TRIAL

Doc. 67

State of Ohio,)
) SS:
County of Cuyahoga.)

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IN THE COURT OF COMMON PLEAS

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Marcia Goldman, et al.,)
)
Plaintiffs,)
) Case No. 144221
vs.)
)
Mark R Lawiman, M.D., et al.,)
)
Defendants.)

- - -

DEPOSITION OF JANET BLANCHARD M.D.

MONDAY, OCTOBER 23, 1989

- - -

The deposition of Janet Blanchard, M.D. a witness herein, called by the Defendants for examination under the Ohio Rules of Civil Procedure, taken before me, Howard J Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, by agreement of counsel and without further notice or other legal formalities, at Lake County Hospital - West, Painesville, Ohio, commencing at 7:00 a m , on the day and date above set forth

APPEARANCES:

On behalf of the Plaintiffs:

Charles M. Delbaum, Esq.
Stege, Delbaum & Hickman
Standard Building - Suite 1620
Cleveland, Ohio 44113

On behalf of the Defendants:

Anthony P. Dapore, Esq.
Craig A. Grimes, Esq.
Jacobson, Maynard, Tuschman & Ralur
100 Erieview Plaza - 14th Floor
Cleveland, Ohio 44114

Also Present:

Tom Baker, Videographer

JANET BLANCHARD, M.D.

a witness herein, called by the defendants for examination under the Rules, having been first duly sworn, as hereinafter certified, was deposed and said as follows:

DIRECT EXAMINATION

BY MR. DAPORE:

Q. Good evening, Dr. Blanchard. My name is Tony Dapore, and I represent Dr. Levine, and I am going to ask you some questions here for the next few minutes.

First of all, could you state your full name for the jury, please?

A. Janet Blanchard.

Q. And what is your profession?

A. I am a plastic and reconstructive surgeon.

Q. And what is your professional address?

A. 7915 Munson Road, suite number 3, Mentor, Ohio, 44060.

Q. And you indicated that your specialty was plastic and reconstructive surgery; what is that?

A. Plastic and reconstructive surgery encompasses a variety of procedures and techniques. One is cosmetic, and that encompasses, for example, face lifts, blepharoplasties, rhinoplasties.

Reconstructive surgery, on the other hand is reconstructing people who have had major trauma, who may have had scarring, who don't like the scars that they had and are asking to have them revised. It also encompasses a great deal of hand surgery.

Q. Could you run us through your education, and background and training, beginning with your undergraduate education, the year you graduated, and the degree that you received from each institution?

A. I graduated from the University of Delaware in 1965. I then took a few years off and worked as a medical technologist.

I then went to graduate school in 1973, for two years, and then I was accepted into my second year of medical school, and subsequently finished medical school in 1976. My Master's was in clinical pathology, and I got my medical doctorate degree in 1976.

In July of 1976, I was an intern at the Cleveland Clinic. I then spent three years in general surgery, followed by two years of plastic surgery and six years of a hand fellowship. I finished my hand fellowship in December of 1981.

Q. During your time at the Cleveland Clinic and

your training, did you have occasion to work with Dr. Harry Moon?

A. Yes, I did.

Q. And how was it that you worked with Dr. Moon?

A. He was -- as I was a hand fellow, he was starting his plastic surgery residency at the Cleveland Clinic.

Q. What have you been doing since the completion of your formal training?

A. I have been working in plastic and reconstructive surgery since May of 1982.

Q. Has that been in a private practice?

A. The first year and a half was spent at Metropolitan General Hospital, which is also affiliated with University. I had a faculty position and was responsible for teaching residents, as well as doing research.

Q. Are you licensed to practice medicine in the State of Ohio?

A. Yes, I am.

Q. And how long have you been so licensed?

A. The exact date, I believe, is 1976. When I came to Ohio, I became licensed.

Q. Are you Board certified in plastic and reconstructive surgery?

A. Yes, I am.

Q. And when were you Board certified?

A. December of 1982, I took my written boards, and then in 1983 I became Board certified.

Q. Now, you indicated that at one point you were working at Cleveland Metropolitan General Hospital and performing teaching duties with residents.

