State of Ohio, )
County of Cuyahoga. )

Doc 113

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IN THE COURT OF COMMON PLEAS

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DEWEY GLEN JONES, et al., )
Plaintiffs, )
v. ) Case No. 306012
) Judge Lillian Greene
MERIDIA HURON HOSPITAL, et al., )
Defendants. )

- - -

THE DEPOSITION OF JOHN PAUL CONOMY, M.D., J.D.

MONDAY, AUGUST 4, 1997

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The deposition of JOHN PAUL CONOMY, M.D., J.D., a witness herein, called for examination by the Plaintiffs, under the Ohio Rules of Civil Procedure, taken before me, Lauren I. Zigmont-Miller, Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice, at the offices of Clinical Neurosciences, Ridgepark Medical Center, 7575 Northcliff Avenue, Brooklyn, Ohio, commencing at 11:40 a.m., the day and date above set forth.

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APPEARANCES:

On behalf of the Plaintiffs:

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On behalf of the Defendant Meridia Huron Hospital:

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On behalf of the Defendant Peter Adamek, M.D:

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(Thereupon, Plaintiffs' Exhibits 1, 2 and 3 to the deposition of John Paul Conomy, M.D., J.D., were marked for purposes of identification.)

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JOHN PAUL CONOMY, M.D., J.D.,

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

CROSS-EXAMINATION

BY MR. LANDSKRONER:

Q. Doctor, my name is Jack Landskroner. I'm one of the attorneys that's representing Dewey Jones in the case filed in Common Pleas Court. You have been retained as an expert in this case.

I'm going to ask you some questions today. I ask that your responses are verbal. I know you've had your deposition taken before. If you don't understand a question, please stop me, ask me to rephrase it. I don't want you to answer a question that you don't understand.

A. Okay.

Q. What is your professional address?

A. 7575 Northcliff Avenue, Cleveland, 44144.

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Q. That's Innova Medical Services?

A. This building is Ridgepark Medical Building. Innova is in transition. The group is fragmented. Part of it is going one way and a part another. In the last month I've joined the Collis-Kim Group of Neurology & Neurosurgery, so I'm no longer employed by Innova Medical Services, although I remain in this building which once housed that organization.

Q. So you will stay in this building in your new position and continue to operate as you have, but with a new entity?

A. At least through the day.

Q. Okay. Who else is involved in *the* new entity -- is that a large group or is that a small group?

A. Which new entity?

Q. The new entity which you've just become a part of.

A. It presently consists of several neurosurgeons, myself, but we're in the process of enlarging and expanding that group.

Q. What is your status in that group?

A. I'm a member of the group.

Q. Do you have any administrative duties within that group?

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A. I assist in structuring the group, in reviewing people who might be candidates for association with the group. It's really not a highly formal role, it's not a designated role, it's not a titled role.

Q. The position that you held with Innova was, one of the positions was director of professional affairs?

A. Correct.

Q. You will not be maintaining a position comparable to that in the new entity?

A. No, not unless we have enough professionals join it eventually. Right now, no.

Q. You've provided me with an updated copy of your curriculum vitae dated July of '97. That has listed Collis-Kim Group on it. Is there anything else on your CV as of July of 1997 that has not been updated?

A. I don't think so. I think there is a couple of publications, but I don't think that they're entirely germane, a couple of committee appointments, that sort of thing. It's not changed substantially in terms of what I do; namely, the practice of medicine, teaching and publications, that has not changed at all.

Q. Aside from the copy that you provided me today dated July of '97, do you have any other curriculum vitaes that you use either in the course of your speeches or your presentations or publications?

A. No; that's the only curriculum vitae I have.

Q. The copy that we were provided did not have the publications attached to it. All your publications, with the exception of the few that you mentioned, are incorporated into this CV?

A. Yes, they are.

Q. Of those publications do any of these deal with issues that are relative to this case?

A. They do. I have not annotated them. I can go through the list briefly if you wish and try to make some marks of things that may be germane.

Q. I would appreciate it.

A. It's going to take me a moment to do this.

Q. Certainly.

A. What I will do is to annotate not only the publications, but some committee work, Mr. Landskroner, is also pertinent to appearance today, particularly the ethics committee in the American College of Neurology and committee work within neurology and neurosurgery, so I'll annotate those, as well.

Q. Great. If you'll note those, that would

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be helpful.

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

BY MR. LANDSKRONER:

Q. Doctor, you've now had the chance to go through your vitae and indicate with marks on the side of relevant publications which may pertain to issues in this case?

A. Yes.

Q. You mentioned earlier that there were a couple other publications that you've been involved with recently that may not be on your CV. What are those publications?

A. They really have to do with work force allocation, changing role of neurological specialists in the era of managed care and so forth. I don't believe they contain anything pertinent to the matters involved in the case of Dewey Jones.

Q. For purposes of the record, let's mark this as Exhibit **4.** While we're doing it, I premarked the report that you've provided related to your review of this matter dated May 7, 1997 as Plaintiff's Exhibit 1 with your shortened version of the CV attached to it, Exhibit 2 is a report dated July 14, 1997, and Exhibit 3 is a report dated July 17, 1997just for

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simplification.

(Thereupon, Plaintiffs' Exhibit **4** to the deposition of John Paul Conomy, M.D., J.D., was marked for purposes of identification.)

BY MR. LANDSKRONER:

Q. Doctor, you have in your history been involved in a fair number of medical-legal cases. Can you give me a number, how many times you've been asked to review files?

A. For any purpose whatsoever it's a couple of hundred, but for purposes of injury to a person, malpractice and so forth it's far less. I would guess it's 50 or 80 over the years. The count is imprecise, I don't have an exact record, but it's been about that many that I've been asked to review.

Q. And that's since 1964 when you started practicing?

A. Yes.

Q. You've reviewed more cases in the recent years than you have in the past?

A. Yes, I would say so. Again, it varies from year to year and type of case to type of case. During the years I was a research fellow, for instance, I don't recall reviewing a case. During the years I

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for Mr. Mark Jones?
A. I may have, I just don't recall. I know there's a case called Carnovice that Anna Carulas had in which I did testify.
Q. Was that also Cuyahoga County?
A. Yes.
Q. How about Ms. Reinker, have you ever worked with her before?
A. I don't believe I've had the pleasure.
Q. Can you tell me approximately how many times you've worked for the Jacobson law firm?
A. I really can't. Some of those firms are so large and contain such platoons of lawyers that I can't remember who they work for. They seem to change their venues frequently, too.
Q. Especially recently.
Doctor, I don't know if I asked you specifically, but do you recall how many times you've been involved in testifying or reviewing files for the Reminger firm?
A. If I guessed ten I think that would be a reasonable number.
Q. Doctor, who is your malpractice insurance carrier?
A. PIE.

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Q. Have you ever sat on any boards or review panels for PIE?
A. No.
Q. Have you talked to any of the other attorneys in this case aside from Mr. Malone and Mr. Casey?
A. No, I have not.
Q. Are you familiar with any of the defendants in this case?
A. I am not.
Q. How much do you charge to review a file?
A. $400 an hour for review or anything else.
Q. That goes for trial testimony, as well?
A. Yes, it does. It does not include travel and that kind of business, it's confined to actual time spent.
Q. Doctor, what percentage of your time now is spent in the active clinical practice of medicine?
A. Over the course of a week, between 70 and 80 percent of my time is spent in medical practice.
Q. What makes up the rest of your time?
A. A combination of writing, teaching, lecturing, work such as this, involvement in medical organizations, constitutive work to medical organizations and health systems, some work for

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governments, United States and elsewhere.
Q. Can you tell me about how many files you review a year related to medical-legal issues?
A. It depends on what you think a medical-legal issue is. It may have to do with a credentialing of physicians, physician performance. I'm not sure that you would consider those medical-legal, so maybe you can tell me.
Q. I'm taking more specifically along the lines of medical negligence cases.
A. Again, it depends on the year, but I would say between five and ten.
Q. Can you tell me what percentage of your income is related to your review of files in medical-legal issues, medical negligence?
A. I can tell you that last year it was less than ten percent, and I suspect it will be less than that this year, too. I'll know better on the 15th of August.
Q. Doctor, you're a Board certified neurologist, correct?
A. I am.
Q. And you passed your Board certification in March of 1972?
A. A great day it was, Mr. Landskroner.

