IN THE COURT OF COMMON PLEAS

OF CUYAHOGA COUNTY, OHIO

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MARY LOU ZIMMERMAN,
et al.,

Plaintiffs,

vs. Case No.

THE CLEVELAND CLINIC 399411
FOUNDATION, et al.

Defendants.

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Deposition of JOHN P. CONOMY, M.D., called for examination under the statute, taken before me, Kimberly K. Hargis, RPR, a Notary Public in and for the State of Ohio, at the offices of Linton & Hirshman, 700 West St. Clair Avenue, Suite 300, Cleveland, Ohio, on Saturday, May 4, 2002 at 9:45 o'clock a.m.

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APPEARANCES:

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On behalf of the Plaintiffs:
Linton & Hirshman, by
ROBERT LINTON, ESQ.
700 West St. Clair Avenue
Suite 300
Cleveland, Ohio 44114
(216) 771-5800

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On behalf of the Defendants:
Reminger & Reminger Co.,
L.P.A., by
ALAN PARKER, ESQ.
113 St. Clair Avenue, N.E.
7th Floor
Cleveland, Ohio 44114
(216) 687-1311

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(Thereupon, Deposition Exhibits-1and2 were marked for identification.)

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JOHN CONOMY, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF JOHN CONOMY, M.D.

BY-MR.PARKER:

Q. Dr. Conomy, will you state your full name for the record?

A. My name is John Paul Conomy.

Q. And your professional address?

A. My professional address is 2709 Franklin Boulevard, Cleveland, 44113.

Q. And can you just outline for me what your current professional activities are?

A. Yes. I can give you an example of a typical week. I schedule

out patients on Mondays, Wednesdays and Fridays. Mondays and Wednesday are my regular patient load, and then I devote Fridays to new patients. This leaves Tuesday and Thursdays free to pursue a number of other activities. However, even though that's a schedule there's hardly a typical week largely because of the overflow of patients' needs.

In addition to those scheduled office days, which are full days, I see persons in a variety of other settings, hospitals, extended care facilities, occasionally nursing homes, on rare but happy occasions -- for me at least -- their own home.

This leaves additional time to pursue writing, seminar preparation, publications, and the occasional pursuit of issues such as we're involved in today.

Q. What is your medical specialty?

A. My medical specialty is neurology.

Q. And are you board certified in that field?

A. Yes, I am.

Q. Do you have any other board certifications?

A. I'm certified by the American Board of Forensic Medicine.

Q. And is that a -- what is the American Board of Forensic Medicine?

A. It's a recently recognized specialty board, and its aim is to provide board certification as the other medical and surgical specialties do for people who are involved in the preparation of and presentation of medical matters for purposes of the administration of justice in some way.

Q. Did you sit for a board certification examination?

A. It's partially sat and partially grandfathered. Now it does involve training and education and examination and attestation of proficiency, but it does not for persons who can show, at this point at least,

the formal residency.
Q. What is your professional training in forensic medicine?
A. I've been trained as I said in neurology and in neuropathology, and I've been involved throughout my career in the presentation of matters in courts and their extension largely as a function of the people I see, many of whom are injured.
Q. Have you had any formal training in forensic medicine?
A. Beyond what I've told you, no.
Q. Okay. It sounds to me as though the forensic medication -- forensic medicine in your case is largely something that you have acquired by way of experience as opposed to formal training?
A. The formal training consisted of law school. I certainly that would portend to that, although it's far more forensic than it is medical.
Q. Okay. What do forensic

medicine specialists do?
A. Basically as I've defined it they do, over a large number of specialties some of which are medical and some of which may not be, such as toxicology or dentistry, analyze material that is being prepared for some aspect of the administration of law.
Q. Do you hold yourself out as an expert in forensic medicine?
A. To the extent that it deals with neurology and with the nervous system, I do.
Q. Do you believe that anyone who holds certification in forensic medicine is say by definition an expert in forensic medicine?
A. No, not necessarily any more than a person with certification in anything is a specialist in some aspect of it.
Q. Are you board certified in any fields other than neurology and forensic medicine?
A. No, I'm not.

Q. Have you ever practiced neurosurgery?
A. No, I have not.
Q. Have you had any formal training in neurosurgery?
A. Formal training consisting of rotations throughout periods of training, yes, I have, but I don't hold myself out to be a neurosurgeon or a specialist in neurosurgery.
Q. Your rotations through neurosurgery, how many weeks or months or years would that be?
A. Oh, goodness, out of a period of training that was four years long, I would think that about four months of that was in neurosurgery rotations in medical school and, you know, association with neurosurgery after that, but let me emphasize again, I am not a neurosurgery.
Q. Have you ever performed any neurosurgical procedures?
A. I've certainly assisted at them, not only in capacity as a medical

student and medical and then neurological house officer, but in a former life when I was an operating room technician and laboratory assistant in neurosurgery I did, yes.
Q. Okay. In your practice in neurology in your current life, do you perform any neurosurgical procedures?
A. No, I don't.
Q. When did you last observe the performance of a neurological -- neurosurgical procedure?
A. Well, it was within the last year. It had to do with an exposure craniotomy of masses that were not known to be neoplastic or infectious. It was simply a bystander role.
Q. And was it of a patient of yours?
A. Yes.
Q. Have you ever performed cingulotomies?
A. No.
Q. Have you ever performed capsulotomies?

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A. No, I have not performed them myself.
Q. Have you ever performed any kind of stereotactic surgery?
A. I've not performed it myself. I've certainly assisted at the performance of such things.
Q. Okay. Would that have included the last procedure that you observed?
A. No, it would have included forms of leucotomy or lobotomy.
Q. Okay. When did you have that experience?
A. When I was about 18 years old.
Q. What were the circumstances?
A. I was employed by the Cleveland Clinic Foundation as an operating room technician. I worked for Dr. W. James Gardener, who did from time to time perform transorbital leucotomies in persons afflicted with a variety of mental disorders.
Q. And when are we talking

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about?
A. Well, I'd like you to think, Mr. Parker, that these were the good old days. They were before your embryonic start I would think in the -- when did I work there? Just before medical school, this would have been about 1959, 60, somewhere in that area.
Q. And for how long did you observe those procedures?
A. I worked in that capacity for a couple of years in one way or another.
Q. And I'm sorry, what were the procedures you told me? I wrote down one word, but I'm not sure it's what you said.
A. They were called transorbital leucotomies.
Q. All right. Have you ever performed limbic leucotomies?
A. No, I've never performed myself, I've never performed any psychosurgical procedure myself.
Q. Okay. What is the

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difference, if you could outline for us, between the specialty of neurology and neurosurgery?
A. If you can name 250 things that commonly go wrong with the nervous system, about 20 of them are diseases that lend themselves to surgical treatment. The drainage of blood clots, the drainage of abscesses, the treatment of certain tumors, and so forth. The rest of them are not amenable to surgical treatment. Those are the province of neurology, although there may be some surgical role in some and medical role in others. There's a great overlap say in the treatment of brain tumors. In the treatment of epilepsy there is some, treatment of Parkinson's disease there is some. But neurologists treat the other 200, 230 forms of illnesses. One is a medical and one is a surgical specialty, but these are highly complementary specialties and have been from the inception of both.
Q. I want to ask you, if you

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could, to outline the distinctions between the practice of psychiatry and neurology?
A. Again, there is a great deal of overlap there as well because the same organ that is responsible for the maintenance, the exercise, the stability of mood, of thought, and of behavior is also responsible for motility, strength, sensation, vision and the like. So that in the disorders that one might see as a psychiatrist and neurologist as well as a neurosurgeon, the overlap at times is quite great.
Q. All right. Do you practice psychiatry?
A. I'm trained in psychiatry. I don't practice it as a formal sort of thing. I mean to tell you that anyone who deals with the nervous system practices some kind of psychiatry, whether it's conscious or not. And I do.
Q. Okay. Are there patients that you treat that you refer to

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psychiatrists?
A. Yes.
Q. Can you give me some general guidelines as to what kind of patient should be seeing a psychiatrist as opposed to having their care followed primarily by the neurologist?
A. Well, persons whose mental life is such that it's so distressful for one reason or another that it interferes with their ability to function, even in a marginally normal way as their role in life may dictate as a parent, a student, a child, an elderly person who might benefit from what psychiatry has to offer are referred to psychiatrists by me.
Q. Okay. Do you treat obsessive compulsive disorder?
A. I see people with obsessive compulsive disease. I don't see them because they have that disorder, but it happens that that's the way it is. They may have that as a concomitant illness to some other illness. It may

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be that certain people with compulsions are thought to have neurologic disease an some of them do.
Q. And I guess what I'm trying to understand is that you may see patients with any number of medical or psychiatric conditions yet not be the primary treater for those conditions. Are you -- do you typically treat patients for obsessive compulsive disorder?
A. I don't treat them for it. I see patients with it who may have some neurologic disturbance in association with it or as part of that disease. I'm really thinking of people with Tourette's syndrome, of which I follow several.
Q. And typically what medical specialty would address itself to the treatment of obsessive compulsive disorder?
A. Psychiatry would.
Q. And to the extent that this case involves how Mrs. Zimmerman's

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obsessive compulsive disorder manifested itself and how it was treated, to what degree do you defer to psychiatrists and neurosurgeons as to those treatment decisions and the appropriateness of those treatment decisions?
A. Yeah, well, I would think that the appropriate treatment needs to be left in terms of drug treatment, psychotherapy, behavioral therapy, and the like to psychiatrists. When it comes, however, to the manipulation of brain substance, this transcends the bounds of psychiatry and enters the province of other persons including neurology.
Q. Okay. Does that province also include neurosurgery?
A. Yes, it does.
Q. All right. I've been provided a couple of reports from you. I'm going to show you what has been marked as Exhibit 1 to your deposition. Can you tell me what that is?
A. Yes, this is a report dated

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December 27th, sent to Mr. Linton regarding Mary Lou Zimmerman. It was done after what you may have as Exhibit 2, which was a report of history and physical examination of Mrs. Zimmerman done by me on the 13th of October, 2000.
Q. Okay. And you have thus identified Exhibit 2 as a report of a physical examination; is that correct?
A. Yes.
Q. Have you prepared any other reports in connection with this litigation?
A. No.
Q. Directing your attention to Exhibit 1, were there any drafts of this report?
A. No, there are no drafts of this. It's done on computer, so that as I -- and it's done by me, so as it's being done, it's revised for spelling and content and so forth, but there's not another version of this hanging out someplace.

Q. Before Exhibit 1 was finalized in its current version, was it circulated to anyone?
A. No, sir, it was not.
Q. With respect to Exhibit 2, are there any other drafts of Exhibit 2 that exist?
A. None.
Q. And before it was finalized in the form that's represented by Exhibit 2, was it circulated to anyone other than yourself?
A. No, it was not. It was double spaced, corrected for spelling and composition, and then finalized and signed by me.
Q. Okay. Do these two reports fairly address the subject matters that you anticipate testifying to in this case?
A. Well, not in a confining way. I think they state the broad outlines of my opinions in the matter, and I continue to hold them. They also, particularly Exhibit 1, open the

door to a number of other issues that aren't fully fleshed out in that report.
Q. Okay. I take it from my review of this, of these reports, that you are critical of the standard of care exercised in the care and treatment of Mrs. Zimmerman at the Cleveland Clinic?
A. Yes.
Q. Can you tell me please in what respects you believe the standard of care was breached?
A. In the following way: I believe that the treatment that Mrs. Zimmerman was subjected to and received at the Cleveland Clinic Foundation, while well intended, was procedurally defective in the following ways: First, that the analysis of her situation was not done in a comprehensive and systematic manner by people expert in what ailed her.
Secondly, she was subjected to a form of innovative therapy done in a combinational way, in a unique sense, the outcome of which was

not known. Hence, it constituted an investigative procedure.
The third point flows from this. Had it been identified as that, as it should have been, then institutional guidance, heightened standards of review, and in particular an assiduous application of developments of the doctrine of informed consent would have been carried out. So I think that these things are missing elements in the approach to her.
Q. Let me see if I have heard your criticisms fairly. I've heard you tell me about three categories of problems that you see in terms of standard of care. First category I heard you discuss was that Mrs. Zimmerman's analysis was not comprehensive and systematically performed by people with the expertise to perform the evaluation?
A. That's correct.
Q. The second area I've heard of criticism is that the treatment that

was rendered was innovative therapy performed in the unique way with an unknown outcome, thus putting it in the category of an investigative procedure?
A. Correct.
Q. And the third thing that I heard from you maybe flows from the second one, and that is that the procedure should have been subjected to heightened standards of review including a heightened requirement for informed consent?
A. That's correct.
Q. Is that a fair statement of the standard of care opinions you hold?
A. Yes.
Q. And are there any other standard of care opinions that you anticipate testifying to?
A. I think what else I may have to tell you are a derivative of those things.
Q. Did Mrs. Zimmerman suffer from obsessive compulsive disorder?
A. Yes.

