1 IN THE SIXTH COURT
IN AND FOR PINELLAS COUNTY, FLORIDA
2 CIVIL DIVISION
3
4 PETER WILMARTH and DEBORAH WILMARTH, :
his wife,
5 :
Plaintiffs,
6 :
vs. CASE NO:
7 02-1501-CI-11
ORTHOPEDIC SPECIALISTS, ANDREW C. MASER,
8 D.O., P.A., and ANDREW C. MASER, D.O., :
individually,
9 :
Defendants.
10 :
11
12 DEPONENT: DAVID PETERSEN, M.D.
13 DATE: JANUARY 9, 2004
3:08 P.M. to 4:12 P.M.
14
LOCATION: 3231 McMULLEN BOOTH ROAD
15 SAFETY HARBOR, FLORIDA
16 REPORTER: AMY CARLA TREVINO
NOTARY PUBLIC
17 STATE OF FLORIDA AT LARGE
18
19
20
21
22 KLEIN, BURY, REIF, APPLEBAUM & ASSOCIATES
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1 A P P E A R A N C E S:
2
3 For the Defendants: JEFFREY GOODIS, ESQUIRE
CHANDRA MILLER, ESQUIRE
4 Thompson, Goodis, Thompson,
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8 For the Plaintiff: FRANK CURRIE, ESQUIRE
Beltz, Ruth, et al.
9 150 Second Avenue North
15th Floor
10 St. Petersburg, Florida 33701
11 Also Present: Alfred Palumbo - Videographer
John Sullivan, M.D.
12 Andrew Maser, D.O. - Defendant
13
14 * * * *
15 I N D E X
16 Examination by Mr. Goodis 3
17 Certificate of Reporter 52
18
19 E X H I B I T S
20 (None marked.)
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1 THE VIDEOGRAPHER: This is the video
2 deposition of Dr. David A. Petersen, taken in
3 the case of Peter Wilmarth and Deborah Wilmarth
4 vs. Orthopedic Specialists, Andrew Maser, D.O.,
5 P.A., Andrew Maser, D.O., individually. The
6 Circuit Court of the 6th Judicial Circuit in and
7 for Pinellas County, Florida. Case number is
8 2001-1501-CI-11 (sic). Today's date is
9 January 9, 2004. We're on the record at
10 3:07 p.m.
11 I'm the videographer, Al Palumbo, and our
12 court reporter is Amy Trevino. Will counsel now
13 introduce themselves, plaintiff first.
14 MR. CURRIE: Frank Currie of Beltz, Ruth,
15 on behalf of Peter Wilmarth.
16 MR. GOODIS: Jeff Goodis, Chandra Miller
17 of Thompson, Goodis, on behalf of the defendants
18 in the cause.
19 THE VIDEOGRAPHER: Will the court
20 reporter please swear in the witness?
21 WHEREUPON,
22 DAVID A. PETERSEN, M.D.,
23 WAS CALLED AS A WITNESS AND AFTER BEING DULY SWORN
24 EXAMINED AND TESTIFIED AS FOLLOWS:
25 EXAMINATION

1 BY MR. GOODIS:
2 Q State your name, please.
3 A David Petersen.
4 Q Dr. Petersen, my name is Jeff Goodis, as
5 you heard from the pre-introductions. We had an
6 opportunity to meet once before very briefly and I'm
7 going to be taking your deposition today.
8 Have you had your deposition taken
9 before?
10 A Yes.
11 Q The court reporter is going to take down
12 everything we say, as you know, and so if you would
13 wait until I finish my question before you start your
14 answer, that would be much appreciated.
15 Human nature finds us all saying uh-huh
16 and huh-uh. If that's the case, I'll ask you, is that
17 a yes or is that a no. I'm not trying to be rude. I'm
18 just trying to be sure that our court reporter gets it
19 down correctly. Okay?
20 A Yes.
21 Q Not a test of endurance, obviously. If
22 you want a break, go to the bathroom, get a drink,
23 something like that, that's certainly within your
24 rights. All you have to do is say so. Okay?
25 A Understood.

1 Q Can you tell me in a narrative fashion,
2 if possible, how you believe that Andy Maser fell below
3 the standard of care in his care and treatment of
4 Peter Wilmarth?
5 A Initially, my history from the patient
6 was that he went and had his hip replaced, had a lot of
7 problems post-operatively, and he was led to believe
8 that everything went perfect and it was in his head.
9 And he subsequently went to another physician. The
10 other physician felt that it was loose cup possibly.
11 There was something atypical going on. He subsequently
12 went and got another opinion from myself, and I felt
13 that certainly there was something wrong. He had what
14 appeared to be sciatic nerve symptoms, which he claims
15 had been there since the surgery. And he was led to
16 believe that everything was fine.
17 Subsequently, he had the hip revised.
18 The acetabulum was solidly fixed. It was not loose.
19 The nerve was in scar tissue right up against the edge
20 of the cup so that motion of the leg caused sciatic
21 nerve symptoms. Once the sciatic nerve was freed up
22 from the scar tissue, the neck shortened using the
23 modular head exchange. There was tension removed from
24 the nerve and his nerve symptoms resolved.
25 Subsequently, the leg lengthening at the

1 time of the hip replacement was directly the reason the
2 nerve was stretched on the edge of the socket.
3 Q How -- when you talk about neck
4 shortening, how much did you shorten the total leg
5 length?
6 A In a linear fashion it's two millimeters,
7 but overall, since it's a three-dimensional structure,
8 it was a four-millimeter exchange.
9 Q In the actual shortening of the leg, not
10 in an overall fashion -- I understand it's a four
11 millimeter exchange -- the net effect, as I understand
12 it, is two millimeters?
13 A Incorrect.
14 Q Okay.
15 A Linear -- you know, linear, if you were a
16 sheet of paper, it is two millimeters. If you look at
17 a three-dimensional structure, the actual nerve tension
18 was relieved by the four-millimeter exchange, because
19 you're getting two millimeters of offset and two
20 millimeters of lengthening, with a four millimeter
21 neck.
22 Q Not quite a -- not quite a half a
23 centimeter then?
24 A Exactly.
25 Q Okay. What is normal leg length

