those
2 circumstances?
3 A. Doctor would go through the ceiling. That doesn't make
4 any difference. Nurses can go through the ceiling and doctors
5 can. The primary objective in an operating room is to protect
6 the safety and well-being of a patient. If a nurse feels like a
7 physician is doing something that might potentially injure that
8 patient, it is her responsibility to stop and find out, until
9 everything -- the I's are dotted and the T's are crossed.
10 Q. Okay. And that responsibility starts with her
11 questioning of the doctor; is that right?
12 A. Yes.
13 Q. Now, with regard to this particular case, in your
14 report, the nurses do not have a medical right technically -- now
15 we're talking about technically -- to prescribe medications to
16 patients; is that right?
17 A. Correct.
18 Q. They do not have the right, technically speaking, to
19 provide orders regarding care of patients; is that right?
20 A. Technically, that's correct.

21 Q. They do not have the right in Texas, technically

22 speaking, to administer to patients informed consent; is that

23 correct?

24 A. I don't think that is correct. There are some aspects

25 of informed consent that nurses do have rights to administer.

1 Q. With regard to the issuance and use of informed consent
2 prior to a surgical procedure, that would be the responsibility
3 of the physician, is that right, to inform the patient of the
4 risks and the benefits of surgery?
5 A. You know, and, again, I might be wrong, but I know in
6 every hospital that I've been associated with, the hospital has a
7 responsibility to make sure that proper consents are filled out
8 and that the patient is aware of possible dangers, risks and
9 benefits of surgery. As a delegated representative of the
10 hospital, I think the nurses do have the right and responsibility
11 to go through specific complications of surgery.
12 Q. Let me change my question. Maybe I'm not asking it the
13 right way, and that's my fault.
14 It's the physician's responsibility to provide his
15 patient with the informed consent necessary for the patient to
16 make a decision as to whether to go forward or not with surgery;
17 is that right?
18 A. Yes. And it is also my understanding that the hospital
19 has a responsibility to be positive that the patient has received
20 that informed consent by administering the same type of informed

21 consent.

22 Q. It is also the physician's responsibility to inform the

23 patient as to the techniques that the physician intends to use on

24 the patient and the medications he intends to use on the patient

25 regarding surgery; is that right?

1 A. Yes.

2 Q. And to inform the patient of the risks of the use of

3 those techniques or materials, correct?

4 A. Yes.

5 Q. And to inform the patient of the benefits that he

6 believes they'll derive from the use of those techniques or

7 materials; is that also right?

8 A. Yes.

9 Q. And that should occur prior to the patient going into

10 surgery; is that right?

11 A. Yes.

12 Q. And that is not something that the doctor can delegate

13 to a nurse, is it?

14 A. Well, again, are we talking practically or

15 theoretically?

16 Q. Well, we're talking technically, because that's what we

17 have to deal with in this case.

18 A. Well, technically, most informed consents are filled

19 out by nurses in the hospital. I would say a significant

20 percentage of informed consents are filled out by nurses in the

21 private office setting, as a representative of the physician.

22 Q. Let's just talk about obligations then. That's

23 probably the better word I'll use.

24 The obligation to verify that appropriate informed

25 consent has been received by a patient and they understand the

1 nature of the case being performed on them and the outcome that's
2 expected or the dangers, that's the doctor's responsibility to
3 make sure that's been done?
4 A. The doctor's and the hospital's, in the same context
5 that we've talked about.
6 Q. Well, you certainly wouldn't want a four-year degreed
7 nurse to give patients medical advice regarding expected outcomes
8 of surgery, would you?
9 A. I'm sorry. Ask that again.
10 Q. Sure. You certainly would not want four-year degreed
11 registered nurses to provide patients with opinions as to what
12 expected outcomes from surgery might be? You would want the
13 doctor to do that, wouldn't you?
14 A. Well, again, I think that might be a shared
15 responsibility also. These nurses don't just go in and pick it
16 up. They are given forms which are drafted and outlined by --
17 generally by committees, by attorneys and by nursing personnel,
18 that outline the risks and benefits. And I think a four-year
19 nurse has the ability to read those, go down the checklist that
20 are specific for each operation, inform the patient what that is

21 and very legitimately tell them the risks and benefits of an

22 operative procedure.

23 Q. And you're saying that in the world of obligations, of

24 medical and legal obligations, that the nurses owe that duty to

25 the patient as opposed to the doctor?

1 A. No. I think both of them do. It's a shared
2 responsibility.
3 Q. All right. Have you seen any evidence in this case
4 that Dr. Smith ever presented this substance to the hospital
5 administration for their review and approval before using it?
6 A. No.
7 Q. And can you and I both agree that notification was
8 ultimately provided to the hospital administration regarding his
9 use of this substance?
10 A. Ultimately, yes.
11 Q. You've seen that information in the records, haven't
12 you?
13 A. Yes.
14 Q. And you've seen information in the records that when
15 they were notified of its use, that they informed him to
16 immediately stop its use; is that correct?
17 A. Was -- your question started off by saying hospital
18 administration?
19 Q. Yes.
20 A. No. I have evidence from the depositions that the only

21 person that owned up or confirmed that they talked to him was the

22 operating room supervisor.

23 Q. That was Ms. Morris, correct?

24 A. Yes.

25 Q. All right. When Ms. Morris was informed of his use of

1 the material, she informed the doctor to stop using the material;
2 is that right?
3 A. Yes.
4 Q. And that was appropriate on her part, wasn't it?
5 A. Yes.
6 Q. From a scientific standpoint, Dr. Jacobs tells me that
7 adhesions are kind of a natural consequence of some types of
8 surgeries, is that right, that the body is going to form some
9 adhesions regardless of what happens in surgery; is that correct?
10 A. Not always. I think adhesions are usually secondary to
11 a break in the normal surface between two tissues, so that
12 there's an exudate that will serve as a paste to stick them
13 together. So if you do an operation where you normally would
14 expect adhesions, you don't have that injury, then you would
15 probably not have adhesions.
16 Q. And so if you have a situation in which a physician is
17 actually performing a lysis of certain adhesions and also
18 removing abdominal tissue, that is a condition in which adhesions
19 would not be an unexpected outcome in a surgery?
20 A. They could occur in that case, yes.

21 Q. And Dr. Jacobs tells me that intra-abdominal adhesions

22 and their formation are something that is not at all unusual in

23 intra-abdominal procedures; is that correct?

24 A. In some procedures, that's correct.

25 Q. And with regard to the type of procedure that Ms. Lee

1 was having performed on her, he tells me that intra-abdominal
2 adhesion formation is something that is a known risk of that type
3 of surgery; is that right?
4 A. Yes.
5 Q. And that with regard to this case, that a patient like
6 Ms. Lee could certainly have expected that some adhesion
7 formation might occur as a result of the surgery; is that right
8 as well?
9 A. Some adhesions, that's correct.
10 Q. All right. Now, with regard to your evaluation in this
11 case, you told us that you think that some of the adhesion
12 formation that has occurred intra-abdominally with regard to
13 Ms. Lee was caused as a result of Dr. Smith's use of the H3O; is
14 that right?
15 A. Yes.
16 Q. And scientifically, is there a way that you can tell
17 this jury in this case which percentage of the adhesions that
18 were formed in Ms. Lee's abdominal cavity were formed as a result
19 of the natural process associated with abdominal surgeries as
20 opposed to Dr. Smith's use of the H3O?

21 A. No.

22 Q. And so with regard to Dr. Smith's use of the H3O in

23 this case, from a causation standpoint, while you may think and

24 believe that some of the adhesions may have been caused by the

25 H3O, you're not able to tell the jury in this case what the

1 extent of the formation would have been, it was related to the
2 H3O use as opposed to related to the natural risks associated
3 with the surgery; is that right?
4 A. I think in this particular case, knowing where the
5 adhesions formed and the way they formed, that I can state in all
6 degree of medical probability that the specific adhesions that
7 led to her partial bowel obstruction were more likely than not
8 associated with the administration of the H3O solution.
9 These adhesions were located in the omentum
10 directly underneath the incision, from the transverse colon and
11 the cecal area directly underneath the incision. When you do a
12 hysterectomy, removing the uterus is a procedure that occurs down
13 in the pelvis, away from the area of her mechanical small bowel
14 obstruction, away from the omentum, that in this particular case
15 was adhered to the anterior abdominal wall.
16 More importantly, after the operation to correct
17 those adhesions, when Dr. Villareal operated on her in Corpus,
18 the only remaining adhesions after his operation were again down
19 in the pelvis and not abdominally, where the H3O would have
20 leaked or been applied as an irrigating solution.

21 So both of those apply specifically to this

22 particular patient. Based on my experience and training, I think

23 in all possibility, the adhesions that occurred in the omentum or

24 on the transverse colon are more likely than not associated with

25 the H3O solution.

