

1 IN THE COURT OF COMMON PLEAS2 MEDINA COUNTY, OHIO

3 HERBERT DAWSON, et al.,

4 Plaintiffs,

5 -vs-

JUDGE KIMBLER

CASE NO. 03CIV04216 MEDINA GENERAL HOSPITAL,
7 et al.,

8 Defendants.

9 - - - -

10
11 Deposition of JOHN CONOMY, M.D., taken as if
12 upon cross-examination before Juliana M. Lawson,
13 a Notary Public within and for the State of Ohio,
14 at the offices of Weston, Hurd, Fallon, Paisley &
15 Howley, 2500 Terminal Tower, Cleveland, Ohio, at
16 4:00 p.m. on Thursday, February 26, 2004,
17 pursuant to notice and/or stipulations of
18 counsel, on behalf of the Defendants in this
19 cause.

20 - - - -

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On behalf of the Defendants.

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

7 CROSS-EXAMINATION OF JOHN CONOMY, M.D.

8 BY MS. HARRIS:

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

10 A. My name is John Conomy.

11 Q. And, Dr. Conomy, we're here taking your
12 deposition in the Herbert Dawson matter. From my
13 understanding, you've written two reports. One
14 dated March 12th, 2003 and one dated November
15 4th, 2003. Is that correct?

16 A. That's correct.

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

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

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

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

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

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

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

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

19 A. Yes, Christino and Ocasek.

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

23 A. No.

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

1 it wrong. It makes me feel better.

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

4 A. Yes, they are.

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

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

11 Q. Just let me stop at the first one.

12 A. Go ahead.

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

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

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

18 A. Yes, they are.

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

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

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

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

9 A. No, there isn't.

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

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

15 Q. So she may have contributed to it?

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

18 Q. Now, also, you've written a report on November 4,
19 2003. And that is recording your review of the
20 various documents, is that correct, in
21 depositions?

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

1 Q. And the opinions and analysis portion?

2 A. The opinions and analysis portion contains those
3 opinions I've offered in this case to Ms. Kolis
4 regarding Mr. Dawson. They deal with issues of
5 causation, damage, the like. Those are not
6 contained in the first document.

7 Q. Am I correct that you are confining your
8 testimony in this matter to causation and
9 damages?

10 A. Yeah. That's correct. Now, having said that, I
11 know we both recognize the intertwining and the
12 close relationship between causation and
13 standards of care. If I touch upon standards of
14 care, it's in the sense of causation. I do not
15 pose myself as an expert in nursing care. Such
16 individuals are involved in this. I've read the
17 report of one of them.

18 Q. Well, in your opinions, would you have put -- set
19 forth in your report, you make no mention of
20 standard-of-care issues; is that correct?

21 A. No. If I've mentioned things in here, they're in
22 the sense of causation.

23 Q. Now, can we -- it is your belief that he had
24 complex regional pain syndrome?

25 A. Yes, it is.

1 Q. Type one or type two?

2 A. Well, it's probably type two. But, you know,
3 that becomes obscured. The nosology of complex
4 regional pain syndrome is a takeoff from
5 sympathetic dystrophy, which has a lineage that
6 reaches back into the century before the last.

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

11 Q. I understand that --

12 A. Most of his --

13 Q. The designation the CRPS is correct. I'm asking
14 you is it type one, where it is no nerve
15 involvement, or type two, where there is nerve
16 involvement?

17 A. I think he has nerve involvement. He is terribly
18 -- he was during the time I examined him so
19 awfully in pain that precise determination of
20 that is hard to make. If you pin me to the wall,
21 which you're doing, and say type one or type two
22 or I will shoot you finally, Dr. Conomy, I would
23 have to say two.

24 Q. In your report, if I'm correct, under the
25 opinions and analysis, this second report is what

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

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

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

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

11 Q. Which nerve?

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

16 Q. Where was he injured, at what level?

17 A. I can't tell you.

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

21 Do you see that?

22 A. Right.

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

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

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

3 Q. Which one?

4 A. Pardon?

5 Q. Which one?

6 A. Infiltration.

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

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

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

14 A. Yes.

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

18 A. Yes.

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

21 A. Occlusion generally. That is --

22 Q. Excuse me, please. Say it again.

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

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

3 Q. How does occlusion occur?

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

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

17 A. Not necessarily, no.

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

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

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

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

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

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

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

13 Q. The records seem to indicate that Mr. Dawson
14 developed phlebitis somewhere around the morning,
15 2400, of August 30th.

