IN THE COURT OF COMMON PLEAS

MEDINA COUNTY, OHIO

HERBERT DAWSON, et al.,

Plaintiffs,

-vs-

JUDGE KIMBLER
CASE NO. 03CIV0421

MEDINA GENERAL HOSPITAL, et al.,

Defendants.

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Deposition of JOHN CONOMY, M.D., taken as if upon cross-examination before Juliana M. Lawson, a Notary Public within and for the State of Ohio, at the offices of Weston, Hurd, Fallon, Paisley & Howley, 2500 Terminal Tower, Cleveland, Ohio, at 4:00 p.m. on Thursday, February 26, 2004, pursuant to notice and/or stipulations of counsel, on behalf of the Defendants in this cause.

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On behalf of the Defendants.

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

CROSS-EXAMINATION OF JOHN CONOMY, M.D.

BY MS. HARRIS:

Q. Would you state your name for the record, please.

A. My name is John Conomy.

Q. And, Dr. Conomy, we're here taking your deposition in the Herbert Dawson matter. From my understanding, you've written two reports. One dated March 12th, 2003 and one dated November 4th, 2003. Is that correct?

A. That's correct.

Q. And since that time, I take it you have reviewed the nurses' depositions?

A. I can read the names of the people whose depositions I have. Now, in the report that is dated November 4th, 2003, I've recorded as having read the depositions of Dr. Abellera, Dr. Kontak, Mr. Dawson and Dr. Cervino.

I have additional depositions from Patricia Christino (phonetic), a nurse, from -- can I have

that other packet. And Margaret Ocasek, also a nurse.

Q. And before we went on the record, I asked you, did you make any notations on either of the depositions?

A. Yes. I've not made notations, but I've used an underliner to let me know that I have read the depositions. There's some underlining in the occasional deposition. Largely dealing with placement of IV lines and observations about IV sites and so forth. They are nearly solely in the nurses' depositions.

There's an occasion underline in one or another of the medical depositions. I think Dr. Kontak's about his prior care and when he was called and when he referred Mr. Dawson to Dr. Abellera and other physicians.

Q. I'm looking at two nurses. And you said --

A. Yes, Christino and Ocasek.

Q. From my quick review of the Ocasek deposition was that there were no underlining things in this deposition.

A. No.

Q. Or highlighted I should say. There are none in the Christino deposition. We've been both saying

it wrong. It makes me feel better.

The two reports that you have written, those are the only reports, right?

A. Yes, they are.

Q. And the first report from March 12, 2003 is your evaluation of Mr. Dawson; is that correct?

A. Yes, it is. It contains a history, an examination and an impression at the end. That being on page four of what I felt was wrong with him. The end of that exercise, the second --

Q. Just let me stop at the first one.

A. Go ahead.

Q. On the first report, May 12, 2003, do you have any office notes regarding your examination?

A. No, I don't. I habitually don't take them.

Q. Any findings of your examination are in this report then?

A. Yes, they are.

Q. Did you have any medical records or any records of depositions that you reviewed and/or about the time that you prepared this report?

A. No. About the time, yes. But I habitually do not review medical records prior to seeing an individual if I know I'm going to see. And I may have had records here. They were shipped in

April. But I don't read them until I've had an opportunity to interview and examine the person concerned. I just think it makes me more attentive and I think it's a more fair exercise to do it that way and that's what I usually do.

Q. Your report of May 12, 2003, is there anything contained in this report that you obtained from any of the depositions or medical records?

A. No, there isn't.

Q. So under the history portion, for example, in this report, that is all the history that was given to you by Mr. Dawson?

A. Yes. Now, his wife was with him through this exercise.

Q. So she may have contributed to it?

A. No, she didn't. He did. There was no need for her to contribute to it.

Q. Now, also, you've written a report on November 4, 2003. And that is recording your review of the various documents, is that correct, in depositions?

A. Yes. And they are listed here. Now, let's review not only who said it, it includes my own examination of him incorporated into that document.

Q. And the opinions and analysis portion?
A. The opinions and analysis portion contains those opinions I've offered in this case to Ms. Kolis regarding Mr. Dawson. They deal with issues of causation, damage, the like. Those are not contained in the first document.
Q. Am I correct that you are confining your testimony in this matter to causation and damages?
A. Yeah. That's correct. Now, having said that, I know we both recognize the intertwining and the close relationship between causation and standards of care. If I touch upon standards of care, it's in the sense of causation. I do not pose myself as an expert in nursing care. Such individuals are involved in this. I've read the report of one of them.
Q. Well, in your opinions, would you have put -- set forth in your report, you make no mention of standard-of-care issues; is that correct?
A. No. If I've mentioned things in here, they're in the sense of causation.
Q. Now, can we -- it is your belief that he had complex regional pain syndrome?
A. Yes, it is.

Q. Type one or type two?
A. Well, it's probably type two. But, you know, that becomes obscured. The nosology of complex regional pain syndrome is a takeoff from sympathetic dystrophy, which has a lineage that reaches back into the century before the last.

He's probably had some direct injury to peripheral nerve, but it extends well beyond that. So I think the designation complex regional pain syndrome is appropriate here.

Q. I understand that --
A. Most of his --
Q. The designation the CRPS is correct. I'm asking you is it type one, where it is no nerve involvement, or type two, where there is nerve involvement?
A. I think he has nerve involvement. He is terribly -- he was during the time I examined him so awfully in pain that precise determination of that is hard to make. If you pin me to the wall, which you're doing, and say type one or type two or I will shoot you finally, Dr. Conomy, I would have to say two.
Q. In your report, if I'm correct, under the opinions and analysis, this second report is what

I'm referring to, you have under number one, he has complex regional pain syndrome, type one?