1 Q. I'm going to try and break that down if I can, for my
2 expert's use in this case and for the jury's understanding as
3 well.
4 Adhesions in the transverse colon, with regard to
5 this type of surgery, are a known risk of the surgery, first and
6 foremost; is that right?
7 A. Not necessarily. You can have adhesions anywhere. And
8 in that respect, technically that's correct.
9 Q. Okay. And the adhesions, because they can form, from a
10 technical aspect, as a result of this kind of surgery, it is
11 true, isn't it, that some of the adhesions that may have formed
12 in the transverse colon could have been associated with the
13 natural consequences of an abdominal procedure?
14 A. Theoretically, but again, not probable.
15 Q. Okay. Now, in this case, the only information that you
16 have as to the type of adhesions that were seen in the second
17 surgery would be those records that were provided by Palestine
18 Hospital; is that right?
19 A. Yes.
20 Q. Those would be Dr. Rodriguez's evaluation of what he

21 saw during that surgical procedure; is that right?

22 A. Yes.

23 Q. Would the post-surgical adhesions formed by the H3O

24 have a different appearance than adhesions that were formed as a

25 natural and direct consequence of this type of surgery, assuming

1 H3O was not used?
2 A. Probably so.
3 Q. Do you have any information in any of the medical
4 records that the adhesions that Dr. Rodriguez saw in that second
5 surgery were noted by him to look different than the normal type
6 of adhesion you might ordinarily find from this kind of surgery?
7 A. He described a thickening of the omentum, which is
8 normally associated with a more inflammatory type procedure as
9 opposed to just adhesion formation.
10 MR. CURNEY: Object to the nonresponsiveness.
11 A. Then my answer would be: Because of the thickening of
12 omentum.
13 Q. (BY MR. CURNEY) So it's your opinion in this case
14 that -- strike that.
15 Your opinion in this case that the adhesion in the
16 transverse colon, you believe is related to the use of the H3O,
17 as a result of the fact that it shows a thickening?
18 A. That's one of the reasons.
19 Q. Is that right?
20 A. That's one of the reasons.

21 Q. I'm hearing you tell me that's the primary reason. Is

22 that not correct?

23 A. Not necessarily. The primary reason is the location

24 and the extent of the adhesions in a lady who, after having

25 another operation which would, beyond question, have normally led

1 to more adhesions, she had less adhesions in the third operation
2 than she did in the second.
3 Normally, after a hysterectomy, the adhesion
4 formation in an uncomplicated hysterectomy is very minimal. And
5 she had massive adhesions, they were located in the upper part of
6 the abdomen, there was thickening of the omentum. We know that
7 this solution was at least used on the incision and probably used
8 intra-abdominally. So to me, the most probable is the use of
9 this corrosive substance that would set up an irritation of the
10 bowel wall, irritate the omentum, cause an exudation, which would
11 stick it together. So more probably than not, that would be the
12 cause, in my opinion.
13 Q. And with regard to -- I know you may think I'm beating
14 this like a dead horse, but I have to beat it.
15 A. I understand.
16 Q. With regard to a scientific evaluation, you haven't
17 performed that with regard to the pathology of the remnants that
18 were removed from Ms. Lee's surgical field; is that right?
19 A. To perform an experiment that would produce that would
20 be totally unethical, and no one has done it, nor will do it,

21 because it would be unethical to be pouring acid into somebody's

22 abdomen to see how the adhesion formation is going to differ.

23 Q. Well, I was asking you really along the lines of did

24 you look at the -- you haven't seen the materials that were

25 actually removed from her abdomen on the second surgery?

1 A. I haven't?

2 Q. Yes.

3 A. I have not looked at them, no.

4 Q. You have not seen any photographs of them or anything

5 along those lines --

6 A. No.

7 Q. -- is that right? Now, what you have seen is you have

8 seen the pathologist's report with regard to what was removed

9 from the abdomen; is that right?

10 A. Yes.

11 Q. And you've seen his report noting what it was he was

12 asked to look at by the doctors who performed the surgery; is

13 that right?

14 A. I better look at it. I'm not following you.

15 Q. It's Page 144 of the records from Palestine. Do you

16 have those in front of you? If not, I'd be glad to show you.

17 MR. MALOUF: Did you say from Palestine?

18 A. I've got them. 144?

19 Q. (BY MR. CURNEY) Yes, sir.

20 A. We're not marked the same way.

21 Q. I don't know what happened there.

22 MR. MALOUF: Oh, yours are from the records/depo

23 service.

24 MR. CURNEY: Yes.

25 MR. MALOUF: Pathology?

1 Q. (BY MR. CURNEY) The one by Dr. Bowen, do you have
2 that?
3 A. Yes.
4 Q. Dated 2/13?
5 MR. MALOUF: That's her birthday.
6 MR. CURNEY: Sorry. Dated --
7 MR. MALOUF: 1/23/02.
8 Q. (BY MR. CURNEY) Do you have that in front of you?
9 A. Yes.
10 Q. Okay. Did you review this report in forming your
11 opinions in this case?
12 A. Yes.
13 Q. And you see on the top line, it says, Clinical
14 Information, and it says, intra-abdominal fluid collection,
15 multiple intra-abdominal hematemesis; is that right?
16 A. Yeah.
17 Q. Did I do a good job with that?
18 A. Yeah. And that means bloody vomitus, so I think that's
19 an error.
20 Q. That's probably not correct then, is it?

21 A. Probably not correct. God, I hope that. Sometimes

22 I've felt like it.

23 Q. And then he goes through and he talks about his gross

24 findings. Do you see that with me as well?

25 A. Yes.

1 Q. And then underneath, he talks about his microscopic
2 diagnosis. Do you see that?
3 A. Yes.
4 Q. And that's really where the rubber hits the road, isn't
5 it?
6 A. Not at all. All this is is the ovary that was removed.
7 It has no relation, no referral whatsoever to the adhesions in
8 the omentum and transverse colon.
9 THE REPORTER: I'm sorry. I couldn't hear you
10 very well.
11 A. This pathology report refers only to the ovarian and
12 fallopian tube that were removed, and in no way refers to the
13 adhesion formation in the omentum or the transverse colon.
14 Q. (BY MR. CURNEY) This is the only pathology report that
15 I saw in the records related to her second surgery. Is that your
16 understanding as well?
17 A. That's correct.
18 Q. And you would have expected that if Dr. Rodriguez had
19 seen remnants of body tissue that he thought were unusual or
20 abnormal, that he should have those examined pathologically,

21 shouldn't he?

22 A. No. What he did was to lyze the adhesions. So you

23 read his operative report and his description of the adhesions to

24 get your opinion about what he found at the time of surgery,

25 which is what I did.

1 Q. What I'm finding -- and I'm looking at his record, and
2 I'll just read it to you. It says, Objective findings, dense
3 adhesions from prior surgeries, most of them collecting down in
4 the pelvis.
5 A. Yes.
6 Q. That was your understanding of what his objective
7 finding was?
8 A. Read -- I'm looking to his operative report, from Dirk
9 Rodriguez.
10 Q. Okay. Well, I'm looking at the operative findings,
11 what he actually saw in there.
12 A. So am I. And if you start, the prior --
13 Q. Let me ask you the questions. It works better that
14 way. The operative findings --
15 A. I'm sorry.
16 Q. That's okay. This is my operating room.
17 A. And I'm the nurse.
18 Q. His operative finding report first says, dense
19 adhesions from prior surgeries, most of them collecting down in
20 the pelvis.

21 Do you see that? I've read that correctly,

22 haven't I?

23 A. I'm sorry. Mine doesn't say that.

24 MR. MALOUF: It's right here.

25 A. Oh, okay. I was down about three paragraphs.

1 Q. (BY MR. CURNEY) No worries.

2 A. Yes.

3 Q. He also notes on operative findings that there was a

4 right perirectal hematoma. Do you see that as well?

5 A. Yes.

6 Q. Let me ask you about that. Do you believe that the use

7 of the H3O was the cause of the hematoma?

8 A. It might have contributed to it. And I'll throw it out

9 so you can follow up on it, and it's really beyond my area of

10 expertise, it would be a question that I would ask another

11 expert.

12 An acidic solution can, as it did in Ms. Lee, or

13 something caused her clotting factors to decrease. She had an

14 increased PT, a very high normal PTT, evidence of some

15 intravascular coagulation, yet she had an extremely high

16 fibrinogen level, which would indicate she was not having

17 disseminated intravascular coagulation, which would imply that

18 there might have been some toxin that was destroying some of her

19 red blood cells and some of her clotting factors. And that is

20 out of my area of expertise, but it's definitely something that I

21 would make inquiries about, were I the physician caring for

22 Ms. Lee.

23 Q. Okay. In this particular case, the long and short of

24 it is you're aware of the fact that the physician, Dr. Rodriguez,

25 was aware of the fact that Ms. Lee -- strike that. Boy, that was

1 a mess.

2 You're aware of the fact that Ms. Lee reported to

3 him that the doctor had used some unknown substance?

4 A. Yes.

5 Q. And then as a result, this physician would have had

6 that at least in the back of his mind when performing his

7 operation on Ms. Lee; is that fair to say as well?