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

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

4 Q. Yes, please.

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

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

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

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

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

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

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

1 Q. And, in fact, there is nothing in this case that
2 would state that the general rule would not
3 apply, correct?

4 A. No, there isn't.

5 Q. If you look at that 2400 hour note, that's when
6 Nurse Ocasek determined that the IV needed to be
7 changed, correct?

8 A. Yes.

9 Q. And can we agree that there is no indication in
10 the previous notes of the nurses that there was
11 anything wrong with this IV?

12 A. No, there isn't.

13 Q. If the nurse in the previous shift, and we assume
14 that she found -- Ms. Ocasek found this at 2400.
15 If the nurse on the previous shift had found that
16 the IV was fine at 2000, 8:00 p.m. --

17 A. Where? At 10:00 the evening before?

18 Q. Yes. 10:00 and 8:00. That would be -- would not
19 be unreasonable, would it?

20 A. Well, I don't know if it's unreasonable or not.
21 He's got a red stripe going down his arm. It
22 takes time to develop that. One can argue how
23 much time. It's usually hours that that occurs.
24 But it's not recorded.

25 Now, the non-recording of the thing leaves a

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

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

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

9 A. No, not really. No.

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

14 A. Correct.

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

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

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

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

1 Q. So that description doesn't give you enough
2 information as to whether you would quantify this
3 as severe phlebitis or mild phlebitis?

4 A. No, it doesn't. He has a red streak running down
5 his arm and that's the end of it. I don't think
6 you can say anything more than that.

7 Q. Doctor, am I correct that you have seen phlebitis
8 in patients in your practice over years?

9 A. Yes. Sure.

10 Q. Doctor, can we agree that --

11 A. Excuse me.

12 - - - -

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

15 - - - -

16 Q. The treatment for phlebitis, is that just as
17 described there?

18 A. Well, it's to stop the offending source. And I
19 think the nurse did that, Nurse Ocasek, when she
20 put a number 22 intracath in his right hand. She
21 changed the IV site. That's the beginning of
22 things.

23 Q. And that was something that you would expect her
24 to do, right?

25 A. Yeah. That's essential. That's the essential

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

6 Q. And she applied the moist heat?

7 A. Right.

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

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

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

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

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

1 A. Which date are you talking about?

2 Q. September 4th.

3 A. I don't have that in front of me, but I recall
4 that. It's got some more marks around it, the
5 3rd and the 4th. Yes, I agree.

6 Q. And that would indicate to you that whatever the
7 nurses were doing and observing, that this was
8 improving, the phlebitis?

9 A. I'm not sure I take that particular view of it or
10 take a consolation. On 2400 and 100 on 9/4/99,
11 there's a note that old IV site, left forearm,
12 FA. Still slightly red and -- the pad was kept
13 there at the patient's request.

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

17 Q. However, can we agree that that appears to be an
18 improvement over the way it was previously?

19 A. I'm not sure. Because the deficiencies -- I
20 don't want to call them deficiencies. The
21 descriptions as they exist are not full enough,
22 at least for me to say that this is really
23 improvement or not. It says the letters SL,
24 slightly, I think that's slightly.

25 Q. Yes.

1 A. You know, may suggest that, at least to some --
2 it's not a good description of what's going on.

3 Q. She does not describe any cord involvement?

4 A. Pardon?

5 Q. She does not describe cord involvement, correct?

6 A. What kind of involvement?

7 Q. Cord?

8 A. Like a cord in his arm?

9 Q. Yes.

10 A. No. She doesn't describe that or swelling or
11 heat or redness in the local area or what has
12 happened to the vein itself or just what his
13 complaints are. It was enough that he requested
14 something to be done about this at a time that
15 he's receiving abundant Demerol and a number of
16 other drugs. So what had been treated was his
17 basic problem with abdominal pain, his
18 diverticulitis and procedures.

19 Q. You saw no evidence in the record that there was
20 cord involvement, correct?

21 A. No. No one has palpated a cord or a rope.

22 Q. In the absence of a cord or a rope, would that
23 indicate to you that this was a milder phlebitis
24 as opposed to more severe?