A. That should be two. I'm sorry.

Q. In the subsequent paragraph you have -- which is labeled number two, you have complex regional pain syndrome, type one.

A. Same thing. Use the stroke and make another vertical line next to that. It should be two. That was typed by me, so I have nobody to blame but myself unfortunately.

Q. Which nerve?

A. Well, it's probably the ulnar nerve. Getting at it in terms of precision is precluded by his pain. It's just not possible to collect all the clinical data you would like to have to do that.

Q. Where was he injured, at what level?

A. I can't tell you.

Q. You indicated in your records that -- reports, excuse me, number four, you have documented infiltration of intravenous fluids and phlebitis. Do you see that?

A. Right.

Q. First off, is there a difference between infiltration and phlebitis?

A. Well, there is a distinction, as you know, one --

it can also be the presence of fluid outside the vascular compartment.

Q. Which one?

A. Pardon?

Q. Which one?

A. Infiltration.

Q. I'm sorry. I interrupted you. Continue.

A. That's right. And phlebitis is inflammatory disease of the vein. It's a red line running down his arm. And that's a good approximation of what probably -- very probably reflects.

Q. Can we agree that IVS do infiltrate in the absence of any negligence on anyone's part?

A. Yes.

Q. Can we also agree that patients can develop phlebitis from an IV in the absence of any negligence on anyone's part?

A. Yes.

Q. Phlebitis, as you said, is an inflammation of the vein. How does -- what causes phlebitis?

A. Occlusion generally. That is --

Q. Excuse me, please. Say it again.

A. Occlusion. That is thereafter associated with inflammatory changes to the point of occlusion extending up and down away from that point.

That's not the only cause. That's simply the most common.

Q. How does occlusion occur?

A. It may be from venepuncture. It may be from the presence of a needle in the vein or in the wall of a vein, that may be something to do with the constitution of fluids itself. It may be from the pressure of surrounding fluid occurring from infiltration.

Q. With phlebitis, if it's caused by an occlusion, such as a venepuncture, the vein punctured the needle and the wall of the vein is with fluids, the types of fluids used, the fact that phlebitis occurred due to one of those causes, would that be because someone acted below the standard of care?

A. Not necessarily, no.

Q. So if the needle into the vein was of the appropriate size and the vein chosen was of the appropriate size, if phlebitis occurred for any of one those reasons, it would be not be caused by the nursing staff, correct?

A. No. But again, I recognize you as asking me standard-of-care questions. The answer is no.

Q. I appreciate that. And again, I'm going back to

what you said before, standard-of-care questions overlap a little bit with causation?

A. Yeah. Well, it's more than a little bit. It's a lot.

Q. And what I'm getting at is that phlebitis can occur in a vein without anyone having been deviated from the standard of care and it can occur from medications or from the needle hitting the wall of the vein?

A. All of these are mechanics. They really don't have to do with the standard of care. They're mechanisms.

Q. The records seem to indicate that Mr. Dawson developed phlebitis somewhere around the morning, 2400, of August 30th.

A. The precise time of that is unknown. Not clear in the mind of the nurse. And I think it was Ms. Ocasek that gave commentary about that. I'm not sure -- the date is written over 29, 30. And the times are around midnight. So I'm not sure exactly what date is reflected in that. There's room for -- there's room for some looseness in the joints, as the Supreme Court chief justice recently put it in a more important case than this, if that's imaginable.

However, the nurse did note that at that time. It's recorded in the chart. Do you want me to get it out?

Q. Yes, please.

A. It's in volume one. It's at the beginning of the note. So let me find the telltale green clip and get to that. That's around the 29th. I think this is the note you're referring to. Is it? 2400 or 29 --

Q. Thank you. Can you pull it out. I can't see across the table. Thank you. That's the note. It looks like 29 and then it's written over 30.

A. Fine. That happens, too. It's kind of like phlebitis. It happens.

Q. By the way, there's no way to predict which patient will develop phlebitis, correct?

A. Not really. There are some people that for one or another odd reason are set up for it. But in general, the answer is no.

Q. What do you mean, some people are set up for it?

A. Well, if you deal with somebody with venous disease or hypercoagulable states or sepsis or god knows what, then they might be more likely to do it. But I don't want to deal with exceptions. The general rule is as you stated.

Q. And, in fact, there is nothing in this case that would state that the general rule would not apply, correct?
A. No, there isn't.
Q. If you look at that 2400 hour note, that's when Nurse Ocasek determined that the IV needed to be changed, correct?
A. Yes.
Q. And can we agree that there is no indication in the previous notes of the nurses that there was anything wrong with this IV?
A. No, there isn't.
Q. If the nurse in the previous shift, and we assume that she found -- Ms. Ocasek found this at 2400. If the nurse on the previous shift had found that the IV was fine at 2000, 8:00 p.m. --
A. Where? At 10:00 the evening before?
Q. Yes. 10:00 and 8:00. That would be -- would not be unreasonable, would it?
A. Well, I don't know if it's unreasonable or not. He's got a red stripe going down his arm. It takes time to develop that. One can argue how much time. It's usually hours that that occurs. But it's not recorded.

Now, the non-recording of the thing leaves a

number of possibilities. It wasn't there. It was there but not observed. It was observed but not recorded.

I don't know which there was. The first clear evidence we have of it, however, is this note.