8 A. I would think he would have.

9 Q. That he should know. And so if he felt like the

10 hematoma was caused as a result of the process you've just

11 described to us, you would have expected that he would have made

12 note of that in his operative report?

13 A. Not necessarily.

14 Q. In either event, with regard to this case, you can't

15 say one way or the other whether the hematoma was caused or

16 exacerbated through the use of the H3O, because you're just not

17 an expert in that field?

18 A. Well, I would say there would be a question in my mind.

19 And to answer that question is out of my field of expertise, but

20 it's certainly one that I would raise, and I think specifically

21 in this case should be evaluated.

22 Q. Had you been the doctor in this case, you would have

23 looked at it, but in this case, as in the confines of your

24 expertise and in your opinions in this case, you don't really

25 have an opinion one way or the other as to whether or not that

1 would have been the cause; is that right? Do you understand
2 that?
3 A. No.
4 Q. I'll try again. With regard to limiting your expert
5 opinions in this case to those that you were retained to provide
6 and that you feel like you're able to provide, your report does
7 not reference -- let me put it to you that way, that may be the
8 easier way to go -- that the perirectal hematoma was caused as a
9 result of the use of the H3O; is that fair to say?
10 A. That's fair. And, again, to defend my opinion, when I
11 was operating, as Dr. Rodriguez, if I had seen that, it probably
12 would have gone by me. But when I was reviewing this case in
13 detail, actually this morning, I noticed the clotting defects and
14 the high fibrinogen, which is an atypical response from a
15 patient, and then started asking the question, Did this solution
16 have some toxic effects on her clotting mechanism and her red
17 blood cells?
18 She had an inordinate drop in her
19 hemoglobin/hematocrit without an expansion of the hematoma, which
20 was shown on x-rays and MRIs -- or CT scans on this lady prior to

21 this surgery. So the area where the blood or hematoma was

22 forming wasn't getting larger, but her blood count was dropping.

23 The clotting factors indicated a use of some of

24 the clotting factors. The red blood cells are decreasing in

25 number. They could have been destroyed or could have been

1 bleeding out into the abdominal cavity. They weren't, because
2 the hematoma wasn't getting bigger.
3 So only this morning, I thought, well, did this
4 H3O, in a side effect that we don't know about and haven't
5 thought about, cause increased destruction of red cells and
6 increased use of clotting factors. And it's not in my report
7 because very honestly, I thought about it this morning when I
8 did -- if I had done the surgery when he did, I would have never
9 thought about it, being honest. But now I do ask the question,
10 did this substance, which we don't know much about at all,
11 contribute to the destruction of the clotting factors and the red
12 blood cells? And that would be a toxicology answer.
13 Q. That would be something that you would look to a
14 toxicologist as opposed to you being the expert in that field; is
15 that fair to say?
16 A. Exactly.
17 Q. And long and short of it is that you really haven't
18 rendered an opinion as to that area, except insofar as you have
19 not mentioned in your report that the hematoma was caused by the
20 use of the H3O?

21 A. Right. But, now, as I wrote in the last paragraph, I

22 reserve the right to change my opinion should additional

23 information become available. This additional information was

24 available, but I just became aware of it or it clicked this

25 morning.

1 Q. Same question with regard to the right pericecal
2 hematoma: You didn't do an evaluation, nor does your report
3 reference whether that was caused as a result of the use of the
4 H3O; is that right?
5 A. That's correct.
6 Q. The right ovary having had a four- to six-centimeter
7 cyst, you've seen that part in the operative finding as well; is
8 that correct?
9 A. Yes.
10 Q. Okay. And I haven't seen in your report that it's your
11 belief that that cyst was caused as a result of the use of the
12 H3O?
13 A. Not specifically. But in my report, I do say that this
14 was an unsterile solution. Beyond question, Ms. Lee had some
15 inflammatory process going on. The presence of the cyst could
16 have been attributed to that inflammatory process. The
17 inflammation could have been introduced into her abdomen and
18 incision or bloodstream through the use of an unsterile H3O
19 solution.
20 Q. But the bottom line and my question is: You just don't

21 know whether that cyst was or was not caused by the use of the

22 H3O; is that fair to say?

23 A. That's correct.

24 Q. Okay. Down under the description of the procedure,

25 there's a sentence down there -- and I think we've already talked

1 about this and probably this horse has been beaten to death as
2 well -- where the doctor notes that there was a very dense
3 inflammatory reaction drawing in the transverse colon and omentum
4 to the area of the cecum and involving the terminal ilium.
5 And that's what we talked about before already; is
6 that right?
7 A. Yes.
8 Q. Okay. And it's that finding that you have relied upon
9 in this case to form part of your opinion in the case that the
10 use of the H3O caused some of these additional adhesions; is that
11 right?
12 A. That's additional information for me to think of, yes.
13 THE WITNESS: Could I take a break?
14 MR. CURNEY: Absolutely.
15 (Break was taken from 1:59 p.m. to 2:07 p.m.)
16 Q. (BY MR. CURNEY) The last thing I have for you,
17 Doctor -- we're almost through here, with me at least -- you also
18 know that Ms. Lee formed an ileus after the first surgery; is
19 that right?
20 A. Yes.

21 Q. And do you have an opinion today as to whether or not

22 the H3O was causative of the formation of the ileus?

23 A. I feel that it was.

24 Q. On what do you base that opinion?

25 A. Based on what I've talked about, the adhesions

1 involving the omentum and upper abdomen and at the site of the
2 partial small bowel obstruction are more compatible with the
3 causative agent being introduced in the upper abdomen as opposed
4 to normal adhesion formation down in the pelvis.
5 MR. CURNEY: Dr. Coney, it's been a pleasure
6 meeting you today. I don't have anything else for you.
7 THE WITNESS: Thank. My pleasure also.
8 EXAMINATION
9 BY MR. DUMAS:
10 Q. Dr. Coney, I represent Dr. Smith. I introduced myself
11 while ago. I've got a few follow-up questions for you as well.
12 And it will be a nice transition. I'm from Hillsboro, and she's
13 not going to have any trouble tracking my questions. Okay?
14 A. See, and my excuse was going to be I didn't understand
15 him, he was talking so fast.
16 Q. I've never had that one used against me.
17 MR. CURNEY: That's the South Texas in me.
18 Q. (BY MR. DUMAS) To cover a few things, just basic
19 things, your rates for being here today, giving a deposition and
20 reviewing records are what?

21 A. I charge $350 an hour to review records, $500 for

22 conferences, depositions and trial appearances.

23 Q. And do you know what you've accumulated up to today?

24 A. $4,300.

25 Q. Have you talked to anybody, outside of us in the

1 deposition and Mr. Malouf and his office, about your review of
2 the records in terms of this case or the use of H3O?
3 A. To be honest, I have.
4 Q. Who have you talked to?
5 A. I mentioned it to one of my partners, the use of H3O
6 intra-abdominally.
7 Q. Okay. Anybody else?
8 A. No.
9 Q. Have you talked to anybody at any TV station, news
10 media, about the review you've done in the use of H3O, any issues
11 in this case?
12 A. No, and I will not.
13 Q. Okay. Have you ever worked with Steve Malouf,
14 Marcellene or Peter before on a case?
15 A. I think I've reviewed one other case for them.
16 Q. I've looked at a few previous depositions. Most of
17 them seem to be OB related, where either you had been retained by
18 the defense attorney or the plaintiff's attorney to review
19 records.
20 Any idea of how many or what percentage of the

21 cases you've reviewed have been GYN cases versus OB?

22 A. No.

23 Q. Have you had any cases that stick out in your mind that

24 dealt with issues regarding adhesions in hysterectomies or

25 abdominal surgeries?

1 A. Yes.

2 Q. Tell me about the cases that stick out in your mind

3 that you reviewed regarding the issues about adhesions or

4 hysterectomy surgeries.

5 A. The one I recall specifically was one not long ago

6 involving Dr. Dodge. And I believe the case was Hall -- I can't

7 remember if Mr. Hall was the attorney or if Hall was the

8 plaintiff, but it was Hall versus Dodge. It was a laparoscopic

9 injury.

10 Q. And were you serving as a plaintiff's expert or a

11 defense expert in that?

12 A. Defense expert.

13 Q. Who was the defense attorney you were working with?

14 A. I'm sorry, I don't recall. Oh, the defense, I think it

15 was -- he's out of Tyler, Texas. And his name might be Hall.

16 No. It's Underwood.

17 Q. Underwood?

18 A. Underwood. I'm almost positive. That's the lead-off

19 name of his firm, I'm almost positive.

20 Q. Any other cases stick out in your mind about adhesions

21 or hysterectomy issues --

22 A. I'm sorry, not that come to mind.

23 Q. -- that you've reviewed?

24 A. Not that come to mind right now anyway.

25 Q. I see some yellow sheets, and it appears to be notes

1 that you've taken. Is my assumption correct?