25 A. No, not at all. Because a swelling in the arm is

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

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

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

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

17 A. No.

18 Q. Did this require notification of the physician?

19 A. Did what?

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

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

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

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

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

12 A. Yes.

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

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

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

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

1 Does that answer your question?

2 Q. No.

3 A. Could you try me again.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 Q. Heat.

11 A. Close observation and so forth.

12 Q. And removal of the course of the IV?

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

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

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

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

24 A. At that point?

25 Q. At any --

1 A. I'm sorry. I don't understand.

2 Q. You've indicated --

3 A. Okay. I think I understand. Mr. Dawson did tell
4 Dr. Abellera that additional treatment was
5 required. He refers to Dr. Abellera, it's at
6 page two in the second, third paragraph.

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

12 Q. That was after he use --

13 A. Yes, yes.

14 Q. I'm talking about in the hospital.

15 A. That's what I asked you. I'm sorry.

16 Q. Let me start again. You have indicated that his
17 arm is, by his description in the hospital, was
18 blown up and it was very painful. You've also
19 read his deposition and you took additional
20 history from him.

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

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

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

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

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

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

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

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

1 A. No.

2 Q. And you saw no evidence in the records that there
3 was tremendous swelling or he was complaining of
4 numbness and tingling?

5 A. No, no, no. The record is a record of a man who
6 has abdominal pain, abdominal problems, potential
7 sepsis and abdominal surgery. And the record is
8 really quite a good mirror to those problems. It
9 is no mirror at all to the problem we're
10 addressing.

11 Q. And you would not expect them to talk about
12 persistent big swelling or tingling and numbness
13 in the hands if those -- record that in the
14 record if those symptoms weren't there? You
15 wouldn't expect that, correct?

16 A. Well, I wouldn't expect it, but I know darn well
17 it happens.

18 Q. He indicated to you, at least from your history,
19 on your first report, that the -- I guess the
20 second paragraph of the second page where it
21 starts postop and intravenous infusions. Do you
22 see --

23 A. Yes, I see.

24 Q. Was started in the dorsum of his left hand.
25 Where was the site of the phlebitis?

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

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

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

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

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

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

20 A. It doesn't say.

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

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

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

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

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

11 Q. Above the wrist. How far above?

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

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

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

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

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

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

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

1 didn't say and he doesn't quite know.

2 Q. How far above the wrist do you think it was?

3 A. I don't know. I can't speculate about how far
4 above the wrist it was.

5 Q. You don't know which vein it was in, correct?

6 A. Of course not. Unless I'm told, how would I
7 know?

8 Q. You don't generally see nurses putting in your
9 records for your patients --

10 A. I don't think the nurses know the name of the
11 vein in the forearm.

12 Q. You don't expect them to?

13 A. I don't expect them to tell me.

14 Q. You don't expect them to tell you which vein?

15 A. No. It was somewhere around his wrist, probably
16 above it and on the left side.

17 Q. And it says postoperatively an intravenous
18 infusion.

19 A. Well, this was not -- this is what he told me.
20 But it's not postoperatively. It's
21 preoperatively.

22 Q. So he was incorrect at that point at least?

23 A. Yeah, right.

24 Q. Did he ever have an IV in his hand?

25 A. I believe he did.

1 Q. Left hand. Let's forget the right.

2 A. I'll have to go back and look. He said IVs
3 changed about five times. He did in the
4 emergency room, I believe. He also didn't
5 remember when the IV was started.

6 Q. After or --

7 A. No, no. When he came in. He had it in his left
8 hand in the emergency room.

9 Q. No. I mean for you to go back.

10 A. No, that's okay. I've got the emergency room
11 note from this admission. He was admitted by the
12 emergency room by a physician there to Dr.
13 Abellera. Number 20 IV. I don't know whether
14 they used an intracath or not. It says left
15 forearm, but where again, not stated. And it's
16 not a criticism. It generally isn't stated.

17 Now it's in his right hand at a later time,
18 12:15, on which day -- this is in the recovery
19 room. So again, he's had IVs in both arms,
20 probably in multiple sites. I wouldn't expect
21 them to be specifically recorded and there's
22 nothing unusual about IVs being changed from arm
23 to arm and site to site in the course of a
24 hospitalization like this. It's normal.