Q. But it would not surprise you that it developed over two hours, correct?

A. No, not really. No.

Q. And that would be reasonable for the phlebitis, as she defined it or described it in the record, she being Ms. Ocasek, would develop within the two-hour period?

A. Correct.

Q. Can you tell me, Doctor, can you grade a phlebitis? Are there stages of it?

A. Well, I suppose there are. I mean, from early to late. When things are badly occluded and swollen and necrotic. I'm not familiar with staging criteria for phlebitis in that regard.

Q. And can you tell me though how you would categorize this as early, late, middle --

A. No, I can't tell you from this description. It's kind of like reconstructing the Egyptian civilization from scratch on a rock.

Q. So that description doesn't give you enough information as to whether you would quantify this as severe phlebitis or mild phlebitis?
A. No, it doesn't. He has a red streak running down his arm and that's the end of it. I don't think you can say anything more than that.
Q. Doctor, am I correct that you have seen phlebitis in patients in your practice over years?
A. Yes. Sure.
Q. Doctor, can we agree that --
A. Excuse me.

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

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Q. The treatment for phlebitis, is that just as described there?
A. Well, it's to stop the offending source. And I think the nurse did that, Nurse Ocasek, when she put a number 22 intracath in his right hand. She changed the IV site. That's the beginning of things.
Q. And that was something that you would expect her to do, right?
A. Yeah. That's essential. That's the essential

piece. Now, it's more than poultice or meaningless poultice. It's soothing, it's sometimes helpful to apply heat, moist heat to the site. It's usually a painful condition. And to keep an eye on it.

Q. And she applied the moist heat?

A. Right.

Q. And they kept an eye on it, correct?

A. Yeah. It's more than keeping an eye on it as a passive act. There's things to look for. Swelling, further evidence of progressive phlebitis, evidence of infection, chemical reactions. He did have I think Flagyl and some other antibiotic running through it, which can under certain circumstances be more than mildly irritating, and tissue destruction. So there are things to look for in terms of the observation.

Q. And you saw nothing in the records to suggest anything adverse?

A. No, no. I did not see evidence of that in the record.

Q. On September 4th, I believe the records indicate that the arm had improved and that the area of the phlebitis was only slightly red. Do you recall seeing that?

A. Which date are you talking about?
Q. September 4th.
A. I don't have that in front of me, but I recall that. It's got some more marks around it, the 3rd and the 4th. Yes, I agree.
Q. And that would indicate to you that whatever the nurses were doing and observing, that this was improving, the phlebitis?
A. I'm not sure I take that particular view of it or take a consolation. On 2400 and 100 on 9/4/99, there's a note that old IV site, left forearm, FA. Still slightly red and -- the pad was kept there at the patient's request.

There's still a problem there. There's little in the way of description of it and it's still slightly red.

Q. However, can we agree that that appears to be an improvement over the way it was previously?
A. I'm not sure. Because the deficiencies -- I don't want to call them deficiencies. The descriptions as they exist are not full enough, at least for me to say that this is really improvement or not. It says the letters SL, slightly, I think that's slightly.
Q. Yes.

A. You know, may suggest that, at least to some -- it's not a good description of what's going on.
Q. She does not describe any cord involvement?
A. Pardon?
Q. She does not describe cord involvement, correct?
A. What kind of involvement?
Q. Cord?
A. Like a cord in his arm?
Q. Yes.
A. No. She doesn't describe that or swelling or heat or redness in the local area or what has happened to the vein itself or just what his complaints are. It was enough that he requested something to be done about this at a time that he's receiving abundant Demerol and a number of other drugs. So what had been treated was his basic problem with abdominal pain, his diverticulitis and procedures.
Q. You saw no evidence in the record that there was cord involvement, correct?
A. No. No one has palpated a cord or a rope.
Q. In the absence of a cord or a rope, would that indicate to you that this was a milder phlebitis as opposed to more severe?
A. No, not at all. Because a swelling in the arm is

enough. You're not going to be able to feel much of anything except indurated tissue. You may not be able to feel that and you may not be able to see a line any longer. It doesn't indicate much of anything except to take her words and abbreviations at their face value. It's still slightly red and he asked for a pad to be put on that.

Q. Was there any evidence in the record that that was swollen?

A. No. The descriptions of swelling are his descriptions. And it's not reflected in the record basically anywhere.

Q. Other than removing the offending agent, the IV catheter, and applying heat, was any other treatment required for this?

A. No.

Q. Did this require notification of the physician?

A. Did what?

Q. Require notification of the physician when the phlebitis occurred?

A. I can't tell from the descriptions here because the descriptions are not full. All I can tell you is he had phlebitis and had persistent troubles enough to ask while medicated for pain

for a local application of a heating pad three or four days later.

Beyond that, it's too speculative for me, Ms. Harris, to say that -- a number of things that he has described are not described here. Now, if Mr. Dawson's descriptions of what was wrong with his arm are valid descriptions, then it's not enough. And if all it is is a little phlebitis and a bump treated with a warm wash cloth to the site, then that is a different case.

Q. You read Dr. Abellera's deposition, correct?

A. Yes.

Q. And if it was as bad as Mr. Dawson has told you and, also, subsequently testified to, would you have expected Dr. Abellera to know about this?

A. The answer again is I don't know. And it demands that I take a choice about who is telling the truth here. And I -- I'm uncomfortable doing that.

Q. Well, I appreciate that. But I'm just saying if it was as bad a description as given by Mr. Dawson, that would have been obvious to someone like Dr. Abellera, correct?

A. If Mr. Dawson is to be believed, then it's not enough attention given to him for his problem.

Does that answer your question?