1 discrepancy in a human pre-operatively?
2 A There's a range of leg lengths. Most
3 people that are normal tend not to have a discrepancy,
4 otherwise it wouldn't be called a discrepancy. But
5 there's an average range of, say, four or five
6 millimeters.
7 Q When I first asked you my very first
8 question, I asked you to explain how Dr. Maser fell
9 below the standard of care. Can you tell me that?
10 A In over-lengthening that leg at the time
11 of the surgery, it put a fair amount of pressure or
12 tension on the sciatic nerve, which had it abutting the
13 edge of the socket. And by not recognizing that that
14 was a problem and not correcting it, that seems to fall
15 below the standard of care, as far as I can tell.
16 Q You indicated that the nerve symptoms
17 resolved; is that right?
18 A Yes. He had a dramatic resolution of his
19 symptoms by freeing up the nerve, moving it away from
20 the socket, shortening the leg, and putting a soft
21 tissue sling to hold the nerve away from the edge of
22 the socket.
23 Q Are there any other ways that you believe
24 that Dr. Maser fell below the standard of care?
25 A No. I believe that the prosthesis was

1 well fixed, a good choice, and no technique issues
2 other than the lengthening.
3 Q What permanent damage does Mr. Wilmarth
4 suffer as a result of the allegation that Dr. Maser
5 fell below the standard of care?
6 A I don't have any recent followup with
7 him, so it's difficult to answer.
8 Q When you last saw Mr. Wilmarth in a
9 treatment situation, what permanent damages, if any,
10 did he have?
11 A He still had some nerve symptoms.
12 Q Do you expect those to resolve over time?
13 A Speculating at best, but I can't really
14 tell. I haven't seen him in two years.
15 Q Okay. Well, you have been named as an
16 expert by the plaintiff in this case, so I'm asking
17 your opinion. Within a reasonable degree of medical
18 probability, do you believe those symptoms will
19 resolve, or do you believe they'll be permanent?
20 A I don't think there's any way that any
21 person can give you an answer other than it's unknown.
22 There's not a large clinical trial based on how much
23 nerve damage -- he had an epidural anesthetic and had
24 absolutely no pain with the skin incision all the way
25 down to the socket. When I touched the nerve, he

1 jumped off the table, and so he obviously had a great
2 deal of sensitivity in that nerve.
3 Q Is nerve entrapment in scar tissue a
4 known risk and complication of hip replacement surgery?
5 A If you identify the sciatic nerve when
6 you do a total hip replacement, you can't help but form
7 scar tissue around the nerve.
8 Q Is that a yes?
9 A If, in fact, when you do the hip
10 replacement you do that. Most of us don't even search
11 for it.
12 Q Do you believe that there was some breach
13 in the standard of care involved in the nerve becoming
14 entrapped in the scar tissue?
15 A No. That's part of the healing process.
16 The nerve was tense up against the edge of the socket
17 based on the leg length discrepancy. That's more what
18 I'm saying.
19 Q Is it your goal while you, personally,
20 are doing -- that assumes something that I'm not sure
21 is true.
22 Do you, in fact, do hip replacement
23 surgery?
24 A Yes.
25 Q How often?

1 A I would say probably -- I don't know --
2 six to ten now a year, probably.
3 Q And what's your experience? I mean, is
4 that more than you used to do, less than you used to
5 do?
6 A No. It's less than I used to do.
7 Q Okay. When you're doing a hip
8 replacement such as Dr. Maser did when he operated on
9 Mr. Wilmarth, is your goal to end with leg length
10 equality?
11 A Absolutely.
12 Q Are there any -- are there ever any cases
13 in which at the end of a hip replacement which you were
14 doing, the patient ends up with a leg length
15 discrepancy?
16 A Absolutely.
17 Q And leg length discrepancy, then, in and
18 of itself, would not be considered to be below the
19 standard of care?
20 A No.
21 Q Okay. What situations, in what
22 circumstances do patients who have undergone hip
23 replacement end up with leg length discrepancy which is
24 not below the standard of care?
25 A Could you rephrase that or restate it?

1 I'm not sure --
2 Q Sure. You and I just discussed the fact
3 that it's not necessarily below the standard of care
4 for a patient to have a leg length discrepancy post hip
5 replacement. Is that fair?
6 A Yes.
7 Q In what circumstances would a patient end
8 up with a leg length discrepancy, but not a breach of
9 the standard of care by the surgeon?
10 A If you have not caused a problem with the
11 leg length discrepancy, that would certainly be
12 acceptable. But if you do cause a problem with the leg
13 length discrepancy, then it needs to be addressed.
14 Q I guess what I'm asking -- and I
15 apologize, but I'm just not able to ask a good
16 question. But in what circumstance will a patient
17 sometimes end up with a leg length discrepancy
18 post-operatively?
19 A Stability can been an issue. If you need
20 to improve stability, that's sometimes an option as
21 long as, again, you're not causing other problems.
22 Q How do you know that intra-operatively?
23 How would you know intra-operatively that if it's
24 required to lengthen the leg to get the stability, how
25 would you know whether it's going to cause problems or

1 not post-operatively?
2 A I don't know that you could know that.
3 Q So you might need to lengthen the leg to
4 get stability and end up with a problem
5 post-operatively anyway?
6 A Yes.
7 Q And in a situation where you lengthen the
8 leg to achieve stability but end up with a
9 post-operative complication, is that a breach of the
10 standard of care, in your opinion?
11 A It's not as long as you resolve the
12 problem that you caused. But if you tend to leave it
13 alone, then I don't think that's true.
14 Q The -- when you say "when you tend to
15 leave it alone," and you indicated earlier that he was
16 led to believe that everything was fine
17 post-operatively, where do you get that information
18 from?
19 A From the patient. He was told
20 everything's fine, there's nothing wrong, and too bad.
21 Q And that's what the patient told you?
22 A Yes. That's the history.
23 Q Have you read anything in anticipation of
24 today's deposition?
25 A Yes. I have read some of his records.

1 Yes.
2 Q Okay. Have you read any depositions in
3 this case?
4 A I don't believe so. No.
5 Q Have you spoken to Dr. Maser?
6 A No.
7 Q Are there other situations in which a
8 patient with a post-operative leg length -- strike
9 that. I'm sorry.
10 Are there other situations, other than
11 the need for stability, where the patient manned up
12 with a post-operative leg length discrepancy which, in
13 your opinion, does not fall below the standard of care?
14 A I think the ultimate goal was to attempt
15 to get back to a more equal leg length, so you know,
16 you're fishing for circumstances that I'm not sure --
17 I'm not sure what you're getting at.
18 Q Well, with due respect, Doctor, I'm not
19 fishing for anything. I'm just looking for your
20 opinions on this.
21 A Yeah.
22 Q I didn't treat Mr. Wilmarth because I'm
23 not a doctor. And I didn't name you as an expert. So
24 that's why we're here, and I'm just trying to get your
25 opinions, and I'm trying to learn from this deposition.