Do you continue to have any teaching responsibilities today?

A. Yes, I have. I am on staff at Lutheran Medical Center, and they have residents -- they used to have their own residents, and then they lost the residency program, and about six or eight months ago, we are now having residents come to Lutheran from Fairview, and so I am responsible for teaching them again.

Q. Do you spend an excess of 75 percent of your professional time in the active clinical practice of medicine and/or teaching?

A. Yes, I do.

Q. Do you perform a surgery known as a blepharoplasty?

A. Yes, I do.

Q. And approximately how many do you perform each year, say for the last five years?

A. The number that you do increases every year. This year I probably will do more than I did last year, simply because my practice is still growing, as is my cosmetic portion of my practice.

I would say by the end of this year, 1 may have done forty.

Q. Are you familiar with the standard of care for performance of the blepharoplasty, postoperative management and care of complications from that surgery?

A. Yes, I am.

Q. What is a blepharoplasty?

A. A blepharoplasty is a procedure that is performed on a patient who either has excess skin and/or excess fat in their upper and/or lower eyelids.

Q. How is that procedure performed?

A. It is usually done in an operating room setting or a surgical center setting. The patient usually has a local anesthetic, and then they have a sedation that is usually intravenous that just kind of makes them relaxed.

What you do then is you make -- first of all, before the operation, you mark them. Usually I mark them so that I know how much skin on the upper lid

to excise.

The procedure is then performed by excising the excess skin and/or fat on the upper lids, it doesn't matter in what order you do them, and then the lower lids are done by developing -- either taking the skin, or the skin and muscle, underneath that is the fat, and you remove as much fat as you think is adequate.

You then perform what we call meticulous hemostasis, or try to find all the bleeders that you can, and you sew them up, put on some ointment on the incisions, and I start immediately with cold compresses.

Q. And what is the purpose of the cold compress?

A. To decrease the swelling.

Q. In terms of postoperative swelling, is there any standard as to how much to expect from a patient?

A. It is difficult -- it is very difficult to tell who is going to get very swollen and who isn't. What I usually try to do after the procedure is show the patient what they are going to look like a few weeks down the line, because after you are finished with the procedure, they usually are not really swollen. It could be an hour to two hours later,

they might be really swollen, or four hours later. So I cannot predict who is going to swell more than others.

Q. Can there be a variance from -- within the same patient, from one side to the other, as to the degree of swelling?

A. Yes, there can.

Q. Is that something that occurs with any type of regularity?

A. Yes.

Q. Now, what are the complications that accompany a blepharopiasty?

A. I think the first most frequent complication is bleeding. I have never seen an infection in a blepharoplasty.

The immediate complications are bleeding with or without pain, and with or without causing a disturbance in vision. And this is an urgent complication that must be addressed immediately.

Q. And why would bleeding with pain and disturbance of vision be important?

A. It is not only important, it can be catastrophic.

When a blepharoplasty is performed, the patients virtually do not have pain. They are

uncomfortable, but they don't have a lot *of* pain. And I counsel them that if, in fact, they do have pain, then they are to call me immediately.

What usually is happening, is if there is pain, it is usually caused by an excessive amount of bleeding, which in turn will cause an insult either to the nerve to the eye, the optic nerve, or the blood vessel. That, in turn, could cause temporary or permanent blindness.

So you really have to -- that is an urgent thing. You see the patient whenever they call you, and evaluate them.

Q. In terms of producing this pain from the blood, what is that mechanism?

A. It puts pressure on the nerve. It increases the intraocular pressure, and that certainly is going to give pain. ***So*** it is bleeding that causes the pain.

Q. And the pain is as a result of pressure on the nerve from the bleeding?

A, Correct, intraocular pressure.

Q. The results of, or the production of that pain, is that something that is immediate, or delayed?

A. Usually it is within what I call the

immediate postop period.

Q. Can you define that, immediate postop period?

A. I would believe that if bleeding were going to occur and cause that kind of pain, it probably would happen within the first few hours after surgery.