2 A. Yes.

3 Q. Okay. Are those notes you've taken in reviewing

4 depositions and records in this case?

5 A. Yes. And some of them are opinions.

6 Q. Okay. Are some of them a rough draft of what you were

7 going to put in your letter, your report?

8 A. No, they're not.

9 Q. If you don't mind, I'd like to get the court reporter

10 to mark your notes as an exhibit.

11 A. Okay. I take a lot of notes.

12 Q. Okay.

13 (Exhibit Number 3 was marked.)

14 Q. What exhibit number is that?

15 A. 3.

16 Q. Are the handwritten notes that you've taken with

17 regards to your review in this case, has that been marked as your

18 Deposition Exhibit Number 3?

19 A. Yes.

20 Q. Okay. Is there any literature that you brought with

21 you or studies that you've reviewed that have been used by you in

22 terms of either reviewing the case or rendering any opinions in

23 the case?

24 A. Yes.

25 Q. Okay. Tell me what you brought.

1 A. I brought the -- it's called Occupational Safety and
2 Health Standards that we refer to as OSHA, and it regards the
3 OSHA requirements, which supercede state and national laws, about
4 labeling, the use of dangerous material, primarily to protect
5 employees and, in this case, nursing and hospital personnel.
6 Q. And in terms of that OSHA information, what was
7 important in that material in terms of reviewing the records or
8 rendering any opinions in this case?
9 A. The H3O solution is certainly a corrosive element. It
10 was brought into the hospital unlabeled, unevaluated, and
11 probably unsterile, and was not labeled in any way, form -- or
12 not appropriately labeled.
13 Q. So is it your opinion that Dr. Smith in some way
14 violated OSHA by bringing in H3O?
15 A. He blew it out of the water, yes.
16 Q. Tell me, what's your understanding about how he brought
17 it into the operating room?
18 A. He brought it in in a plastic container, in his hand,
19 it's my understanding, and carried it into the operating room in
20 the same manner.

21 Q. Where did you get that understanding from?

22 A. From the depositions in the case.

23 Q. Do you have any recollection of him bringing -- giving

24 testimony regarding taking a syringe after he had diluted the H3O

25 at his clinic and bringing a syringe to the operating room, or is

1 your understanding different about how he transported it?

2 A. Actually, he said that that is the way he normally did

3 it. And I think in this particular case, the scrub technician,

4 Steve Ramirez, and Mrs. Lee and the circulating -- I'm not sure

5 if she's a circulating nurse, but three different individuals

6 described the plastic container, then the plastic container that

7 was carried to the floor was described also. So four different

8 people described it as a plastic container. And no one referred

9 to or specifically did not mention a syringe coming into

10 anyplace.

11 Q. Other than Dr. Smith, when he testified in his

12 deposition?

13 A. I don't think he testified that he brought that in. I

14 think he testified that's the way he mixed it up.

15 Q. Is it your understanding of your role as an expert to

16 decide what the facts are?

17 A. As best as I can, yes.

18 Q. But in terms of whether he brought it in with a syringe

19 or whether he brought it in an unlabeled container, that's going

20 to be a fact question for the jury to determine how he brought

21 that substance into the operating room. Would you agree with me

22 there?

23 A. Well, I think I have to rely on the depositions that

24 have been given, and I don't think there's anyone that disagrees

25 that the plastic container with H3O written on it was in her

1 room, beyond question. There is -- and I'll just stop there.

2 Q. And I'll give you that. I mean, certainly the H3O came

3 into the operating room.

4 What I'm just wanting to make sure is that in

5 terms of giving expert opinions, you don't try to prefer one

6 version of the facts over another, you try to apply them

7 consistently, based on what you're seeing in the records. Would

8 you agree with that?

9 A. Yes.

10 Q. In other words, you're not advocating one version of

11 the facts over another? You don't view that as your role as an

12 expert witness, do you?

13 A. Unless I have something that would substantiate that

14 opinion by a contradictory statement made by someone.

15 Q. Fair enough. If Dr. Smith had used a syringe to bring

16 the H3O into the operating room, would that dispel your concerns

17 about at least it being unsterile?

18 A. No.

19 Q. You'd still have the same concern about that?

20 A. Certainly.

21 Q. Why is that?

22 A. Number one, you don't know how he got the solution in

23 the syringe. Number two, when you carry a syringe in your hand,

24 not in a plastic sterilized container, your hand introduces

25 bacteria to the syringe. If you take the syringe and inject it

1 into a container, it's very easily contaminated, either the big
2 plastic container or the wash basin in the back.
3 So for something that enters the operating room
4 that's going to be used in the operation, it's in an enclosed,
5 usually a plastic container, sterilized, and then introduced into
6 the operative field, sterile operative field, and not carried in
7 in a pocket or --
8 Q. I'm trying to think about how to word this, Dr. Coney.
9 A hysterectomy procedure, is it pretty difficult to keep a
10 hysterectomy procedure sterile, in terms of the location of the
11 area of the body you're working on and the type of procedure
12 you're doing?
13 A. The vagina, even though we do prep it, we consider a
14 contaminated field. So in that respect, when you do a
15 hysterectomy and you do enter into the vagina, the possibility
16 for bacterial contamination is definitely present.
17 Q. Now, besides -- you discussed having chemistry in high
18 school, and obviously you had chemistry in medical school.
19 You've never held yourself out as a chemist, have you?
20 A. No.

21 Q. And in terms of the effect of diluting H3O, as

22 Dr. Smith has testified he did in this particular case, you don't

23 have any opinions about the effect that dilution would have on

24 the content of the sulfuric acid in H3O, would you?

25 A. I think the -- my only comment would be his deposition

1 testimony, that the pH, when he mixed it, it was 1.8. That would
2 be significant to me. The depositions of Dr. Armstrong and
3 Dr. Snodgrass are way over my head. I read them two or three
4 times and just said, okay, I'll take what they say at the end and
5 run with that. That's out of my field.
6 Q. Okay. Do you know the pH of gastric acid in the
7 stomach?
8 A. It can be quite high. It would be around 1 -- I used
9 to know that, and for some reason, 1.4 sticks in my mind, but
10 don't hold me to it. That's been too long. It's very acidic.
11 Q. It's very acidic?
12 A. Yes.
13 Q. Have you had instances where you've treated patients
14 with perforated ulcers, or is that outside your area of
15 expertise?
16 A. If I had such a patient, I would immediately refer them
17 to a surgeon, so I would not take care of the patient. I might
18 make the diagnosis.
19 Q. Are you aware of any studies or literature where
20 gastric acid from the stomach or from an area of the body due to

21 a perforation or a perforated ulcer has caused adhesion

22 formation?

23 A. Yes.

24 Q. One of Ms. Lee's complaints in this case is that

25 somehow this H3O fused her organs together.

1 Do you have any opinions about whether the H3O
2 would cause her organs to fuse together?
3 A. Yes.
4 Q. What's that opinion?
5 A. Certainly it would be a contributing factor to causing
6 the intestines and the omentum to fuse together or form
7 adhesions. The definition of organs -- intestines and omentum --
8 the intestines are organs; omentums are not. But my
9 interpretation of her deposition would be that the acidic H3O
10 would cause enough inflammatory reaction to cause an exudate,
11 which would then cause the intestines and the omentums to stick
12 together and form adhesions. In that respect, I would agree with
13 that.
14 Q. And in terms of -- we've established, and I don't want
15 to go back over it, but there's not any studies where H3O has
16 been determined to have caused adhesion formation, to your
17 knowledge?
18 A. To my knowledge, none of those studies have been done,
19 and I would think in humans it would be unethical to perform such
20 a --

21 Q. Same thing with sulfuric acid?

22 A. Certainly.

23 Q. In terms of -- are you aware of any studies where

24 they've done it on any lab animals or anything like that, either

25 with H3O or sulfuric acid, ingestion of it?

1 A. Not that I recall right now. And I do want to clarify
2 that. I'm aware that some studies with acids and the tissue
3 reaction have been done. I am totally ignorant of what the
4 concentrations were and which acids were used.
5 Q. Obviously, I'm not a physician, so I'm going to ask you
6 a fairly basic question that just does not make much sense to me,
7 and I think a jury is going to want to understand it.
8 If Dr. Smith and his family, if you take it as
9 truth, that they're gargling with it, that they're using it, that
10 he's using it on diabetic patients for their wounds and not
11 having complications like Ms. Lee has had, what is the
12 explanation medically for why Ms. Lee's omentum adhesed, caused
13 the small bowel obstruction, when they're not having the same
14 types of complications?
15 MR. MALOUF: Objection, form.
16 A. I think that is literally the perfect question for this
17 case. And the answer to it is: The degree of injury that occurs
18 in human tissue, and specifically that I think would apply in
19 this case, would be determined by the concentration of the acid,
20 which acid it was, how long the tissue was exposed to it and,

21 most importantly, what the characteristics of a particular tissue

22 are.