Q. And was it refractory?
A. That point is less clear. Certainly she suffered from this for a very long time. Certainly it was impairing her ability to function in her ordinary life role. Certainly it had a telling effect and a negative one on her own happiness, her own situation in life and that of those around her, particularly her husband.
Having said all of that, and in spite of the I think it's about 70 pounds of records that I've been privileged to see, there had been efforts at treatment over time, some have been sustained and some have not been sustained. The one element of treatment -- of comprehensive systematic treatment that has not been sustained, or at least I have very little record of it, is behavioral modification. I know that to be a major form of therapy in the treatment of obsessive compulsive disorder or obsessive compulsive disease. It seems to be a missing

piece. Again in spite of the length of treatment, a large number of treaters, and a serious mental illness, the notion of comprehensive systematic treatment is not closed. I think it's open and a large piece of it does not seem to be there.
Q. Did you have any understanding as to why behavior modification was not a substantial course of treatment for her?
A. No, I don't. Don't at all.
Q. Do you have any impressions as to whether it was attempted with her?
A. I think there are a couple notes about it. I don't remember which doctor is responsible. I have no notion of its content, it's duration, or its effect.
Q. Okay. Is there any other kind of treatment that you feel perhaps should have been explored in greater depth before she was referred for psychosurgery?
A. Yes, and it's what I would

offer to you in this respect. While she's been treated with a number of drugs and combination of drugs over time, a careful, ad seriatim controlled experience with drugs, particularly more lately appearing drugs, could have been systematically carried out.
Q. What medications are you referring to?
A. I'm referring to specifically to a variety of serotonin uptake inhibitors, certain anticonvulsants, and certain other psychotropic agents, of which there are a very large number.
Q. Which ones do you think were most indicated as a trial for this patient?
A. I think she's probably received many that are indicated. In what combination and with what sequence is the issue rather than the names of the drugs. She's received I'm sure more drugs than I can remember to tell you about.
Q. Well, are you going to be

testifying that a particular course of action along these lines should have been undertaken?
A. Not particular drugs. My point is that under the guidance of informed people, a systematic approach to the use of single and multiple drug -- combinations of various drugs needs to be carried out over sufficient time to really judge their adequacy. This does not name specific drugs, of which there are probably 20 or 30.
Q. Okay. Were there any other sustained courses of treatment that were available to her that you believe should have been attempted?
A. Well, she did have treatment sustained over time, whether it's sustained in sufficient intensity and in proper combinations are questions that I would have. They're not definitely answered from the record.
Q. Are you critical of Dr. Donley's referral of she and her family to the Cleveland Clinic?

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A. No, I'm not.
Q. Do you believe that Dr. Donley should have undertaken more sustained courses of treatment for her?
A. Well, no, I think that Dr. Donley did what Dr. Donley could do. And he was looking for additional expertise and help in taking care of her. He went to the Internet to find out about it.
Q. How long had Mrs. Zimmerman suffered with obsessive compulsive disorder?
A. I think elements are mentioned in her early adult life. When this really started, I don't know. There's variable expressions in the chart about when it might have been.
Q. I often see reference to about a 30-year history. Does that seem reasonable?
A. Again, that's I think a fair surmise. Whether it began one day when she was shaving her legs as it said occurred, I don't know. There may have

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been elements -- there frequently are -- going back to much earlier in life.
Q. What was your impression as to how disabling obsessive compulsive disorder was for her?
A. At times it was very disabling. It didn't permit her to leave her own home, and it didn't permit her to actually have the freedom of her own home. Largely it had to do with germs and her relationship to the potential presence of dirt or germs.
Q. Do you have an understanding as to when she was last employed?
A. No, I don't.
Q. Do you have an understanding of whether she was employed at the time that she ultimately sought treatment from the Cleveland Clinic?
A. No, I don't.
Q. Do you have any impression as to whether she was employable in the last year or two before her coming to the Cleveland Clinic?
MR. LINTON: Objection.

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You may answer.
A. I really don't know. I surmise not, but it's simply a surmise. I don't have facts to back up that notion.
Q. In addition to the obsessive compulsive disorder being at times quite disabling for her lifestyle, did she suffer any other psychiatric or psychological problems?
A. Epilepsy is not a psychological problem, although it may be at the root of some. She has a history of a seizure disorder. Not a severe one. Evidently well controlled. Beyond that she wasn't, as I recall, an unhealthy lady.
Q. Did you notice any bouts of depression?
A. Well, depression is certainly a part of her disorder. At times depression is very hard to get at in persons with obsessive compulsive disease. It's there very often and I think that it kind of ripples through

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this. It's, if I can say, it's axiomatic in persons with obsessive compulsive disease that depression is a cyclic and at times major element, and it's tied up in the kind of self loathing people with obsessive compulsive disease do. Their image of themselves and their insight. They frequently have symptoms that not only disable them, but damage others around them. So depression is a concomitant and very at times very major element of obsessive compulsive disease.
Q. Was it for her?
A. Again, it's hard to say. It's threaded through her record. There is the focus at least in the record about her compulsive behavior rather than the depressive element, but there's certainly evidence of it in the -- in these lengthy records as well.
Q. Did you note whether there was any history of suicidal ideations or suicidal attempts?
A. Both.

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MR. LINTON: At any time? You're talking about any time in her history?

MR. PARKER: Yes.

A. Yes, I think there were both. There's a record of nihilistic thinking, of rumination. I think there were acts as well involving pills and threats of cutting, so forth.

Q. How significant was that in terms of the severity of this woman's disorder?

A. Well, it's a, you know, a threat against one's life is a cry for help in her as well as it is in anyone that has such ideas and who will even attempt such acts. It's a serious problem, yes.

Q. Okay. In your report that was identified as Exhibit 1, the December 27, 2001 report, you list materials that were reviewed prior to generating this report?

A. Yes.

Q. Is that a comprehensive list

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of materials that you reviewed?

A. Yes, I believe it is. I'm trying to think if there's been any additional things since. I did see a deposition from Dr. Lichtin. And as far as I can recall the other things are here. I did see a report from Dr. Gildenberg. Is that here? And depositions from Dr. Jenike, Dr. Rees Cosgrove.

MR. LINTON: You mean reports?

THE WITNESS: Reports, yes, not depositions, reports and CVs.

Q. Have you reviewed any reports or depositions of infectious disease experts in this?

MR. LINTON: Pozanski.

A. Yes.

Q. Did you review a report of Dr. Pasansky or deposition of Dr. Pozanski?

A. A report of Dr. Pozanski.

Q. Will you be addressing any issues as to the treatment of the

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infection that she developed?

A. Depends on what you have to ask me. Treatment of brain infections is part of neurology as well as other specialties, but, you know, I don't know what you might have in mind.

Q. What I'm most concerned with is whether or not you have any criticisms of the standard of care employed in the treatment of the infection.

A. No, I know there are infectious disease experts involved and I would think that's sufficient. But am I somewhat knowledgeable about brain infections, yes, I am.

Q. Do you anticipate expressing opinions with regard to the source of the organisms that infected Mrs. Zimmerman, or do you think that falls more predominantly into the sphere of the infectious disease specialists who will be testifying?

A. I think it falls more specifically under their sphere, but I

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can't anticipate what you may or may not ask me. I don't know.

Q. Okay. Do you treat brain abscesses?

A. Yes, I take care of patients with brain abscesses, but I can tell you it's never a solitary act nor is it for anyone. It usually involves neurology, neurosurgery, infectious disease, and frequently other specialties because it's a very serious illness.

Q. Okay. Going back to any additional materials that you have reviewed, is there any other that you haven't already disclosed to me?

A. I don't think so. I've got the largest suitcase I could find here with everything in it. I don't -- again, I don't think so, but again there's so much there that if you were to ask me about a specific piece of paper on a specific day, I think this list and what I've told you is pretty comprehensive about what I've reviewed.

Q. What I'm going to do is take

about a five or maybe ten-minute break, take a look briefly at your files and see if I have follow-up questions as to the specific materials.

A. Mr. Parker, if you can review that stuff in five or ten minutes then you have a mind that operates faster than the speed of light. With what efficiency, I don't know. And I will tell you, Mr. Parker, that I made one yellow mark in one chart in one of those volumes on one part of one piece of paper.

MR. LINTON: Your task is to find it.

Q. I was about to say, if that's the case, if you can tell me that document or find it, it may be less than five or ten minutes.

A. I plead amnesia.

MR. PARKER: Let's take a break.

(Recess had.)

BY MR. PARKER:

Q. I think we did this in about

ten minutes, but I don't pretend to have read these.

A. I'll pretend to have read them.

Q. Okay. I am interested in having you read some handwriting that I can't read.

A. Sure, absolutely.

Q. On an enclosure letter of March 26th, 2002, from Mr. Linton to you. In which defense expert reports of Dr. Cosgrove, Dr. Jenike and Dr. Pozanski were forwarded to you. You have some seven handwritten points and if you could simply read that into the record, I would appreciate it.

A. Yes, I'd be happy to. It calls upon my facility to read my own handwriting, which may be only slightly better than yours to read my handwriting.

There's a note to file on the top, which meant I'm putting it in a file. Then it says, Brain infection secondary to sepsis not likely, not sick

and multiple organisms. Then there's a parenthesis and the word nosocomial, meaning from the hospital. And I think that MCP, it does not signify male chauvinist pig, it's Mark C. Pozanski. I think it had to do with some relation to his report, and at this point I'm not sure exactly what.

The timing equals postop infection. That notion is mine. The timing and presentation connotes something that derived from the operative experience.

The number two point is what is experience GRC? That's GRC meaning Dr. Cosgrove and MP, Dr. Pozanski, with psychosurgery. The question is of tautology. To me, I'm aware of certainly Dr. Cosgrove's name and his writing from some of the literature in the subject, but it had to do with specificity. And I wasn't aware of Dr. Pozanski's experience with postoperative neurosurgical infections and frankly am still not.

Third point is, What is done in their own institution -- this means the Harvard system -- regarding Institutional Review Board or other review. And then I have parentheses, patient protection, because this is largely what those boards function in doing.

Number five, to Jenike, the preop review of Pozanski was piecemeal, incoordinative and effectually nonexistence. That comment is an opinion of mine.

Number six, J plays on benefit -- that probably means Jenike -- instead of the hazard of combined procedures.

Number seven, evaluation in, quote, their institution -- again this means the Harvard system -- as a coordinated effort. Those are the points.

Q. Okay. Your first point in which you write brain infection secondary to sepsis not likely, not

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secondary, multiple organisms, what do you mean by that?

A. Do you want me to take that whole comment, because it should really all flow together and you read only a part of it.

Q. Go ahead.

A. Brain infection secondary to sepsis not likely, not sick, multiple organisms nosocomial, and then the initials MCP.

Timing is that of a postoperative infection. Persons who develop brain infections as a result of systemic infections have a source outside of the nervous system for that infection. Those infections frequently involve the heart valves, the urinary tract, at times the gastrointestinal tract or lungs. Less -- very uncommonly the skin. But they are sick because prior to the institution of a focal brain infection, they've got an infectious source and infection in their bloodstream. These are metastatic

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infections, if you will.

If you look at persons with severe urosepsis or say a heart valve infection and subacute bacterial endocarditis or acute bacterial endocarditis, for instance, these persons are very, very sick before they develop a brain abscess.

Persons with a primary brain abscess, meaning it started this, don't show this prodromal illness which is characteristically severe. The timing in which this -- the evidence for this evolved certainly within a couple weeks after the surgical procedure was identified point to a period of smoldering or incubation, if you will, in which infectious organism came to prey largely upon dead brain tissue. In the site of the lesions in which brain tissue was destroyed or extirpated in the course of the attempted correction of her psychopathy.

Nosocomial means that these organisms have originated in the

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hospital and not out on the street. Klebsiella infection walking in from the street can occur, but they occur in people with immunodeficiency problems, with known sources of infection or in the hospital. They are organisms, Klebsiella particularly, that are far more likely to pervade the interstices of the hospital then they are say from somebody's home. Klebsiella comes from the intestinal tract, a fecal organism. It's an uncommon cause of an infection out on the streets if you will. Less -- not frequent, but less common in hospitals as well.

Staph organism infections are problematic in hospitals. They may occur on the skin of anyone, patient, care giver, surgeon, whoever. So they are the kinds of things that occur in hospitals rather than de novo infections that somebody is likely to pick up in their home.

She is infected with both organisms, which makes anyplace other

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than the hospital in my opinion unlikely. And the timing points to the time around surgery as the temporal connection for this problem.

Q. Let me ask you some follow-up on some of the issues you raised in that answer. Nosocomial infection means it's hospital related in some manner?