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Q. Since that time have you had another great day when you were recertified?
A. This board has not dealt with recertification, so I've been spared the embarrassment and ardor of having to undergo preparation and then the horror of facing yet another examination. At this point in my life I've decided if anybody wants to give me an examination for anything I won't take it. They can have my driver's license.
Q. So you're not required to recertify under your board?
A. God forbid.
Q. Did you pass your Board certification on the first attempt?
A. Yes, I did.
Q. I notice from your CV that you have a J.D. as well as an M.D.
A. Yes.
Q. You did not sit for a Bar examination?
A. I did not.
Q. I understand now why.
A. Correct.
Q. Do you have any intention of taking the Bar examination?
A. I don't know. I can't see myself doing

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was in the military I didn't. It has its ups and downs. The recent years most of the materials I've been asked to review do not involve medical malpractice, they involve some other aspect, professionals in health care.

Q. Can you tell me how many times you've had your deposition taken related to a medical negligence issue?

A. Again, I'm guessing. I would say 25, maybe 30.

Q. Can you tell me how many times you've testified at trial related to medical negligence issues?

A. Again, it's a guess. A half a dozen,

Q. [illegible] can you give me a percentage of the number [illegible] files [illegible] you've reviewed for the [illegible] to the defendant?

A. Yes, I can. That's actually something I did a tally on, at least as of a couple of years ago, and it turned out to be half and half. It's frankly not of great importance to me as to whether it's a or a defendant.

Q. In [illegible] case you've been retained by Meridia or [illegible] lawyers for Meridia Huron Hospital; is

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that accurate?

A. That's correct.

Q. Mr. Malone and Mr. Casey or the attorneys who are working on behalf of the Reminger law firm in this case. Have you ever worked for Mr. Malone and Mr. Casey before?

A. Not Mr. Casey, but Mr. Malone I have on a couple of occasions in the past.

Q. Can you tell me on what occasions; what were the cases that you were involved in with Mr. Malone?

A. I recall one was a fellow named Williams who had a problem with lung disease and I believe had a stroke in the course of surgical treatment for another condition. That one I recall clearly. There may have been one or two more over the course of the years, but I don't recall the names.

Q. Did you testify in trial in that case?

A. No.

Q. Do you recall if that was a Cuyahoga County case?

A. Yes, it was.

Q. Any other names that you can recall of cases that you've testified in for Mr. Malone?

A. I really can't.

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Q. How about other lawyers for the Reminger law firm?

A. Mr. Scott, a case called Wolmer, W-O-L-M-E-R.

Q. Was that also Cuyahoga County?

A. I don't think so. I think it was Youngstown or somewhere. I also did not testify in that case, although it came to trial. I'm sure there have been other cases scattered over the years, I just don't remember them.

Q. Have you developed a relationship with Mr. Malone or anyone else in the Reminger office outside of reviewing these files?

A. No.

Q. Have you ever authored any [illegible] joint effort with anyone in their office?

A. No, I haven't.

Q. How about done any presentations [illegible] sat on any panels with anyone from the Reminger office?

A. I spent a week tagging after members of their firm as part of my legal education, but beyond that I had no association with them.

Q. [illegible] the office you about out of law school?

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A. No. They had more sense than that.

MR. MALONE: That's not true.

BY MR. LANDSKRONER:

Q. Have you worked with Mr. Spisak in the Reminger law office?

A. I believe I have on one occasion. Again, I don't recall the name of the case.

Q. Do you recall in any of the cases that you worked on for the Reminger law firm did you testify at trial?

A. No, I don't.

Q. Have you ever declined to become involved in a case where you were requested to review materials by the Reminger law offices?

A. Not by the Reminger law firm, but refusing to get involved for one reason or another, basically I don't see merit or claim in it, is not infrequent.

Q. Certainly. But that hasn't occurred with the Reminger firm?

A. No.

Q. Have you done work for the Jacobson, Maynard law firm?

A. I believe I have.

Q. Have you ever done any work individually

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that. I'm doing what I want to do with my law degree as it is and would I take the bar I suppose I'd be tempted to litigate and give up everything else I do, which I don't want to do.

Q. You were a full-time law student from 1989 to 1992, correct?

A. Well, according to the hours per semester, I either qualified or nearly did so. I must tell you my curriculum was irregular. It consisted of classes given at 8:00, 9:00 and 10:00 in the morning so I could go to work as a full-time department chairman during that time. Then I went to school during summers and took sabbatical time and so forth to complete my degree.

Q. Did you give up clinical practice at that time and just maintain your administrative functions?

A. No. I did exactly what I do now. They were long days, Mr. Landskroner.

Q. I know those long days.

You presently are involved in teaching in a law school capacity?

A. At both law schools from time to time and in the medical school, as well.

Q. Both law schools, you're referring to Case Western and Cleveland Marshall?

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A. Yes.

Q. Are you [illegible] on faculty at those institutions?

A. Not at Cleveland State, but I am at Case.

Q. What classes do you teach?

A. It varies from semester to semester, but basically they're classes that deal with health policy, medical ethics or some aspect of health law. I tend not to deal with litigation unless I'm posed as some medical defender or medical charlatan in a trial practice class by Jim Mackelhaney. They're more of didactic classes that have to do with administrative law relative to health care, professional organizations, the structure of disorganized medicine as we know it today, that sort of thing.

As to your teaching you have participated in trial advocacy courses?

A. I have from time to time, maybe once every third year or something. I don't do it regularly.

Q. In a role as either a witness or [illegible] a judge?

A. As a judge or a witness or a person offering critique.

Classes to cover areas including ethics?

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A. Yes.

Q. Have you ever discussed patients' rights as part of your classes?

A. Yes.

Q. Have you ever discussed living wills as part of your classes?

A. Yes.

Q. And have you ever discussed the ethical considerations of obligations of family members to incapacitated members of the family medically?

A. Probably touched upon it. I don't recall discussing that as a topic by itself.

Q. Do you have any written materials that are related to your teaching?

A. I've got publications in the CV. There's a huge amount of written material produced over the year that is not in there that's didactic, class-related, not been subjected to peer review. The things in front of you have been.

Q. The things that have not been subjected to peer review, are there handouts or written materials that you use in your classes?

A. Tend to be prepared from class time to class time.

Q. Do you have those on file?

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[illegible] ancient at this point.

Q. The documents that you have related to the subject of families' [illegible] their [illegible] ones, living wills and patients rights, I'd like you, if you can, to screen through your materials and see if you have [illegible] related to those teachings, and provide them to counsel so I [illegible] at those.

A. I can't promise you I can come up with what you want, but I will look.

Can you tell me that I've taught classes that relate to those issues?

A. Well, for many years. I mean, I've actually participated in ethics teaching at John Carroll University, held classes in medical ethics for high school students at Hawken. It's probably the most challenging teaching I've ever done, to sit down with a family and a patient in a room full of high school students and bat some issue around. I've engaged in that teaching literally since at least 1970.