23 You've already mentioned that the inside of the

24 stomach, you can -- the stomach can tolerate extremely acidic

25 solutions without any damage whatsoever. You can put some acids

1 on your hand, it doesn't bother it all. But mucus membranes,
2 with a lot of water in the cell and a lot of protein in the cell,
3 are extremely sensitive to acidic solutions. Specifically the
4 intestines are one of those organs that are very sensitive to
5 minor irritations and how they respond, just like some people do
6 with a sunburn. The tissue swells up, some of the intracellular
7 fluids go out through the cell wall because the cell wall
8 permeability has changed. It has a protein content in it, and
9 protein, just like the white of an egg, can solidify and
10 basically stick organs together.
11 In Ms. Lee, this solution applied to her skin
12 caused blisters. Beyond question, the structure of the skin
13 makes it much more resistant to reacting to that acid than the
14 intestine would be. The skin of the small -- or the mucus
15 membrane of the cells of the small bowel are much more sensitive
16 to acidic solutions, so they would respond sooner and more
17 severely than the skin would. We know in Ms. Lee that her skin
18 had blisters.
19 On the intestines, their response would be an
20 exudation with protein in it, causing it to stick together. As

21 was demonstrated in the second operation, the omentum around it

22 had the same reaction. When you put acid on fat, it swells up

23 and starts turning white and thickens and gets an inflammatory

24 response. Exactly what happened in her case.

25 So I think the key thing in this instance is we

1 know that whatever the concentration of the H3O was on the skin,
2 it was strong enough that it caused changes on Ms. Lee's skin.
3 Likewise, it's my contention that, in all degree of medical
4 probability, that the introduction of that same concentration to
5 the intestines would cause an increased reaction to the
6 intestines and the surrounding tissue, leading to scar formation,
7 partial obstruction, the problems that led to her additional
8 surgeries.
9 Q. The H3O on her skin, what did you see in terms of the
10 medical records in regards to her wound healing? Was it healing
11 well?
12 A. It's conflicting. Some of the nurse's notes would say
13 clean, dry and intact, but there is a nurse's note that describes
14 the blisters that are there, and Ms. Lee obviously refers to the
15 blistered skin that she had. And I think that this is on the
16 12th. It's -- the nurse's notes sometimes are dated on the 12th
17 of January and sometimes the 11th of January. But this
18 particular one is at 06:15 in the morning, and it says, Dressing
19 soaked in wound care 30 minutes, removed; patient denies any
20 pain, discomfort at this time; abdomen with blisters noted at

21 distal end of incision; abdominal pad applied prior to abdominal

22 binder being reapplied. But other places it refers to it as

23 clean, dry and intact. So that's one of the instances where I

24 say there are some contradiction in the records. Ms. Lee

25 obviously describes the blisters appearing to her incision.

1 Q. Is it unusual, in your opinion, after sealing a wound
2 with a hysterectomy patient to have any type of blistering on the
3 end of the wound?
4 A. I think that's very unusual, particularly with an
5 abdominal binder.
6 THE REPORTER: With an abdominal?
7 THE WITNESS: Binder.
8 Q. (BY MR. DUMAS) Do you recall what Dr. Rodriguez and
9 Dr. Bates, or mainly Dr. Rodriguez at Palestine, how they
10 described the wound when they saw it?
11 A. I'm sorry, I don't.
12 Q. Would there be any medical explanation, in your
13 opinion, as to why Ms. Lee would have the problems she had if --
14 and we're assuming H3O was irrigated intra-abdominally, and
15 another lady that had the same procedure and H3O was used to
16 irrigate intra-abdominally didn't have adhesions and the
17 problems, the bowel obstruction that Ms. Lee experienced?
18 MR. MALOUF: Objection, form.
19 A. Yes.
20 Q. (BY MR. DUMAS) And what is that medical explanation?

21 A. There was absolutely no quality control about the

22 dilution or the pH of the solutions. It's my understanding there

23 might even be as much as a two percent variation in analyzing the

24 H3O solutions. So not knowing the concentration that was used on

25 Ms. Lee as opposed to another patient, you just can't answer it.

1 And that's something that you just have to say this is the end
2 results, and this is the most probable cause of the end result.
3 But to me, scientifically, there's absolutely no controls at all.
4 He was mixing it up. He might have mixed it up in
5 the back pan; he might have used a syringe; he might have brought
6 it in in a plastic container; he might have poured a little bit
7 in; he might have poured a lot; he could have used other
8 solutions to dilute it and wash it off. There's just -- it's
9 just pure speculation to say why one reacts and another one
10 doesn't. So you have to look at specifically what Ms. Lee did
11 and the most probable explanation for why she did it. That's why
12 the third operation is so important to me, the decreased amount
13 of adhesion that she had when Dr. Villareal operated on her.
14 Q. You have no idea, as we sit here, what the
15 concentration was that Dr. Smith used on Ms. Lee?
16 A. No.
17 Q. You don't have any idea, as we sit here today, what
18 volume of H3O he used to irrigate her intra-abdominally, if he
19 did?
20 A. No.

21 Q. And so -- and you've said this, but your opinions are

22 based on the location and the extent of the adhesions and what

23 happened after Dr. Smith's surgery and comparing and contrasting

24 that to her condition before and then this third surgery; is that

25 correct?

1 A. Well, anticipating that question, I listed 1, 2, 3, 4,
2 5, 6, 7, 8 -- 9 reasons why I feel like he definitely used some
3 concentration of the H3O intra-abdominally.
4 Q. Okay. I want to go over those with you and get you to
5 list those for me. But getting back to my question, in terms of
6 why you believe it's a -- why you believe H3O caused the problems
7 that Ms. Lee experienced with the adhesions and with the bowel
8 obstruction and the ileus, your opinion's based on the fact that
9 the location and the extent of the problems she had, and it's
10 also based on what her preexisting condition was and then what
11 you're seeing in this third surgery after she had the surgery
12 with Dr. Rodriguez; is that correct?
13 A. That's one of the primary aspects, right. The other
14 aspect that I think is important is the possibility of the
15 solution being an unsterile solution, introducing bacteria that
16 would have caused the infection --
17 Q. Okay.
18 A. -- which I think everybody would agree infection is
19 also a cause for adhesion formation.
20 Q. And in terms of the sterile nature or unsterile nature

21 of the solution, we've talked about your concerns there, but

22 you're not aware of anybody testing it one way or another to

23 determine whether it was not carried over there in a sterile

24 condition, are you?

25 A. Well, I think it would be universally accepted that

1 introduction of any liquid solution carried in in anybody's hand
2 or pocket and introduced into the operative field without being
3 sterilized prior that introduction would be considered a
4 contaminated field.
5 For instance, if we go in and accidentally raise
6 your hand up and hit the lamp, we'd immediately change gloves.
7 That small contact of something that's been sterilized before it
8 was screwed in, we consider contaminating the field. So beyond
9 question, the introduction of this without sterilizing it would
10 be considered a contaminated operative field.
11 Q. Tell me the nine things that you said you listed in
12 terms of --
13 A. That made me feel comfortable in saying it was
14 introduced intra-abdominally?
15 Q. Yes, sir.
16 A. Dr. Smith testifying that it was his usual practice in
17 hysterectomies, because of the possibility of bacterial
18 contamination from an open vagina, to use it as an irrigant
19 intra-abdominally. He also said if there was bleeding, that he
20 would use it because he felt that it decreased bleeding. His

21 operative note did state that he irrigated intra-abdominally. It

22 does not in any way define what the solution was. He obviously

23 had admitted that he did use it on her. Mrs. Lee, in her

24 deposition, reported that Dr. Smith reported to Dr. Russell

25 postoperatively that he used the solution intra-abdominally. He

1 stated in his first deposition that he did use it on her, and
2 then in his second deposition clarified that he was sure he used
3 it on the incision, didn't remember if he used it
4 intra-abdominally. I put that as 50/50.
5 Steve Ramirez, the scrub nurse, stated that
6 Dr. Smith did use the H3O on Ms. Lee. I mentioned already that
7 fresh abdominal incisions are not watertight as they're closed
8 immediately after surgery and would certainly allow the leakage
9 of some of the solution that was used on the incision into the
10 abdomen in the area that the adhesions formed. Then -- that was
11 the next one, location of the abdominal adhesions. And then the
12 fact that the second operation had extensive adhesions and the
13 third one didn't. And I think, surgically speaking, this is
14 extremely important because we all know when we go in and operate
15 on somebody with adhesions, that's almost fighting a losing
16 battle, because the operation to take down the adhesions creates
17 more raw surfaces, which tend to encourage more adhesion
18 formation.
19 The fact that when Dr. Villareal operated on her
20 she had only minimal adhesions compared to what she had the

21 second -- or less adhesions than she did the second operation

22 would imply that the mechanism that had introduced excessive

23 adhesion formation was no longer present. And that's, again, a

24 suggestion.