A. That's what it means.

Q. Does it mean that there was negligence or breach in the standard of care by the hospital?

A. It doesn't point to negligence per se.

Q. Okay. So a person can have a nosocomial infection. Doesn't mean it's the hospital's fault in the sense of negligence or breach of standard of care?

A. No. It certainly raises the issue, but there's nothing conclusory about the organism equals negligence, no.

Q. Okay. Let me ask this to

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see if I understand it. Is it true that brain abscess can be seeded or inoculated from bacteremia?
A. Yes, it can, but for the reason I've given you, I think it's very improbable here. In fact, I think it's very, very improbable.
Q. Okay. I understand. I'm just trying to understand that that can happen.
A. It's possible.
Q. All right. Is it true that following the surgery that Mrs. Zimmerman had, there would be necrotic tissue in her brain as part and parcel of the surgical procedure?
A. Yes, there is.
Q. Is Mrs. Zimmerman immunosuppressed following surgery?
A. Not in a general sense. The areas of surgery are immunosuppressed. There's dead tissue with no blood supply to them. That is absolute immunosuppression because there's no access to an in vivo type of immunologic

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response. There's only attack from the periphery.
Q Does she have any medications that would diminish her immunosuppressant abilities?
A. Not really. I suppose one can argue that this or that or the other drug has this or that effect, but in my opinion, no.
Q Okay. If I recall correctly, your second numbered point --
A. Yes, can I read it to you.
Q Sure.
A. What is the experience of Rees Cosgrove and Dr. Pozanski with psychosurgery.
Q All right. As you read these initially I numbered them wrong so I guess I'm still on your first point.
A. Sure.
Q I wanted to ask about -- may I see it for a minute. At the end of your first written point it says timing equals postop infection. Do you have an opinion as to whether or not

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the brain was inoculated with these organisms at the time of surgery or following surgery?
A. I think it's more likely to have occurred at the time of surgery, but that's just my opinion.
Q Okay. Is that a matter on which the infectious disease specialists perhaps is more appropriate for them, or is that something that that you anticipate testifying to at trial?
A. I anticipate saying not only if you ask me, I think it's more properly the province of infectious diseases people. You asked me my opinion and that's my opinion.
Q So I'm not surprised at the time of trial, tell me the basis for your opinion that it was more likely inoculated at the time of surgery.
A. First of all, I think infections tracked down from an external source are very, very uncommon. So I think there's that piece of it. The notion that these are organisms that are

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common in hospital acquired infections is another piece of it. Just didn't happen from somewhere else. And, you know, again I can't overlook devitalized dead tissue as an itis for organisms that somehow got put there. So having said that, I again would defer to people who have spent much more of their life studying infectious diseases than I have.
Q. Okay. Earlier you were kind enough to outline areas of breach of standard of care. I want to follow up on that. The first area you criticized had to do with the comprehensive and systematic analysis of this patient. What in your opinion needed to be in place in order to comprehensively systematically analyze this patient?
A. I can answer your question, but my answer to the question -- and I want to answer it that way -- does not include the set of circumstances and facts that would prompt the answer I'm giving you. Having said that, let me

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say that that system of analysis would have involved a comprehensive analysis among persons with special training, special interest, special knowledge of psychosurgery and the features surrounding it. Those would be certainly a review by persons in psychiatry, neurosurgery, neurology, psychology including testing, and others who have some expertise to offer regarding the appropriateness of an intended procedure with respect to the person about to undergo it who would do their own analytic piece and then would meet together to try to make some decision about how to proceed and whether to proceed.

Q. Are you telling me that one of each of those specialties would have to review?

A. I'm not being so specific that I would say that it must be this bunch of people all of the time. It would be a bunch of people, a group of people working together who have

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training, experience, and knowledge about such patients, such procedures, such outcomes, such risks, and so forth, who would work together in communication to do that kind of analysis and to judge safety and propriety for such a person.

Q. Would I be correct in understanding that your essential point is that a review be done by people with special interest and knowledge in the field of psychiatric surgery?

A. Who then communicate with each other, yes, who come up and determine a plan of how to proceed.

Q. Okay. If such a review had occurred in this case, would Mrs. Zimmerman have been a candidate for surgery?

A. I can't tell you what such a group of people may have decided. That's speculative depending on how that group would function and what they looked at as criteria, calling to mind that there are pieces not only analytic

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but advisory, and the advice they give is couched in what they know of risk and outcome and so forth.

You know, I would simply have to leave the question open. I can't tell you what a group of people may have thought. They may have picked up on the issue of a lack of sustained systematic measured treatment outcomes. They may have said, well, this could be the case. Let's make sure all of these things are done in a certain order and certain sequence and see where we stand and then revisit this problem. That is a frequent outcome of such analytic exercises. They may have said this woman already has a seizure disorder and such experience might pose a special risk. They may have said -- again I don't know -- that in spite of lucidity, of lack of cognitive impairment as she's said to have, her depression, her sense of self-loathing and her low self-esteem and self-worth are such that she's really not competent to make this

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decision. Let's look at what outcomes happen on treatment again.

It really leaves the field open. And I can tell you that these things can and do happen under circumstances of such analysis. Can I tell you that they might not have said yes, this is quite the thing to do, let's just go ahead now and do it? You know, that's a possibility as well, but not having undergone the exercise, not knowing the constitution of these people, not knowing what their own professional attitudes would be, I can't tell you what would have been said. I know it would have been more thoughtful, more careful, more systematic, and hence safer for her no matter what the decision would have been.

Q. But ultimately it's true, isn't it, that you don't know what the results or recommendations would have been if there'd been a systematic and comprehensive review?

A. For their piece of it, no.

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I don't know what her response to their recommendation and her family's response to their recommendations might have been either. This is a very complicated, time intensive, labor intensive kind of thing involving many people whose ultimate outcome I can't judge. You know, it is literally beyond speculation.

Q. By beyond speculation you mean highly speculative?

A. It's beyond my ability to speculate, but it's still speculation.

Q. Okay. The second criticism that you had earlier raised was that ultimately this was an investigative procedure?

A. Yes.

Q. I'm assuming -- correct me if I'm wrong -- I'm assuming that where that leads us in our discussion is that if it were an investigative procedure, then it should have been subject to the reviews of an Institutional Review Board; is that what you're getting at

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there --

A. Yes, it's getting at it, but again your question to me precludes the issue of why this is investigative at all.

Q. And I will ask about that later. Right now I'm simply trying to find out where that takes us.

A. Yes.

Q. If this is an investigative procedure, the consequence of that is Institutional Review Board supervision?

A. Not necessarily Institutional Review Board itself. There are other ways that institutions deal with this. The issue, however, becomes one of procedural justification and diminution of risk. The Institutional Review Board in most institutions is the best equipped body to do this and that's usually where the responsibility lies. But there may be special panels as well who bear in an institutional sense the same responsibility for that kind of review to say. To say it is always

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done by an Institutional Review Board is not quite correct, but it is the Institutional Review Board in most institutions which bears the responsibility for the regulation of such things within the walls of the institution.

Q. Okay. Will you be telling a jury that Mrs. Zimmerman's surgery should have been presented to the Institutional Review Board?

A. It should have been reported to the Institutional Review Board or some other board so constituted as to look into the issues of justification of safety.

Q. Okay. I'm going to spin off for a minute the concept of other boards and ask specifically whether or not this procedure in your opinion should have gone to an Institutional Review Board?

A. It should have gone to the Institutional Review Board or some board persons who are imbued by the institution, as part of the

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Institutional Review Board or not, with the responsibility to do just what I told you and that is to look into the issues of justification, of procedural fulfillment, and safety for persons undergoing an innovative procedure.

Q. I note that among the materials that you were provided for review was a portion of the Code of Federal Regulations, 45 CFR 46 and the Belmont Report?

A. Yes.

Q. Do you anticipate telling the jury that under the Code of Federal Regulations Mrs. Zimmerman's surgery should have been under the auspices of the Institutional Review Board?

A. The Code of Federal Regulations is problematic for two things. One is its length, and the other is the assumption that everybody knows what research is. The Code of Federal Regulations when they define research simply lift the definition out of the Oxford dictionary. That does not

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address the issues of what should be research. They say what is research, as if it's a factual thing that everybody understands all of the time. That's not the operation of the real world. My point rather is that what this woman underwent should have been designated an investigative procedure.

Q. Under 45 CFR 46, should Mrs. Zimmerman's surgery have been under the auspices of an Institutional Review Board?

A. Predicated on what I told you, yes. Whether it's the IRB or some derivative is not the issue, but it should have been something that garnered institutional oversight and protection.

Q. Does 45 CFR 46 establish the requirements of Institutional Review Boards and establish what is to go before the Institutional Review Board?

A. It establishes the procedural aspects of what Institutional Review Boards ought to do almost solely assuming that a decision has been made

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somehow that what is going on constitutes research. That is not just the job of the Institutional Review Board. That's a job of the Institutional Review Board or its designees, the institution, and the investigator, and to overlook any one of those elements is wrong.

Q. Does 45 CFR 46 define research?

A. Only in the sense that the Oxford dictionary does.

Q. Does it define research?

A. In that sense, yes. It defines what research is. It does not define what research should be and whether a person ought to bring this issue to the IRB itself. That's what we're talking about here, not whether they use the Oxford dictionary definition. They certainly did.

Q. It sounds to me like you disagree with the definition they used.

A. No, I don't disagree with the definition of research. It is what

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research is. But it does not say what in the mind of an investigator ought to constitute research that ought to come and should come and must come to an Institutional Review Board. It doesn't define that.

Q. Under the terms of research as defined by 45 CFR 46, do the regulations require that Mrs. Zimmerman's surgery be under the auspices of the Institutional Review Board?

A. In my opinion, yes. A correct reading of that fascicle of federal law means yes to me. That is my opinion.

Q. And what do you mean by a correct reading?

A. A correct review is this: It demands an analysis involving -- beginning with the investigator and then involving the institution as to whether or not someone is doing research. Without that you can't bring anything to anybody. So it becomes, I think, moot

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to define what research is if the notion never occurred to a person.

Q. Okay. And that takes us back -- I don't mean to belabor this, but it's an important point as you might well imagine -- it takes us back to whether or not the federal regulation has a definition of research. Does it?

A. Yes, it's the same as the Oxford dictionary, which is where they got it.

Q. And you apparently believe that that is too restrictive a definition of research?

A. No, it's a fine definition of research once you've know what research is. It does not tell you -- nowhere in the CFR does it say, investigator, here is what you should do under these circumstances. That's not what the CFR addresses. It assumes that you know what research is and that's what you're doing, and then spins out over thousands of pages certain qualifications and regulations as to

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what it is ought to be done. A good deal of it is given over to the function of Institutional Review Boards.

Q. What is research in your opinion?

A. Certainly I'd agree with the definition once you've established it. But how you get to the notion that you're doing research is not in that definition. That demands other tests.

Q. What is your definition of research?

A. Okay. I'm sure -- well, I don't know, but I can imagine you've been well educated in the course of these depositions as to this point, and I don't mean to be redundant. Forgive me if I am. It has to do with something, a concept that is called equipoise. And equipoise is something that is known say in the literature about ethics, I would think law in some respects, and about the principles governing the actions of investigative medicine or research. Laid out simply

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it's this: If one is employing a new drug, procedure, or technique, the outcome of which is in some sense unknown, outcome being benefit, outcome being risk, outcome being whatever you choose to have, that is clearly research or ought to be. It may be done for therapeutic benefit, but it has these other -- the unknown hanging off of it.

The other condition has to do with things that are known, but are being put to a new combination or a new use. The answer to effectiveness or risk or outcome, an honest answer in the mind of an investigator when asked what will this do, if an element to the answer is I don't know, then that triggers the kinds of protections and procedures that govern investigative medicine.

It's the latter that was done here. Questions that are asked about treatment to which the answer is I don't know or I can't find out or there's no experience, some form of I

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don't know, become the province of investigative medicine. They do this ethically and they certainly do it legally. Do they -- does this conform to a textbook definition of research? In the end it does, but not at the beginning. That kind of thinking, that kind of calculus needs to go on in the mind of an investigator first. Then if the answer is I don't know, that triggers the kind of procedures and safeties for patients that we've talked about.

How an institution chooses to spin this out doesn't need to be done just one way. I think the principles however of justification and safety are those that arise. Who is best prepared to do this? It's the Institutional Review Board, the ethics committee, a special constituted group.

Q. I want to see if I understand what you're telling me. Are you saying that if one poses the question what will the outcome of this

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procedure be, and the answer is I don't know, that that question and answer takes us into the field of research?

A. If, not -- I don't know is the answer to a lot of questions. If however you're using innovation to do this, a thing or combination of things which were not done either in that combination or for this purpose before, that's a predicate to I don't know. I don't know what will happen to you when you walk out the door to me. It has to do with something other than a general ignorance of the future. It has to do with ignorance of the outcome predicated on what it is you've posed.