Q. No.

A. Could you try me again.

Q. I sure will. If, as Mr. Dawson has testified and also told you on your examination, about this site, would that be something that would be readily apparent to a physician who comes in to check his patient after surgery?

A. Well, if his description to me -- and I quote him, the late Mr. Dawson, it blew up like you wouldn't believe. And he's referring to his left hand and forearm. If that's the case, Dr. Abellera should have been called. And if this is simply a wild exaggeration of what went on, then no.

Q. My question though is the following day, Dr. Abellera came in to see this patient, did he not?

A. Yes, he did. Dr. Abellera was attending him I think quite diligently in terms of frequency of visits and so forth.

Q. And then my next question is if it blew up as big as Mr. Dawson said and Dr. Abellera came in the following day, as was his routine, would you expect that Dr. Abellera would have seen this and known about it?

A. Dr. Abellera would have been informed about it either by Mr. Dawson or by the nurses. I expect he would have been.

Q. Would you have expected, if it was as bad as the description given by Mr. Dawson, that he would have mentioned this to Dr. Abellera?

A. I expect he would have mentioned it now. Dr. Abellera's focus of attention, his phobia for Mr. Dawson is his diverticulitis and very serious condition going on in his abdomen pending and then following complex operation. This may have been relegated if he were told about it to the category of something, quote, minor, quote.

Q. However, you would expect that if Mr. Dawson was in the shape that he has testified to, in extreme pain and swelling, that he would have mentioned it to Dr. Abellera even if Dr. Abellera's attention was not on it?

A. I would have expected it. And again, his extreme pain is treated with big doses of Demerol every two or three or four hours. So again, this is another compounding feature.

But if his arm would have been blown up like you wouldn't believe, as he stated to me, I suspect he would have called it to Dr. Abellera's

attention. Whether Dr. Abellera would have recorded it or remembered it or considered it something serious beyond simply an infiltrated IV, I don't know.

Q. If he had called it to Dr. Abellera's attention, was any treatment, other than what was done, required?

A. What was done being what? The application of heat?

Q. Heat.

A. Close observation and so forth.

Q. And removal of the course of the IV?

A. No. Beyond that -- if that's all that was wrong and that's all he complained about, then no.

Q. Did you read anything in Mr. Dawson's testimony or did he tell you anything that indicated that additional treatment was required?

A. Mr. Dawson never told me that additional treatment was required.

Q. No. No. I said is there anything in Mr. Dawson's discussions with you or in his testimony that would indicate that additional treatment was required?

A. At that point?

Q. At any --

A. I'm sorry. I don't understand.
Q. You've indicated --
A. Okay. I think I understand. Mr. Dawson did tell Dr. Abellera that additional treatment was required. He refers to Dr. Abellera, it's at page two in the second, third paragraph.

He visited his physician. This was the postop visit from Dr. Abellera and it's in his testimony, too. But more or less shrugged his shoulders and said it wasn't his problem and was told that things would improve.

Q. That was after he use --
A. Yes, yes.
Q. I'm talking about in the hospital.
A. That's what I asked you. I'm sorry.
Q. Let me start again. You have indicated that his arm is, by his description in the hospital, was blown up and it was very painful. You've also read his deposition and you took additional history from him.

I'm asking you, in the hospital, for the phlebitis of the forearm, was any other treatment required if you believe the description of Mr. Dawson?

A. I understand. I hope I'm answering you in a

direct way. If all he complained about was some minor puffiness and tenderness at the site of a former IV, no. If he was complaining of tremendous swelling and as he told me he was having tingling and numbness in his hand, then the answer is yes.

It comes down again to which of these dissimilar description of events one chooses to believe. On one hand we have a non-description and on Mr. Dawson's part to me and in his testimony, the notion that things were going badly even when he was in the hospital.

Q. In that case, what treatment, if any, should Dr. Abellera have --

A. If there is persistent swelling and if he's complaining of a loss of feeling in his hand, then he needs to be specifically examined for those complaints. The choice of who to examine him can be a number of people.

Dr. Abellera himself looking for compartmental compression. A neurologist or neurosurgeon looking for evidence of nerve injury in the face of an infiltrated IV in a man who now complains of numbness in his hand.

Q. And that was not done in this case, correct?

A. No.
Q. And you saw no evidence in the records that there was tremendous swelling or he was complaining of numbness and tingling?
A. No, no, no. The record is a record of a man who has abdominal pain, abdominal problems, potential sepsis and abdominal surgery. And the record is really quite a good mirror to those problems. It is no mirror at all to the problem we're addressing.
Q. And you would not expect them to talk about persistent big swelling or tingling and numbness in the hands if those -- record that in the record if those symptoms weren't there? You wouldn't expect that, correct?
A. Well, I wouldn't expect it, but I know darn well it happens.
Q. He indicated to you, at least from your history, on your first report, that the -- I guess the second paragraph of the second page where it starts postop and intravenous infusions. Do you see --
A. Yes, I see.
Q. Was started in the dorsum of his left hand. Where was the site of the phlebitis?

A. Well, the site of the red line is in his forearm. The site of phlebitis is not necessarily at the site of venepuncture. It extends from it. And in this case, you would expect it to travel up the arm.

Q. Where was the IV at the time of the phlebitis?

A. As best he can recollect, the site of the puncture was somewhere around the wrist and forearm. It was not around the hand itself.

Q. I'm sorry. At the time the nurse wrote the phlebitis, where was the site of the IV?

A. Well, it's a DC IV site. I'm not sure exactly where around his wrist. Whether it's toward his hand or toward his forearm. That's as close as I can come.