Q. What about the complication of a hematoma, how is that handled?

A. Well, it depends. If a patient develops a hematoma, and it is significant, then depending -- and this is an individual judgment, as far as I am concerned -- a physician can either elect to let the hematoma eventually resolve on its own, or take them back to the operating room and evacuate it.

Sometimes it is difficult to tell whether that is due to swelling, or due to a hematoma.

Q. Have you had instances where you have elected not to take patients back to surgery for significant swelling or hematoma postoperatively to evacuate?

MR. DELBAUM: Objection.

A. I have not taken a patient back to surgery for a hematoma, in my practice of five or six years.

MR. DELBAUM: Move to strike.

Q. How about the complication of an ectropion? First of all, what is that?

A. That is a condition that exists when a patient either has an excessive amount of swelling, and/or it could be caused by an excessive amount of skin being resected from the lower lid, from the lower eyelid.

Q. And how is that treated?

A. It depends. If it is not significant -- and again, that is determined by the individual physician -- if it is not significant, you can usually wait until the swelling goes down, and if the ectropion resolves, then no further treatment is necessary.

If it is because of swelling, usually you can wait through that period and see whether or not it is significant, and then decide at that time.

If it is due to an excessive amount of skin, and you wait that amount of time, it will usually never resolve.

Q. Do ectropions also result from development of scar tissue in that eyelid that develop postoperatively?

A. Yes, they can.

Q. And how are those treated?

A. Again, it is an individual decision. They can either be corrected by reoperating and excising

the scar tissue, or trying a period of massaging and the tincture of time, again, to see whether it will resolve.

Q. When a patient is taken to the recovery room after a blepharoplasty is performed, what are the responsibilities of the nursing staff with respect to that patient?

A. If it were my patient, I would expect them to call me if there is any problem with pain, excessive amount of swelling, and anything really that bothers them. If they have a little ooze from the incision and they are not comfortable with it, so that their responsibility is to tell me if they think that there is a problem.

Q. Are they trained to observe for excessive amounts of swelling'?

A. Yes.

Q. And you then would expect them, if that were to occur, to report that to you?

A. Absolutely.

Q. Would that be the same for an excessive amount of drainage or bleeding from the incision?

A. Yes.

Q. Do they do anything with respect to carrying out orders that may be given?

A. Yes.

Q. Such as giving pain medications, or things of that nature?

A. Yes.

Q. And when they do these things, make the observations, or contact you, as a physician, with patient complaints, what do they do, then, with respect to the patient chart?

MR. DELBAUM: Objection.

A. They should document it.

Q. And how would that be documented?

MR. DELBAUM: Objection.

A. For example, patient has excessive amount of swelling, doctor here, there is no hematoma, or no significant swelling, or something. It depends on -- but usually they document that you were there, and what has transpired thereafter.

Q. If a nurse were making an observation of a patient early on in the postoperative period of no significant swelling, and later in that postoperative period there was significant swelling, what would be the appropriate thing for that nurse to do?

MR. DELBAUM: Objection.

A. To call me.

Q Would it be appropriate for the nurse there to chart that, as well?

MR. DELBAUM: Objection.

A Correct

Q So I know that in this case, Mrs Goldberg developed some complications after her hysterectomy performed by Dr Lewine The first one is an infection

Do you have an opinion whether it was appropriate for Dr Lewine to recommend on Mrs Goldberg for this procedure one month after her first surgery?

First of all, do you have an opinion?

A Yes, I do have an opinion

MR DELBAUM: Objection

Q And what is your opinion?

A. That I think it was appropriate for him to operate

MR DELBAUM: Objection

Move to strike

Q And what is the basis for that opinion?

MR DELBAUM: Objection

A. The basis -- I think it is an individual judgment. I am not sure I understand the question

Q. Well, what would it be about a patient to

make that judgment?

A. Okay.

Q. Whether it be Mrs Golden specifically, or the things that you would look at, as a physician, to make that judgment?

MR. DELBAUM: Objection.

A. The first thing that I would -- that would make me do this, would point me in the direction of operating, is if the patient had a significant conjunctivitis, or irritation to the eye, if, in my opinion, I didn't think that it was going to resolve in three months for just because of excessive scar tissue, those are the kinds of things that would lead me to think that.