Q. In your [illegible] last [illegible] can tell where you might have taught and [illegible] written materials related to [illegible] te

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A. Again, I can't recall with any precision that there have been written materials in the last two years that address what you're talking about, but the issue of medical ethics and so forth come up routinely in law school discussions and medical school.

Q. Do you provide copies of the written materials for your classes you teach at the law schools to the law schools that they keep on file?

A. They might, I don't know. There has been very little written material. Most of the classes in which I participate involve patient participation, patients' families, issues of genetics information, who holds privileges for keeping that information and so forth. I tend not to deal with a lot of written material, although there may be reprints from a journal or sections of a textbook or something.

Q. When is the last time you taught at Cleveland State?

A. Last February.

Q. And at Case Western?

A. Probably four months ago.

Q. Doctor, have you ever attended a class or read any materials on taking a deposition?

A. Yes, I'm certain I have.

Q. Anything in preparation for today's deposition?

A. No.

Q. Have you taught any classes on taking a deposition?

A. No, I haven't.

Q. Have you taught any classes or written any materials on sitting for having your deposition taken?

A. No. I've written an article about expert witnesses in neurologic literature and actually am giving a piece of a seminar for attorneys next week, or this Friday.

Q. Where is that at?

A. I hope you attend.

Q. I may very well do that.

A. It's some expensive downtown venue only affordable by major law firms. I think it's at The Forum. I think it's Friday and I think it starts at 9:00.

Q. Who is sponsoring that event?

A. The State Bar Association, I believe.

Q. What time are you scheduled to speak?

A. I start on Friday morning at 9:00 and I'll end it Monday at noon. It's from 9:00 to 12:00.

Q. The publication you referred to, is that listed in your CV?

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A. Which publication?

Q. The publication concerning experts in neurology.

A. Yes, it is.

Q. What's the title of that one?

A. Maybe I can show it to you, it would be easier. It's on page 35, it's the fourth one from the bottom. Maybe if you stop by, Mr. Landskroner, my secretary can give you a copy of it and I won't have to try to remember to send you or somebody else it.

Q. That would be great.

Doctor, can you tell me how it is you first became involved in this case?

A. I believe that I received a phone call from Mr. Casey and I believe -- I don't have a precise recollection of it. Most of those phone calls come in the middle of Wednesday afternoon when I have two people in the room who have already waited a long time and are now in. I have no recollection of the phone call or what he told me. I know that I received records subsequently and I think that was sometime in May of this past year.

Q. What was your understanding at that time of what your involvement would be in this case?

A. My understanding was that I was asked to review records to come to some opinion as to what it was that characterized Dewey Jones' neurologic state and to offer a prognosis thereafter as to his continued life and ill health.

Q. Can you tell me what you were told initially of Mr. Jones' condition when Mr. Casey contacted you?

A. I can't tell you anything more than I have. I have no recollection of that conversation.

Q. You mentioned you were sent some materials to review.

A. Yes.

Q. Can you list for me the items that you were sent?

A. Hardly. I can give you their weight. They're 35 and one quarter pounds and they're sitting in my office, and they're not even the complete records either.

Q. What do those records consist of?

A. I weigh those things when they get to be that heavy.

Q. I figured you did when I saw the note of 35 pounds in the report.

A. Now it's more because they've sent me additional ounces of things to read.

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Q. I'll come back to that.
How much time have you spent reviewing this file?
A. Altogether, probably 12 hours at this point. There's just a lot of material.
Q. Is there anything else that you'd like to review in this case that you haven't had the opportunity to review?
A. Well, I've seen his current medical records when I examined him. I believe it's from the Heritage nursing facility. You know, as time goes on, should this matter wind its way to resolution and should I be called upon to speak again, I'd certainly want to see up-to-date records.
Q. Of the records that you reviewed, can you tell me what you recall seeing?
A. I can tell you what I've seen and I can tell you what I've not seen. I've seen records from University Hospitals of Cleveland; I've seen records from MetroHealth Medical Center; I've seen records from the Southwest Hospital; I've seen records from the Aristocrat nursing facility and some other nursing homes.
As I told you, I reviewed his records from Heritage when I was there to examine him and I

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have examined him and submitted a report. I've seen the deposition of Dr. Winkler given on July 10, 1997 and I've seen the Life Care Plan that was previously furnished by Dr. Winkler.
What I've not seen are the records of Meridia Hospital; I've not seen anybody else's deposition, nor do I know of the status of those depositions, other than Dr. Winkler's; I've not seen reports, other than his Life Care Plan. If there are additional reports that he's furnished, I have not seen those.
Q. Did you receive any summaries of medical records along with the records themselves?
A. No, I have not.
Q. You have not been asked to render any opinions concerning anything that happened prior to October 20, 1994 and related to the care received by Mr. Jones?
MR. MALONE: He hasn't seen anything prior to November 21st when the guy was transferred to University Hospitals.
BY MK. LANDSKRONER:
Q. You have not been asked to render any opinion about care rendered prior to the University

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Hospital admission?
A. Thank you, Mr. Malone. I could not have said it better myself. My knowledge of him begins on the day of his transfer to University Hospitals. I know nothing of him before that in terms of contemporary records.
MR. MALONE: we have not asked him to evaluate, nor will we ask him to evaluate or comment on any of the so-called liability issues in this case.
MR. LANDSKRONER: Thank you, Mr. Malone.
BY MR. LANDSKRONER:
Q. Doctor, did you undertake any literature searches at any time related to your involvement with this case?
A. Yes and no. I don't want to be vague about it. During the time that I chaired and was a member of the American Academy of Ethics Committee the whole notion and concept of persistent vegetative state was really born and brought to maturity. So I am familiar with that literature, I'm very familiar with it, and, in fact, contributed to a number of the committee reports and so forth to finding the state and looking at prognosis, so I'm mindful of that literature

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and I know what's in it, but in terms of precise literature on the condition, no.
Q. I noted in at least one of the reports that you've authored there's some reference to statistical information.
A. That's correct.
Q. I'll get to the opinion a little bit later, but can you tell me where that information is pulled from?
A. That information was eventually published in a variety of places, perhaps the best known is the New England Journal of Medicine, I think in 1994. It's a report of the task force on the determination of persistent vegetative state, it has a title like that.
The information that went into it is really a distillate of 20 years of looking into the subject. That report was contributed to by organizations of neurologists, neurosurgeons, pediatricians, other medical organizations, so it really involves two decades of work and hundreds of people.
Q. Did you go back to that article, that publication at the time you authored that report?
A. Well, I'm familiar, very familiar with the article, so I really didn't have to go back to it.

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That article, however, has a foundation in a number of committee reports that are not, as I know it, part of the public domain, meaning you can't walk into the medical library and get one, they exist in committee reports from medical organizations and so forth. They're not different in substance than what's in that, the report I've mentioned to you.

Q. *Are* there any other reports aside from that one that you can refer me to that deal with issues concerning vegetative states of patients?

A. I certainly can refer you to them. There's a huge amount of literature on persistent vegetative state, literally thousands of sites regarding it, copious medical literature regarding it.

Q. Where? If you can, just give me a couple of the sites that I would go to.

A. Let me give you just one and that can lead you. It's probably got 200 references in it and they themselves have their own progeny. The committee of the task force on persistent vegetative state in the New England Journal of Medicine, I believe it's 1994.

Q. Have you individually contributed to any of these studies on persistent vegetative state?

A. I have, but not to the authorship of a report. That was done by a committee of six or seven

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people. As I told you, I did, in fact, head one of the committees that worked for a couple of decades before the report ever came out.

Q. Can you tell me what your role was on that committee?

A. I chaired it.

Q. What did the committee undertake?

A. It was the ethics committee of the American Academy of Neurology. It undertook, first of all, definitional aspects of just what that state might be, it looked at prognosis. Its primary focus had to do with the ethical considerations of the degree to which life processes might be supported or elected not to be supported given an individual so afflicted.