25 I mentioned the change in hemoglobin and

1 hematocrit is above, which this really concerns me, as an
2 indication that the H3O was present in amounts enough that at
3 least make me wonder if some degree of toxicity had been
4 introduced into the bloodstream or affected the red blood cells
5 themselves. And that's where I mentioned the unexplained
6 significant drop in hemoglobin/hematocrit that was occurring at
7 about the time of the 12th or 13th, not explained by expanding
8 hematomas, producing an unusual clotting picture on the blood
9 tests that were done.
10 And then the final one was the blisters on the
11 skin incision and the difference in resistance to burn with
12 acids. The skin's much higher resistant to burns than the bowel
13 is.
14 Q. With regard to the hematoma and the hematocrit, can you
15 attribute any of that to hemodilution?
16 THE REPORTER: I'm sorry?
17 Q. (BY MR. DUMAS) Can you attribute any of that to
18 hemodilution?
19 A. At the time of surgery, usually someone goes in and
20 they're NPO.

21 Q. Yes, sir.

22 A. And so that would hemoconcentrate. At the time of

23 surgery, they usually give them Ringer's lactate. So you notice

24 at the time of surgery, her admitting hemoglobin/hematocrit was

25 12.8 and 37, so you would expect that to drop. You then take the

1 estimated blood loss that Dr. Smith projected and then look at
2 the significant degree of decrease in her hemoglobin and
3 hematocrit, and then the fact that even starting about the 12th
4 and 13th, it was dropping even more.
5 Specific numbers: On the 12th, her
6 hemoglobin/hematocrit was 8.3/24.7; it dropped to 7.8 and 23.9;
7 and then 8.3 and 24. On the day of discharge, it was 7.7 and 24.
8 So after -- actually, if you recall, Dr. Russell gave her a huge
9 fluid load on the 12th, and it continued to drop. After being
10 reestablished or equilibrating on the 13th and 14th, it continued
11 to drop, which, to me, I don't think is secondary to
12 hemodilution, to that degree. And considering that the hematomas
13 were not expanding, there's just not a good explanation for why
14 it was going down that much.
15 Q. Did you see any evidence in any of the pathology
16 reports, any of the operative notes, that there was any evidence
17 of necrosis, ulcers or organ perforations?
18 A. No.
19 Q. In terms of your criticism of Dr. Smith regarding the
20 H3O, setting aside the H3O for right now, in terms of any other

21 criticisms either in whether there was an indication to do the

22 hysterectomy, whether there was concerns about the way he

23 performed the surgical technique, do you have any criticisms

24 about those two areas, the indication to do it and the surgery

25 itself?

1 A. No.

2 Q. When you -- do you perform hysterectomies?

3 A. Yes.

4 Q. In terms of informed consent for hysterectomies, what
5 are the known complications of a hysterectomy that you talk to
6 patients about?

7 A. I talk about the possibility of doing damage to other
8 organs. I think the one I spend most time on are damages to
9 either the bladder or the tube from the kidney to the bladder,
10 the ureter. I do talk about the possibility of bowel damage;
11 hematoma formation, having to go back and reoperate to find a
12 bleeder; infection; do talk about nerve damages that might occur;
13 finding something that would cause us to do additional surgeries
14 at the time of surgery that she was not prepared for. I do talk
15 about the anesthetic risk. I talk about the recovery period and
16 what to look out for, including wound infections and draining
17 that might require even skin grafts because of infection from a
18 staph-type infection. Pretty much that's what I talk about in
19 the office.

20 Q. In terms of hematoma formation, infection, those types

21 of risks can occur absent a physician's negligence, wouldn't you

22 agree with me?

23 A. Yes.

24 Q. In your practice as an obstetrician, did you ever use

25 medications off label, in other words, that you were using it for

1 a nonrecommended use?

2 A. Asked that way, the answer would be no. I think to

3 answer what you want me to answer, there are times when I would

4 use a medication that is not approved by the Food and Drug

5 Administration, but only when peer review articles have

6 substantiated its use.

7 The one that's commonly used in obstetrics and

8 gynecology is Cytotec to induce cervical ripening. And I think

9 it's used because of the peer review literature that

10 substantiated its use. It's not an unlabeled use because of

11 precautions taken by the company that we can't discuss.

12 Q. Do you still use Cytotec even though the PDR and the

13 manufacturer expressly are now saying don't use it in terms of

14 ripening a cervix?

15 A. Not since April of this year.

16 Q. Okay. Prior to April?

17 A. But I would use it in small dosages, yes.

18 Q. Is that something -- when you made a decision, prior to

19 April, to use Cytotec, would you talk to the patient and get a

20 written consent from the patient to use Cytotec?

21 A. Yes. And, again, that's hospital protocol and practice

22 by both the physician and the nurses.

23 Q. Have you done any experimentation in terms of using

24 H3O? There's been -- I believe Dr. Armstrong put an egg in the

25 substance to see what it would do over a 24-hour period. Have

1 you done anything like that?

2 A. No.

3 Q. Do you feel like today, between Mr. Curney's questions

4 and my questions, that you've explained your methodology in terms

5 of your opinion as to how H3O caused Ms. Lee's problems regarding

6 adhesion formation, the small bowel blockage or obstruction and

7 any other complication, the ileus?

8 A. I think certainly in general terms, yes, I have.

9 Q. Do you have anything you intend to do in terms of

10 literature search or some clinical trials or studies that you

11 think would help you in terms of expressing your opinions about

12 what caused Ms. Lee's problems?

13 A. I'm certainly going to do no experimentation at this

14 point. I'm not planning to do a literature search, but that --

15 if I do, I'll let you know.

16 MR. MALOUF: Be sure and let me know first.

17 THE WITNESS: Okay.

18 MR. DUMAS: Pass the witness.

19 EXAMINATION

20 BY MR. BOLFING:

21 Q. Dr. Coney, my name is Jerry Bolfing.

22 THE WITNESS: Would this be a good time for me to

23 run to the bathroom?

24 MR. BOLFING: Oh, sure.

25 (Break was taken from 2:50 p.m. to 2:52 p.m.)

1 (Exhibit Numbers 4 and 5 were marked.)

2 Q. (BY MR. BOLFING) Dr. Coney, again, right before we

3 took a break, my name is Jerry Bolfing. I represent Lumen Food

4 Corporation in this lawsuit. I've got a few questions. I'll try

5 to be brief with you.

6 First of all, based on your review of the

7 materials and your work done in this case, do you have any

8 criticisms of the seller of the H3O, that is whoever it was that

9 sold this product to Dr. Smith?

10 A. Well, I really try to review it as far as being an

11 expert in the case, and in that respect, don't personally -- you

12 know, I don't like Internet advertising, and the advertising that

13 have referred to by them was a turnoff to me, but it's -- that's

14 personal and not related to expert opinions.

15 Q. So you don't have any opinions -- professional expert

16 opinions one way or the other?

17 A. That's correct.

18 Q. Now, you were asked whether you did any experiments

19 with H3O. Have you ever even seen H3O, like a bottle of H3O?

20 A. No.

21 Q. Never used it for any purpose?

22 A. No.

23 Q. Now, you mentioned and were asked some questions about

24 some of the reasons that you believe that H3O caused Ms. Lee's

25 problems, and one of those items you mentioned was the blister on

1 the -- at the ends of the incision post-operatively?

2 A. Yes.

3 Q. And I believe you made reference to a note on January

4 the 12th of 2002; is that right?

5 A. Yes.

6 Q. Now, I believe you've testified that you reviewed

7 essentially all of the records from Parkview for her stay there

8 from that surgery, her first surgery done by Dr. Smith; is that

9 right?

10 A. Yes.

11 Q. Okay. Now, my review of the records indicates that she

12 had the surgery done on January the 8th of 2002. Does that sound

13 right to you?

14 A. Yes.

15 MR. MALOUF: Misty?

16 MS. KIRTLEY: Yes.

17 MR. MALOUF: Okay. We've already started, but you

18 only missed a couple minutes. You didn't miss anything

19 important. Sorry.

20 Q. (BY MR. BOLFING) And that she was there essentially

21 for a week. She was discharged, I believe, on the 15th of 2002.

22 Does that sound right to you?

23 A. I thought it was later than that, but I could be

24 mistaken. You're right. You're correct.

25 Q. Okay. Now, during that period of time, there are --

1 nurses are coming in and out of the room and making notes of
2 their observations of her condition when they're in and out of
3 the room; is that right?
4 A. Yes.
5 MS. KIRTLEY: This is cutting out.
6 MR. MALOUF: The phone keeps cutting out?
7 MS. KIRTLEY: Yeah. I haven't heard anything for
8 a little bit.
9 THE WITNESS: I'll speak louder. It's probably
10 me. I start mumbling.
11 MS. KIRTLEY: All right. Thank you.
12 Q. (BY MR. BOLFING) Now --
13 MR. MALOUF: Hang on just a second. Let me scoot
14 the phone closer to Jerry. Maybe that will help you a little
15 bit.
16 MR. BOLFING: Is that better?
17 MS. KIRTLEY: Yes.
18 Q. (BY MR. BOLFING) Okay. Dr. Coney, during your review
19 of those notes from that week-long stay at Parkview in Mexia, are
20 there any other notes or records or any indication anywhere,

21 other than that one note, that there were any kind of

22 blistering -- that there was any kind of blistering on her

23 abdomen?