If I knew that I did not excise an excessive amount of skin, then depending on how severe the ectropion was, I would may be reoperate

MR DELBAUM: Move to strike as unresponsive

Q. Because Mrs Golden developed an ectropion in this case, does it mean that medical malpractice was involved in her care?

MR. DELBAUM: Objection.

A. No, I do not think that malpractice was involved.

MR. DELBAUM: Move to strike.

Q. In this case, the ectropion was caused by scar tissue; is that correct?

MR. DELBAUM: Objection.

A. Yes, I assume that that is correct, in my opinion.

MR. DELBAUM: Objection.

Q. If you wish to refer to Dr. Levine's operative report for the second surgery when he corrected the ectropion, you may do so, but do you recall what it was that he noted as the cause?

A. I am sorry, I misunderstood you. I thought you were asking --

Q. Sure.

A. -- me for my opinion.

He noted that there was scar tissue.

Q. And that second procedure he performed was what?

A. He released adhesions and scar tissue.

Q. Do you have to have scar tissue in order to heal in surgical incisions?

A. Absolutely. The basis of wound healing is scar formation.

Q. It is also thought that Mrs. Golden had a hematoma.

Do you have an opinion whether it was appropriate to advise Mrs. Golden *to* use cold compresses for the first 24 to 48 hours postoperatively to control swelling?

MR. DELBAUM: Object. w1)

Q. (Continuing) First of all, do you have an opinion?

A. Yes, I have an opinion.

MR. DELBAUM: Objection. w1)

Q. And what is your opinion?

MR. DELBAUM: Object -- w1)

A. My opinion is that I --

MR. DELBAUM: Excuse me, Doctor, I am w0) sorry.

Objection. I just want *to* get that on the record.

Q. And what is your opinion?

A. That I think it was appropriate to use ice for 24 to 48 hours.

Q. Further, once there was a diagnosis of hematoma on July the 7th, 1987, would it be appropriate -- do you have an opinion whether it would be appropriate to treat that hematoma by advising the patient to use warm compresses?

A. Yes.

Q. First of all, do you have an opinion?
A. Yes, I have an opinion.
Q. And what is your opinion?
MR. DELBAUM: Objection.
A. And I think it was appropriate.
Q. Mrs. Golden reports that there was significant swelling in her left lower eyelid and upper cheek area in the immediate postoperative period about the width of a golf ball, and projecting out about the third of the size of a golf ball, and I want you, for purposes of this question, to assume that that, in fact, is correct.
Do you have an opinion whether such swelling was handled appropriately by prescribing that the patient use cold compresses --
MR. DELBAUM: Object.
Q. -- for 24 to 48 hours?
MR. DELBAUM: Objection.
Q. (Continuing) First of all, do you have an opinion?
A. Yes.
Q. And what is your opinion?
MR. DELBAUM: Objection.
A. That I think it was appropriate.
Q. And what is the basis for that?

MR. DELBAUM: Objection.

A. I think mine is based on my judgment of that situation. If a patient has a significant amount of pain, then they need to be re-explored. If they have a significant amount of swelling -- and I have seen a significant amount of swelling after blepharoplasties -- and you treat it with cold compresses, and a tincture of time, then it resolves on its own.

Q. With respect to Mrs. Golden's complaints of nerve problems, do you have an opinion to a reasonable degree of medical probability whether the surgeries performed by Dr. Levine caused any nerve problems that she claims to experience today?

First of all, do you have an opinion?

A. Yes, I have an opinion.

Q. And what is that opinion?

A. That I do not think that the nerve problems that she had were the result of the blepharoplasty that was performed.

Q. Do you have an opinion to a reasonable degree of medical probability whether it was related to the revision of the ectropion that was performed one month later?

First of all, do you have an opinion?