Most of the focus of the committee's work and, in fact, nearly all the committees in other medical organizations looked at the rights of individuals, the duties of caregivers, the rights and duties of caregivers and families relative to persons in persistent vegetative state and states like it.

Q. Is that what's referenced on your CV as the neurosurgery centers task force chairmanship?

A. I'm not sure. I don't know what's in that. That was a position, not a publication.

Q. I don't know if this is listed as a

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position. That was during your time frame at the Cleveland Clinic?

A. Right.

Q. Were there any other publications that that task force put out, published?

A. No, not really. The purpose of the task force was really to put that out. They did it and then disbanded. They exist as individual committees and organizations, but not as a task force. A task force job is limited in time and their purpose was to put that out.

Q. What year were those publications?

A. I believe 1994.

Q. Doctor, in reviewing the chart did you take any notes, handwritten notes, to assist you in your review?

A. No.

Q. Did you [illegible] anything to [illegible] you in coming back and writing reports at a later time?

A. never no.

Q. I [illegible] th [illegible] rt th t we [illegible] marked. Are there any other reports that you've authored besides the three that we have marked here today?

A. No.

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Q. Wer [illegible] y [illegible] ft of [illegible] s reports?

A. No.

Q. [illegible] you at any p [illegible] t in time review the complaint and answer filed in this case?

A. I believe not.

Q. Do you have any criticisms of any of the caregivers to Mr. Dewey Jones as it relates to this case?

A. No, I don't.

Q. You referenced in your report that Mr. Jones suffered a cerebral anoxic injury. Do you know what the cause of that injury was?

A. My understanding of it from the University, the Southwest and the Cleveland MetroHealth reports is that he was undergoing a cholecystectomy, that he had not recovered from anesthetic. The operation, as I understand it, had been completed, but at the end of the surgery and operation there was some difficulty. I don't know the nature of the difficulty, nor do I know the participants in the difficulty, but there was some difficulty resulting in injury to him in his weakened state.

Q. Can you tell me what your experience is hands-on in dealing with patients with coma or persistent vegetative states?

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A. It's abundant.
Q. Can you tell me how many patients that you've actually been the attending physician for who have been in that state?
A. In persistent vegetative state?
Q. Yes.
A. Probably two dozen over the years.
Q. Can you tell me when the last time you were the attending physician for a patient in a coma or if you're presently --
MR. MALONE: Do you distinguish attending from consulting? There is a difference between being an attending and being a consultant. I'm not sure if the doctor is mindful of it when he answers your question or if he's being expansive.
BY MR. LANDSKRONER:
Q. Let me ask it in terns of your active involvement in the care of a patient in a persistent vegetative state.
A. I have to think back. Probably a couple of months ago. You mentioned coma and a few other things. Again, I'm talking about persistent vegetative state only, not coma.

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Q. That's a good point. Can you define for me persistent vegetative state?
A. Yes, I can. It might be useful to turn to one of the reports, if you wouldn't mind. It's report No. 3. The criteria for persistent vegetative state are listed under the bullets, and save for one, that is the issue of time, it is an accepted medical standard that the use of persistent vegetative state is not applied in general to a child or an adult unless they've shown evidence of unawareness for a period of at least 30 days.
Now, having said that, there are a number of other things that are essential to the diagnosis of that condition. One is evidence of person, self-awareness or awareness of the environment as evidenced by some ability to interact with that environment in a meaningful way, in a way that shows understanding or learning. Dewey Jones has none of that.
The next is the absence of voluntary or purposeful behavioral responses. He has none. Now, does this mean he's unresponsive, no, he has lots of responses, but the problem is that they're not purposeful, not linked to the stimulus, they tend to be generic, predictable, stereotyped kinds of things.

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Let me give you an example. A purposeful responsc to sticking a pin in your nose would be alert, to look at me as an overly aggressive and cruel individual, to get your hcad out of the way and grab the pin and my hand and push it out of the way. That's a natural response on the part of an infant or child or adult.
A stereotyped responsc would be to arch your hcad, arch your neck, stiffen your arms and stiffen your legs and snort. It would matter little whether the pin stick is in your nose, on your cheek or somewhere else, the response is stereotyped, it's not purposeful.
Q. If I can interrupt you for just a second and ask, withdrawal from painful stimuli as in turning your head away or withdrawing from the actual pain, the stimulation, moving back away from the painful stimulation, is that a natural response?
A. It's natural, but you can do it with your brain stem and your spinal cord, it doesn't require participation in cerebral hemispheres.
Let me give you an example. You in the course of a beautiful weekend are walking barefoot along the glistening, expansive beach at Edgewater Park. Some buffoon has left his Macanudo cigar still

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lighted in the sand and, as poor fortune would have it, your foot comes to rest on the lighted cigar butt. Your nervous system is organized in such a way that before you can register and say ouch your foot has moved.
The initial withdrawal of your foot does not require participation of anything except the organization of normal spinal cord function, it's not a conscious act. The ouch part or looking down and knowing it's a cigar butt and knowing your foot is burned are complex behavioral responses and they do require an awake brain to do, but before any of that has gone into place there's been a mechanical or reflexive part. Turning a head or getting your foot out of *the* way or snorting does not require conscious participation, it's reflexive activity.
Q. That's not a purposeful response?
A. That in itself is not purposeful.
Q. Continue on.
A. He has no access to language. Now, there's no discrimination between language and noise and, in fact, there's no predictable response to either one. In Mr. Jones' examination whether his name was whispered to him, whether it was shouted to him, whether there was ambient noise in the room or some

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sudden noise, shouting, banging things, there's no no to

Q. Was there any reaction to it?

A. It's really hard to link it in time. From time to time he will do such things on his own as twitch his cheek or rove his eyes, but he does that whether or not there's anything going on in the room. So it takes a process of imbuement or attribution to say yes it's linked to that. In my opinion, then: is no predictable linkage of environmental activity and his response to it at all, they are random events and not linked in time.

He has intermittent wake/sleep cycles that are really quite striking. They're not entirely regular, they're irregular. He will appear to be in repose for a couple of minutes and then appear to wake and his eyelids will retract and he will appear to look off into the space around him not focussing on anything, his eyes will rather wander, and that will be kept up for a couple of minutes and then he'll happen to go to sleep again. The cycle tends to repeat itself at variable lengths, the length of each apparent sleeping or waking being brief rather than long. Intact wake/sleep cycles are characteristic of persistent vegetative state.

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He has the ability to maintain his heartbeat, his blood pressure, the kinds of things that are done as part of the intact activity of the autonomic or vegetative nervous system. He can cause oil to be secreted on his skin; his gastrointestinal track is motile; he can secrete mucous and other secretions in his lungs. Those are nervous system mediated but not muted by parts of the nervous system that deal with wakefulness or learning or consciousness.

He is doubly incontinent, his bowel and bladder. He has preservation of certain reflexes that do not require again the participation of the cerebral hemispheres, eye movements, respiration, pupillary reactivity to light and the like. Those are criteria that are established clinically to determine that a person is persistent vegetative state. That is a clinical diagnosis.

Q. Are there other clinical signs which could be looked for that also encompass persistent vegetative state?

A. There are, but these are the essential requirements.

Q. Can you tell me what the others are?

A. You may see a person in a persistent

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vegetative state yawn or tear, grimace, giggle. He didn't display those. They can be seen. They are not essential to the diagnosis.

Q. Anything else

A. No.

Q. What's the definition of coma?

A. Coma differs from this. First of all, coma is used to designate acute states. It may be prolonged, but in general it connotes an acute state. Persons in coma frequently require support of vital functions, like their blood pressure and so forth.