1 So I'm trying to learn, are there
2 circumstances -- and you have discussed one,
3 stability -- where a patient -- where a doctor can end
4 up with a leg length discrepancy on his patient and not
5 breach the standard of care? I'm just trying to ask
6 you to enumerate as many of those as you know of.
7 MR. CURRIE: Move to strike anything that
8 wasn't a question.
9 MR. GOODIS: Sure.
10 A Your basic premise is that it's a
11 standard, routine total hip replacement without any
12 other specific issues like a tumor fracture, unusual
13 whatevers, so no.
14 Q Why don't we use Peter Wilmarth as an
15 example.
16 A No. I felt that, you know, he should
17 have his leg where it should be and it wasn't, and
18 there was a problem, and it wasn't addressed. So I'm
19 trying to be as clear as I can.
20 Q Well, I asked you before whether you had
21 opinions whether there were other breaches of standard
22 of care. So what I'm hearing you say now is you
23 believe that the post-operative care breached the
24 standard of care as well. Is that true?
25 MR. CURRIE: Move to strike every part of

1 that that wasn't a question.
2 MR. GOODIS: You can have a standing
3 objection to that, Frank.
4 MR. CURRIE: Oh, no. No. I'll make
5 them. Don't worry.
6 A I believe the fact that the leg was
7 lengthened too much, which caused a problem which was
8 subsequently ignored, is the problem.
9 Q And your basis that it was ignored, tell
10 me that.
11 A Yes. That the records I saw showed very
12 scant notes with comments about his pain medications,
13 that he wasn't on pain medicine when he was. And just
14 in hearing him tell me that that's what happened, why
15 he went to another doctor --
16 Q How do you know he was -- I'm sorry to
17 interrupt you.
18 A Mm-hmm.
19 Q How do you know he was on pain medication
20 when the records say he was not?
21 A Because Dr. Hicks's notes show that he
22 was on pain medication.
23 Q And whose records have you reviewed?
24 A Dr. Hicks's notes, some of the Orthopedic
25 Specialists notes.

1 Q Which notes from Orthopedic Specialists
2 have you reviewed?
3 A Some of the post-operative notes.
4 Q Which ones?
5 A Handwritten ones.
6 Q Which ones?
7 A Two weeks post-op, a month post-op, six
8 weeks, eight weeks post-op. Post-op notes when he came
9 in.
10 Q You have reviewed all those notes?
11 A I have seen them. Yeah.
12 Q I understand you have seen them. I'm
13 asking, have you reviewed them?
14 A Yes. I have reviewed them.
15 Q Okay. When you -- when you're doing this
16 operation, if you had a patient who comes in to you,
17 hypothetically, and let's say hypothetically that he
18 comes in with Mr. Wilmarth's history. Okay?
19 A Mm-hmm.
20 Q And he comes in. And in order to achieve
21 stability of the hip during the operation, okay, you
22 lengthen the leg where you're doing it, the side where
23 you're doing the hip replacement, by four millimeters.
24 Okay?
25 Can you imagine that happening at any

1 point in your practice?
2 A Sure.
3 Q Okay. And post-operatively, the patient
4 develops a problem. Okay? Say he's got sciatic pain
5 post-operatively.
6 Would that, in your opinion, be your
7 breach of the standard of care?
8 A First of all, it wasn't lengthened four
9 millimeters. It was lengthened more than that. Second
10 of all, if there was a problem, I would try to figure
11 out what the problem was and try to fix it.
12 Q But would the lengthening of the leg by
13 four millimeters, the question I asked, be a breach of
14 the standard of care?
15 A No.
16 Q How much was Peter Wilmarth's leg
17 lengthened?
18 A If you have the x-rays, I can measure it
19 for you.
20 Q Well, did you bring your chart with you
21 today?
22 A I did not.
23 Q Did you bring any of the materials that I
24 asked you to bring via the subpoena that I served on
25 you?

1 A I sent you that information, faxed.
2 Q Well, you sent me a narrative response.
3 You wrote in some answers. But did you bring any of
4 the materials that I asked you for via the subpoena
5 that I served you with?
6 A No.
7 Q Is there some reason you didn't comply
8 with the subpoena that I was -- that I served upon you?
9 A Because most of the information you
10 already had, and I thought it was a duplicate.
11 Q Did you bring your chart, your reports,
12 notes, memoranda, outline, anything like that?
13 A No, I have not.
14 Q I'm going to reserve the right to come
15 back another time to obtain the materials that I
16 served; two -- three, actually, duly certified court
17 subpoenas for these records.
18 A The material was copied and sent to you
19 ahead of time, so there is nothing else that's new that
20 you don't have. So that's why.
21 MR. CURRIE: You can reserve the right to
22 be at President Bush's space station, but I -- I
23 do think all of these materials have been
24 responded to --
25 MR. GOODIS: Absolutely not.

1 THE WITNESS: They absolutely were.
2 MR. GOODIS: We'll argue in front of
3 Judge Schaefer.
4 MR. CURRIE: I know that's coming. But I
5 just didn't want somebody to think that my
6 silence was some sort of acquiescence.
7 MR. GOODIS: I didn't consider it as
8 much.
9 BY MR. GOODIS:
10 Q One of the reasons I asked you to bring
11 these materials so that we could discuss the case, and
12 you just said, If I have the x-rays. If you had
13 brought the materials that I asked you to bring, then
14 we would have those, right?
15 A The post-operative x-ray that I recall
16 was 1.6 centimeters longer than the other leg. So your
17 point of four millimeters is incorrect, and I'm tired
18 of talking about it because it's not true. Okay?
19 You're leading to the four millimeters that I changed
20 the hip, not the four millimeters of the leg length
21 discrepancy. It was at least 1.6 centimeters as a
22 discrepancy.
23 Q When you were done with your operation,
24 the leg length discrepancy remained 1.2 centimeters?
25 A Yes.