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

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

3 A. Is it unusual to have that?

4 Q. Yes.

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

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

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

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

19 A. Yes.

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

23 A. Yes.

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

1 A. Which entry do you want now? Right wrist.

2 Q. I think it's 0410, the late entry --

3 A. Yes. I have the same. Go ahead.

4 Q. My question in that is that is -- would that be

5 the one that Mr. Dawson is referring to?

6 A. I don't know which one he's referring to. I

7 don't know.

8 Q. The fact that he --

9 A. This is one of many. So beyond it, I can't tell

10 you. I don't know.

11 Q. The fact that he had an infiltration in the

12 forearm and that one that was put in the wrist --

13 A. This is leaking. It's not infiltrating in his

14 forearm. It's probably leaking around the needle

15 site someplace. So they changed it. That's

16 another reason to change an IV.

17 Q. Did that cause any damage or harm to Mr. Dawson,

18 that IV?

19 A. The one you had me look at here?

20 Q. Yes.

21 A. Not that I know of it didn't.

22 Q. So let's be -- thank you. Let me be clear,

23 because it took me a while to find this. There

24 is an entry in the nurses notes on 9/3/1999.

25 It's a late entry. It's timed 0410. It says,

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

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

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

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

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

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

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

25 A. I'm sorry.

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

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

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

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

12 Q. Not inappropriate?

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

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

17 A. Sure. The second report. Yes.

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

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

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

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

10 Q. There is --

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

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

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

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

1 phlebitis?

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

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

8 A. No.

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

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

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

25 So that early treatment does mean something.

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

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

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

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

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

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

1 Q. Then how did he develop the median and ulnar
2 nerve injury?

3 A. It's most probable it's from compression of
4 fluid, both from the IV itself and from
5 associated edema associated with inflammation and
6 phlebitis, squeeze peripheral nerves because
7 there's no place else for fluid to go until it's
8 absorbed somehow.

9 Q. How much fluid would you need to spread into his
10 tissue to cause a compression?

11 A. It depends on the compartment involved. If it's
12 around the wrists, you need very little. A
13 cupful. And if it's in soft tissues of the upper
14 arm, a good deal more.

15 Q. You read Dr. Cervino's deposition?

16 A. I did.

17 Q. Did you take away from that deposition that he
18 did not believe he had complex regional pain
19 syndrome?

20 A. I'm not sure what to take away from that
21 deposition. I think he's waffled a bit on it. I
22 don't know what else he could have thought he
23 had.

24 Q. Did you read the Social Security records from
25 this --

1 A. I don't have the Social Security records.

2 Q. I don't know what they're called, but they were
3 to evaluate him for disability.

4 A. I don't have them.

5 Q. Were his symptoms always consistent from the
6 various examination he had?

7 A. Again, I don't have all the examinations he's
8 had.

9 Q. Of the ones you saw?

10 A. Of the ones I saw, in general they are, I think,
11 given ordinary human latitude. He tells a
12 consistent story and has consistent findings.
13 You know, I look at the examinations he's had by
14 physicians and mine and Dr. Hanna's, you know,
15 the statements may be a bit different, but I
16 don't think the conclusions are.

17 Q. Was there a difference between your examination
18 and Dr. Hanna's examination?

19 A. There's always going to be some distinction.
20 Even with the distinctions recognized. I think
21 the kind of things I would expect as
22 intraexaminer variability. They're not
23 inconsistent with what everyone -- virtually
24 everyone who has seen this man thinks is wrong
25 with him.

1 Q. What distinctions were there?

2 A. I don't know. I'd have to go a back and look.

3 The way he states things, the way he examines
4 people and records them is different than mine.
5 Mine tends to be more literary and his more --
6 how shall I put it? Telegrammatic.

7 Q. You are more flamboyant than he is?

8 A. Pardon?

9 Q. You are more flamboyant than he is?

10 A. To each his own.

11 MS. HARRIS: Just record that he
12 was laughing.

13 Q. You under number four in your report, the second
14 report, the medical records document infiltration
15 of intravenous fluids and the presence of
16 phlebitis in the left forearm.