A. Yes, I have an opinion.
Q. And what is your opinion?
A. That it is not related to the second surgery, either.
Q. And why is it that you feel that those nerve complaints are unrelated to her surgeries?
A. When the blepharoplasty was performed, there was no dissection down below the infraorbital rim, the swelling may have gone down below the infraorbital rim, and if she were going to have swelling that was going -- that would cause nerve problems, it would almost always be immediate.
Q. What would be almost immediate?
A. The first symptom that she probably would have had, if it was immediate, is numbness in the distribution of the infraorbital nerve.
Q. Were there any complaints of numbness in that distribution immediately postop?
A. Not any that I was able to ascertain in the notes that I reviewed.
Q. What would you expect in terms of the nerve being severed or cut during the surgical procedure?
A. Again, if it had been severed, the symptoms would have -- the onset would have been immediate.
Q. What about scar formation causing nerve

problems in the infraorbital nerve?

A. I really think that it is highly unlikely that that would occur, and if it were going to occur, it probably would have occurred within the first three to four weeks after surgery.

Q. And why do you think that it is highly unlikely that it would occur?

A. That the scar tissue?

Q. Certainly.

A. First of all, the dissection did not go below the infraorbital rim; secondly, when there is swelling, that doesn't necessarily -- it sets up an inflammatory reaction, and if it were going to do that, it would have done it immediately, the swelling, and then subsequently the scar tissue would also -- the symptoms probably would have occurred within the first three to four weeks.

Q. Have you, yourself, ever heard of or seen a case where there was an injury to a peripheral branch or twig of the infraorbital nerve producing symptoms throughout all three divisions of the trigeminal nerve?

MR. DELBAUM: Objection.

A. No, I have not.

MR. DAPORE: Thank you, Dr. Blanchard.

I have nothing further.

THE WITNESS: You are welcome.

CROSS EXAMINATION

BY MR. DELBAUM:

Q. Dr. Blanchard, my name is Charles Delbaum. As you may recall, we met a while back.

A. *Yes.*

Q. And it is my privilege to ask you some questions now, also.

First, I would like to ask you about Dr. Moon, the physician that Mr. Dapore asked you about, also.

Can you tell me whether you followed his career since the time that you and he were at the Cleveland Clinic at overlapping times?

A. I have followed it from a distance, so therefore I know what he is doing, and where he is now, for example.

Q. Do you know where he was in 1987?

A. I believe he was at the Cleveland Clinic.

Q. And do you know what he was doing there?

A. He was doing plastic and reconstructive surgery.

Q. He was no longer a resident at that time?

A, Correct.

Q Has was on the staff of the Clevelano Clinic?
A Correct.
Q Now you have inoicateo that you are Boaro certifieo in plastic ano reconstructive surgery
A Yes
Q You are not an examiner for Boaro certification for other plastic or reconstructive surgeons, are you?
A No, I am not.
Q That is consioereo an honor is it not?
A Yes
Q You have also inoicateo on oirect examination that you have performeo more ano more blepharoplasties as the years go by ano as your practice grows.

Am I correct in unoerstanoing that more ano more women in our country are interesteo in having blepharoplasties on their eyes?
A I think that is correct
Q Now, I woulo like to direct your attention to some of the questions about hematomas and how to hanole them.

Isn't it true ooctor that if a patient has an excessive amount of swelling from a hematoma while still in the recovery room after a

blepharoplasty, then the hematoma should be promptly evacuated?

A. Yes, 1 do.

Q. And in general, it is good practice to evacuate localized hematomas which appear postoperatively after a blepharoplasty?

A. May I answer that with qualifying my answer?

Q. You certainly may.

A. I think that if a hematoma, in my judgment, needs to be evacuated, if I have examined the patient, then I would do that.

I cannot speak in generalities. I am only speaking from the fact that if in my own judgment, I thought that they should be evacuated, then I would do it. You have to be there to make that judgment.

Excuse me.

(Thereupon, a discussion was had off the record.)

BY MR. DELBAUM:

Q. Specifically with respect to a localized hematoma which appears postoperatively after a blepharoplasty, would it not be good practice to evacuate that localized hematoma?

