

State of Ohio,)

County of Cuyahoga.)

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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, Ridgemark Medical Center, 7575 Northcliff Avenue, Brooklyn, Ohio, commencing at 11:40 a.m., the day and date above set forth.

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<p>1 APPEARANCES:</p> <p>2</p> <p>3 On behalf of the Plaintiffs:</p> <p>4 JACK LANDSKRONER, ESQ. PAUL GRIECO, ESQ. 5 The Landskroner Law Firm 55 Public Square, Suite 1040 6 Cleveland, Ohio 44113-1904 (216) 241-7000</p> <p>8 On behalf of the Defendant Meridia Huron Hospital:</p> <p>9 JAMES MALONE, ESQ. JAMES S. CASEY, ESQ. 10 Reminger & Reminger The 113 St. Clair Building 11 Cleveland, Ohio 44114 (216) 687-1311</p> <p>12</p> <p>13 On behalf of the Defendant Peter Adamek, M.D:</p> <p>14 SUSAN REINKER, ESQ. Jacobson, Maynard, Tuschman & Kalur 15 1001 Lakeside Avenue, suite 1600 Cleveland, Ohio 44114 16 (216) 736-8600</p> <p>17</p> <p>18 - - -</p> <p>19</p> <p>20</p> <p>21</p> <p>22</p> <p>23</p> <p>24</p> <p>25</p>	<p>1 (Thereupon, Plaintiffs' Exhibits 1, 2 and</p> <p>2 3 to the deposition of John Paul Conomy,</p> <p>3 M.D., J.D., were marked for purposes of</p> <p>4 identification.)</p> <p>5 - - -</p> <p>6 JOHN PAUL CONOMY, M.D., J.D.,</p> <p>7 a Witness herein, called for examination by the</p> <p>8 Plaintiffs, under the Rules, having been first duly</p> <p>9 sworn, as hereinafter certified, deposed and said as</p> <p>10 follows:</p> <p>11 CROSS-EXAMINATION</p> <p>12 BY MR. LANDSKRONER:</p> <p>13 Q. Doctor, my name is Jack Landskroner. I'm</p> <p>14 one of the attorneys that's representing Dewey Jones in</p> <p>15 the case filed in Common Pleas Court. You have been</p> <p>16 retained as an expert in this case.</p> <p>17 I'm going to ask you some questions</p> <p>18 today. I ask that your responses are verbal. I know</p> <p>19 you've had your deposition taken before. If you don't</p> <p>20 understand a question, please stop me, ask me to</p> <p>21 rephrase it. I don't want you to answer a question</p> <p>22 that you don't understand.</p> <p>23 A. Okay.</p> <p>24 Q. What is your professional address?</p> <p>25 A. 7575 Northcliff Avenue, Cleveland, 44144.</p>
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<p>1 INDEX</p> <p>2</p> <p>3 PAGES</p> <p>4 CROSS-EXAMINATION BY</p> <p>5 MR. LANDSKRONER 4</p> <p>6</p> <p>7</p> <p>8 - - -</p> <p>9</p> <p>0</p> <p>1 PLAINTIFF'S EXHIBITS MARKED</p> <p>2 1, 2 and 3 4</p> <p>3 4 9</p> <p>4</p> <p>5</p> <p>6 - - -</p> <p>7</p> <p>8</p> <p>9</p> <p>0</p> <p>1</p> <p>2</p> <p>3</p> <p>4</p> <p>5</p>	<p>1 Q. That's Innova Medical Services?</p> <p>2 A. This building is Ridgepark Medical</p> <p>3 Building. Innova is in transition. The group is</p> <p>4 fragmented. Part of it is going one way and a part</p> <p>5 another. In the last month I've joined the Collis-Kim</p> <p>6 Group of Neurology & Neurosurgery, so I'm no longer</p> <p>7 employed by Innova Medical Services, although I remain</p> <p>8 in this building which once housed that organization.</p> <p>9 Q. So you will stay in this building in your</p> <p>0 new position and continue to operate as you have, but</p> <p>1 with a new entity?</p> <p>2 A. At least through the day.</p> <p>3 Q. Okay. Who else is involved in the new</p> <p>4 entity -- is that a large group or is that a small</p> <p>5 group?</p> <p>6 A. Which new entity?</p> <p>7 Q. The new entity which you've just become a</p> <p>8 part of.</p> <p>9 A. It presently consists of several</p> <p>10 neurosurgeons, myself, but we're in the process of</p> <p>11 enlarging and expanding that group.</p> <p>12 Q. What is your status in that group?</p> <p>13 A. I'm a member of the group.</p> <p>14 Q. Do you have any administrative duties</p> <p>15 within that group?</p>