24 A. No. And I specifically looked for it.

25 Q. And I believe that Ms. Lee had been to see Dr. Smith, I

1 believe the day before she went in for the surgery. I believe

2 she -- and I don't remember, but I believe that's right. She saw

3 him on the 7th?

4 A. Yes.

5 Q. And she had the surgery the very next day?

6 A. Yes.

7 Q. That being the 8th?

8 A. Yes.

9 Q. Does that strike you at all odd?

10 A. I'm in a different location. You couldn't possibly get

11 her on the surgery schedule, unless it was an emergency, where I

12 operate, so that would be unusual, yes.

13 Q. In the absence of that, do you find it unusual that a

14 patient goes to see her doctor on one day and then the next day

15 has a hysterectomy, a partial hysterectomy?

16 A. A little bit unusual, but I would not give any

17 significance to that.

18 Q. The surgery that she had done by Dr. Smith was not an

19 emergency type of surgery, was it?

20 A. No.

21 Q. I want to show you what's been marked for

22 identification purposes as deposition Exhibits 4 and 5 to your

23 deposition, Dr. Coney.

24 Now, are those the OSHA standards or regulations

25 that you were asked about earlier?

1 A. Yes.

2 Q. And those relate to labeling?

3 A. Well, specifically, that's what I read it for. It

4 relates to basically handling different medications and

5 procedures that are mandated to -- and training to protect

6 employees that are mandated by the OSHA committees.

7 Q. Did you get those materials yourself or were they

8 provided to you by someone?

9 A. No, I got them myself. These are from my office. We

10 live and breathe those.

11 Q. Okay. You comply yourself on OSHA regulations?

12 A. We try to be. Very candidly, I think it would be

13 impossible to comply with them 100 percent.

14 Q. Again, in the practical world versus the ivory tower

15 world.

16 A. It's an expensive proposition to try to keep up with.

17 Q. If I understood your testimony here today, it's your

18 understanding that the H3O, when it's in the bottle that

19 Dr. Smith has, before he does anything to it, is composed of

20 sulfuric acid of about eight percent sulfuric acid; is that

21 right?

22 A. Yes.

23 Q. Now, you've also seen his testimony where he said he

24 used a ratio of, I believe, 7 cc's of H3O and a liter,

25 essentially, of saline solution. Do you remember that?

1 A. Yes.

2 Q. So less than one percent H3O to the saline solution?

3 A. Again, I'm going to extract myself on being an expert

4 in that particular respect. When you're dealing with acids, one

5 thing I do remember is that you start off with the available

6 hydrogen ions and you make more type solutions, and the strength

7 and chemical actions of the acid are more dependent upon that

8 than they are the volume and, in some instances, the percentages.

9 And that's as vague as I can be and that's the extent of my

10 knowledge.

11 Q. Do acids have any type of antibacterial properties?

12 A. That would kill just about anything if they're strong

13 enough or in contact with it long enough.

14 Q. Would sulfuric acid be one of those acids?

15 A. Yes.

16 Q. Almost done here. We know that Ms. Lee had a partial

17 hysterectomy in which her -- I think her left ovary was removed.

18 I think you may have referred to the right, but her left ovary

19 was removed by Dr. Smith on January the 8th of '02; is that

20 right?

21 A. I could have well been mistaken. One of her ovaries

22 was removed.

23 Q. All right. Now, in your experience, is a woman who has

24 had one ovary removed but still has a remaining ovary, is she

25 going to be without any type of need for hormonal treatment or --

1 I mean, does it have an effect or no effect? Can you tell us
2 about that?
3 A. Usually the one ovary will compensate and provide
4 adequate hormone replacements for the lady.
5 Q. You say normally. So what I'm hearing you say is that
6 there are instances where that will not be the case?
7 A. That's correct.
8 Q. And that there will be some need for hormonal treatment
9 of some sort?
10 A. Yes.
11 MR. BOLFING: I believe that's all I have. Thank
12 you.
13 MR. CURNEY: Just a few more questions.
14 MR. MALOUF: Misty, you got any questions?
15 MS. KIRTLEY: Just a few.
16 MR. MALOUF: Okay.
17 EXAMINATION
18 BY MS. KIRTLEY:
19 Q. Okay. Dr. Coney, my name is Misty Kirtley, and I
20 represent Greg Caton, Herbologics Limited and Alpha Omega labs.

21 You have had no contact with Greg Caton; is that

22 correct?

23 A. Correct.

24 Q. And you've had no contact or communication with

25 Herbologics?

1 A. Correct.

2 Q. And same for Alpha Omega?

3 A. Correct.

4 MS. KIRTLEY: That's it. I have no further

5 questions at this time.

6 THE WITNESS: Fantastic.

7 FURTHER EXAMINATION

8 BY MR. CURNEY:

9 Q. Just a few more questions, Dr. Coney. You have not

10 performed any kind of evaluation or asked someone else to perform

11 an evaluation as to whether or not the H3O in either the form it

12 was provided by the manufacturer or the form that was used by

13 Dr. Smith was antibacterial?

14 A. No, I have not.

15 Q. Now, with regard to Ms. Lee's situation and any type of

16 operative procedure involving hysterectomy, you always prescribe

17 a course, I assume, prescribe a course of antibiotics along with

18 that type of treatment; is that correct?

19 A. Ask that question again. I'm sorry.

20 Q. Sure. Whenever you're performing a vaginal

21 hysterectomy, which I think is what Dr. Smith did in this case,

22 am I remembering that correctly?

23 A. No. He did an abdominal hysterectomy.

24 Q. An abdominal hysterectomy. You would normally

25 prescribe a course of antibiotics afterwards; is that correct?

1 A. We give single-dose prophylactic antibiotics at the
2 time of surgery.
3 Q. And the reason you do that is to try to prevent any
4 type of bacterial infections from occurring; is that right?
5 A. Yes.
6 Q. Okay. And the information that we have in the hospital
7 records in this case seems to indicate that when she was checked
8 into Palestine Hospital, the doctors were concerned about whether
9 she was septic. Do you remember seeing that?
10 A. Yes.
11 Q. And do you remember the doctors ever drawing a
12 conclusion that she was, in fact, septic?
13 A. Not that I recall.
14 Q. Okay. After the second surgery, with regard to
15 Ms. Lee's abdominal adhesions, you've made an inference in this
16 case, and I want to make sure I'm understanding it correctly, is
17 that at the third surgery, it's your belief that the adhesions
18 that were seen at the time of the third surgery would be those
19 kinds of adhesions that you would normally associate with an
20 otherwise healthy individual; is that right?

21 A. Well, you'd normally associate it with a pelvic

22 operation and, specifically, in an individual where you go in and

23 you take down adhesions from the anterior abdominal wall and you

24 operate on them after that, it would not be uncommon to find

25 additional adhesions to the anterior abdominal wall. And the

1 fact that in this particular individual she did not have those
2 adhesions, that would give you specific references to that
3 particular patient that she was not one that we would call, in
4 clinical terms, prone to form adhesions.
5 Q. Okay. And that would provide an inclination or at
6 least the idea that any problems she was having associated with
7 the use of the H3O, certainly by the time of the third operation,
8 those problems seemed to have resolved themselves; is that right?
9 A. Correct.
10 MR. CURNEY: That's all I've got. Thank you.
11 MR. DUMAS: Done.
12 EXAMINATION
13 BY MR. MALOUF:
14 Q. Dr. Coney, I get to ask you just a few questions
15 myself. In your opinion, were the surgeries that Sharon Lee had
16 reasonable and necessary, the first one and the subsequent two
17 surgeries?
18 A. I think the first one was certainly indicated and
19 reasonable and necessary. I think the second operation was made
20 necessary because of the complications from the first one. The

21 third one, as I read this, I think was secondary to discomfort,

22 secondary to staples, and I would not consider that a – I mean,

23 that happens to anyone who uses staples and it's a recognized

24 complication, so I don't think that would be related to the H3O

25 complications.

1 Q. But would you consider it reasonable and necessary as a
2 result of the first surgery, having had the first surgery?
3 A. I take serious complaints of dyspareunia secondary to
4 staples being present at the apex of the vagina, so I would think
5 it would be necessary.
6 Q. And I'm going to represent to you that the three
7 surgeries that Sharon Lee had from Parkview, Palestine and
8 Northwest, that the cost of those were roughly $100,000.
9 In your opinion, based on your experience, is that
10 amount reasonable?
11 A. For the total combined time that she was in the
12 hospital, to me, that would be low. I know in Dallas, a one-day
13 surgical procedure to perform a tubal ligation is about $7,000,
14 plus anesthesia costs and surgery costs, which would run it up to
15 around $10,000. That's for one day. So I think that's low.
16 Q. And I just have one other question. Mr. Bolfing asked
17 you a question about Alpha Omega Labs, and he said would you be
18 critical of them, and you said no.
19 Would your opinion as to -- or would your
20 criticism change of them if they advertised on their Internet web

21 site the use of H3O for medicinal purposes, such as

22 gastroenteritis, athlete's foot, wound care, etcetera, etcetera?