1 Q That would not have been below the
2 standard of care, in your opinion?
3 A It was enough the take the tension of the
4 nerve and correct the problem without having to
5 completely remove an ingrown stem to fix the problem.
6 Q Which -- which film did you review which
7 showed a 1.6 centimeter leg length discrepancy?
8 A It was a post-operative film from the
9 peri-operative period.
10 Q What was the date of it?
11 A I don't have it on the top of my head,
12 but it was close to the time of surgery.
13 Q What is the -- what's an acceptable leg
14 length discrepancy post-operatively? How much can it
15 be?
16 A There's no real acceptable number, but we
17 agreed that four millimeters, five millimeters was
18 acceptable.
19 Q Okay. Is 1.6 centimeters acceptable?
20 A No.
21 Q How did you make the determination that
22 the leg was lengthened 1.6 centimeters
23 post-operatively?
24 A In the post-operative film, the leg
25 length discrepancy was 1.6 centimeters, if I recall

1 correctly, from post-operative film to the other side.
2 Q And you don't recall what date of film
3 that was?
4 MR. CURRIE: Asked and answered.
5 A I don't recall. It was peri-operative.
6 It wasn't very long after the surgery.
7 Q Now, when you first saw the patient, who
8 referred the patient to you?
9 A He had come over after seeing Dr. Harker
10 to see me as a second opinion, and it was from
11 Dr. Hicks.
12 Q And what was your initial impression of
13 what was wrong with the patient?
14 A I was trying to rule out that he had a
15 lumbar disc to his reasons for his leg symptoms.
16 Q Did you rule that out?
17 A We did an MRI scan of his lumbar spine,
18 we did plane films, and yes, we ruled that out.
19 Q Did you believe that it was necessary for
20 you to meet the standard of care to rule out lumbar
21 symptomology?
22 A I believed it was important to make sure
23 it wasn't another case for his leg symptoms, which
24 certainly could have, you know, been coincidental.
25 Q Are you certain within a reasonable

1 degree of medical probability that lumbar symptomology
2 was not the cause of Mr. Wilmarth's problems?
3 A Yes.
4 Q The -- have you reviewed any materials
5 from Mr. Wilmarth pre-operatively which suggest whether
6 or not he had a pre-operative leg length discrepancy?
7 A No. I don't recall.
8 Q Assume that he had some, whatever,
9 pre-operative leg length discrepancy, and
10 post-operatively he has more of a leg length
11 discrepancy. Is there a way for you to tell me, you
12 know, how much more you can lengthen a leg before
13 you're, you know, violating the standard of care?
14 A No. You can -- there's several papers
15 way back that describe leg lengthening and the
16 occurrence of symptoms, and there are ranges. And
17 certainly, there is at the lower end of the range that
18 should cause symptoms. It should not have caused
19 symptoms, but the fact is, it did.
20 Q So just to be 100 percent certain I
21 understand your testimony, if this had ended up 1.6
22 centimeters longer and no adverse symptoms had been
23 suffered by the patient, you do not believe it would
24 have been a breach of the standard of care?
25 A We wouldn't be here because he wouldn't

1 have had symptoms and we wouldn't have gone through all
2 this.
3 Q I understand that, but that's not my
4 question. Do you believe that a 1.6 centimeter
5 post-operative leg length discrepancy without
6 symptomology, in that hypothetical situation, is a
7 breach of the standard of care?
8 A Without symptoms, no. No injury.
9 Q What other -- when you first saw the
10 patient, other than the potential for lumbar
11 symptomology, what other potential causes did you
12 believe might be associated with Mr. Wilmarth's
13 symptomology?
14 A We looked at a lot of things;
15 trochanteric bursitis, we looked at SI joint. I
16 checked him to make sure it wasn't something else. I
17 checked his knee to make sure it wasn't a peroneal
18 nerve. Just a lot of things that you need to rule out.
19 Q Did you rule all those things out?
20 A Yes. It didn't make sense to me that he
21 was having sciatic symptoms from that procedure when he
22 had a bone scan that said the parts were not loose,
23 even though it sounded like an acetabular loosening.
24 And he had an arthrogram where the needle touched the
25 cup and sent him through the roof. I knew the nerve

1 was next to the cup.
2 Q Did you tell the patient at any point
3 that you were certain that he had a loose cup?
4 A I told him that I thought it might be
5 loose and that Dr. Harker thought it was loose, and it
6 sounded like it was loose from his groin symptoms and
7 the pain he was having, and that he probably needed to
8 have it revised. That was the pre-operative plan.
9 Q Did you tell anyone that you recall that
10 you were certain that this symptomology was associated
11 with a loose cup?
12 A I don't believe I did.
13 Q That would have been because ultimately,
14 you wouldn't have been certain without operating on the
15 patient?
16 A Absolutely.
17 Q Okay. Did you review your own chart in
18 anticipation of today's deposition?
19 A Yes.
20 Q Does your own chart discuss leg length
21 discrepancy?
22 A Yes. I believe it does.
23 Q What is -- what did you tell the patient
24 about leg length discrepancy pre-operatively?
25 A I don't recall what I told him. As to

1 whether I told him that it was significant or what it
2 was, I don't recall.
3 Q You would have charted whatever you would
4 have told him, as you recall?
5 A Most of the time, yes.
6 Q Was the leg length discrepancy that you
7 had seen on the post-operative films, was that one of
8 the reasons that you were operating on Mr. Wilmarth for
9 the revision?
10 A No.
11 Q What was, to your recollection -- you
12 indicated that you discussed Mr. Wilmarth's history
13 with him. What was his -- the condition of his hip
14 prior to Dr. Maser's surgery?
15 A Between the Stage 2 and Stage 3 avascular
16 necrosis.
17 Q Did you believe that -- that the hip
18 replacement surgery was indicated?
19 A I believe he could have gone either way.
20 He could have had a cord decompression and not had a
21 him replacement, being that he was so young.
22 Q Was there collapse of the femoral head?
23 A Minimal.
24 Q Do you do cord decompression in the face
25 of collapse of the femoral head?

1 A You can. And there's still a reasonable
2 improvement in longterm outcome in some papers. I feel
3 that it's well worth it in a young person because,
4 obviously, total hips don't last forever.
5 Q Well, are there any contraindications, in
6 your opinion, pre-operatively to cord decompression?
7 A No. I don't believe so. I think he
8 should have had a cord decompression. In my practice,
9 he would have.
10 Q Do you believe it was below the standard
11 of care for the patient to undergo hip replacement
12 rather than cord decompression?
13 A I think that's a judgment call. I don't
14 think it's below the standard of care to do a total
15 hip. I think I certainly wouldn't have, based on his
16 age and other factors.
17 Q Did you ever speak with Dr. Maser about
18 this patient?
19 MR. CURRIE: Objection. Asked and
20 answered.
21 A No.
22 Q Did you ever speak with any of the other
23 physicians in the Orthopedic Specialists group?
24 A I did. I talked to Dr. Sullivan about
25 it.