Now, Mr. Jones requires the use of a respirator to keep him alive. He has respirations without a respirator, the problem is they're not very effective and may fail, so with him it's an assistive rather than a required device. Persons in coma lose their brain stem reflexes of which he has in abundance.

Those are the fundamental differences Now, coma frequently blends into persistent vegetative state. In it it all of the time.

Q. How about semi-comatose state?

A. to me

Q. Is there a clinical diagn for a sen con state that you're aware of?

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A. There are lots of definitions. That is not a particularly useful definition. It's too much like beauty.

Q. I guess in response to the question there is no clinical diagnosis that you're familiar with that defines --

A. That's not what I said. There's plenty. You can find the word semi-coma appearing all over the medical literature. It's like beauty, you don't know if it's a lot or a little bit.

If I were to define the basic unit of beauty as one millennium it would at least give me a start. That amount is sufficient to launch a single ship. What a little bit of semi-coma is I haven't the slightest idea.

MR. MALONE: I have to run, so Mr. Casey will stay, but I have to excuse myself, I have another commitment that I've got to get moving on.

BY MR. LANDSKRONER:

Q. Dr. Conomy, we were talking about comatose stat and I as going to inqu if Mr. J is in what you would decrn t this point a comatose state.

A. No, he's not.

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Q. I've read through the literature that there's something recognized as a deep coma. Do you have any knowledge of the definition of deep coma?

A. If you took a person who had just received all of those anesthetic agents required for cardiac transplant, you would be seeing a person in a deep coma.

Q. No functions whatsoever?

A. Well, they may have some intact blood pressure, they can probably maintain their temperature at least with assistance and they may be able to sweat, but that's about it.

Q. Now, you referenced in that report in the definition that Mr. Jones has autonomic function to permit instant survival. What does that mean?

A. Well, if you take his breathing tube away and let him breathe on his own he can breathe, although the mechanics of his breathing are not normal. He'll maintain his blood pressure at least for a while, his heartbeat. He can manufacture urine and his intestinal tract can growl.

Q. Jumping back to your experience with PVS patients with that I understand the definition. Have you ever had a patient who was in a persistent vegetative state, persistent vegetative state who has come out of it?

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A. I have not. I've had people change over time and show something that would be evident as a kind of neurologic recovery. I've seen persons go from coma through a persistent vegetative state.

Again, let me make a small distinction, if I may. Persistent vegetative state need not be permanent. Permanent is another issue. I've seen some young people who have gone through persistent vegetative state, recovered to the degree that they can be sat up in a chair, they may have some intermittency of visual recognition. But the degree of recovery in general in my experience, and I think in general experience, has been that persons who emerge from persistent vegetative state have extraordinarily poor degree of function and poor quality of life thereafter.

Q. They are able to comprehend to some extent?

A. Not necessarily. A relative or caregiver may say they think they understand or so forth, they may feel they have some level of communication. In general, they're people who are very badly damaged, but are somewhat more awake, if you will, than they were when they couldn't be roused or stay roused.

Q. I assume there's no way to definitively tell what awareness these people have as a physician?

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A. In general, no. Now, there is the very rare, the very odd case of some recovery after persistent vegetative state. One case in New York, a young man I think was in PVS around two years. One published from Houston, Texas, a young woman who had been in a persistent vegetative state for a period of 15 to 18 months, she wrote as she recovered I love you mom.

I have never seen such a thing, but I know it can occur. It's extraordinarily rare and it's not seen in people with very long periods of time in persistent vegetative state. The cases of which I'm aware even with very poor quality of recovery have been months and not years in PVS.

Q. What is the longest situation you are aware of where a patient was in PVS and recovered at least partially?

A. Probably two years or thereabout.

Q. What's the longest that you're aware of has a patient was in in a PVS state?

A. can even [illegible] names.

Q. Just if you can give me --

A. [illegible] names. woman named Elaine Esposito survived for 41 years, she never recovered. Another one named Rita Green for, I

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think, 31 years. There are a bunch that are in the teens, but again, you're talking about one in a very large number.

Of all of the persons in the United States in PVS today, that number is not known for sure largely because of definitional problems, it's between 10,000 and 25,000. Of that there may be one with prolonged survival and there may be three with some recovery after several months of PVS. Again, I think numbers are very important here and the numbers you're talking about are vanishingly small, they are close to zero.

Q. In your experience in patients that you've had hands-on care with, what's the longest a patient has been maintained in a PVS state?

A. I'm trying to recollect. It's been some time since I've seen either of these patients. One is a young man who is still alive who was in PVS for about six or eight months who is now in a very badly damaged condition but still living. He's had some degree of recovery. The other was a woman that was probably around five and a half years.

Q. Have you ever suggested to the family of a patient who was in PVS state that they should give up on the patient and, quote, pull the plug?

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A. I've never used those terms -- nor would -- a
are in a constant situation as to knowing what are the wishes of a person number one and, number two, knowing what is to be in their best interests, and this really has to be worked out on an individual basis with a family.

I think the known wishes of the person, if they are known -- most of the time they're not -- and the wishes of their family have to supervene. That's been my own approach to things.

There have been times in which I've requested that a family not escalate measures beyond their current level of care, enterostomal feeding, pulmonary toilet, the treatment, the infections, any evidence of pain to treat it and not go beyond that. I've been in that position many times.

Q. Conversely, h you ever encouraged a family t upgrade the care for a patient in a 'S state?

A. Not in a PVS state. I certainly have in persons with comas, particularly kids in coma. The younger they are, the healthier they are the more likely you are to come up with something good, and tries there ought to be sustained.

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Q. You're not critical of the Jones family in brother, are you?

A. Absolutely I'm not. I'm not critical of anybody.

Q. And again, you're not critical of the family for pursuing what they believe their brother's wishes would be, to keep him in a PVS state?

A. I'm not privy to what their brother's wishes might have been. Again, I've not seen any testimony or correspondence with the family, but the family, I don't know what their wishes are. You know, assuming that they really support his well-being and know more, then I'd agree with them, but I don't know what those wishes are. I'd like to.

Q. Do you have any understanding of why or how a patient comes out of PVS?

A. Well, when you say comes out, I mean, I'm not talking about going back to the astronomy faculty at M.I.T. because they don't do that. They gradually increase their periods of wakefulness and at times may develop some awareness.

They tend not to be mobile; they tend not to take walks; they don't learn things; they remain dependent in their care nearly to the extent that they

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were when they weren't quite as alert. Basically it's the appearance of more alertness that goes on in those rare situations that it does go on. Again, it usually does not go on.

Q. Have y u had the opportunity to read Dr. Winkler's deposition?

A. Yes.

Q. Did you note in tl lq tl t Dr. Winkler referred to a p ti t of s wh recovered from what he deemed a comatose t t fter nine ars in tl and is now tl an t member of society?

A. I have read that in his deposition. I don't know any documentation for it. I think it's extraordinary.

Q. Do you have any reason t believe tl t that s not the case?

A. I'd like to see more data about it. I'd like to know what he is doing or where the value. He believes he knows such an individual; I don't know such an individual.

Q. Dr. Winkler, I think, also referei ed later in his deposition that he had a patient that was also in a coma tl was in for three y that also

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came out of the comatose state and, although did not improvements and was aware --

A. I have no quarrel with anybody that can point to the occasional rare patient who has made any kind of recovery. The recoveries tend not to be substantial. I don't know of any person in a persistent vegetative state that went back to being a, quote, functional member of society. I'm not sure what that means, employed, have a job, pay taxes.

Q. Balance the checkbook.

A. No, I know of no such person.

Q. You've had a chance to look at Dr. Winkler's Life Care Plan, as well?

A. Yes.

Q. Do you have any criticisms of that plan in terms of the care that was for Mr. Jones in a home setting as well as the cost of the care?