23 MR. CURNEY: Objection, form.

24 MR. BOLFING: Objection, form.

25 A. And maybe I didn't make myself clear. I said I wanted

1 to express -- or I felt like my job description was to be a
2 medical expert referring to Mrs. Lee and her problems. Were I
3 asked to be a medical expert regarding that lab, yeah, I would
4 criticize them for their advertising, from a medical standpoint.
5 MR. MALOUF: No further questions. Reserve the
6 rest until time of trial.
7 FURTHER EXAMINATION
8 BY MR. DUMAS:
9 Q. To follow up a couple of questions Peter had. In terms
10 of the three surgeries and the reasonableness and necessity of
11 the expenses, as I understand what you're saying, the first
12 surgery, you have no qualms about the indications to do a
13 hysterectomy, she presented with symptoms, she needed that
14 surgery; is that correct?
15 A. That's correct.
16 Q. In terms of the second surgery, you're saying because
17 of the use of H3O, you think adhesions developed, and we've gone
18 over all that, and as a result of those complications, that
19 surgery became necessary; is that right?
20 A. That's correct.

21 Q. And then the third surgery, you said you have no

22 criticisms of the use of staples or the technique that Dr. Smith

23 employed in the first surgery, but that that surgery was

24 necessary because of Ms. Lee's complaints; is that right?

25 A. Yes.

1 Q. Okay. You're not saying that surgery became necessary
2 in any way, shape or form because of the use of H3O, are you?
3 A. That's correct.
4 MR. DUMAS: Pass the witness.
5 MR. MALOUF: Anything else?
6 MR. CURNEY: That's it.
7 MR. MALOUF: Misty, anything else?
8 MS. KIRTLEY: No.
9 THE REPORTER: Do you want the witness to read and
10 sign his deposition?
11 MR. MALOUF: Yeah, send it here.
12 (End of proceedings at 3:09 p.m.)
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1 CORRECTIONS AND SIGNATURE

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1 I, DONALD J. CONEY, M.D., have read the foregoing

2 deposition and hereby affix my signature that same is true and

3 correct, except as noted herein.

4

5

6

7 ___________________________
DONALD J. CONEY, M.D.
NO. 26,836-B

8

9 STATE OF ____________)

10

11 COUNTY OF ____________)

12

13 Before me, ____________________, on this day personally

14 appeared DONALD J. CONEY, M.D., known to me (or proved to me

15 under oath or through ___________) to be the person whose name is

16 subscribed to the foregoing instrument and acknowledged to me

17 that they executed the same for the purposes and consideration

18 therein expressed.

19 Given under my hand and seal of office this _____ day

20 of _______________, 2004.

21

22

23

24 __________________________
NOTARY PUBLIC IN AND FOR

25 THE STATE OF ____________

1 NO. 26,836-B

2 SHARON LEE, * IN THE DISTRICT COURT
Plaintiff *
3 *
VS. * 87TH JUDICIAL DISTRICT
4 *
PARKVIEW REGIONAL HOSPITAL, *
5 INC.; PROVINCE HEALTHCARE *
COMPANY; CHARLES RONALD *
6 SMITH, D.O.; ALPHA OMEGA LABS; *
GREG CATON; HERBOLOGICS, LTD. *
7 AND LUMEN FOOD CORP., *
Defendants * OF LIMESTONE COUNTY, TEXAS
8
REPORTER'S CERTIFICATE
9 DEPOSITION OF DONALD J. CONEY, M.D.
JANUARY 29, 2004
10

11 I, Wendy Breeland, a Certified Shorthand Reporter in and for

12 the State of Texas, hereby certify to the following:

13 That the witness, DONALD J. CONEY, M.D., was duly sworn by

14 the officer and that the transcript of the oral deposition is a

15 true record of the testimony given by the witness;

16 That the deposition transcript was submitted on

17 _______________ to the witness or to the attorney for the witness

18 for examination, signature and return to me by _______________;

19 That the amount of time used by each party at the deposition

20 is as follows:

21 Mr. Curney - 0 hours, 52 minutes,

22 Mr. Dumas - 0 hours, 44 minutes,

23 Mr. Bolfing - 0 hours, 10 minutes,

24 Mr. Malouf - 0 hours, 3 minutes,

25 Ms. Kirtley - 0 hours, 0 minutes;

1 That pursuant to information given to the deposition officer

2 at the time said testimony was taken, the following includes

3 counsel for all parties of record:

4 FOR THE PLAINTIFFS:

5 MR. PETER MALOUF
The Law Offices of Stephen F. Malouf, P.C.
6 3506 Cedar Springs Road
Dallas, Texas 75219
7 (214) 969-7373
(214) 969-7648 (Fax)
8

9
FOR THE DEFENDANT, PARKVIEW REGIONAL HOSPITAL and PROVINCE
10 HEALTHCARE COMPANY:

11 MR. JOHN M. CURNEY, JR.
Curney, Garcia, Farmer, Pickering & House, P.C.
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FOR THE DEFENDANT, CHARLES RONALD SMITH, D.O.:
16
MR. DAVID DUMAS
17 Haley & Davis, P.C.
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Waco, Texas 76710
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21

FOR THE DEFENDANT, LUMEN FOOD CORP.:

22

MR. GERALD L. BOLFING

23 Fulbright Winniford

1105 Wooded Acres, 7th Floor

24 Waco, Texas 76714

(254) 776-6000

25 (254) 776-8555 (Fax)

1 FOR THE DEFENDANTS, ALPHA OMEGA LABS, GREG CATON and HERBOLOGICS,
LTD.:
2
MS. MISTY KIRTLEY
3 Phelps Dunbar, L.L.P.
3040 Post Oak Boulevard, Suite 900
4 Houston, Texas 77056
(713) 626-1386
5 (713) 626-1388 (Fax)

6 I further certify that I am neither counsel for, related to,

7 nor employed by any of the parties or attorneys in the action in

8 which this proceeding was taken, and further that I am not

9 financially or otherwise interested in the outcome of the action.

10 Further certification requirements pursuant to Rule 203 of

11 TRCP will be certified to after they have occurred.

12 Certified to by me this _____ day of _______________, 2004.

13 ____________________________
WENDY BREELAND, TEXAS CSR 6211
14 Expiration Date: 12-31-05
Esquire Deposition Services
15 Firm Registration No. 286
703 McKinney Avenue, Suite 320
16 Dallas, Texas 75202
(214) 965-9200

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1 FURTHER CERTIFICATION UNDER RULE 203 TRCP

2

3 The original deposition was ____ was not ____ returned to

4 the deposition officer on _____________;

5 If returned, the attached Changes and Signature page

6 contains any changes and the reasons therefor;

7 If returned, the original deposition was delivered to

8 __________________, Custodial Attorney;

9 That $__________ is the deposition officer's charges to the

10 Defendant for preparing the original deposition transcript and

11 any copies of exhibits;

12 That the deposition was delivered in accordance with Rule

13 203.3, and that a copy of this certificate was served on all

14 parties shown herein and filed with the Clerk.

15 Certified to by me this _____ day of _______________, 2004.

16

17

18

19

20 ____________________________

WENDY BREELAND, TEXAS CSR 6211

21 Expiration Date: 12-31-05
Esquire Deposition Services
22 Firm Registration No. 286
703 McKinney Avenue, Suite 320
23 Dallas, Texas 75202
(214) 965-9200
24

25

1 COURT REPORTER DISCLOSURE STATEMENT

2 X Please be advised that pursuant to Rule IV.B4 of
the standards and rules for Certification of Certified Shorthand
3 Reporters as promulgated by the Supreme Court of Texas with
regards to disclosure, I have no existing or past financial,
4 business, professional, family or social relationships with any
of the parties or their attorneys which to some might reasonably
5 create an appearance of partiality.

6 ___ Please be advised that Esquire Deposition Services has
entered into a volume-related discount fee structure with a party
7 in this lawsuit; and that if such discount is in effect, all
parties in this case will receive the same discount for any like
8 product and/or service.

9 ___ Please be advised that there is an existing or past
financial, business, professional, family or social relationship
10 with counsel involved in this case, separate and apart from
counsel simply doing business with Esquire Deposition Services
11 (or related companies) in the past. This relation is:
.
12

13
Court Reporter: WENDY BREELAND, CSR
14 CSR Number: 6211
Date: January 31, 2004
15

16

17 WENDY BREELAND, CSR

18
CERTIFICATE OF SERVICE
19
This is to certify that a true and correct copy of the foregoing
20 disclosure statement has been presented to all counsel present at
the deposition, and a copy of same will be attached to all

21 copies.

22

23

WENDY BREELAND, CSR

24

25