Q. At what point does uncertainty as to outcome become so significant that a procedure falls under the term research?

A. If again you're using things that haven't been done before or using them in a combination for which there's no experience and the outcome is unknown, it's the predicate that matters

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here. Let's assume that, God forbid, you in the course of your travels are mauled and have severe bilateral acute subdural hematomas and need to be operated. I don't know what the outcome is going to be, but the treatment used to treat you with this is not innovative and not unknown. It's taking blood clots out of your head through a craniotomy. The predicate here is you're using a standard -- accepted standard for treating a terrible condition, the outcome of which is unknown. If, however, your condition is to be treated with immersion in ice cubes followed by surgery done through two little tubes in your ears, both of them standard treatments for certain things, that combination poses an unknown outcome and certainly risk to you, then that becomes investigative. What I've posed to you is not particularly a good idea. I mean, I don't mean to cite bad ideas as examples, but I don't think bad ideas

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should be examples. The issue is not the unknown quality of the outcome alone, it's the outcome related to the predicate you've proposed to get to the outcome at all.

Q. So the trauma physician that treats me in that horrible hypothetical is doing so under circumstances you would call research?

A. No, no, no, no. Only if he's using ice cubes and little tubes in your ears.

Q. Okay. That's what I'm getting at. If he's using ice cubes and little tubes in my ears, standard well accepted procedures in their own right, but if he's using it in that situation that's going to demand IRB?

A. It demands a heightened level of justification and when done in institutions who do this, whoever the institution designates, usually it's the IRB.

Q. Okay.

A. And somebody needs to inform

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you or the people around you that what we're doing here is not what's generally done. We don't know exactly what's going to happen. There's always an investigator bias. The general idea is, but we think it will help. And it may or may not help, but the honest answer in the mind of that investigator when you say what is the outcome of ice cubes and little tubes in the ears with respect to this condition, the answer is I don't know.

Q. Okay. In this case if Dr. Barnett's procedure had been submitted to an IRB, would the procedure have been performed?

A. It comes down a few steps in the line because we haven't talked about consent of her family to that.

Q. Let me ask a different question then that takes that out. If the -- I don't mean to cut you off, but you're absolutely right.

A. I'm getting hoarse from answering your questions, so hopefully

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at the end of your interlude a question will emerge.

Q. I hope so too. If the procedure that Dr. Barnett performed had been submitted to an Institutional Review Board, would the Institutional Review Board have prohibited the procedure?

A. I can tell you what I think it would have -- a duly constituted board of experts would have done. They would have developed criteria; they would have developed a procedure over time for analysis; they would have looked for exclusionary criteria; and they would have come with Dr. Barnett to creating a set of criteria or circumstances that needed to be fulfilled before the surgery would be carried out. That's -- I'm 100 percent certain that that would have been done.

Q. That would have to be done under the regulations?

A. It would have to be done under an ethical imperative about how to

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treat patients. That's what the regulations address. I want to make sure we're talking about which one is the horse and which one is the cart. The regulations are the cart. So that that would have certainly have been done. And Dr. Barnett working with the IRB or some duly constituted board, again I don't want to say this is only the IRB, if the IRB is what you have in place to deal with these things, fine, then it's the IRB. If the institution has created something else, then it's something else. It's the function that I address. There would have emerged from this a set of principles and criteria to be fulfilled before a person could be considered and during the course of intended surgery.

Q. Okay.

A. Had that been done, I don't think she would have had the surgery certainly at this time. And whether she would have had it at all, I don't know.

Q. Okay. So let's see if I'm

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hearing your opinion correctly. If Dr. Barnett's procedure that was ultimately done had been submitted to an IRB or some other duly constituted review board, it's your opinion that there would have been criteria and procedures developed, but is it true that ultimately you don't know whether she would have undergone the procedure or not? Let me say that differently. Ultimately you don't know whether or not the procedure would have been permitted to be performed?

A. I don't mean to be unresponsive to your question, but I don't want to miss another important piece here. That committee, whoever its name may be, let's call it the IRB, would have also developed a set of criteria for informed consent.

Q. Right.

A. About this.

Q. And I want to address that.

A. I again don't mean to preempt your question, but it's part of

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the procedure and what they do. Again, I don't pretend to know what exactly would have happened. I can tell you what I think would have probably happened. Had she and her family been appraised of the consequences, the possible consequences, possible in that they can and do happen, given that, given the holes in systematic analysis in spite of the length of her illness, I suspect there would have been great pause on her part and the part of her family to undergo this procedure. That is my opinion. But are there other potential outcomes, yes, there's an array of them that could have happened.

Q. Are you going to go so far as to say that she and her family would not have had the procedure or is that speculation?

A. I don't know how to answer it. I'd like to hear her family's answer and I don't know what they would have answered. I didn't ask them. I don't know what their answer would be.

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Had they known what they should have known, would they have then proceeded? I don't know.

Q. Okay. Before this case have you ever testified on the subject of surgeries for psychiatric conditions?

A. No, I never have. I've seen such patients. I've cared for such patients. I'm familiar with them, but I've never given testimony on this subject before.

Q. Your report, Exhibit 1, has as part of it kind of a brief synopsis of the history of various kinds of surgeries for psychiatric conditions.

A. Yes.

Q. I assume that that is review that you did for this case?

A. No, it's not. I've had a long history in human behavior and its connection to the structure and the function of the brain. It's one that I continue to exercise and I have really had a lifelong interest, far preceding my matriculation in medical school.

Q. Do you know Dr. Rawlings, the neurosurgery expert of the plaintiff in this case?
A. No.
Q. Have you reviewed his report?
A. I've not.
Q. Do you know the plaintiff's infectious disease expert, Dr. Kerr or Dr. Martinelli?
A. No.
Q. Do you know Dr. Martinelli?
A. Yes.
Q. Do you know Dr. Malone, Dr. Don Malone?
A. I've met him. Dr. Barnett I know well and I like, by the way, and like greatly.
Q. Is Dr. Barnett a physician of integrity in your opinion?
A. Yes, he is.
Q. Is there any doubt in your mind that his treatment was intended for and an attempt to help the patient?
A. Oh, no doubt. The intent is benevolent here.

- - - - -
(Thereupon, Deposition Exhibit-3 was marked for identification.)
- - - - -
Q. Showing you what's been marked as Exhibit 3, can you identify that please?
A. Yes, this is the course of my life, Mr. Parker.
Q. Your curriculum vitae, I think, is the fancy name for it?
A. But I didn't invent it. Some Roman did.
Q. Is it current?
A. Current as of January. I've revised it recently. There are some more publications, committee appointments, that sort of thing, but it's not been changed otherwise.
Q. Okay. And you were kind enough before the deposition to tell me where I can get the most recent version of your CV?
A. Yes, if you call Cynthia

Forte, F O R T E, she will send you one instantly through the magic of cyberspace.
MR. LINTON: Why don't we go ahead and have her send a copy to me and I'll provide you a copy.
MR. PARKER: That will be fine. I appreciate that.
THE WITNESS: I don't know if she's redone it.
MR. LINTON: You're not sure if it's actually available.
THE WITNESS: No, because it's not due to be redone until June, so I don't know if she's done it or not.
BY MR. PARKER:
Q. Have you published in the medical literature anything on cingulotomy?
A. No.
Q. Anything on capsulotomy?
A. No, not on those surgical procedures.
Q. Anything on subcaudate

tractotomy?
A. No, not on any psychosurgical procedure yet.
Q. Do you have plans to?
A. I don't know. This has been a stimulating case.
Q. What research have you performed to understand the neurosurgical issues in the case if any?
A. Well, you know, I don't want to be overly specific. I'm familiar with the surgical, psychologic, psychiatric and neurologic literature which is continuous. I mean, this stuff appears in all sorts of conference proceedings and in journals that I read. So there's plenty of it out there. And it's my own familiarity with the relationship between brain and behavior over the years. It's a long time --
Q. Do you know Dr. Peter Breggin?
A. I know the name. I know that Breggin has been one of the contributors to the area of

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psychosurgery and particularly the controversy that surrounded it not for 10 years or 20 years or 15 years or 60 years, whether it's 12 or 2,000 years, I don't know. This is a -- this is an area that attracts special attention and should because it's surgery with the end result that there's biological alteration on a person. It's not like gallbladder surgery or an amputated foot. Something that's serious and technically difficult and so forth. The effects are far different.

Q. Have you reviewed Dr. Breggin report in this case?

A. I have not.

Q. Have you reviewed his deposition testimony?

A. No, sir, I've not.

Q. Dr. Breggin pretty freely admits that he does not believe in the clinical use of psychosurgery.

A. Well, again --

Q. Do you agree, disagree, have comment on that?

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A. I don't know if it's a fair characterization of what he has to say. I've never talked to him and I can't tell you I've ever read everything he's ever written.

I know that he's a critic in regards to certain aspects and outcomes. I've read enough literature involved in surgical mind-altering behavior, altering of psychiatrically ill people. He's not the only one. Dr. Breggin has great company and respected company throughout the world. I can't speak to him beyond that.

I can tell you I'm not a participant in the argument as to pros and cons. I think psychosurgery is something that needs extremely careful analysis in terms of its science, in terms of its underpinnings and what we understand of the brain.

It has a history of enthusiasts and detractors throughout time. This is not a new paradigm. This is not a new situation. This is

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not a new problem in spite of advances in neuroimaging or drugs. It's a persistent one.

I think the thing that really makes it persistent is the willingness, the ambition, the at times the arrogance -- I'm not speaking of Dr. Barnett, I'm speaking in a historical sense -- of people to use brain surgery to alter psychopathy, mental illness, bad behavior, social problems, errant politics. I recognize all of that as being part of the argument here, so I'm aware of it. I don't have a particular side to take, pro or con, my beliefs or so forth. I think that it's an area that demands very, very special attention and special safeguards if ever to be performed.

Q. Have you reviewed the psycho -- the report of the Psychosurgery Commission from I believe the mid 1970s?

A. The Belmont Report and the things that followed?

Q. Not the Belmont Report.

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A. The 1977 stuff, yes, I've -- well, again, I think I probably read all of it in pieces over time, but again this shows one of the gyrations in this.

Q. What do you mean?

A. 1977 came along because of the CAT scanner. People could find targets so-called more easily than they could with ventriculography and encephalography, so there's this recrudescence as to why we ought to be doing psychosurgery with a great social response at that time following upon civil rights, following upon political expression to a sense in our country and in places throughout the world, so there became again a division of people's attitudes about it, not only professionally but particularly.

They would cite, for instance, the work of Orlando Andy, who is a very fine neurosurgeon from the University of Mississippi who did involuntary psychosurgery on juvenile delinquents and so forth, being a great

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medical, moral, medical and social problem. Louis Stokes proposed legislation about that time -- he wasn't alone -- saying it should never be done at all or done with such safeguards that it made it unlikely largely on the fear of suppression of minorities and prisoners and so forth.

There was a spade of medical cases and law cases about the same time that gave a peak to the persons who would oppose this. And then things kind of went along for a while, kind of died out. The recommendations that came out in 1977 were attended to, but really not implemented and I think in a very strong way until new scanning and isotopic and localizing procedures came along again. That made the arguments revivified. They are not new. None of them are. Before 1977 there were the 1950s. 50,000 psycho surgeries of one kind or another had been done by then, but along came powerful psychotropic drugs which spoiled both

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the need and the enthusiasm of many people, not all, to do them.

This is psychosurgery done on the brain. There has been psychosurgery done on the ovaries and other organs in excess of what has been done on the brain. Well intended, accepted by many, argued about and now passe. What will happen to psychosurgery in the future? I don't know. It's an interesting and challenging paradigm. There are those who say, and I agree with them in many senses, that the performance of manipulation, surgical and otherwise, exceeds what we really know about the structure and the function of the human brain. And until there's more parity, I think these arguments are going to persist and that your grandchildren and mine may find themselves in a similar discussion some day.

Q. Okay. I'll get off this literature topic in just a moment. Let me just make sure I understand correctly

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that you have not performed any specific review of medical literature in preparation for this report or your opinions?

A. I've done general reading about it, but it's a continual kind of thing.

Q. In terms of staying up-to-date as neurologist and in the fields you're interested in?

A. Yeah, again it has to do with my own interest in behavior. I'm a member of the American Academy of Neurology behavioral committee where this comes up, I can tell you, literally at every meeting.

Q. You have given depositions before?

A. Yes, I have.

Q. About how many times?

A. Oh, gosh, probably 300 depositions in the course of my brief life.

Q. Over what period of time?

A. Since I've had a brief life.

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The first deposition I ever gave was to the prosecutor of the city of St. Louis because some man had the poor taste to try to shoot me with a gun when I was sewing up his head in the emergency room when he actually intended to shoot a policeman. I was simply an unfortunate bystander.