1 Q About the patient?
2 A Yeah. After the fact.
3 Q And what was the topic of your
4 discussions?
5 A Basically, I was told about my reputation
6 in the town after this suit and was given a nice
7 photocopy with an article circling that I could be sued
8 for frivolous suits and other pleasantries.
9 Q Have you ever done this type of work
10 before?
11 A One other case.
12 Q And was that also relative to a local
13 physician?
14 A In St. Pete. Yes.
15 Q What was the outcome of that case?
16 A It's being appealed.
17 Q I understand that. What was the outcome
18 of the case?
19 A Went --
20 MR. CURRIE: That there was a notice of
21 appeal.
22 A I don't have the final outcome.
23 MR. GOODIS: That's not the outcome. If
24 he knows what the outcome is, I think, Frank, I
25 think he's entitled to -- you know, that I'm

1 entitled to ask him if he knows the outcome.
2 MR. CURRIE: Yeah. I had just thought
3 maybe you would say, you know, How did the trial
4 turn out, because by asking outcome, it just
5 seemed like you were not exactly asking a fair
6 question.
7 BY MR. GOODIS:
8 Q Okay. What was the outcome?
9 A To my knowledge, the doctor won and they
10 were appealing.
11 Q Does there come a point where there's
12 been -- strike that.
13 Is there a point where cord decompression
14 is no longer an option for a patient and a total hip is
15 the necessary surgery?
16 A That's a very controversial topic. I
17 think it's very mixed in the orthopedic community as to
18 people that believe in cord decompression and people
19 that don't. I think anything you can do to prolong a
20 total hip replacement in a young person is well worth a
21 try. Especially, it's in certain papers, it's been
22 shown that it does improve longevity.
23 Q If a doctor undertakes a cord
24 decompression which does not work and then the patient
25 needs to undergo a total hip, is the doctor who

1 undertakes the cord decompression below the standard of
2 care, in your opinion?
3 A Absolutely not.
4 Q Are there any circumstances where you
5 believe cord decompression is not the proper surgery to
6 do?
7 A If you've got joint space narrowing where
8 you have severe degeneration of the joint, it's
9 pointless to do that.
10 Q Is collapse of the femoral head one of
11 those situations?
12 A If you're talking about a minimal
13 collapse, no. If you're talking about a severe
14 collapse with most of the head involved, yeah. I think
15 it's pointless.
16 Q Can a patient have complications from
17 cord decompression, whatever they may be, without the
18 doctor being below the standard of care?
19 A Yes, they can.
20 Q What type of symptoms do patients
21 sometimes suffer following cord decompression?
22 A The first obvious one would be no
23 resolution of their pain. Next, they could easily
24 have blood clots, infection, all kinds of problems.
25 Q Are those what you would consider to be

1 known risks of a cord decompression?
2 A Yes. And of most surgeries, to be honest
3 with you.
4 Q And would it be fair to say, Doctor, when
5 you're seeing a patient, you don't guarantee your
6 results?
7 A No.
8 Q You wouldn't want to do that because you
9 don't know that it's going to, for certain, work?
10 A Right. They also need to understand with
11 cord decompression that they should at some point end
12 up with a hip replacement. It's just trying to delay
13 the inevitable.
14 Q Now, you talked about the stage of
15 avascular necrosis of Mr. Wilmarth's hip
16 pre-operatively. Remember that?
17 A Yes.
18 Q And you said Stage 2 or 3; is that
19 correct?
20 A Yes.
21 Q What is your word -- what's the basis for
22 that statement?
23 A With the standard classification system
24 there's ways of grading it, and there's obviously some
25 interpretation in the grades. There's stages. So you

1 can't -- you're not gonna get a room full of
2 orthopedists who agree which stage it is. So I might
3 call it a 2 and somebody else might call it a 3. So
4 it's a 2 or 3, depending on how you look at it.
5 Q How many stages are there?
6 A Well, there's some that systems are six
7 different stages, but practical ones, there's really
8 four stages. So with 4 being the severe degeneration
9 where total hip was absolutely appropriate, and on
10 down.
11 Q Was -- during your care and treatment of
12 Mr. Wilmarth, was he compliant with your instructions?
13 A Yes.
14 Q Are you aware of any circumstances during
15 his treatment with any physician prior to coming to you
16 where he was noncompliant with physician orders?
17 A No. I'm not aware of any.
18 Q Can a patient contribute to their own
19 lack of healing by being noncompliant post-operatively?
20 A Yes.
21 Q Have you ever had any patients who were
22 noncompliant with your recommendations post-operatively
23 who contributed to cause their own injuries?
24 A No. All of mine are perfect, of course.
25 No. Certainly.

1 Q Okay. And is that something that you
2 would consider to be your fault, if a patient is
3 noncompliant with your post-operative orders?
4 A No.
5 Q Did you review Dr. Maser's operative
6 report?
7 A Yes.
8 Q Did you have any criticisms of the
9 technical aspects of Dr. Maser's surgery?
10 A I don't recall any issues with stability
11 problems, so I didn't see a need for lengthening of the
12 leg.
13 Q Would that be the only circumstance that
14 you can think of which would require lengthening of the
15 leg?
16 A Which would require lengthening the leg?
17 No.
18 Q Yeah. Are there any other circumstances
19 in which you would lengthen the leg other than seeking
20 stability?
21 A I can't really think of any. No.
22 Q Did you -- or do you have an opinion
23 within a reasonable degree of medical probability
24 whether Mr. Maser -- Mr. Wilmarth. I'm sorry -- was
25 going to be able post total hip to return to his