A. I have no criticisms, save for the projection that he's going to live 33 years.

d fr r tl t ould you gree h plan the extent that accurately depicts what the t of care ould bc for Mr. J e in a home setting?

A. I believe it does, yes.

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Q. Do you have any question as to the qualifications of Dr. Winkler to prepare such a plan?
A. No. I'd have an additional quarrel or question about the home setting. Clearly Mr. Jones can be cared for in a home provided the home is turned into a hospital, that's what it would take. I don't think it's best suited to a home because of the burden of his care.
Q. Is that what, in essence, the Life Care Plan sets forth?
A. Yes.
Q. You, I think, have referenced in one of your reports that Mi-. Jones is exposed to some risks, a variety of dire health threats which include repeated septicemia, infection; is that accurate?
A. Yes, it is.
Q. Is Mi-. Jones at greater risk for these infections in a hospital setting than he would be in a home setting?
A. I don't believe so. Most of the trouble he's going to get into has to do with aspiration, bed sores, urinary track sepsis. He in a nursing home setting is really not going to be victimized by the same kind of nosocomial infections that go on in hospitals.

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Would they be present in a home to the same degree they're present in a rehabilitation facility or nursing home, probably not, but the level of care that he requires, as I said, would literally convert his home into a hospital or nursing home with staffing and the like which would then contain the same kinds of risks that are present where he is.
Q. Isn't he exposed to greater risks where he's at now because of exposure to other patients and other nosocomial infections?
A. I don't believe he is. I think that one can raise that possibility. His exposure is not as open as it would be, say, in an intensive care unit where he's surrounded by other very ill or septic people or immunosuppressed people and so forth.
Q. Dr. Winkler said in his deposition that it's his opinion that the nursing home facility increases the likelihood of him experiencing increased morbidity, particularly in terms of infections from cross-contamination being in a health care facility such as that. Do you agree or disagree with that?
A. Yes, I agree with that. If you bring three or four health care workers into his home then his exposure goes up even though he's at home. I don't think you've saved anything. When this is weighed

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against the burden of medical care that he requires, I don't think there is an advantage to that.
Q. Is there an advantage to having family members close by who care for his well-being in a home setting as opposed to in a hospital?
A. I don't know the capacity of his family to take care of him. My understanding from the nursing home is they haven't been around in a while. I don't know what their propensity for care giving or their skills in care giving may be whatever they are. Mr. Jones clearly requires professional help and lots of it to get by.
Q. What is your understanding of Mr. Jones' family's attendance at the nursing home facility?
A. I don't have an understanding.
Q. You mentioned that you --
A. It was mentioned to me, I think by one of the nurses, that people from his family had not been there in a while. I don't know what a while is and I didn't pursue it.
Q. Did you review any documentation at the nursing home aside from his medical charts?
A. No.
Q. You had a conversation at your visit With the head nurse, nurse manager of the facility?

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A. I believe so. I talked to the charge nurse and to the head nurse, yes.
Q. Tell me about what those conversations entailed.
A. I wanted to know about his current vital signs. I reviewed his record as to temperature, blood pressure and so forth. I wanted to see his medication list, which I did go over. Charted notes about his level of reactivity response and the like. Basically that was it.
Q. Is that true of both conversations?
A. Yes.
Q. Doctor, let's look, if we can, at your report concerning -- I believe it's the July 17th report marked as Exhibit 3. In that report you've indicated that you believe that Mr. Jones will not continue to live beyond the year's end, correct?
A. Yes.
Q. Can you tell me what the basis for that opinion is?
A. Well, it really rests on medical probabilities. He's suffered this state, the beginnings of this state since October of 1994. If one looks at persons such as Mr. Jones -- and I put Mr. Jones in the sickest of this group because of his

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burden of ill health from heart disease, seizures, sepsis, diabetes and the like -- they're meeting survival just over three years. He's about to that limit.

Now, this is no criticism of his care, his caregivers or anybody else, it's just a very tough job to keep Mr. Jones going in spite of great attention to his general medical care.

(Thereupon, there was a brief recess.)

BY MR. LANDSKRONER:

Q. Doctor, the name of the nurse that you spoke to at the health care facility, do you recall her name?

A. It was a him.

Q. I know the gentleman that was the charge nurse, but I'm talking about the person --

A. No, I don't.

Q. -- the person who indicated to you that the family members had not been there, do you recall her name?

A. No, I don't.

Q. We were talking a moment ago about the risk of infections to Mr. Jones. I note that you are on the board of the Aristocrat nursing facility's ethics committee.

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A. I chair it. I formed the committee and chair the committees that deal with ethics at three of their facilities.

Q. Do those ethics, at least from the standpoint of that chairmanship, deal with issues concerning patients in vegetative states?

A. They have, yes.

Q. Have you ever discussed anything related to the care of Mr. Jones while you were in that position?

A. No.

Q. Were you familiar with Mr. Jones' treatment at Aristocrat while you were in that position in any way?

A. No.

Q. One of the concerns, I guess, that they had for Mr. Jones was the problem with infection when he was at Aristocrat, correct?

A. They have that problem with Mr. Jones every place, including Aristocrat.

Q. The facility he's in now presently, can you tell me when the last time it was that he had a problem with infection?

A. guess. at his chart. I can tell you this, he has a problem with

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infection all the time.

Q. Aside from the preventative maintenance from infection, do you know how many times since he's been in that facility he's run into a problem where there was ongoing infec[illegible]?

A. I'd need his chart in front of me as I had said. Infection from him is, if you will, a bird flying around the room all the time. The last time an infection was detected I don't know, but he has infection all day every day.

Q. Do you know if he's been transferred at any point in time since he's been in the new it to the hospital for treatment and care?

A. Not to my knowledge. But again, that's a matter of choice. It really doesn't depend on whether he has an infection, it depends on whether you want to send him to a hospital to have it treated.

Q. How many patients were in the room that he's in now when you did the exam?

A. When I saw him he was the only person in the room.

Q. How many beds were in the room?

A. He was the only bed in the room at the time. There was room for another bed but no one in the bed.

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Q. Do you know how many patients were in the room that he was maintained in at Aristocrat?

A. I don't know.

Q. Would the fact that there were four patients in the Aristocrat room contribute in any way to the frequency of infection that Mr. Jones dealt with?

A. I believe not. I think Mr. Jones' survival to date is really a function of the care he got whether there were one person, no persons or four persons in the room. It's been of a very high quality, frequent intervention, lots of drugs and so forth. I don't think that's relevant to his infections. His condition is highly relevant to infections, not persons in the room.

Q. So the number of patients in the room would not increase his likelihood of getting an infection?

A. That's not what I said.

Q. That's what I'm asking.

A. I don't think he should be in the room with a hundred infected people, but I think to be in an ordinary room, whether there's two or three or one person, is not going to be an issue.