Q. I'm sorry. When the IV was discontinued at 2400 either on the 30th or the 29th, whatever the day might be, the IV that was discontinued, where was that IV placed originally?

A. It doesn't say.

Q. Was there anything in the records that indicates where the IV was placed?

A. No. He's said the IV was in a number of sites. Right hand, left hand, his forearms. Intracaths -- intracaths are generally not placed in arm

veins and hand veins. But he's had them in a number of places.

Q. And it's your belief that the IV that resulted in the phlebitis was located somewhere in the dorsum of the hand?

A. No. Somewhere around his wrist. Probably above it. He called it his hand. But it was clear from his description to me that it wasn't down near the fingers. That it was around the wrist, probably above it.

Q. Above the wrist. How far above?

A. I don't know. He can't tell me and I don't know.

Q. From your review of the records, where do you think this IV was?

A. Probably above the wrist in the forearm, just above the wrist someplace, with a vein large enough to accept standard intravenous lines.

Q. I appreciate that. I guess I'm very confused, Dr. Conomy. I don't think of the wrist and the forearm as being the same.

A. I'm sorry. You don't what?

Q. I don't think of the forearm and the wrist as being the same. And I'm trying to get a sense of where you think this was.

A. I can't be any more precise than that. They

didn't say and he doesn't quite know.
Q. How far above the wrist do you think it was?
A. I don't know. I can't speculate about how far above the wrist it was.
Q. You don't know which vein it was in, correct?
A. Of course not. Unless I'm told, how would I know?
Q. You don't generally see nurses putting in your records for your patients --
A. I don't think the nurses know the name of the vein in the forearm.
Q. You don't expect them to?
A. I don't expect them to tell me.
Q. You don't expect them to tell you which vein?
A. No. It was somewhere around his wrist, probably above it and on the left side.
Q. And it says postoperatively an intravenous infusion.
A. Well, this was not -- this is what he told me. But it's not postoperatively. It's preoperatively.
Q. So he was incorrect at that point at least?
A. Yeah, right.
Q. Did he ever have an IV in his hand?
A. I believe he did.

Q. Left hand. Let's forget the right.
A. I'll have to go back and look. He said IVs changed about five times. He did in the emergency room, I believe. He also didn't remember when the IV was started.
Q. After or --
A. No, no. When he came in. He had it in his left hand in the emergency room.
Q. No. I mean for you to go back.
A. No, that's okay. I've got the emergency room note from this admission. He was admitted by the emergency room by a physician there to Dr. Abellera. Number 20 IV. I don't know whether they used an intracath or not. It says left forearm, but where again, not stated. And it's not a criticism. It generally isn't stated.

Now it's in his right hand at a later time, 12:15, on which day -- this is in the recovery room. So again, he's had IVs in both arms, probably in multiple sites. I wouldn't expect them to be specifically recorded and there's nothing unusual about IVs being changed from arm to arm and site to site in the course of a hospitalization like this. It's normal.

Q. Is it unusual to have IVs changed so that they

are in the forearm and then down into the wrist area?

A. Is it unusual to have that?

Q. Yes.

A. No. You try to stay away from the hand because they don't last. They infiltrate or plug up or something. If you can avoid the hand as a site, generally you do.

Q. But it's perfectly appropriate to put an IV in the forearm and then when that infiltrates, rotate to the other arm and then come back to the wrist?

A. Well, you try not to go back to a prior site, because the reason it didn't work in the first place is likely to happen again. You choose another site.

Q. I appreciate that. But to go from the forearm to the wrist is choosing another site, correct?

A. Yes.

Q. And that's perfectly appropriate to do the forearm and then after a period of time to do the wrist?

A. Yes.

Q. Doctor, I'm looking down here at the late entry, I believe it is.

A. Which entry do you want now? Right wrist.
Q. I think it's 0410, the late entry --
A. Yes. I have the same. Go ahead.
Q. My question in that is that is -- would that be the one that Mr. Dawson is referring to?
A. I don't know which one he's referring to. I don't know.
Q. The fact that he --
A. This is one of many. So beyond it, I can't tell you. I don't know.
Q. The fact that he had an infiltration in the forearm and that one that was put in the wrist --
A. This is leaking. It's not infiltrating in his forearm. It's probably leaking around the needle site someplace. So they changed it. That's another reason to change an IV.
Q. Did that cause any damage or harm to Mr. Dawson, that IV?
A. The one you had me look at here?
Q. Yes.
A. Not that I know of it didn't.
Q. So let's be -- thank you. Let me be clear, because it took me a while to find this. There is an entry in the nurses notes on 9/3/1999. It's a late entry. It's timed 0410. It says,

"IV, right wrist leaking around insertion site. IV DC." And now there's one put -- "number 22 protracted. Inserted left hand without difficulty."

A. It's protect. It's an intracath. Now, leaking generally means that it's leaking out of the room or out of the IV puncture site. That's usually not a description of infiltration. But it's not working for him, so they changed it.

Q. And they put it into the left hand, the number 22 protected intracath. That was appropriate to do that, correct?

A. They changed the IV site. Sure it is.

Q. And it was appropriate to go back to the left arm even though he had phlebitis in the left forearm?

A. If they stay away from the phlebitic site and get the IV to run, yes. And he doesn't appear to have an active infection or something terrible going on at that site. You try to stay away from the site of prior infiltration or elude that bad site of infiltration. But they apparently got it going this time in the left hand.