1 previous employment?
2 A That's difficult to say.
3 Q Would you expect a patient who was his
4 age at the time of surgery who was undergoing a total
5 hip to be able to return to his work as an auto
6 mechanic, within a reasonable degree of medical
7 probability?
8 A It's probably not advised to go back to
9 that kind of work. Yes.
10 MR. GOODIS: Let's take a break.
11 (Whereupon, a brief recess was taken.)
12 THE VIDEOGRAPHER: Back on the record at
13 3:44 p.m.
14 Q Thank you. Thanks for your patience
15 while we were taking a quick break.
16 Is there a way you can quantify for me --
17 is there a percentage of patients who undergo hip
18 replacement surgery who suffer post-operative
19 complications in the absence of physician negligence?
20 A I would probably say the overwhelming
21 majority are, because of -- most of the complications
22 are pulmonary embolism, blood clot, you know, those
23 sorts of things. I don't think that's physician --
24 that's not from negligence.
25 Q Is there some percentage, either through

1 your training, education, experience or your own
2 empiric data of patients who have thigh pain after a
3 total hip replacement?
4 A If you're talking similar to Mr. Wilmarth
5 with a non-cemented stem and somebody with avascular
6 necrosis, I would assume it's probably a little higher
7 than the general population. That article's been done.
8 And I would say it's probably in the neighborhood of 20
9 percent.
10 Q You mentioned early in the deposition
11 that when Mr. Wilmarth came to see you, that he had
12 groin pain.
13 A Yes.
14 Q What did you do in your surgery to solve
15 that problem?
16 A His socket was evaluated and not loose.
17 The nerve was up against the socket which caused his
18 pain. Even with his epidural, he felt a great deal of
19 pain when the sciatic nerve was manipulated. So that
20 was felt to be the origin of his pain.
21 Q What -- we've taken Mr. Wilmarth's
22 deposition and that of his wife. When you did the
23 surgery, did you find anything out of the ordinary when
24 you did your revision that, you know -- unreattached
25 muscles, that type of thing?

1 A No. Most of the external rotators don't
2 reattach. Those were down, but that's normal.
3 Piriformis was down, but that's not usually reattached,
4 and if it is, it usually ruptures. So there were some
5 that were down, but those are normally down.
6 Q Were you critical of Dr. Maser's care of
7 the patient in any way other than the leg length that
8 we have talked about already?
9 A The biggest problem, I guess, is that the
10 problem was ignored, overlooked, whatever you want to
11 call it. That's my biggest problem.
12 Q How soon after surgery would a patient --
13 would you expect a patient to start suffering sciatic
14 nerve problems if -- if a patient is gonna end up
15 with -- Mr. Wilmarth?
16 A Should be relativity soon, right after
17 the procedure. I would assume within a few weeks.
18 Q And is it your understanding that's what
19 occurred in this case?
20 A He kept having pain and was not better
21 from Day 1.
22 Q Have you had an opportunity prior to
23 today to meet Mr. Currie or anybody from his law firm?
24 A Yes. The other day when he came by the
25 office. Yeah.

1 Q Other than that, have you had an
2 opportunity to meet him?
3 A I don't recall. Maybe -- I don't recall.
4 Q Have you had any discussions relative to
5 this case?
6 A I discussed it with somebody, but I don't
7 know if it was somebody -- whether it was you or from
8 your group or -- yeah.
9 Q Do you recall the topic of conversation
10 at that time?
11 A No. That was a while ago.
12 MR. CURRIE: Just so you know, Jeff, I
13 stopped in on Friday. Dr. Petersen was too busy
14 to talk to me. He took my cell phone number,
15 and whoever wrote it down wrote it down
16 incorrectly.
17 MR. GOODIS: Yeah. You told me that
18 story before last depo.
19 MR. CURRIE: And also, I do believe that
20 you met with Mr. Beltz at one time or another.
21 THE WITNESS: That's who I remember
22 seeing. Yeah. That's who I talked to.
23 BY MR. GOODIS:
24 Q Where was that?
25 A That was in my office.

1 Q Was that about this case?
2 A Yes.
3 Q And what was the topic of the discussion,
4 if you remember?
5 A I don't recall. He had several questions
6 about the case, but I don't recall specifics of them.
7 Q Was ultimately the purpose of your
8 surgery -- I understand that there's a pre-operative
9 diagnosis and a post-operative diagnosis, and that much
10 I do know from doing some of this kind of work. Was
11 ultimately the post-operative diagnosis, from your
12 revision, your initial surgery -- I understand you did
13 a cord decompression on the other -- the contra lateral
14 side at some point in the future, right?
15 A Yes, sir.
16 Q Eventually I'm gonna get this question
17 out. Was your post-operative diagnosis that the nerve
18 was in contact with the cup as a result of the leg
19 lengthening?
20 A I don't recall exactly what I put on the
21 post-op diagnosis, but that's the gist of it. Yes.
22 Q Yeah. And I'm not asking about your
23 operative report at this point. I'm asking about your
24 opinion.
25 A Yes.

1 Q Okay. Leaving the operating room, from
2 your initial surgery with Mr. Maser, your --
3 Mr. Wilmarth -- I keep doing that. I honestly believe
4 that I caught the flu at lunch today, just all of a
5 sudden at lunch. It was that, or bad grouper.
6 Wow. Start again. When you were leaving
7 the operating room from your initial surgery with
8 Mr. Wilmarth, your impression was tension caused by too
9 long a leg?
10 A Yes.
11 Q What is neurolysis?
12 A There are different forms of it, but
13 basically releasing scar tissue around the nerve.
14 Q Did you and Mr. Wilmarth discuss that
15 prior to your initial surgery?
16 A No.
17 Q Why not?
18 A Because that wasn't really part of the
19 thought process behind an acetabular loose cup.
20 Q As I understand it, you ultimately did
21 intra-operatively do neurolysis?
22 A Yes.
23 Q And -- this is what I get for looking at
24 my notes instead of listening to your answer. I
25 apologize. Explain to me again what neurolysis is.