A. I don't think I understand what you mean by localized.

Q. One that is contained within a relatively small area?

A. I think that depends on whether or not you think it is a hematoma.

Q. If you do think it is a hematoma, then it would be appropriate to evacuate it?

A. Possibly, possibly. Swelling can cause bruising, can cause a hematoma, so it is difficult for me to answer precisely yes or no. I would have to say it would depend on the situation at hand.

Q. Would you agree with me that Goldwyn's work on Unfavorable Result in Plastic Surgery is an authoritative and reliable text?

A. Yes.

Q. According to that text, "localized hematomas noticed in the postoperative period should be evacuated," and that sentence is in a discussion of blepharoplasties.

MR. DAPORE: Objection.

Let her see the article that you are referring to so she can read it, please.

MR. DELBAUM: Certainly.

(Thereupon, the document was handed to the witness.)

Q. (Continuing) The beginning of the chapter,

Doctor, is on the second page of that photocopy, and it is at page 484, I believe, the sentence that I just read to you.

A. Are generally --

Q. It is on the next page.

A. Oh, I am sorry.

Q. That is okay.

A. I had the wrong page.

Q. That is all right.

Marked in blue, on the left.

A. Correct, and I agree with that.

Q. Okay.

A. If, in my opinion, I thought it needed to be -- that is what I am saying, I can't speak in generalities. Certainly I think that is true.

Q. That statement is general?

A. Yes.

Q. And the reason for evacuating the hematoma promptly, in your judgment, if that is what is necessary, is because waiting to evacuate it can cause injury to the patient?

A. It may cause injury to the patient.

Q. For example, once you get a hematoma, it starts to dissect or move through tissues and can set up an inflammatory reaction?

A. Correct.

Q. Once it does that, it is more difficult to remove it?

A. Correct.

Q. And the reason that that sort of dissection or moving through tissues can occur is because of gravity or drainage from the operative site; is that correct?

A. Correct.

Q. Usually that drifting downward from the operative field doesn't occur the same day as the hematoma itself appears?

A. Correct.

Q. So if the hematoma is evacuated promptly in the recovery room, then the downward drift of blood products would be minimized?

A. Correct.

Q. Now, the inflammatory reaction to the blood from the hematoma dissecting through the tissues results in scarring in the area; isn't that true?

A. It can, yes.

Q. And that scarring would also be minimized if the hematoma was evacuated promptly?

A. Correct.

Q. Is it also considered good practice to keep

the patient in the hospital overnight if you are worried about swelling following a blepharoplasty?

A. I can't answer that yes or no. I think it is an individual judgment, and I think if someone had -- I think it is individual judgment, and what the symptoms of the patient are.

Q. But if you were worried about the swelling --

A. Of course I would.

Q. -- then the surgeon should keep the patient in the hospital overnight, shouldn't he?

A. Yes.

Q. I would like to show you a photograph, and I apologize if there is a lot of rumbling on the tape of this deposition.

Showing you what has previously been marked as Exhibit 1-B, and I will ask you to assume that that is a photograph of Marcia Golden which was taken in mid-July, 1987, would you agree with me that she appears to still have some swelling under her left eye in that photograph?

A. That is correct.

Q. And the swelling that she had -- if she had swelling postoperatively -- I am sorry, let me start that question again.

The swelling that she had postoperatively,

whether it was significant or insignificant, was at least enough so that it extended down to the area of her upper cheekbone?

A. Correct.

Q. Thank you, Doctor. That is all I have on that photograph.

Would you also agree with me that Marcia Colden's ectropion was caused by the postoperative swelling under her eye?

A. And scar tissue, yes.

Q. Am I correct that postoperative complications from blepharoplasties are rare?

A. Relatively, yes.

Q. And most people who have blepharoplasties don't get ectropions?

A. That is correct.

Q. Some of the people who do get ectropions get them because a surgeon removed too much skin?

A. That is correct.

Q. That is not the reason Mrs. Golden got one?

A. I can make the assumption that it is not.

Q. So if complications from blepharoplasties are rare, and ectropions sometimes are caused by something other than postoperative swelling, it would be a reasonable assumption that ectropions

from postoperative swelling following a blepharoplasty are very rare?