Q. Oh, dear.

A. Scared the hell out of me, the shot did, but to be presented with a document with blacks marks around the edge of it, I was sure I was being sent to jail about something. I took it to my chief resident, chief surgical resident, a man named Solomon who made a paper airplane with it, told me he had a lot of those, sailed it across the room. That was the first one when I was 25 years old.

The next was a woman who had tardive dyskinesia and I still follow her. When I saw her I was about 30 years old. She still has tardive dyskinesia and I still take care of her.

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So forth.
Most of them have not been in the -- none of them have had to do with psychosurgery and most have not been anything touching medical malpractice. They've involved a personal injury, grantsmanship and institutions, institutional reviews of credentials, and on and on and on. They've involved a lot of things. But I suspect over the course of 38 years it's probably within that number.
Q. Can you give me a reasonable estimate of how many times you've been deposed when you were a medical expert in a malpractice case?
A. I don't know. I'm guessing 50. The number could be a plus, minus on either side of that. I don't know.
Q. How many cases have you reviewed as an expert in a medical malpractice case?
A. Ever?
Q. Yes.
A. I don't know, probably 150

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over again nearly 40 years.
Q. Those times you've testified in that kind of case as an expert, do you have an estimate of the percentage plaintiff versus --
A. I have not only a percentage, but a trend over time. I've seen more people at the behest of the defense than I have at the behest of plaintiffs. I've written more reports at the behest of defense than I have plaintiff. I have to a point about four or five years ago given more testimony or at least equal testimony for defense and plaintiffs.
Then something happened. The defense cases, I don't know if it's a matter of selection or changes in the operations of the defense bar, they tend to go away far more frequently for defense than they do for plaintiffs. So recent testimony I think has clearly favored plaintiffs, but I'm not sure how much it has to do with me.
Q. Dr. Barnett you were telling us that you know him well. Have yc ever known him to intentionally mis a patient?
A. No.
Q. In your report on page 2 you have analysis and opinions, and the first paragraph describes in summary fashion some of the consequences to Mrs. Zimmerman. Can you tell us which of her conditions resulted from infection versus those that resulted from the procedure itself had it not been complicated by infection?
A. No, I think there's a contribution certainly from infection. It becomes very difficult to weigh that contribution because the infection and the original lesions, particularly those in the region of the anterior limb of the anterior capsule, come wrapped in the same skin.
It's my opinion that her major deficits flow from the performance of the surgery itself, the psychosurgery itself. The presence of infection and

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its additional damage are contributors. It's very difficult for me to separate one from the other.
Q. So if we can propose the hypothetical situation of Mrs. Zimmerman undergoing the surgery without complication of infection, do you have an opinion as to what she would be lining now?
A. Mr. Parker, I can, you know, throw up a number and we can both sit here and shoot at it, but if I were asked to parse it out it would be 80/20, 75/25, but the smaller number is allocated to her infection. Not that it wasn't serious and quite dreadful, but I think the major culprit here are the lesions put in the region of the anterior limb near the interior capsule on both sides of her brain.
Q. Why do you say that?
A. Because of what is there in an anatomic way, what's known about the consequences of such lesions in other individuals, at least some of the time

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and at least a very substantial percentage of the time.
Q. Have you seen and examined other patients who underwent cingulotomy?
A. Yes, I have.
Q. How many?
A. It's a small number, maybe three or so. And I've seen them because they've had seizures. I was not asked to analyze other aspects of their behavior and some of the behavioral derivatives were unavoidably prominent, probably because I'm sensitive to look for them. These are, you know, people who are a bit more torpid or sleepy or apathetic than they were before perhaps, in a sense improved vis-a-vis what went on prior to this infliction, the infliction of impairment. That's what this does. Therapeutic in a sense, beneficial perhaps, but certainly I see people many times because things don't go well. They go badly.
Q. Sure.

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A. I'm not sure I can give you a representative cross-section of things gone right. Happy, doing well, don't need a doctor people don't come to me.
Q. Sure. There's a selection bias in terms of the patients you see because they're there because they're having problems.
A. There's a selection bias for all of us, certainly.
Q. Have you had occasion before seeing Mrs. Zimmerman to have patients who had undergone anterior capsulotomies?
A. Yes.
Q. Are there any particular aspects of Mrs. Zimmerman's behavior or personality that you can say, no, that's the infection process and completely unrelated to surgery?
A. Can I tell you that the apractic and spastic disturbance of her gait, the neurologic impairments in her legs are due completely to one or partially one to the other, I can't.

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Q. Okay. What about the reverse, is there anything about her findings on examination that you can say are absolutely the result of the surgical procedure and not the infection?
A. No, what I can tell you is that her composite picture, her appearance as a person, her findings on examination are consistent with large bilateral lesions in that portion of the frontal lobe occupied by the anterior limb of the internal capsule of both sides of the brain. The effects particularly on her gait are more derivative of lesions in the cingulum. Beyond that, which one was due to a bacterial infection, which one was due to the production of lesions, of the coagulative lesions in her brain is a kind of speculation in which I could not engage with comfort nor with certainty.
Q. Okay. Have you reviewed any CT images of Mrs. Zimmerman's brain?
A. I did see a CT and think it

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was from Kansas City at some point. It came and it went. And I recall seeing the lesions in the anterior brain and these were, I think, preoperative. I don't know if there were any postoperative films of her visit to the neurosurgeon, whose name I don't recall, in Kansas City after she was discharged from Cleveland Clinic.
MR. LINTON: We also showed you the CD images that were provided.
THE WITNESS: Yes.
MR. LINTON: Which I understand are not complete records.
MR. PARKER: That's correct. The CD that -- I'm not sure, I've been out of town, but at the time I left town I was told we had gotten to you the CT images that I have, but I don't believe that that is every slice of CT every time a CT was done.
MR. LINTON: Do you know when we're going to get all the CTs on CD as well as all the CTs on film which

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we've been requesting for some time now?
MR. PARKER: It is my intention --
MR. LINTON: We're nine days from trial.
MR. PARKER: It is my intention that you have all the CTs. I thought that it would be easy for them to get all the CTs on CD. That may not be the case, but I am trying to get you all the CT images. If I can get them to you on CD and on film, I will. But I intend to get you all those images.
MR. LINTON: Do we know by when?
MR. PARKER: I do not. Off the record.
(Discussion off record.)
BY MR. PARKER:
Q. Let's go back on. What is your understanding of the location of Mrs. Zimmerman's brain abscess?
A. It was in the region of the anterior cingulum and I believe on the right side.

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Q. All right. Yesterday I was deposing the plaintiff's experts in infectious disease and at the risk of characterizing the testimony, they were without explanations that they were very comfortable with about why an abscess on the right side would be associated with draining of puss on incision sites on the left side.
MR. LINTON: I'll object to the characterization. Why don't you just ask him the question.
Q. Do you know how that can happen?
A. You know, infections track through places where they can seep out. I mean, if everything in your icebox melts, the goop may run into your basement under the left side of the room and the leak was on the right side of the room. I don't know. Again, I don't have an explanation for it.
Q. Is there communication from the location on the right side to the incision site on the left side?

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A. Assuming what you told me, let me make that assumption. This is not a challenge to your recollection or veracity, but I'll assume those are the facts. She has had transgression of the anatomic structures of her head which leave the possibility open for how things get out. They'll follow the path of least resistance, and there's no obligation for puss to find its way either right or left. Simply out.
Q. Okay. Are there tracks or paths of communication that would permit puss from an abscess on the right side to get to the incision sites on the left?
A. It may because puss has the capacity to make its own egress. It destroys tissue in the way. It gets out and it will simply take what's available.
Q. Is it possible in Mrs. Zimmerman's case that in addition to the infection at the brain abscess she also had superficial wound infections?

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A. Anything is possible. She could have had that.
Q. Do you have an opinion one way or the other whether that, in fact, happened in this case?
A. I don't know. There's a note. It's almost two weeks postop that she was picking at her scalp, but a lot of confused people will pick at things. Picking is preventible if that's what happened. I'm not of the opinion that Mrs. Zimmerman through some condition of picking caused her infection. That's not my notion, but I know it's been expressed.
Q. Do you have an understanding of what limbic leucotomy is?
A. Yes.
Q. What is it?
A. It's a combination of cingulotomy and lesions undercutting the infrabasal white matter and some nuclear structures that are under the head of the caudate between the lateral portion of caudate and putamen.

Q. Is one component of the limbic leucotomy a cingulotomy?
A. No. Pardon me. I'm sorry. Cingulotomy is a part of it. Anterior capsulotomy is not a part of it.
Q. Okay. Is part of a limbic leucotomy aimed at fibers en passage?
A. En passage. Unfortunately the fibers en passage are mixed in with structures that are fibers that are not en passage.
Q. What's meant by the term? I got the term en passage from your report, fibers en passage?
A. Means they're on the way from one place to another. For instance, the local electric company and your light bulb.
Q. What are those fibers?
A. Which ones?
Q. The fibers en passage?
A. They're all over the brain. Do you have a specific place that you have in mind?
Q. No, I'm trying to understand

what -- are these fibers part of a discrete structure or are they simply interconnections?
A. You really can't take a picture of the brain and say that here are some passing from here to there. The notion of where they originate and where they pass is determined by other techniques other than eyesight. It's not how you can analyze where they're going in the brain.
Q. But the limbic leucotomy in part is directed towards fibers on passage?
A. Yes, as is capsulotomy and other forms of operation. Those are all tracts. They're -- tracts by definition are fibers going from one place to another.
Q. What's meant by the term stereotactic surgery?
A. Well, it is the use of a device of some kind which will allow a 3-D view of targeting, in this case in the brain, where you wish to supply some

treatment or extirpation or lesioning of some kind. Again, it's something with an extremely long history in neurosurgery and other branches of medicine including neurology.
Q. Is the fact that this surgery was stereotactically guided, does that make it experimental?
A. Not necessarily, no. The use of a stereotactic apparatus does not dictate whether this is an experiment or not.
Q. Does the fact that Dr. Barnett's procedure was a combined procedure, does that in and of itself make it research?
A. Not a combined procedure. Limbic leucotomy is a combined procedure. What he does is a unique combination of things as far as I can tell. I don't know of a case collection or reports of the particular combination of cingulotomy and anterior capsulotomy done in a single setting of a bilateral fashion. If there is, I

would very much appreciate being illuminated.
Q. On page 4 of your report, I'm going to go back to our discussion earlier about research, on page 4 of the report, you make the statement that the question of whether a medical treatment of any kind constitutes research involves arises when one or both of the following conditions are met. And you list a couple of conditions. The first condition that you raise is when the procedure is designed or should be designed at least in part to answer the question of whether a treatment is safe and effective. Where do you get that definition from?
A. This is really what I've posed to you in terms of the equipoise test. Where do I get it from? There's a large body of literature regarding it. I suppose if I were compelled and rewarded to produce it for you, I would. But it approaches those conditions. The conditions are two again. Perhaps the

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word "or" shouldn't be there because it's not just the safety aspects of doing this. It's the notion of newness or of innovation, the outcomes, risks and benefits of which are answered in the honest opinion of the investigator with the answer I don't know, or should be answered that way. That is the first condition.

And in which there is the anticipation of substantial risk. Here the substantial risk is very much up front. It involves biologic alteration of the person. And the answer to the first question in my opinion is I don't know. I'm not sure how it could be any other answer quite frankly.

Q. Would I find the definition that you have placed in your report, would I find that in 45 CFR 46?

A. No, CFR 45 does not approach this.

Q. Okay. The --

A. CFR 45.14 does not guide the individual investigators as to what or

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what not that person can or should do. It is related to Institutional Review Boards in which those predicatory questions -- not predatory -- predicatory have already been answered. They have defined research because they've lifted a few words out of the Oxford dictionary.

Q. I understand.

A. But they don't approach the moral and ethical and scientific decisions that have to be made in the heart and mind of a person or persons before they can bring anything to an institution or review board.

Q. I understand your opinion in that regard. The second arm of the definition you place in your report is when the intended procedure entails unknown but substantial risks to the individual person?

A. Yes.

Q. Does that arm appear in 45 CFR 46?

A. Yeah, but if you ask me why,

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I don't know. It has to do with the sections pertaining to the protection of subjects and human beings in research. I'm not sure that's quite the right name, but is it addressed? In fact, a great deal of the regulations are addressed to that. Again assuming that the preliminary question, is this research, answer yes, has been made. Then that series of protections becomes triggered.

Q. I want to ask a few questions about your examination of Mrs. Zimmerman.

A. Yes.

Q. How many times have you examined her?

A. Well, once to date and that was on the 13th of October. Should I be called to testify regarding her, I would appreciate the opportunity to examine her again.