1 A Basically, removing the nerve from the
2 scar tissue.
3 Q Do you make an effort to be accurate
4 while you're writing your operative -- or dictating
5 your operative reports post-operatively?
6 A I try to.
7 Q And you indicated that you had an
8 opportunity to review your operative report relative to
9 your initial surgery of Mr. Wilmarth?
10 A Briefly. Yeah.
11 Q When you did that briefly, did you notice
12 any inaccuracies?
13 A I think there was a typo or two. I don't
14 recall.
15 Q When you mean a typo, something that was
16 misspelled?
17 A I don't do the typing and sometimes when
18 you read it, you're reading it just tired and -- yeah.
19 I do recall something, but I don't recall what it was.
20 Q Okay. Was it something when you recalled
21 it that you thought needed to be, you know, corrected,
22 that you needed to do an addendum?
23 A If it struck me odd, yes. And I don't
24 know whether I did or didn't make a note on it or not.
25 Q Those of us, at least in the

1 medical/legal profession, and certainly those of you in
2 the orthopedic surgery profession, have heard of hip
3 prosthesis recalls. You have certainly heard of those,
4 right?
5 A Yes.
6 Q And I know there was some investigation,
7 from talking to Mr. Wilmarth, of the potential that his
8 prosthesis was one of the ones that needed to be
9 recalled. Do you recall that at all?
10 A Actually, it was done on a couple of
11 occasions, because I was very concerned with the
12 loosening in the cup that that may have been the
13 problem, because it was about the right timeframe for
14 that prosthesis. Even though it had already been done,
15 I checked into it again just to be sure.
16 Q I understand it was not one of the ones
17 that was in the recalled lots.
18 A Correct.
19 Q Are there defective hip prostheses which
20 are not part of the recall?
21 A Certainly.
22 Q Did you give any consideration to that in
23 this case?
24 A No. Because I -- you know, there's no
25 way to check that.

1 Q You indicated that -- sorry. I promised
2 Chandra that when we came in today, I wasn't going to
3 take mass notes as I usually do, and I'm failing
4 miserably at that goal -- that the patient had pain
5 response when the needle touched the cup. Was that
6 during the arthrogram?
7 A Yes.
8 Q Were you present for the arthrogram?
9 A No.
10 Q You reviewed the report?
11 A Yes. And I was also called and spoke
12 with the person that performed it, and they said that's
13 the weirdest thing they ever saw.
14 Q When you did your surgery, was the
15 patient under general anesthetic or epidural
16 anesthetic?
17 A He was under an epidural anesthetic.
18 Q Did he have pain response during your
19 surgery?
20 A Absolutely.
21 Q When?
22 A When I touched the sciatic nerve near the
23 edge of the cup, he was out of control on the table.
24 Q What happens to a patient physically when
25 they have pain response? And by that, I mean increased

1 heartrate, increased BP, that type of thing? Does that
2 occur?
3 A Absolutely.
4 Q And that occurred with this patient, do
5 you recall?
6 A He was visibly very upset and moving all
7 over the table, trying to get away. As to whether his
8 blood pressure changed or whether it was monitored, I
9 don't know. He certainly had a pain response.
10 Q Just so you know, Doctor, when I'm
11 completely quiet here, it's because I'm reading my
12 notes, and the faster I go through these pages, the
13 faster we'll be done.
14 A I don't recall complaining about it.
15 Q No, sir. I was just trying to give you
16 the courtesy of letting you know why I'm sitting here
17 not talking to you.
18 A I appreciate it, but you're not hurting
19 my feelings.
20 Q Okay. I think you told me that you
21 discussed leg length discrepancy with Mr. Wilmarth.
22 Maybe I imagined that, but did you?
23 A After the fact, yes.
24 Q After the surgery?
25 A Yeah. I told him that I shortened it to

1 try and take some tension off the nerve.
2 Q Was the first time that you discussed leg
3 length discrepancy with Mr. Wilmarth post-operatively,
4 post your operation?
5 A I don't recall if it was or it was
6 before. I don't recall.
7 Q Did any of the x-rays that you saw
8 post-operatively show any loosency (sic) around the
9 cup?
10 A There was what looked like a loosened
11 around the cup that Dr. Harker noted and I also noted.
12 And again, with his groin pain and complaints, it
13 seemed like that was probably the origin of his pain,
14 was a loose socket. And that's what prompted the
15 investigation into whether it was a recalled hip or not
16 with a loosening, et cetera.
17 Q What type of symptoms would a patient
18 suffering sciatic nerve irritation suffer?
19 A He had straight leg issues. He had pain
20 down the leg. He had enough to prompt me to order an
21 MRI scan of his lumbar spine to be sure he didn't have
22 a disc rupture.
23 Q Thinking that there might be some
24 radicular symptomology?
25 A Yeah. Maybe that was coincidental and

1 that maybe everybody was looking at this loose cup and
2 not seeing the bigger picture.
3 Q Is a one centimeter post-operative -- we
4 talked about a .4, a 1.6, and now I want to know if a
5 1.0 centimeter leg length discrepancy post-operatively
6 is within an acceptable post-operative range.
7 A You can lengthen the sciatic nerve seven
8 centimeters if you need to for a severe leg length
9 discrepancy during total hip. As long as they're
10 monitored and there are no symptoms, it's okay. So
11 trying to figure out it 1.0 --
12 Q It doesn't really matter, is what you're
13 saying?
14 A As long as there's no problem with the
15 lengthening and you lengthened it for a reason, then
16 it's fine.
17 Q Okay. The surgery that you ultimately
18 did, did you consider it to be exploratory in nature?
19 A In that I wasn't sure whether his cup was
20 loose or not, yes.
21 Q Prior to this spade of recalls, would
22 that surgery have been done?
23 A Yes. It appeared that his cup was loose.
24 And with the groin pain and the problems that he was
25 having, it seemed pretty clear that was probably the

1 origin of his problems.
2 Q You told me about another case in which
3 you were involved with, and you did provide me with
4 that information in the material that you faxed to me,
5 and I thank you for that.
6 Have you been involved in any other
7 lawsuits other than this one and that one?
8 A I've been deposed for probably a half a
9 dozen cases and, you know, they were all auto or
10 whatever, work injuries, that kind of stuff. I don't
11 recall any specifics.
12 Q That was a bad -- my bad question. Any
13 other medical negligence claims?
14 MR. CURRIE: Does that encompass claims
15 where he might have been a plaintiff or a
16 defendant himself?
17 MR. GOODIS: No.
18 A I don't recall any.
19 Q Have you ever been a defendant in a
20 medical malpractice case?
21 A No.
22 MR. CURRIE: Plaintiff?
23 A No.
24 MR. GOODIS: Thanks.
25 MR. CURRIE: My pleasure.