17 A. Right.

18 Q. And you're referring to the time around August
19 30th and 2400 the time?

20 A. I'm talking about the lump or bump and the red
21 line.

22 Q. And that's the time August 30th or 29th, depends
23 on how you look at it.

24 A. Sometime around midnight that day.

25 Q. And no other IVs contributed to the development

1 of this complex regional pain syndrome that you
2 can tell?

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

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

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

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

22 - - - -

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

25 - - - -

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

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

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

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

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

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

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

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

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

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

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

23 A. On his own, no.

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

1 A. Well, the physician would have to make the
2 suggestion for him to do that and he didn't. I'm
3 not sure how to answer your question.

4 Q. Are there any suggestions after you examined him
5 in 2003 that you felt would have helped or should
6 have helped his condition?

7 A. Let me make sure I understand it. Is there
8 something any physician could have done between
9 the time he began to develop this and the time
10 something was done that could have helped him.
11 Is that the question?

12 Q. No. The question is is there any treatment that
13 could or should have been done to have helped him
14 once he developed these symptoms?

15 A. Well, once he developed these symptoms which was,
16 according to him, when he was still in the
17 hospital, am I to take that as a go point or a
18 month later when he sees Dr. Abellera?

19 Q. When he sees Dr. Abellera.

20 A. That's a month and he's already -- well, then
21 it's not exactly early and the treatment he
22 eventually got was the right treatment. And
23 that's pain medication and, for what good they
24 may do, calcium channel blockers or other types
25 of blocking agents that are vascular-active

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

5 Q. How about psychological counseling?

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

9 Q. Are you of the school --

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

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

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

1 suspect as developing this disease.

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

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

13 A. No.

14 Q. -- underlying --

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

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

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

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

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

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

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

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

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

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

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

25 Q. There would be nothing in your examination --

1 excuse me. That was not a good question.

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

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

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

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

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

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

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

3 MS. HARRIS: Go off the record.

4 A. And that's substantial.

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

9 A. Yes.

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

12 A. Yes.

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

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

23 There's not a lot in those depositions about
24 specific information related to this man.

25 There's some, but little. Most of the reliance

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

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

8 A. No, there's not.

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

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

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

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

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

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

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

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

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

8 A. All but that.

9 Q. Got to answer me.

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

23 Q. I appreciate that.

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

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

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

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

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

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

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

1 apparently did.

2 Q. Is that it, Doctor?

3 A. Unless you have more questions.

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

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

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

11 - - - -

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

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JOHN CONOMY, M.D.

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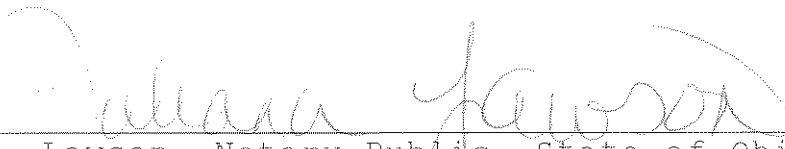
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2
3 C E R T I F I C A T E
4

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

7 I, Juliana M. Lawson, a Notary Public within
8 and for the State of Ohio, authorized to
9 administer oaths and to take and certify
10 depositions, do hereby certify that the
11 above-named witness was by me, before the giving
12 of their deposition, first duly sworn to testify
13 the truth, the whole truth, and nothing but the
14 truth; that the deposition as above-set forth was
15 reduced to writing by me by means of stenotypy,
16 and was later transcribed into typewriting under
17 my direction; that this is a true record of the
18 testimony given by the witness; that said
19 deposition was taken at the aforementioned time,
20 date and place, pursuant to notice or stipulation
21 of counsel; and that I am not a relative or
22 employee or attorney of any of the parties, or a
23 relative or employee of such attorney, or
24 financially interested in this action; that I am
25 not, nor is the court reporting firm with which I
am affiliated, under a contract as defined in
Civil Rule 28(D).

17 IN WITNESS WHEREOF, I have hereunto set my
18 hand and seal of office, at Cleveland, Ohio, this
19 1st day of March A.D. 20 07.

20
21 
22 Juliana M. Lawson, Notary Public, State of Ohio
23 1750 Midland Building, Cleveland, Ohio 44115
24 My commission expires October 3, 2007
25

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RECOVERIES BY THE COURT OF COMMONS

[illegible]