MR. LINTON: You have to go to Kansas for that.

A. If I don't have to go to

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Kansas. I'll go to Missouri.

But, you know, I assume there may be issues of convenience and other things involved, but, you know, I think the beginning of knowledge about a patient is their history and their examination over time.

Q. To date you've examined her once?

A. Yes.

Q. Where was that done?

A. In my office.

Q. Do you have any handwritten notes of that examination?

A. No, I characteristically don't make them.

Q. And I note from the dictation or I note from this report that it's dictated the day of the examination?

A. It's dictated immediately from the time she and her family left the room to go home and I went to my office. There is no hiatus.

Q. Part of your history included

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a statement that you attribute to Mr. Zimmerman. I'm looking at page 3 right at the top of the page. The third sentence?

A. Yes.

Q. The family was not well informed as to what it was that was going on with her according to Mr. Zimmerman.

Are you simply relating that by history, or is that a matter on which you intend to express opinions?

A. No, this is a matter of history. If I were asked to explain what I meant by it or where the statement came from, I would certainly do that. I can tell you the statement reflects his contribution -- the wife is really not able to give a history -- and his daughter's as well that they were troubled over the condition of their mother. She was obviously sick and not moving and not talking and not continent, having medical problems that they couldn't quite get answers to, and

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that's what that statement was. They felt they were not well informed about what was going on with her medical and mental condition. The statement is from them.

Q. Have you reviewed the deposition testimony of the family members and various health care providers in order to determine the degree of consistency in the recollection about family discussions with the health care providers and things like that?

A. No, I've not seen that, but a feature of human life I'd not be surprised to find any and find it as an exponential function of the people you talk to. So this again, this statement simply reflects that the family's expression to me that they were not informed well of what was going on with their wife and mother.

Q. And you have known Dr. Barnett for some time, I take it. Does it sound consistent with how he

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practices medicine that he would withhold information from the family?

MR. LINTON: Objection.

A. I don't think it's a matter of withholding. He's busy, he's in the operating room, his time is pressured. May not have time to stop by or it may be an inconvenient time when they're there. I don't know. I don't think that he made -- it would be hard for me to imagine Dr. Barnett made a special plot to avoid dealing with the family. Granted there's a tendency I think among all of us to kind of shy back from confrontations with families of people who, for one reason or another, are not doing well. It's uncomfortable for a physician to do that. So might there have been some reluctance? Yeah, but I don't think Dr. Barnett is the kind of person who deliberately misinforms a family including the kind of misinformation that comes with isolating them.

Q. We could probably agree that

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these kinds of situations are very stressful for the family as well?

A. They're stressful for everyone. Dr. Barnett is faced with a patient who is not doing well at all, and the family is dealing with what they perceive as avoidance and a lack of information.

Q. I want to ask you a few questions about specific findings on your examinations. You mention an infrequent blink of her left eye and the appearance of a mild facial diplegia?

A. Yes.

Q. What would explain that?

A. Well, she's had damage with the innervation of the mimetic, if you will, musculature of her face, but this again is a consequence of lesioning the cortical tracts bilaterally which are part and parcel of the fibrous en passage in the region of the anterior limb of the internal capsule, so her face is not very mobile. When she blinks she's more likely to blink with

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the left eye rather than the right as I'm demonstrating.
Q. You also note that she shows uninhibited blinking to -- I can't say the word, glabellar --
A. Glabellar.
Q. -- tapping and pursuing movements to percussion about her lips. What's the significance of that?
A. Pursing. It's an inability to learn. I won't demonstrate on Mr. Linton; I'll demonstrate on myself. If I were not me but another person and I as a neurological examiner were to do this on the glabellum, which is this area --
Q. Above the bridge of the nose?
A. I would blink a couple times and then I'd stop blinking, wondering what is this foolish person doing? What I've done is habituated to that stimulus. It was novel and surprising for the first one, two, or three times, but after that I've learned that in

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spite of an unusual circumstance, nothing bad is going to happen to me, and I quit blinking. It involves learning at a very fundamental level. At a reflex level, if you will. It's different than pursing the lips. She does not learn. Each stimulus is novel. It's like the first time all the time. And if I had to do it once or five times or 500 times, she'll blink.
The business of pursing is the elicitation of a primitive reflex. It is built in the human brain but overcome with a maturation of the frontal lobes. It is essential to the well-being of a newborn because without this sucking reflex, when contactual stimulation occurs around the area of the mouth, they tend to seek it as if in grabbing a nipple. With damage to the frontal lobes from anything, from any kind of illness or condition or dysfunction you could care to mention, that reflex becomes recrudescent. It is a so-called primitive reflex.

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What it connotes is some sort of dysfunction or damage to the frontal lobes. It is not specific for leucotomies of some kind or another. It is not specific for any particular disease and occurs in a variety of them, but it always points to the same place. It points to the frontal lobes of the human brain.
Q. What about the uninhibited blinking to the glabellar tapping?
A. Same thing. Adult mature frontal lobes, well functioning and properly constructed, don't allow that to happen.
Q. Have you ever served on an Institutional Review Board?
A. Yes.
Q. When?
A. I've served on several. In the military service, on University Hospitals, Cleveland Clinic, IRBs in other places, in medical groups.
Q. Do you currently serve on any?

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A. No.
Q. Have you served as a principal investigator in any research projects?
A. Yes.
Q. In what -- can you paint for me the picture of the types of things that you have been an investigator on?
A. Yes, I've been investigator in a number of drug trials that have to do with stroke, hypertension, its effects on the brain, diabetes, and epilepsy, pain. Most of those have been drug trials. Not all of them have been drug trials. Some of them have looked at the development of procedures and instrumentation for measurement of neurologic function.
Q. I noted that you were provided with a copy of Dr. Lichtin's deposition?
A. Yes.
Q. Did you have any particular criticisms of matters he discussed?
A. Not in a general way. If

you have specific questions I'd be happy to try to respond to them, but I don't have a blanket report on his deposition to offer you.

Q. In the materials you reviewed there were really just a handful of pages that you have specifically tabbed. I assume they're your tabs, these bright yellow tabs?

A. Can I take a look?

Q. Certainly. That's what I'm going to want you to do. So turn them around so you can take a look at them. But my first question is are those tabs placed by you?

A. I believe so. I will own them. They look like my yellow paper, but again this is fungible yellow stick-ems.

Q. I understand that. I'm trying to find out if you can tell me the significance of your having tabbed a page from the IRB guidelines book that you were provided.

A. Well, this page is tabbed

because of the paragraph that begins, The distinction between research and treatment can become blurred in patient care settings. A great deal of our discussion today has dealt with this blurry area. Blurry doesn't mean it's impenetrable. It's not and it can't be. It's simply the way that IRBs and people connected with them as investigators or members need to think and know how to behave.

The Code of Federal Regulations does very little, by the way, to dispel the blur. They accept the blur. Investigators can't. They have to find their way through it. They have to be able to answer in the end, should this be research or not.

Q. I'm looking at your notebook upside down, but it looks as though the page you're looking at is out of the Belmont Report?

A. This is out of -- it's Institutional Administration.

Q. Okay.

A. Yeah.

Q. The next page that you have tabbed appears to be from the same book. Can you identify what that is?

A. This is from the Institutional Review Board Guidebook, and it's a companion to the Code of Federal Regulations.

Q. What is the significance of what you have tabbed there?

A. Well, okay. It has to do with tagging a paragraph that states, The fact that much biomedical research was conducted for the purpose of evaluating new treatment or therapy leads to two problems for IRBs.

Without reading all of this, I can tell you what the problems are. One is jurisdiction and the other is safety. Those are the problems.

Q. What do you mean?

A. Jurisdiction is to let the IRB know somehow where their jurisdiction ends. And it's a legalistic term, but it's what's used in

this legalistic textbook. This is not a textbook of medicine. The answer to that is, if it constitutes research, then it's the province under the jurisdiction of the IRB. It doesn't tell the IRB or people how to solve that problem. I've tried to pose a way of doing that for you, which I think is a reliable way, safe for investigators, safe for institutions, and safe for people to do. It is not my invention. There's a world of people who use this.

And the other has to do with issues of safety that rest in the end upon the implications and the implementation of doctrine of informed consistent. Predicatory to that implementation is the definition of a bona fide question to ask or should be asked. That's what this says.

Q. Okay. Next page that you have a note on?

A. I don't think -- I'm not sure where this got stuck, but it's on -- it is from the Belmont Report and it

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addresses the same base, the boundaries between practice and research. It's a very nice exposition of saying what those boundaries are without telling you how to deal with them. It's largely an ethical sort of things. It talks about principles of autonomy, competency, justice, benevolence, and so forth, basic ethical principles to be applied in performance of research involving human beings.

MR. PARKER: Before I move to the next topic, the first couple of passages that Dr. Conomy described to me came from a book entitled Guidebook of -- I forget what. Bob, do you anticipate having testimony from that book at trial or showing him passages of that to the jury?

MR. LINTON: I don't know.

MR. LEUTHOLD: Okay. Then at the end I'll be asking for a copy of that publication.

MR. LINTON: I'm sure you

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have it, but you're welcome to have a copy of whatever you want here.

MR. PARKER: I'm not positive whether I have that particular book in that particular version or not. The Belmont Report I do, so I'm not going to ask for what he's reading from now. Let's go on to the same page.

THE WITNESS: The Belmont Report.

MR. PARKER: Well, we'll -- now let's make sure I understand correctly. Right now you're reading from the Belmont Report. But this --

MR. LINTON: That was the guidebook.

MR. PARKER: The guidebook.

THE WITNESS: You can get it off the Web. That's where this came from. I mean, it's published as a book too. You can get it a lot of places.

MR. LINTON: We'll copy it for him.We'll find out.

MR. PARKER: I just want

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to clarify that what we were reading a few minutes ago and what you're commenting on a few minutes ago was not the Belmont Report per se. I believe it's called Guidebook for Institutional Review Boards?

MR. LINTON: He's commenting from both. He first did the guidebook, then he did the Belmont Report. He's getting ready to go back to the Belmont Report.

A. It's a product of both the Bush Senior and Clinton administrations. That's when it was done.

Q. Okay.

A. The Belmont Report is earlier.

Q. That's right.

A. Okay.

Q. I understand that. I want to go to the next page that you have marked and simply find out the significance of that page being marked.

A. Okay. I'm not sure it has any significance. This was stuck on a

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page, and I'm not sure what I had it stuck on, but it's a page that talks about boundaries between practice and research.

Q. It's a page out of the Belmont Report?

A. Yes, it is.

Q. Okay.

A. It's not only a page. It's the next several pages because it's a long dissertation.

Q. Okay.

A. The next is the Code of Federal Regulations, Title 45, that has to do with the protection of human subjects.

Q. And then the last page that you have marked in that notebook?

A. It's general requirements for informed consent. This is not an original piece of work. It's the 10 principles cited by the Nuremberg trials under the principles of informed consent. They didn't just sit there and make this stuff up. They had general

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requirements for informed consent. They have the arrangement made a little bit differently than the original publication did, but the 10 elements in the original Nuremberg publication are all here and they're here in order.

Q. What's the document you're reading from?

A. It's from CFR 45, part 46, and this is a 1991 version.

Q. Okay.

A. Of such.

Q. And then in one of the other black binders of materials you've reviewed, we have a few more pages marked with yellow tabs. Can you tell me what the first page is that you have marked.

A. Page 72 of the deposition, I think it's a two-part deposition from Dr. Rezai. There's something on this page that might be under the tag.

Q. This is the April 2, 2001 deposition?

A. Can I look at this for a

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minute and try to remember what I thought was important. You know, a lot of this has to do with the availability of yellow stickers more than it does succinctness or importance. Sometimes I have yellow stickers and sometimes I don't. If I have yellow stickers while I'm reviewing something on an airplane, you're going to see a lot of yellow stickers. If I don't have any, then you don't see them.

Q. I can relate.

A. Not everything I thought was important is marked with one of these things. Okay. This talks about two things. It talks about informed consent. It's on all the page so I don't have a particular sentence. It's this section of his deposition.

Q. I'm just trying to find out what the significance of that marker is?

A. Let me ask, would you agree that the multi-disciplinary team puts in place a system of checks and balances to make sure that the surgery being done is

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only done on appropriate candidate?
Answer: That's our intention.

There are a number of comments like this that have to do with multi-disciplinary teams, and then there are some more that have to do with what a person needs to be told. This goes on to say do you need a psychologist, should you have a neurosurgeon, do they need to be performed, on and on. It really covers things we've covered in a portion of today's deposition.