1 Q Loose cup would be considered a
2 mechanical complication of an internal orthopedic
3 device. Is that a fair statement?
4 A Yes.
5 Q Is a mechanical complication of an
6 internal orthopedic device a breach of the standard of
7 care?
8 A Depends on the reason it became loose.
9 Q Is the potential for a loose cup or other
10 mechanical complication a statistical risk of
11 undergoing hip replacement surgery?
12 A In general, it shouldn't be loose. So if
13 it's loose, there needs to be a reason for it. So I'm
14 not sure I understand your question. If the cup was
15 put in wrong and it's loose, then that's a problem. If
16 it was put in properly and it got loose, then there are
17 reasons for it that are not the doctor's fault. Yes.
18 Q There are situations in which there can
19 be a mechanical complication, which are simply a known
20 risk and complication of procedure, they're not
21 anybody's fault?
22 A Absolutely.
23 Q There are situations where a patient
24 undergoes a total hip replacement, ends up with a leg
25 length discrepancy, suffers complications associated

1 with the leg length discrepancy, and that there's no
2 breach of the standard of care?
3 A I don't know that to be true.
4 Q Is it your opinion that any patient who
5 undergoes a total hip, ends up post-operatively with a
6 leg length discrepancy and complications, results from
7 the breach of the standard of care?
8 A That would make sense. Yes. Assuming
9 that you're indicating a complication is directly
10 related to the leg length and not to a blood clot or
11 some other issue.
12 Q If the complication's associated with, in
13 your opinion, a leg length discrepancy, that's a breach
14 of the standard of care?
15 A Right. Not if the patient had had a leg
16 length discrepancy and a blood clot. I don't feel that
17 that would be.
18 Q One of the things that you mentioned
19 earlier in your testimony was a possible right hip.
20 No, you didn't. You said trochanteric bursitis, I
21 think. Did I say that right?
22 A Close enough.
23 Q Did this patient have that condition?
24 A No.
25 Q Did you look at anything which outlined

1 this patient's condition pre-operatively which would
2 give you the ability to tell me now what, you know,
3 both sides were like, what his right hip was versus his
4 left hip prior to Dr. Maser's surgery?
5 A His right hip was more advanced, but both
6 hips had AVN.
7 Q Avascular necrosis?
8 A Yes.
9 Q What surgery did you do on the right
10 hip -- I'm sorry -- the left hip?
11 A The left hip, I did a cord decompression
12 and bone graft.
13 Q And that was to stem the tide of the
14 avascular necrosis?
15 A Yes.
16 Q And you expect that this is a patient who
17 will ultimately end up with the need for left total
18 hip?
19 A There's probably longterm about a
20 70-something percent chance that he will progress to a
21 total hip, but that implies that there is a chance that
22 he won't need a total hip.
23 Q Did you feel like your cord decompression
24 on the left side was an indicated surgery?
25 A Yes.

1 Q A necessary surgery?
2 A Yes.
3 Q Given the choice in your practice between
4 leg length equality and stability, which is more
5 important to you?
6 A I would opt for the stability, obviously,
7 initially at the time of surgery so we don't have
8 subsequent dislocation. However, I would attempt not
9 the over-lengthen it to cause problems. And if there
10 were problems, I would try to address them.
11 Q If a patient undergoes hip replacement
12 surgery under -- you know, has a leg length discrepancy
13 post-operatively and then -- strike that.
14 Let's assume it's your patient. You go
15 in -- and I think you've already told me that just
16 because the patient ends up with a leg length
17 discrepancy doesn't necessarily mean there's a breach
18 of the standard of care. We agree on that, right?
19 A Right.
20 MR. CURRIE: Asked and answered.
21 Q I think you also told me that -- here's
22 my question. The patient ends up post-operatively with
23 a leg length discrepancy. It causes a complication,
24 but you recognize it and go in and fix it. Okay?
25 Is that a breach of the standard of care,

1 the original leg length discrepancy?
2 A No. I believe that if you notice there's
3 a problem and you attempt to fix it, that's
4 appropriate.
5 MR. GOODIS: Can I have just two minutes?
6 THE VIDEOGRAPHER: Going off the record
7 at 4:09 p.m.
8 (Whereupon, a brief recess was taken.)
9 THE VIDEOGRAPHER: Back on the record at
10 4:12 p.m.
11 BY MR. GOODIS:
12 Q Thank you. Are you still seeing
13 Mr. Wilmarth as a patient?
14 A No. I haven't seen him in -- well, I saw
15 him in the hospital, just happened to notice he was in
16 there recently with cellulitis in his legs. But, no.
17 I haven't seen him in a couple years.
18 Q Is the cellulitis related to anything
19 that is associated with this case that you know about?
20 A No. I just happened to notice he was
21 laying in a bed when I walked by, and I said, Hey, how
22 you doing?
23 Q Why did he stop coming to you? Do you
24 know?
25 A I don't know.

1 Q Thank you. That's all I have.
2 MR. CURRIE: No questions.
3 THE VIDEOGRAPHER: We're off the record
4 at 4:13 p.m.
5 (Whereupon, at 4:13 p.m., no further
6 questions were propounded to this witness.)
7 THE COURT REPORTER: Do you need this
8 transcribed?
9 MR. GOODIS: Yes, please.
10 THE COURT REPORTER: Mini and ASCII?
11 MR. GOODIS: Yes. What's your standard
12 turnaround?
13 THE COURT REPORTER. Ten business days.
14 MR. GOODIS: Expedite it, please.
15 THE COURT REPORTER: Okay. When do you
16 need it?
17 MR. GOODIS: As soon as you can get it to
18 me.
19 THE COURT REPORTER: And would you like a
20 copy, too?
21 MR. CURRIE: Copy, condensed, and an
22 ASCII.
23
24
25

1 STATE OF FLORIDA
COUNTY OF HILLSBOROUGH
2
3 I, the undersigned authority, certify that DAVID
PETERSEN, M.D. personally appeared before me and was
4 duly sworn.
WITNESS my hand and official seal this 12th day
5 of January, 2004.
6
7
8 AMY C. TREVINO
Notary Public, State of Florida
9 My Commission Number: DDO74354
Expires December 15, 2005
10
11
12 STATE OF FLORIDA
COUNTY OF HILLSBOROUGH
13
14 I, AMY C. TREVINO, certify that I was
authorized and did stenographically report the
15 foregoing deposition; and that the transcript is a true
record of the testimony given by the witness.
16
17 I further certify that I am not a relative,
employee, attorney, or counsel of any of the parties,
18 nor am I a relative or employee of any of the parties'
attorneys or counsel connected with the action, nor am
19 I financially interested in the action.
20 Dated this 12th day of January, 2004.
21
22
AMY C. TREVINO
23 COURT REPORTER
24
25