A. I don't think very rare. I think they occur with more frequency than blindness, and that is very rare. So I think there are some people who have a transient ectropion secondary to swelling, and it usually resolves itself.

Q. Mrs. Golden's ectropion was not transient, was it?

A. Correct.

Q. So that a non-transient ectropion secondary to postoperative swelling is very rare?

A. Correct.

Q. Am I correct in understanding that the scarring which Dr. Levine found under Marcia Colden's left eye when he did the repair surgery on July 22nd, 1987 could have resulted from a hematoma?

A. And scar tissue, yes, it could have.

Q. Now, there was some discussion during your earlier testimony regarding the infraorbital nerve.

Am I correct in understanding that some of the fibers of the infraorbital nerve go up from the place where it exits the skull, which is known as the infraorbital foramen, towards the eye?

A. It may, yes.

Q. When you say it may, do you mean in some people --

A. It may not.

Q. -- it does, and some people it doesn't.

A. Correct there are always anomalies.

Q. In most people it does, though?

A. They have a few -- yes, but the major distribution is inferior to that.

Q. Are you familiar with Frank Netter's work as a physician and illustrator?

A. The an -- excuse me.

Q. The anatomical drawings?

A. Yes.

Q. By Dr. Netter?

A. Yes.

Q. Okay.

Have you ever seen any drawings by Dr. Netter that were anatomically incorrect?

A. No, but there are always exceptions to every rule, that is all I am saying. I wasn't --

Q. There are branches, or small branches, at least, of the infraorbital nerve which are in the area where this surgery was performed, the blepharoplasty; is that correct?

Yes, from that standpoint.

Q. And referring you again to Exhibit 1-B, the large photograph of Mrs. Golden, is it your opinion to a reasonable degree of medical certainty that Mrs. Golden could have had some swelling in the vicinity of the infraorbital nerve?

A. Yes, I think she could here, but I also think she could here, because she has ecchymosis on the other side, as well (indicating).

Q. Would you agree with me that pressure caused

cause sensory neuropathy?

A. If it is significant enough.

Q. If you need to explain your answer, Doctor, you may do that.

A. Well, in other words, if you look at the amount of swelling that she has, most of the swelling that she has is above the infraorbital rim. Down here (indicating), she is swollen, but she is also swollen over there (indicating).

Q. And is it also true that pressure from scar tissue or blood infiltration on a nerve, if it is significant enough, can cause neuralgia?

A. Yes, but if it were going to do that, it would do that in the immediate postop period.

Q. Or within several weeks?

A. Correct.

Q. Thank you. Sorry to have you keep holding it.

Am I correct in understanding that you do not like to testify against doctors in the Cleveland area?

A. That is correct.

Q. And you don't think it is a good idea, to do that?

A. Yes, yes.

Q. So if I came to you and asked you to look at a plastic surgery case where I was investigating whether the surgeon was or was not negligent, you would not consider testifying in that case once you learned that the potential defendant was a doctor in the Cleveland area?

A. I probably would not.

Q. However, you do recognize that in some instances, a physician's bad judgment or inattention can cause him to do something which is below the standard of care for physicians treating similar problems?

A. Certainly.

MR. DELBXUM: Thank you, Doctor.

I don't have any other questions.

MR. DAPORE: A couple of questions for you, Dr. Blanchard.

REDIRECT EXAMINATION

BY MR. DAPORE:

Q. If you were asked to review a case against a local physician, and you did review that case and found that the physician had been negligent in his or **her** care of that patient, would you render such an opinion?

A. Of course I would. Of course I would, and I have.

Q. Physicians in this community --

A. Yes.

Q. -- or the greater Cleveland area?

A. Greater Cleveland area.

Q. In the questions regarding blood infiltration and scar formation causing neuralgia type pain, you indicated that it would be immediate to several weeks before -- or within which you would expect the symptoms to occur; is that correct?

A. That is correct.

Q. And by several weeks, you are referring to what time period?

A. Maybe three or four weeks, but I have never seen symptoms related to the nerve in that kind of

surgery, and normally -- excuse me -- if they occur, they occur immediately, and then they resolve over a period of time.