Q. So that's not below the standard of care to use that --

A. I'm sorry.

Q. It was not a deviation from the standard of care to use that site then?

MS. TAYLOR-KOLIS: I'm going to object only to the extent he's already testified within the first five minutes of today's deposition that he's not an expert in nursing standard of care. Go ahead.

Q. You can put them in without any injury to the patient, correct?

A. Well, in terms of a chain of events in causation, no, it's not inappropriate.

Q. Not inappropriate?

A. It's not inappropriate. The guy needs an IV. He's on Flagyl and -- what else? Demerol by that point. So no, it isn't.

Q. Let's go back to your second report.

A. Sure. The second report. Yes.

Q. Can we agree that one can't predict which patients will develop complex regional pain syndrome?

A. Not entirely. I mean, it becomes increasingly predictable to crushing injury to a limb. That's its usual origin when it does occur. Someone with minor injuries, such as the attorney I once saw who hanging her coat upon a hook in her

office at a large firm located in the Terminal Tower was said to have developed complex regional pain syndrome. That's a minor injury, if injury at all. And is a very unlikely inciting event.

Someone who has compartmental compression from crush or from the extravasation of fluid, intravenous or otherwise, once into the limbs is much more likely to develop complex regional pain syndrome.

Q. There is --

A. So what it comes down to, you can't tell. The answer is yes. But it becomes much more likely under some circumstances than others. You are not likely to get run over by a car on the 25th floor of the Terminal Tower. If you run across the street during rush hour, it increases the likelihood you'll get hit.

Q. There's no evidence he had a crush injury in this case, correct?

A. Not a crush injury. I don't point to the crush itself and say crush injury. But rather the extravasation of the fluid into tissues that follows it.

Q. But there was no evidence from the records to show that he had edema accompanying this

phlebitis?

A. Not from the records. It's only his testimony that states that. His testimony and the results of what it is that happened to him.

Q. But the fact that an IV infiltrates and you get edema from it and develop complex regional pain syndrome, that's not predictable, is it?

A. No.

Q. And in a case such as this, can we agree that in general you can't prevent this syndrome from developing?

A. You know, I'm probably in a minority of physicians. But I'd agree with the statement. There's always the caveat that early treatment is determinative. And I think it's a correct caveat to be employed.

Persons who are in the process of developing this, when they're seen at a time that all they have is some tingling and perhaps some uncomfortable diffuse feeling in the disproportion of the limb, are likely to do better than someone who is left a month in that condition and now appear with a limb that's on fire and can't be used for anything.

So that early treatment does mean something.

I don't think it's clear at all that early treatment of reflex sympathetic dystrophy or now complex regional pain syndrome is necessarily going to abolish it once the wheels are set in motion for its inception.

Q. Was there a nerve injury caused by this IV?

A. That's very hard to say. It's likely that he's injured in the course of what I believe is compartmental compression in both his median and ulnar nerves. But the problems arising in examining him. Where his limb can't be touched, fondled, brushed or moved. It makes things very hard to do. And in an electrophysiologic determination of his injuries is an ion to impossible because the pain involved. I'm sorry?

Q. Do you know if he had prior injury to his median and ulnar nerve?

A. Not that I know about. Now, he's a person who has been injured playing football, as many of us have. He's a carpenter and a tradesman. He's injured himself at work.

But there's nothing in his history as I know it and as I've taken it or understand that he's had peripheral nerve injuries from trauma or burns.

Q. Then how did he develop the median and ulnar nerve injury?
A. It's most probable it's from compression of fluid, both from the IV itself and from associated edema associated with inflammation and phlebitis, squeeze peripheral nerves because there's no place else for fluid to go until it's absorbed somehow.
Q. How much fluid would you need to spread into his tissue to cause a compression?
A. It depends on the compartment involved. If it's around the wrists, you need very little. A cupful. And if it's in soft tissues of the upper arm, a good deal more.
Q. You read Dr. Cervino's deposition?
A. I did.
Q. Did you take away from that deposition that he did not believe he had complex regional pain syndrome?
A. I'm not sure what to take away from that deposition. I think he's waffled a bit on it. I don't know what else he could have thought he had.
Q. Did you read the Social Security records from this --

A. I don't have the Social Security records.
Q. I don't know what they're called, but they were to evaluate him for disability.
A. I don't have them.
Q. Were his symptoms always consistent from the various examination he had?
A. Again, I don't have all the examinations he's had.
Q. Of the ones you saw?
A. Of the ones I saw, in general they are, I think, given ordinary human latitude. He tells a consistent story and has consistent findings. You know, I look at the examinations he's had by physicians and mine and Dr. Hanna's, you know, the statements may be a bit different, but I don't think the conclusions are.
Q. Was there a difference between your examination and Dr. Hanna's examination?
A. There's always going to be some distinction. Even with the distinctions recognized. I think the kind of things I would expect as intraexaminer variability. They're not inconsistent with what everyone -- virtually everyone who has seen this man thinks is wrong with him.

Q. What distinctions were there?
A. I don't know. I'd have to go a back and look. The way he states things, the way he examines people and records them is different than mine. Mine tends to be more literary and his more -- how shall I put it? Telegrammatic.
Q. You are more flamboyant than he is?
A. Pardon?
Q. You are more flamboyant than he is?
A. To each his own.
MS. HARRIS: Just record that he was laughing.
Q. You under number four in your report, the second report, the medical records document infiltration of intravenous fluids and the presence of phlebitis in the left forearm.
A. Right.
Q. And you're referring to the time around August 30th and 2400 the time?
A. I'm talking about the lump or bump and the red line.
Q. And that's the time August 30th or 29th, depends on how you look at it.
A. Sometime around midnight that day.
Q. And no other IVs contributed to the development

of this complex regional pain syndrome that you can tell?