Q. Okay. The next marker is also?

A. Page 98.

Q. Dr. Rezai's deposition of April 2, 2001, page 98, and just what's the significance?

A. That's correct, Mr. Parker. It has to do with success rates about gamma knife surgery with particular reference to obsessive compulsive disease and the use of the Yale Brown Obsessive Compulsive Index. It's a standardized method of scoring that

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attempts to numerically evaluate the severity of symptoms, obsession, compulsion, associated psychopathy, depression and the like, with a standard scale. I'm familiar with the scale. I don't use it routinely in my practice, but he's talking about the relative success rates of certain procedures, about cingulotomy and capsulotomy. And if I may summarize Dr. Rezai's testimony, because it's lengthy, he said essentially they had about the same success rates.

He was asked further about the success rate of combined cingulotomy and capsulotomy, and he didn't know that and he didn't know of any literature that pointed to the utility of that particular innovative -- that word is mine, not Rezai's -- combination of procedures in treating this illness. He wasn't aware of experience with that.

Q. Okay. The next page that you have marked appears to be from Dr. Rezai?

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A. Dr. Rezai, but this is the September 14th, 2001, second part of this deposition.
Q. It's around page 120 that you have a marker and just what was the general significance of that testimony?
A. It addresses his notion of risk, and it's talking basically about combined procedures and his own experience with brain stimulation and brain extirpation and a variety of illnesses. They're talking about at this point about combined capsulotomy and anterior cingulotomy. They've talked about a lot of other things and it's a good deal of jumping around as many depositions, including today's.
When he's asked about this, he's asked about the combined procedure, he said, I do not believe that was the thing to do for my patient, so that's why I didn't include it. And why not? Answer: Because I think it may carry an increased risk in my opinion.

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He's asked about increased benefits and in all fairness and he says there may be, but he wasn't sure.
Q. Okay. The next document that you have tabbed?
A. Yes, okay. I have -- this is an affidavit.
Q. You actually have a tab though on a particular page?
A. Okay.
Q. Identify what it is that's been marked.
A. These are procedures.
MR. LINTON: This is the Clinic's response to our Sixth Request for Production of Documents, and it specifically sets forth who was on the IRB as of December 1998.
Q. Is there a particular reason that's marked?
A. I want to know who they were and who I knew.
Q. Okay. The next marking is also attached to that document request and this contains the Stagno study on

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cingulotomy that was submitted and approved by the IRB in 1994. Is there a particular reason that that page is marked?
A. Well, that they had a study on cingulotomy someplace. I don't know. I've not seen it. And the CV of the gentleman who is currently the chairman of the IRB.
Q. I have not studied your curriculum vitae you were kind enough to -- actually Bob was kind enough -- to give me at the beginning of this deposition.
A. I'd be kind enough to do the same thing. I'm at least as kind as Bob.
Q. You absolutely are. Even before the deposition started you gave me that phone number where I could get the updated copy that Bob is going to get for me and provide to me, but the reason I do this lengthy introduction is because I'm apologizing in advance for having to ask some basic questions.

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A. Quite all right. I'm pleased that you do.
Q. You've already told me about employment at the Cleveland Clinic in a prior life you called it. Have you served at the Cleveland Clinic --
A. Yes, I don't want to call it a prior life. I really don't expect recreation, but I was chairman from 1975 to '92, and I was operating room technician and file clerk when I was a teenager, so I've had a bimodal life. I think it's a wonderful institution, and my appreciation for them and what I was able to do with many people working in that group was a wonderful experience and experience of a lifetime.
Q. Can you tell me what the circumstances were that led to your departure?
A. I didn't want to be a department chairman the rest of my life. I can't imagine you want to take depositions the rest of your life. Being a department chairman is a

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wonderful job. The average lifetime of a department chairman at that level is four years, and I did it for 17. I did what I set out to do and more. And then I just didn't want that life anymore.

Q. Your reports are on a letterhead called Health Systems Design. What does that company do?

A. Well, company, I mean, I wish it were quite like General Motors, but it's not. It's me. It's a matter of convenience that keeps my work and my life organized. And it's devoted to a number of things I do that touch upon medicine, some upon law, that do not deal directly with the care of patients. That is not a medical organization. It's a way for me to collect and to keep in an orderly way for my own purposes as well as the IRS and a number of other things, such things as consultation work of a variety of kinds, publication, lecturing, and the occasional appearance before you here

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today.

Q. Is it fair to say it's your work other than your clinical medical work?

A. Yeah, it's not the only nonclinical work. I've developed the same kind of separateness for people I'm asked to see to evaluate personal injuries, some for law firms, but predominantly for work-related organizations, for life planners, for a whole variety of things, some of whom are involved in litigation and most of whom are not. And the reason for that is to see that the billing for such things which are not medical care, they touch upon medicine in a fundamental way, but they don't involve a patient physician relationship, do not get billed to health care providers and to Medicare in places where I don't think the billing ought to go. So it's my effort to keep things straight. That's what this is too.

Q. What does the term mean to

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you clinical practice of medicine?

A. It means the care of a person with whom you've established by one means or another direct, open, implied or not, a patient physician relationship with everything that tails off of it, confidentiality, availability.

MR. LINTON: I sense we're going to another topic. I need to take a two-minute break.

MR. LEUTHOLD: I think I have one more question on this topic.

Q. Of your total professional time, how much is spent in clinical medical care?

A. I can tell you over the course of a year, it's about 80 percent in clinical work and 20 percent in other things, but day-to-day it's sometimes more or less. Today I'm not going to do much clinical work except I'll visit a hospital on the way home.

MR. LINTON: Today is Saturday by the way for the record.

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MR. PARKER: We'll take that break.

(Recess had.)

Q. Doctor, you've been very forthcoming about specific procedures and reviews that you feel should have been done in this case. But I want to ask this. Ultimately you have opinion irrespective of the procedures and reviews that you feel should have been done. Do you have an opinion as to whether or not for this patient psychiatric surgery was appropriate and indicated?

A. Let me deal with both of them. Indicated would pend a thorough review of a prior treatment and the systematic fulfillment of criteria by a group of experts. I don't think it was indicated by the validation of indicators. That's what I would use as a guide rather than some surmise or heartfelt opinion of my own. I'd rather rely on data.

Indicated is another level

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of problem. What was done here --
Q. I'm sorry, I thought you were just discussing indicated.
A. Indicators. I'm sorry. Appropriateness was the other branch that you asked me about.
Q. Yes.
A. In terms of obsessive compulsive disorder, even pending that kind of a review, the appropriate procedures, at least as I understand it by a standard of medical care, are cingulotomy or limbic leucotomy or one or another procedure, not this combination of procedures. So I have reservations as well about the appropriateness of the procedures that were done. My answer then is to respond in the negative over both branches of that question.
Q. I'm going to ask you if you agree with the following statement: Research means a systematic investigation including research development, testing, and evaluation

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designed to develop or contribute to generalizable knowledge.
A. That's what the word means.
Q. Okay.
A. You've given me an Oxford English Dictionary first definition, of which are many more to follow if you care to look at where they got that one. But that's what the word means.
Q. Do you agree with the following statement: The term practice refers to interventions that are designed solely to enhance the well-being of an individual patient?
A. Again, that's what the word means, but it has no exclusivity vis-a-vis research, that is it does not the antithesis of research. One can do both simultaneously and frequently do.
Q. Okay.
A. One does.
Q. Let me ask if you agree with the following statement: The purpose of medical practice is to provide diagnosis, preventative treatment, or

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therapy to particular individuals?
A. As far as it goes. The purpose of practice also includes somehow, some way the advancement of the goals of medicine.
Q. Okay. Do you agree with the following statement: The term research designates an activity designed to test a hypothesis, permit conclusions to be drawn, and thereby to develop or contribute to generalizable knowledge?
A. That's an operational definition. It is what research does. It does not say how you get to the word leading to that operational definition, how a thing operates.
Q. Does innovation in and of itself constitute research?
A. Not necessarily. I think when you look at the specifics of research that pertain to human beings, there is that kind of innovation in which the outcome can be clearly perceived. The use of two Band-Aids, for instance, versus one on certain

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cuts. I don't want to use an oversimplified example, but that would be one. When innovation has an outcome that can't be ascertained, verified, clearly perceived, that is research and whether there is the additional component of the cognizable substantial risk to the person undergoing it triggers what institutions should do relative to research, call it innovative medicine, call it exploration medicine, call it expansion. There are a number of words. They constitute the same sort of things in terms of their moral imperative.
Q. In a similar vein, does the fact that a procedure is new or untested or different automatically place it in the category of research?
A. No, it doesn't. Again, let's look at the invention of a new toothbrush. It may do what the old toothbrush does, may do it supposedly better, but there's no real consequence to individuals along the way. Or its

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use may be, you know, clearly intended with no risk.

Once the answer to the question does it work becomes I don't know and substantial risk anticipated, then the question changes. Then it is research under the spirit of clinical research.

Q. Have you had any communication with Tracy Wingate, do you know who that is?

A. Is that a life care --

Q. Yes?

A. Somewhere in these multiple volumes is a care plan, but I've had no correspondence or contact, no.

Q. Have you specifically reviewed the life care plan?

A. I've seen it. I have to have it in front of me if I were asked to answer questions about specifics on it.

Q. Okay.

A. I looked it over. It's part of the medical record.

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Q. Okay. I understand you've looked at it. But I take it that as you sit here today you don't understand it to be your role to be the person testifying as to this particular needs in the life care plan?

MR. LINTON: I don't think that's necessarily true.

A. I would answer the same thing myself had I the opportunity. I think vis-a-vis her neurologic impairment and disability, it is my role.

Q. Okay. When did you review the life care plan?

A. Before I wrote a report. It's embodied somewhere in these records.

Q. Was it before your evaluation or after your evaluation?

A. After all the -- review was done after my evaluation of her. I did not read a thing until I completed my evaluation of her.

Q. Did you review the life care

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plan before or after your standard of care report?

A. I think it was part of that because it came incorporated in one of these volumes.

Q. Okay.

A. There's again those -- that collection incorporates everything that I was sent. Sometimes it's an addendum to somebody else's file.

MR. LINTON: We can check the dates to make sure.

A. I don't know at what point I did that, but it's part of the medical records.

Q. Does Mrs. Zimmerman have any chronic diseases or ailments or conditions other than those that are specifically related to the surgery.

A. I'm taking time to look over my report. She's basically a healthy lady and has at least known to me no life threatening or limiting condition.

Q. Do you have an opinion as to her expected duration of her life?

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A. Well, given proper care it should be a normal span in terms of years, but certainly not in terms of quality of her life.

Q. What is she not getting in terms of proper care now that she needs?

A. I don't know. I don't know what kind of care she's getting now. I don't know how she is now.

Q. Is she at heightened risk of developing any significant diseases or conditions that would affect her life expectancy?

A. I don't think so. Left to her own devices, issues of accidents and derivative of clumsiness, weakness, and poor judgment, I think need to be at least surmised, but they can be addressed with proper care and treatment. It doesn't -- her condition does not put her at greater risk for the usual killers, heart disease, cancer, the like.

Q. What do you charge for review, preparing reports, testimony, et

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cetera?
A. I charge $500 an hour for everything.
Q. Mrs. Zimmerman was on antibiotics at the time of her surgery?
A. I think that's routine to give people undergoing stereotactic procedures a dose of one or another sort of antibiotic.
Q. What are the effects of that dosing of antibiotics with respect to the development of infection?
A. Well, hopefully it's preventative. That is the hope and expectation rather than the fact. Infections occur in spite of that.
Q. Are infections a risk of all surgical procedures?
A. Yes.
MR. LINTON: Objection.
Q. Can the risk of infection be eliminated by appropriate techniques or is it a matter of minimizing?
MR. LINTON: Objection. Talking about any infection or the

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infection in this case? The Klebsiella and --
MR. PARKER: My question stands as asked.
MR. LINTON: Same objection. He is not here to give standard of care opinions on the issue of infection.
A. A sepsis is a principle of surgery and medical care is designed to eliminate infections. In effect, infections are minimized by procedures of sterility and prophylactic care.
Q. Do you have an opinion as to whether or not the surgical probe was contaminated?
MR. LINTON: Objection. He's not here on the standard of care as an infectious disease expert. He's not giving opinions. This is improper.
MR. PARKER: Okay. If he's not giving an opinion on that, then I'll move on.
MR. LINTON: He's giving causation and timing opinions, and he's

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not a standard of care on the infection issues. We had two of those yesterday.
MR. PARKER: He won't be expressing an opinion as to whether or not the probe was contaminated?
MR. LINTON: Correct.
MR. PARKER: Or whether or not the skin was contaminated?
MR. LINTON: Correct. He told you his opinion concerning timing, but not cause.
MR. LEUTHOLD: That's fine. He won't be giving an opinion as to whether or not surgical prep was appropriate?
MR. LINTON: Correct.
MR. PARKER: Usually when I'm done I think of 100 more questions, but right now I'm out of them. I appreciate your being here today and responding to my questions. And I do want to get either a copy or the web page site. I'll be happy to print my own copy of that guideline book. I may have it, but I don't recognize the book