MR. DELBAUM: Objection.

Move to strike.

Q. Is there any evidence in this case that Mrs. Golden had scar formation anywhere than except immediately in the eyelid?

A. There is no indication.

Q. And you indicated that if there was a significant hematoma evidenced in a recovery room, or if it was severe and evidenced in a recovery room, it should be evacuated.

Why would you evacuate it in that circumstance?

A. Because usually if you are going to see a hematoma in the recovery room, it is going to be an expanding one, you will have drainage from the area. It is just something that if you see that, then it has to be your judgment as to whether or not you are going to do that.

Q. And because it may be an expanding hematoma, what is your concern for that patient?

A. That they will eventually -- it will increase the intraocular pressure enough to cause damage to

the nerve, and visual disturbances.

Q. And when you say damage to the nerve, which nerve are you referring to?

A. The optic nerve, intra -- the optic nerve.

Q. And if that is damaged, what happens to the patient?

A. Then there is a potential for blindness.

MR. DAPORE: I have nothing further.

MR. DELBAUM: Dr. Blanchard, just, I think, two or three more questions.

RECROSS EXAMINATION

BY MR. DELBAUM:

Q. You were not asked by me to review this case: is that correct? I would just like the record to be clear about that.

MR. DAPORE: Objection. That is outside the scope of redirect.

Q. (Continuing) I am sorry, let me repeat the question. Mr. Dapore can certainly repeat his objection.

You were not asked by me to review this case, were you?

MR. DAPORE: Objection, outside the scope of redirect.

A. No, I was not.

Q Just one question or series of questions about the scarring location which Mr Dapore asked you about

He asked you whether there was any evidence that there was scarring near the infraorbital nerve, and you indicated there wasn't?

A. Correct.

Q. There is also no direct evidence that there is no scarring near the infraorbital nerve, isn't that correct?

MR APORE: Objection to the form of the question.

A. I am not sure I understand the question

Q. I will certainly try to clarify it for you

What I am asking you is that by direct evidence, in my question, what I mean is there is no evidence by reason of surgery having been done in the area so that somebody looked in that area there is no evidence by reason of x-rays, or any other kind of technique, or any injections, or anything along those lines that indicates that there is not scarring from this surgery near the infraorbital nerve?

MR. DAPORE: Objection.

A Yes, correct

Q. But there is, as the photograph shows, evidence of swelling and blood products in the area of the infraorbital nerve?

A. As it is on both sides.

Q. I understand.

But what I said is correct, too?

A. Yes.

MR. DELBAUM: Fine.

Thank you very much, Doctor.

MR. DAPORE: You have the right to review the videotape now, while the court reporter and video camera recorder are here, to review it for accuracy. You must do that right now, if you are going to do so.

Otherwise, you can waive your right to do so, and having had these gentlemen before, at videotape depositions, you can safely waive your right to do so.

THE WITNESS: I shall do that.

MR. DAPORE: You also have the right to review the written transcript of these proceedings to insure its accuracy. Again, you may waive your right to do so.

Having worked with Miss Gantverg in the past, you can feel safe in waiving your

right to review the transcript.

THE WITNESS: I shall do that, as well.

MR. DAPORE: Chuck, waiver of filing?

MR. DELBAUM: Certainly.

- - -

(DEPOSITION CONCLUDED)

(SIGNATURE WAIVED)

- - -

CERTIFICATE

State of Ohio,)
) SS:
County of Cuyahoga.)

I, Ivy J. Gantverg, Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the above-named JANET BLANCHARD, M.D., was by me first duly sworn to testify to the truth, the whole truth, and nothing but the truth in the cause aforesaid; that the deposition as above set forth was reduced to writing by me, by means of stenotype, and was later transcribed into typewriting under my direction by computer-aided transcription; that I am not a relative or attorney of either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office at Cleveland, Ohio, this 25th day of October, 1989.

Ivy J. Gantverg, Notary Public
in and for the State of Ohio.
Registered Professional Reporter.
My commission expires September 13, 1993.

LAWYER'S NOTES

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