A. I don't think so. I don't know. But here is a man beset with abdominal pain, full of drugs. You know, he has enough Demerol to prevent most of us from knowing which day it is. His IVs are being rotated as they need to be, who then emerges when he comes to his senses with an arm that is virtually on fire, very painful. I don't think he remembers all the IVs and all the changes --

Q. I'm sorry, Doctor. That's not what my question was. Can you --

A. I keep answering some other question. I'm not sure of the nature of the questions or the fact that I don't want to give that answer at this time, no matter what the question may be. I did not answer her question.

MS. HARRIS: Can we shut up enough so she can read it back, otherwise she can't.

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(Thereupon, the requested portion of the record was read by the Notary.)

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Q. We just talked about item number four in your report. My question to you is the IV that we were talking about earlier that was removed on August 30th or the 29th at 2400, that's the only IV that you're talking about that is involved in the development of the complex regional pain syndrome in this gentleman?

A. I hope I'm being responsive. I go on to say, "Beyond this, the record lacks precise description on what was going with on with Mr. Dawson's left arm." That's the only IV I know that has merit in any kind of description of things going on at all. It's certainly not the only IV in his left arm at or about that time.

Q. But there's nothing in the records that you could find that said any other IV was involved in the development of this problem?

A. No, there is nothing in the records -- and that's part of the problem. In fact, a great part. There is nothing in the record beyond what I've stated.

Q. So the IV that we talked about was put in the wrist on September 3rd, in your opinion, that IV was not involved?

A. Not that I know about, but it's because I don't

know. You know, I think anything put in his left arm is not above suspicion. Certainly that placed on the 29th is the one I know most about, not that there is that much to know about it from those records, that has caused the nurses to comment on inflammation and swelling.

Q. In your examination of Mr. Dawson, you said towards the history, the examination, was there anything he could or should have done to have helped with his complex regional pain syndrome?

A. You know, I've thought about this. I think that he's responded in a reasonable way. He recognized something that was wrong. He -- again, I'm talking about what he told me. I'm talking about his testimony. He brought it to the attention of the nurses. He brought it to the attention of the physicians and eventually got care for it.

I don't see him experiencing these things and being mute about it for say a month.

Q. Is there any other treatment that he should have engaged in?

A. On his own, no.

Q. At the behest of any of his physicians that would have helped his condition?

A. Well, the physician would have to make the suggestion for him to do that and he didn't. I'm not sure how to answer your question.
Q. Are there any suggestions after you examined him in 2003 that you felt would have helped or should have helped his condition?
A. Let me make sure I understand it. Is there something any physician could have done between the time he began to develop this and the time something was done that could have helped him. Is that the question?
Q. No. The question is is there any treatment that could or should have been done to have helped him once he developed these symptoms?
A. Well, once he developed these symptoms which was, according to him, when he was still in the hospital, am I to take that as a go point or a month later when he sees Dr. Abellera?
Q. When he sees Dr. Abellera.
A. That's a month and he's already -- well, then it's not exactly early and the treatment he eventually got was the right treatment. And that's pain medication and, for what good they may do, calcium channel blockers or other types of blocking agents that are vascular-active

drugs. And treatment with sympathetic blockade from -- with local anesthetics. He got all of those. I don't think there was anything he could have done.

Q. How about psychological counseling?

A. Well, that's not a place to start. Persons with this, such as he, are tremendously depressed. Suicidal, in fact.

Q. Are you of the school --

A. That I think it's possible? You know, he's a memorable man. There are a lot of things I'm going to forget and have forgotten in the course of my professional life. But I'll tell you, Herbert Dawson wouldn't be one of them.

Q. Is there a theory and do you subscribe to the theory that those patients who develop complex regional pain syndrome have underlying psychological problems to begin with?

A. No. I don't think they start -- complex regional pain syndrome starts off with underlying psychological depression. The world is so full of underlying psychologic depression. It seems to be a disease of any conscious adult who has thought about their station in life. If one looks at that as a starting point, then we're all

suspect as developing this disease.

Certainly it's a cause for reactive depression, certainly in persons like Herbert Dawson. I mean, this is a physical guy, grandchildren he plays with, pride in what he's done and what he's accomplished. His depression is certainly a reaction to the loss of the self-esteem that comes along with all those roles. He couldn't do any of them anymore.

Q. The question is you don't subscribe to the theory that in response to the complex regional pain syndrome is due to --

A. No.

Q. -- underlying --

A. I don't think it's condition of people who at the time they were hurt were already busy whining in the streets about their sad role in life. No.

Q. Would he have benefitted from counseling at any time?

A. Well, I think there's a benefit to all of us from counseling when we're having troubled times, sure.

Q. Do you agree with the conclusion in Dr. Hanna's report that he needed psychological counseling?

A. Well, first impression, I put it a little

differently than Dr. Hanna did. But the reasoning behind Dr. Hanna's suggest may or may not be mine. Depression acts as a magnifying glass to pain. As long as it's there, pain can't be successfully treated. So depression needs to be treated quite commonly with whatever else needs to be treated or else treatment is not likely to be effective.

Q. Can we agree that if one develops complex regional pain in an extremity, one doesn't generally see the complex regional pain syndrome migrate to the other side?

A. It happens, but it happens very rarely. And I'm only suspicious about it when it does. Complex regional pain syndrome in certain respects has become a kind of religion in terms of the necessity for belief in terms of its expression.