Q. So it would not affect or increase his

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likelihood or risk of infections with more persons?
A. I wouldn't put him in a room with two lepers and a tubercular, but in general, no.
Q. Let's jump back to the basis of the opinion that Mr. Jones will not survive through the end of the year. You mentioned you put him in the highest risk group because of his other health concerns. Are presently his other health concerns, including his cardiac status and diabetic status, controlled with medication?
A. Well, they're controlled at times and not controlled at other times. They require ongoing management with skilled care and multiple drugs. They're controlled to the degree he can survive with them. They are very substantial burdensome illnesses.
Q. Nonetheless, with medication and care, they are controlled?
A. Presently they're controlled. There's no guarantee they're going to stay that way.
Q. Now, when you talk about Mr. Jones' life expectancy, again, you said with probability, that is, with 51 percent medical probability he will not survive through the end of the year, correct?
A. Correct.
Q. So you're not guaranteeing that Mr. Jones

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is going to pass on before the end of the year?
A. I would hardly guarantee that.
Q. And in terms of the basis for the statistical information, I believe you referred me to the articles that gave you the numbers that you've referenced in Exhibit 3 as to the 3.3 year life expectancy for a person in a vegetative state.
A. Yes.
Q. You've also rendered the opinion that Mr. Jones within reasonable medical probability, again, 51 percent, will not come out of coma, correct?
A. Correct.
Q. And you cannot say --
A. Excuse me, he's not in coma, persistent vegetative state.
Q. PVS, thank you for correcting me.
So you're not saying that Mr. Jones absolutely positively will not come out of his vegetative state?
A. Well, there's a possibility that he may live life eternal, it's not probable that he will.
Q. And that's what I'm getting at. The probability we're dealing with is in terms of him passing on before the end of the year and in terns of his not living, coming out of coma or coming out of the

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vegetative state that he's presently in, correct?
A. Correct.
Q. Again, you're not suggesting that he could not live to 69 years old as set forth by Dr. Winkler, but just within reasonable probability that he will not live until he's 69 years old?
A. That's correct.
Q. Doctor, how many times have you been called upon to give a probability as to life expectancy for one of your patients?
A. I really don't know the number of times. It's more than a score I would think.
Q. And in every instance you were not correct in terms of predicting life expectancy, were you?
A. I've never been entirely correct in predicting anything.
Q. Of course, I assume you're very happy when your patients exceed the life expectancy that you may have to render for their future care?
A. In general, yes.
Q. Can you tell me the last time you had a patient exceed the medical life expectancy that you based your opinion on?
A. Yes. A person who lived to be 103 years old was a patient of mine, very famous and has a local

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automobile museum named after him. I was a guest at his 100th birthday party. I never thought he would live that long or stand up to do it, but he did. I was not only surprised, I was delighted to see that occur. He made it to almost 103.
Q. Have you had that happen with patients who are in their 30s and 40s?
A. Have what, have them live to be 103, not in my experience.
Q. Live beyond what the medical expected life expectancy would be.
A. A few do, a lot don't unfortunately.
Q. Your CV mentioned an award you received for quantization of cutaneous sensation. What is that award?
A. Well, that was a study to apply mathematics and statistics to describe the ability of a person to feel stimulation on their skin.
Q. And was there a publication that was related to that, as well?
A. Several.
Q. What were the results in short form of that study?
A. Well, the threshold is age dependent, sight dependent and has to do with predictable

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variations in disease and that one can come away with a connotative measure **of** what a person feels the way that **one** can develop connotative measures **of** the accuracy of vision.

Q. Does Mr. Jones feel?

A. If by feel you mean a conscious act that links an appropriate behavior with a stimulus both in quality and quantity, no. If by feel you mean does he respond in some fashion, yes, he does respond in some fashion.

Q. Doctor, have you ever contributed to any legislation or model statutes concerning the termination of care guidelines for a patient in PVS?

A. Not in PVS, no, but I have contributed in some small way to legislative guidelines that have dealt with the Uniform Brain Death Act.

Q. What year was your contribution?

A. Again, I don't know precise year. That work began in the early 1970s. The Uniform Brain Death Act started to get legislative activity sometime around 1980.

Q. Does Ohio recognize that act?

A. Yes, it does.

Q. It's still in effect?

A. Yes.

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Q. Have you contributed recently to any modifications of that?

A. Not to that act, no.

Q. Do you advocate at all that a patient in a PVS should be declared legally dead?

A. No, they're not dead.

Q. Do patients in PVS still have all the rights of all other patients?

A. Well, a person who is in persistent vegetative state is incompetent and as a consequence of incompetence they don't have the capacity to exercise their rights. Do they have them, yes, but the exercise of rights becomes a more complex matter because they can't exercise any right personally because of their incapacity.

Q. You've indicated in the examination you did that Mr. Jones is responsive, correct?

A. By responsive I mean he responds by extending his quadriceps muscle to a tap on his infrapatellar. They are responses, yes.

Q. He has an apparent alertness?

A. He does not have alertness, that is, that kind of alertness that allows him to incorporate his environment in a meaningful way so as to change it in relation to himself, he does not have it. What is

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have a senescent mummy for that reason.

Q. I don't know that; I'm not familiar with that.

A. Now you are.

Q. What is the senescent mummy?

A. Think about it for a moment. The appearance of wakefulness. If you were to sit there with your eyes open, not nodding, moving or doing anything, but appeared to be senescent, could do nothing, not move, not think, not feel, propped up, a mannequin.

Q. Do you know that Mr. Jones can't think?

A. There's no way of knowing that ever. That becomes a philosophic argument. It's one of the constant and ongoing sorts of things in relation not only to persistent vegetative state, but to coma, to any form of incapacity. So far it's not been possible for one person to crawl inside the mind of another person, even a healthy one, if there is a mind.

Q. So we have no way of really knowing if Mr. Jones is aware of his surroundings or his situation?

A. We can know what we know according to the

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best evidence of it. It gets down to questioning reality altogether. Cartesian argument.

Q. So I assume the answer to that is, no, we have no way of knowing?

A. We have no way of knowing that we really know what we know much less what somebody else knows is the problem. Not a very useful position in court.

Q. Doctor, what role did your wife play, if any, in the examination that was done on Mr. Jones?

A. She provides assistance to me. When I see a person in a nursing facility, I don't know who is going to be there or what help I may need, particularly if it's somebody who can't move and needs to be rolled over, has medical conditions that require some knowledge of them, so she helps.

Q. Did she take any notes?

A. No.

Q. Did you take any notes during the exam?

A. No.

Q. You did a procedure on Mr. Jones involving the use of injection of cold water into his eardrum area. Can you explain to me what that procedure was for?

A. It's to test the integrity of the brain stem and to come away with some notion of whether the

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cerebral hemispheres are awake.
Q. And, in fact, Mr. Jones' brain stem appeared to be intact?
A. Yes.
Q. And what else did you glean from that test that you performed?
A. I gleaned exactly that.
Q. I think you mentioned during the examination that if Mr. Jones were awake and conscious he would have a gazed fixation and the eyes would move away from the cold.
A. When you get -- his eyes moved very rapidly away from the cold stimulated side. Persons who are awake and conscious develop a particular kind of nystagmus with very rapid movement away from the cold stimulated side. Persons in coma develop tonic gaze deviation or no deviation at all, may be completely unresponsive to cold stimulation.
The quality of his responses suggests an intermediate position; namely, that those connections to the brain stem that subserve this are intact, but those centers above that level are not participating. It's a test in that sense for the integrity of the cerebral hemispheres. His don't work.
Q. You indicated that prior to performing

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that test you expected different results, correct?
Persons with PVS have some degree of responsiveness in this test, some more than others. The character of the nystagmus may vary from person to person depending on just how intact the brain stem is. His is the quality of response that you see in persistent vegetative state, not what you see in wakefulness and not what you see in coma.
Q. I think you indicated though that you expected before the test that his eyes would move towards the cold, which indicated that he was not wakeful, correct?
A. If they move toward the cold stimulated side you're dealing with profound coma. He developed some slow irregular wide amplitude sustained nystagmus to that, and that's what you see in PVS.
Q. Prior to doing that test on the patient I think you stated as you were preparing to do the test that you thought that his eyes would, in fact, move towards the cold stimulus.
A. It's hard to predict until you did it. He did have some slow movement away. I'm not sure what a surprise it was.
Q. Was that prediction based on your review