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entitled that way.
MR. LINTON: I have a couple follow-up questions.
EXAMINATION OF
JOHN P. CONOMY, M.D.
BY-MR.LINTON:
Q. First of all, Dr. Conomy, for the record I took a break to go to the rest room. You and I have not talked at any time since Mr. Parker has been examining you about the subject matter of your testimony, have we?
A. We have not.
Q. Mr. Parker was asking you questions from the Belmont Report, whether you agreed or disagreed with them, and he did not complete the questions. I want to put that in front of you and ask if you agree or disagree with these statements. First of all, he omitted the term experimental when he read the statement, The fact that a procedure is, quote, experimental in the sense of new, untested, or different does not automatically place it in the

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category of research.
You agree with that statement?
A. Yes, I do.
Q. Do you agree if the further statements from the Belmont Report that were not read to you: Radically new procedures of this description should, however, be made the object of formal research at an early stage in order to determine whether they are safe and effective. Thus, it is the responsibility of medical practice committees, for example, to insist that a major innovation be incorporated into a formal research project.
Do you agree with that statement?
A. I do.
Q. Research and practice may be carried on together when research is designed to evaluate the safety and efficacy of a therapy. This need not cause any confusion regarding whether or not the activity requires review. The

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general rule is that if there is any element of research and activity, that activity should undergo review for the protection of human subjects.
Do you agree with the remaining statements I just read to you from the Belmont Report?
A. Yes, I agree with it. I endorse it heartily. I think it's the iteration in a legal document, if you will, of an ethical principle guiding medicine, particularly an innovation in institutions which have a penchant, an admirable penchant to innovation.
Q. Would you agree that the procedure that Dr. Barnett performed on Mary Lou Zimmerman was experimental in the sense of it being new, untested, or different?
A. Yes.
Q. Mr. Parker did not ask you to go into any details about what was required in the way of informed consent, but do you have an opinion first of all whether or not given the fact this was

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experimental, that it was novel, it was untested, that it did require heightened informed consent requirements?
MR. PARKER: Objection.
A. My answer, if I understand the question, is that this is the type of procedure that should have been deigned research and hence a heightened attention to all of the principles aforementioned should have been applied. Having said that, I recognize that in one of Dr. Barnett's notes there's a note that to the effect a procedure discussed with the patient and family. That's not enough to know about how these things are fulfilled.
I can tell from you my own experience that when a procedure is dignified by having an element of research in it and institutional committees become designated, these things are spelled out in paper for people to read and write. There is frequently the use of an auditor witness to make sure that patients and families

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understand exactly what these words mean. Frequently medical words and unavoidably medical words. So this is what I mean by heightened attention to the principles of informed consent. They are written out and they are certain that they are all understood. Those principles are 10 in number and I've already referred to them.
Q. Would that include the fact that this combined procedure presents increased risk to the patient?
A. Well, it provides an unknown risk. The question -- the answer to the question how risky is this, is I don't know.
Q. How about success rates?
A. I don't know that either. If there's nothing written about it or published about it and people who are recognized experts in the field of brain stimulation, brain extirpations, psychosurgery don't know either, I don't know how the answer can be otherwise than I don't know the answer to the

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question. Certainly my answer is I don't know.
Q. We'll ask Mr. Zimmerman if, in fact, he and his wife would have consented to the procedure under those circumstances. My question to you is this: Do you have an opinion within a reasonable degree of medical probability as to whether a reasonable patient, had they been told what was required, would have consented to this combined novel, untested, experimental procedure?
MR. PARKER: Objection.
A. My answer in all candor is no. I think the question may never have been reached because the whole process of preliminary fulfillment and the exposition of indicators isn't here. That would have to be done first before you even get to the question.
Q. Let me stop you just so -- let me stop you to make sure we're clear of the question. My question was simply do you have an opinion and you said no. Are you saying you don't have

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an opinion or are you answering no to the ultimate issue?
MR. PARKER: Objection.
A. To the ultimate issue, not to the question.
Q. The question first of all is do you have an opinion?
A. Yes.
Q. What is that opinion, Doctor?
MR. PARKER: Objection.
A. That a reasonable person would have at this point replied in the negative. My response also includes the notion that this is a procedure; it is not an instant decision. It is not irrevocable. It needs to be made in stages and first stage is to do what's preliminary; that is to ensure the adequacy over time, quality and intensity of treatments that do not cause permanency and potential injury to a person in terms of biological alteration in the sense that surgery does.
MR. LINTON: Okay. Thank

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you.
Q. (By Mr. Leuthold) I think I heard you say that there was nothing written about success rates for these kinds of surgery.
A. There's plenty written about the success rates of these kinds of surgeries.
MR. LINTON: Separate surgeries.
MR. PARKER: I'm asking the question. Thank you.
MR. LINTON: I don't want you to get confused. I'm assuming you mean separate cingulotomy and capsulotomy.
MR. PARKER: I'm following up the specific statement I heard him say. That's all my questions is intended to do.
MR. LINTON: We need to be specific on what you mean by procedures.
MR. PARKER: You can ask your questions.

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MR. LINTON: I'm going to object.
MR. PARKER: I'm going to ask another question now.
MR. LINTON: I'm going to object to the form of the question because there's been no evidence at all by anybody including the Cleveland Clinic or its experts that there's any literature concerning the combined procedures at the same time in the same segment. There's a request to admit that has been answered in the affirmative by court cord deeming that commission. I don't want to confuse the issue here. That's all. When you use something like procedure, vaguely, it's needs to be defined.
MR. PARKER: Are you through?
MR. LINTON: I'm through.
MR. PARKER: Okay. I was finished with my questioning until you asked some and I heard a statement and I'm following up to a statement.

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I'm going to follow up to another one.
Q. I heard you discuss heightened requirements of informed consent being necessary in this case, correct.
A. Yes.
Q. And I take it that you were referring at least in part to the fact that if the procedure falls within the federal regulations that we've discussed, then there is an explicit requirement for written informed consent; is that true?
A. Most of the time. Certainly in this case there would be. If it's a procedure that involves minimal risk, that is blood drawing or data collection, then written informed consent is not the rule. But in the circumstances of this matter, written informed consent is the rule.
Q. Okay. Now I want to ask you this: If we set aside the federal regulations that we've discussed, isn't it true that Ohio law recognizes

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informed consent to be a process and does not specifically require written forms?
A. Yes and no. Informed consent in general may not require a written document. For commonly employed procedures involving substantial risk, Ohio and other states do not necessarily require written informed consistent. Many institutions use it in spite of the absence of a mandate of law in doing that. There is to my knowledge no exception in Ohio law for research involving human beings. The reliance still is on the federal regulation when it comes to that.
So in this circumstance I don't think Ohio law would waive -- you're asking me a legal question -- I don't think the application of Ohio law would waive the need for written informed consent.
Q. I'm not arguing otherwise. I'm simply trying to clarify what Ohio law requires in a nonresearch situation.

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A. Yes, but again this is not an appendectomy.
Q. Okay. Before this case have you ever testified on the subject of the Belmont Report?
A. Not the Belmont Report. I have, if I may anticipate the next question, about issues of informed consent, but I can't cite the cases and matters to you. I know it's come up.
Q. Well, I don't want to anticipate the next question because that wasn't anywhere near the next question.
A. I can save us time.
MR. LINTON: Actually I don't know if you're saving us time by asking yourself more questions.
Q. That's exactly the problem is you're not saving us more time. I want to make sure I'm clear. You have not previously testified on the subject of the Belmont Report?
A. No, I have not.
Q. Have you ever served on the

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expert on the subject of Belmont Report?
A. Not with respect to psychosurgery, no.
MR. PARKER: Thanks. That's all I have. Thank you.
MR. LINTON: I want to clarify the record.
Q. Mr. Parker was using the term procedure or procedures. Let me clarify. Dr. Conomy, are you aware of any literature in which a capsulotomy and a cingulotomy have been performed at the same time in the same setting on a patient with OCD?
A. No. I'm aware of their combinational effects performed for other reasons like tumor removal or frontal lobe injury due to trauma, but not for the purposes of psychosurgery. I know of no such literature.
When I responded to his question about procedures, I was not responding to any knowledge I might have -- of which I have none by the way -- about psychosurgery consisting of

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cingulotomy and anterior capsulotomy done bilaterally on the same person in the same study. I know of no such experience.

MR. LINTON: Thank you.

EXAMINATION OF
JOHN P. CONOMY, M.D.

BY-MR.PARKER:

Q. What's the physiologic relationship between the subcaudate tract and the anterior capsule?

A. Let me try to respond in the following way: The anterior capsule contains a number of fibers that deal with behavior and memory among other functions. They tend to run from the cingulum through a portion of the anterior internal capsule to other targets in the brain, variety of places, some of them eventually winding up a few in the temporal lobe, some in the basal nuclei in the forebrain, and in the thalamus that run through that particular loop. The anterior limb of the interior capsule also contains a

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number of other important tracts. Its extirpation by any means damages by and large fibers en passage; at least that's its intent. It's surrounded by nuclear structures, however, that have to do with volitional movement, with strength, continence of bowel and bladder. They're all in the same place. When one deals with lesions in the anterior portion of the internal capsule, one deals with this. Those fibers, particularly those -- some coming from the cingulum, but others come from prefrontal area of the frontal lobe, particularly its medial portion, have to do with certain other aspects of one's emotional behavioral life, such as the initiation of activity including speech, the maintenance of attention, the ability to synthesize memory. So things get very complex when you talk about the fiber structure of the anterior limb of the internal capsule much less what's around it.

Q. You've discussed so far the

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anterior limb of the internal capsule. What about the subcaudate tract?

A. The subcaudate tracts arise underneath the caudate nucleus and kind of underneath the putamen. They are in proximity to the anterior limb of the internal capsule, but separate from it, not by which you can see by your naked eye. You can't. But in terms of what is really going on in terms of highways and the traffic going over them, those tracts largely arise in cell systems originating in the prefrontal area, particularly the basal forebrain in the cortex, the part of the brain that's right above your eyes and above your nose. Also there are fibers running through that area that come from certain target zones in the dorsal medial portion of the thalamus, ultimately in some temporal lobe structures. But it's also a region that contains intermixed and intermingled with those fibers en passage and inseparable from it nuclear structures, the septal nuclei, the

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nucleus of diagonal band of Broca, B R O C A, the substantia nomina, which is white matter. It's kind of interdigitated in those tracts and inseparable from it. So the notion that in a subcaudate tractotomy is one of just cutting tracts is never quite true because you can't avoid what else is there. It is a somewhat separate, not entirely discrete portion of cells and fiber systems which have to do with certain aspects of behavior.

Q. Okay. Do you know Dr. Cosgrove, Rees Cosgrove?

A. Not personally. I know his work. He writes a great deal about this subject.

Q. Dr. Jenike?

A. Jenike I know. Again, I don't know him personally, but I know his work. He's one of the I think outstanding people in the field of obsessive compulsive disease, a psychiatrist.

Q. And Dr. Cosgrove, do you

know of his reputation in the field of neurosurgery?

A. No, I wouldn't assume it's a good reputation, but I don't have a personal knowledge of that.

MR. PARKER: Thanks.

THE WITNESS: You're welcome.

MR. PARKER: I'm done.

MR. LINTON: He will be testifying on the life care plan. If you want any questions about that or not.

MR. PARKER: Off the record.

(Discussion off record.)

MR. LINTON: I thought it was abundantly clear by now that Dr. Conomy will testify to Mrs. Zimmerman's neurological deficits and will testify to the life care plan as reasonable and necessary based on his examination.

MR. PARKER: Okay. I'm satisfied with the record.

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CEFARATTI GROUP FILE NO. 6703
CASE CAPTION: MARY LOU ZIMMERMAN, et al. V. THE CLEVELAND CLINIC FOUNDATION, et
DEPONENT: JOHN P. CONOMY, M.D.
DEPOSITION DATE: MAY 4, 2002

(SIGN HERE)

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

Before me, a Notary Public in and for said County and State, personally appeared JOHN P. CONOMY, M.D., who acknowledged that he/she did read his/her transcript in the above-captioned matter, listed any necessary corrections on the accompanying errata sheet, and did sign the foregoing sworn statement and that the same is his/her free act and deed.

IN TESTIMONY WHEREOF, I have hereunto affixed my name and official seal at , this day of , A.D. 2002.

Notary Public Commission Expires

ERRATA SHEET

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CERTIFICATE

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State of Ohio) SS.:
County of Geauga)

I, Kimberly K. Hargis, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, was duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the event of this action.

I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28 (D).

IN WITNESS WHEREOF, I have hereunto set my hand this day of , 2002.

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Kimberly K. Hargis, Notary Public
within and for the State of Ohio

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My commission expires June 15, 2006.

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