Quite frankly, most of the persons I see who are said to have it don't. He's not one of them.

Q. But as a general rule, it does not migrate to another extremity?

A. It migrates. That's one of its characteristics. And it may migrate to another extremity. That's rare.

Q. There would be nothing in your examination --

excuse me. That was not a good question.

There would be nothing in your evaluation of this gentleman that would for -- in your diagnosis of complex regional pain syndrome, that would account for him having trouble walking up stairs or stumbling?

A. Well, not as such, unless it's his treatment or the pain is so great that he's not able to do that. The pain can be severe enough to keep him from walking upstairs at all, even if it's in his arm. Any jostling, any movement, a touch, a brush or change in position is enough to set off a volley of suffering. Not only in Herbert Dawson, but in persons like him.

Q. Is it your contention then that any stumbling that he complained of would be related to the complex regional pain syndrome?

A. I think much of what he complained of is related to it.

Q. That's not my question. If he complained that he was stumbling when he walked, is it your opinion that that would be related to the complex regional pain syndrome?

A. Well, it could be related, as I said a number of ways. If he's taking a mouthful of Vicodin --

let's see his dose, calculated it, one-twelfth of --

MS. HARRIS: Go off the record.

A. And that's substantial.

Q. You have in the concluding paragraph of your second report that it is my understanding that additional depositions are taken or were taken, whatever.

A. Yes.

Q. We've talked about those depositions that you have since read of the two nurses.

A. Yes.

Q. Have any of your opinions changed as a result of their testimony?

A. No. I think the depositions of the nurses particularly, and not unexpectedly, and again, without criticism of the nurses, include things like lack of specific memory, reliance on what usually is done, therefore, it must have been done in this case. Habit and condition and precedence and so forth. They would be largely correct about it.

There's not a lot in those depositions about specific information related to this man. There's some, but little. Most of the reliance

is based on the distant recollection of what is usually done under such circumstances, the management of IV lines and the like.

Q. Based upon what they testified and to their usual patent of behavior, there was nothing in that testimony that you would change your opinions, correct?

A. No, there's not.

Q. And can we agree that four years after the fact, if this man was not memorable at the time, that you would not expect them to remember this patient?

A. No, I don't. Again, this is as I said, this is not a criticism of the nurses.

Q. But I just want to be clear. You would not expect them to remember these -- this patient and thus, they have to rely upon what they generally do?

A. This is -- it's completely expected. It doesn't yield a lot of specific information is my point.

Q. Do you have any opinions or -- that we have not already discussed that you will be testifying to at the trial?

A. Yes. Only this. Pluralites non estponeuda sine necessitate.

Q. After that he's going to translate it. I am not a Latin scholar. I'm an Italian Catholic. We did not get Latin in high school.

A. At least you recognize it as a native tongue. It's Occam's razor.

Q. All I want to know, have we covered all your opinions that you're going to testify to?

A. All but that.

Q. Got to answer me.

A. It means that a multitude of causes may not be invoked when a sufficient and efficient cause is already present. For instance, this man really had had an arm that swelled up like I wouldn't believe, that it hurt so much -- and again, I'm quoting. I would never use the quote myself -- I would like to cut the son of a bitch off. There's loaded guns in the house it hurts so much he wants to kill himself. I mean, that's an extraordinary degree of pain, but it does happen with injuries such as his given and I believe in his description. The thing that prompts me to accept his description is the end result.

Q. I appreciate that.

A. So that may be circuitous reasoning. You may object to it. But I don't think we have to take

Q. And if it was as he described it -- and again, I don't use these words either, but it hurts so much that I would like to cut the son of a bitch off and it swelled up so big, you would then have expected, would you not, the doctors would have noted this?

A. Yes, I would. But my expectations are mighty high.

Q. And you would have expected the nurses, the dozens of nurses that took care of this patient, someone to have made mention of that?

A. I'm not sure it was dozens, but I would have expected it. Now, are my expectations met in the real world. They're not, hence my presence here today.

Q. But you would have expected, also, that Mr. Dawson would have told Dr. Abellera if this was swollen to the extent that he wanted to cut it off and the pain was that intense?

A. Yeah. He said he did. Not cut it off. Maybe he didn't use those descriptions. That happened later. But he complained of tingling to Dr. Abellera. And Dr. Abellera either doesn't record it, didn't respond to it or thought it was a minor problem, that it would go away. Which he

apparently did.

Q. Is that it, Doctor?

A. Unless you have more questions.

Q. I asked you if you had more opinions. Is that it?

A. Not unless you would like more Latin. I have no more opinions. I have much more Latin and a lot of other languages to share with you.

Q. I know you want to say a lot more words, but that's it. Thank you.

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

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JOHN CONOMY, M.D.

C E R T I F I C A T E

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

I, Juliana M. Lawson, a Notary Public within and for the State of Ohio, authorized to administer oaths and to take and certify depositions, do hereby certify that the above-named witness was by me, before the giving of their deposition, first duly sworn to testify the truth, the whole truth, and nothing but the truth; that the deposition as above-set forth was reduced to writing by me by means of stenotypy, and was later transcribed into typewriting under my direction; that this is a true record of the testimony given by the witness; that said deposition was taken at the aforementioned time, date and place, pursuant to notice or stipulation of counsel; and that I am not a relative or employee or attorney of any of the parties, or a relative or employee of such attorney, or financially interested in this action; that 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 and seal of office, at Cleveland, Ohio, this 1st day of March A.D. 20 07.

Juliana M. Lawson, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires October 3, 2007

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LAWYER'S NOTES

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