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of the medical records?
A. Pardon me?
Q. Was that prediction that he would not --
A. No, it's based on my examination of him.
Q. I *think* you made reference during your examination to the significance of the response of his hand pulling when you put your hand in his hand, What is the significance of that response?
A. Well, it's a traction response. It's of that category or classification of responses that tends to incorporate a stimulus into the body. They're very old responses and they have a teleological meaning.
I don't mean to be personal, but have you any children?
Q. No.
A. If you take a young newborn infant whose cerebral hemispheres are not working, not myelinated, you can take that baby, take their hands and they'll pull back on you as, you know, look, the baby is standing and he's only two days old type of thing. That class of response tends to incorporate stimulation into the person.
It's the same class as sucking responses, it allows small babies to survive, allows small monkeys to cling to the back of their mother and

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allows small possums to find their mother's pouch. Very primitive reflexes and not themselves evidence of learning or friendliness.
The normal response in a conscious awake individual given my fingers scraping their palm is to pull their hand away and wonder what kind of a fellow they're dealing with.
Q. Along the same lines, the response that you elicited by using the pin around the facial area is significant of what?
A. Withdrawal, grimacing, reflexive stuff. It's not a purposeful form of response.
Q. To clarify, Mr. Jones had both cranial nerve reflexes and spinal reflexes?
A. That's correct.
Q. He also had his gag reflex present?
A. Well, it's not an also. That is a brain stem reflex mediated by cranial nerves.
Q. You indicated Mr. Jones had spontaneous respirations?
A. Yes, he does.
Q. Doctor, in your report of July 14th you've noted at the end of the first paragraph under impression, the lack of distal reflexes may suggest superimposed diabetic neuropathy. What is that?

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A. That is an affliction of the peripheral nerves seen in conjunction with diabetes in which the cells that invest the peripheral nerves become diseased as part of the diabetic process. Persons with it develop numbness, weakness, lose their reflexes. It's common in diabetes.

Q. It seemed from the examination that Mr. Jones seemed to have more response with the left side of his body than he did with the right side of his body. Why is that?

A. The condition of anoxia is never completely symmetrical. In anoxic ischemic injury there are always imbalances. The brain does not resemble two sides of an Oreo cookie in terms of the distribution of pathology. I think what it connotes is one hemisphere is somewhat more damaged than the other. You know, that is a neurologic fact, but it has no relevance in terms of changing what I've said to you in terms of his overall function.

Q. So I'm clear, there's no way to say or you're not saying with reasonable medical certainty that Mr. Jones is not aware of his surroundings?

A. I do not believe he is aware of his surroundings at all. That is my opinion.

Q. And you're saying that you do not believe

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within medical certainty that he's aware of his surroundings?

A. Correct.

Q. If you can, just tell me what the basis for that opinion is.

A. No predictable awareness, no visible interaction, no function of language, no formed response to stimulation from the environment such as noise and so forth, no detractability, no learning.

Q. And so you've for the most part outlined what you said the qualifications are for persistent vegetative state, correct?

A. In that particular parameter we've talked about that has to do with awareness, not the other things.

Q. Is it your opinion that all patients in a PVS state do not have awareness?

A. Right, if they're in persistent vegetative state. If they do have awareness then they're not in a persistent vegetative state.

Q. I understand.

Doctor, do you currently expect to testify on any matters -- I've asked you a lot of questions -- any matters other than those expressed in your report and those opinions that we've discussed

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here today?

A. No. They really have to do with his neurologic state and his prognosis. I don't expect to be asked questions regarding other matters. I'll certainly try to answer them if I am, but I don't expect to be.

Q. Is there anything that relates to those matters that you think is important for me to know? I don't want you to come in to trial and surprise me with anything, any opinions we haven't discussed here today. Nothing else you think I need to know that you expect to talk about?

A. I don't believe so, no.

Q. Have you rendered any opinions to defense counsel other than what you've expressed in your report and indicated here today?

A. I have not.

Q. Do you expect to do any additional work or research studies or anything else before trial?

MK. CASEY: He will get the Heritage Care records as soon as I have them, Susan.

A. Only if I'm asked.

Q. Is there anything else you would like to see besides the Heritage Care records that you've

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indicated earlier today?

A. No. You talked to me about the care giving capacity of his family. It might be useful to know something about that. Are they trained to do the kinds of things that Mr. Jones would require? I can think of that only as an additional set of information.

Q. Do you expect to appear at person in trial?

A. If asked, yes.

Q. Have you been asked yet?

A. I've been asked to put time aside in the expectation that there actually will be a trial.

Q. Do you have a specific date when you have been asked to testify?

A. Yes, but I don't have my book with me. I think it's next week sometime, but I'm not sure of the day.

MR. CASEY: can you give me an estimate of when you will be done with your case in chief?

MR. LANDSKRONER: I wish I knew.

BY MR. LANDSKRONER:

Q. Doctor, you stated at the beginning of your exam of Mr. Jones a statement which I just want

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some clarification on. The statement was that somehow related to the exam that this was a Barnum & Bailey Circus. What did you mean by that?

A. Where is that?

Q. Something you said just prior to doing your exam of Mr. Jones.

A. I don't remember; I don't know.

Q. No recollection of that statement?

A. No. They were famous people. I don't know what I was talking of.

Q. The testing that you did on Mi. Jones, the injection of the water into his ear, is that deemed an invasive procedure?

A. No, really not invasive. You don't open up blood vessels and make holes, you're just using an existing orifice. It's not invasive. An awake person is not comfortable.

MS. REINKER: Jack, I'm going to sign off now.

MR. CASEY: NO questions, Susan?

MS. REINKER: I have no questions. Are you going to continue or are you done?

MR. CASEY: I think they

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may just have a few. They're talking amongst themselves.

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

BY MR. LANDSKRONER:

Q. Doctor, the biting reflex, what is that indicative of?

A. That's indicative of a very low level kind of response. It's an embryonal reflex that appears in adult life or in children under conditions of severe injury to cerebral hemispheres. If you wish to know more about it than that, I'll be happy to tell you.

Q. What's the significance of it in Mr. Jones?

A. Again, tremendous evidence of damage to his cerebral hemispheres described by two Romanians, Romanesco and Dragonesco. Children who were suffocated in a fire in a French barn in 1920, they put sticks in their mouth, they bit on the sticks and you could lead them around, they don't let go. That class of reflex that tends to incorporate stimulation. See its use in an infant that needs to eat. It has no use.

Q. Do we have that reflex as an adult when we're sleeping?

A. No, we do not.

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Q. Finally, who in the course of your examination authorized you to take off the respirator from Mr. Jones?

A. I authorized myself to do it to judge the quality of his spontaneous respirations which he's had and to which I've testified. The presence of spontaneous respirations are part of the diagnosis of persistent vegetative state.

MR. CASEY: Are you suggesting some harm was done to Mi. Jones by that?

MR. LANDSJSRONER: Just inquiring. I think that's all I have, Doctor. I thank you for your time. I just would want to get a copy of that one publication that you referenced.

THE WITNESS: you're welcome to.

MR. CASEY: Read or waive, Doctor?

THE WITNESS: I waive, but I would like to read.

(DEPOSITION CONCLUDED.)

(SIGNATURE WAIVED.)

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STATE OF OHIO, )

COUNTY OF CUYAHOGA. ) SS:

CERTIFICATE

I, LAUREN I. ZIGMONT-MILLER, Registered Professional Reporter and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named witness, JOHN PAUL CONOMY, M.D., J D., was by me first duly sworn to tell the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was reduced to stenotypy in the presence of said witness, and afterwards transcribed by me **through** the process of computer-aidedtranscription, and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 6th day of August 1997.

Lauren I. Zigmont-Miller, RPR and Notary Public in and for the State of Ohio.