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

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

9 A. Correct.

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

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

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

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

25 Q. Aside from the copy that you provided me

1 be helpful.

2 hereupon, there was a discussion off the
3 record.

4 BY MR. LANDSKRONER:

5 Q. Doctor, you will now list the chance to go
6 through your vitae and indicate with marks on the side
7 of relevant publications which may pertain to issues in
8 this case?

9 A. Yes.

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

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

19 Q. For purposes of the record, let's mark
20 this as Exhibit 4. While we're doing it, I premarked
21 the report that you've provided related to your review
22 of this matter dated May 7, 1997 as Plaintiff's Exhibit
23 1 with your shortened version of the CV attached to it,
24 Exhibit 2 is a report dated July 14, 1997, and Exhibit
25 3 is a report dated July 17, 1997 just for

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1 today dated July of '97, do you have any other
2 curriculum vitae that you use either in the course of
3 your speeches or your presentations or publications?

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

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

10 A. Yes, they are.

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

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

16 Q. I would appreciate it.

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

18 Q. Certainly.

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

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

1 simplification.

2 (Thereupon, Plaintiffs' Exhibit 4 to the
3 deposition of John Paul Conomy, M.D.
4 J.D., was marked for purpose of
5 identification.)

6 BY MR. LANDSKRONER:

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

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

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

19 A. Yes.

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

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

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1 for Mr. Mark Jones?

2 A. I may have, I just don't recall. I know

3 there's a case called Carnovice that Anna Carulas had

4 in which I did testify.

5 Q. Was that also Cuyahoga County?

6 A. Yes.

7 Q. How about Ms. Reinker, have you ever

8 worked with her before?

9 A. I don't believe I've had the pleasure.

10 Q. Can you tell me approximately how many

11 times you've worked for the Jacobson law firm?

12 A. I really can't. Some of those firms are

13 so large and contain such platoons of lawyers that I

14 can't remember who they work for. They seem to change

15 their venues frequently, too.

16 Q. Especially recently.

17 Doctor, I don't know if I asked you

18 specifically, but do you recall how many times you've

19 been involved in testifying or reviewing files for the

20 Reminger firm?

21 A. If I guessed ten I think that would be a

22 reasonable number.

23 Q. Doctor, who is your malpractice insurance

24 carrier?

25 A. PIE.

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1 Q. Have you ever sat on any boards or review

2 panels for PIE?

3 A. No.

4 Q. Have you talked to any of the other

5 attorneys in this case aside from Mr. Malone and

6 Mr. Casey?

7 A. No, I have not.

8 Q. Are you familiar with any of the

9 defendants in this case?

10 A. I am not.

11 Q. How much do you charge to review a file?

12 A. \$400 an hour for review or anything else.

13 Q. That goes for trial testimony, as well?

14 A. Yes, it does. It does not include travel

15 and that kind of business, it's confined to actual time

16 spent.

17 Q. Doctor, what percentage of your time now

18 is spent in the active clinical practice of medicine?

19 A. Over the course of a week, between 70 and

20 80 percent of my time is spent in medical practice.

21 Q. What makes up the rest of your time?

22 A. A combination of writing, teaching,

23 lecturing, work such as this, involvement in medical

24 organizations, constitutive work to medical

25 organizations and health systems, some work for

1 governments, United States and elsewhere.

2 Q. Can you tell me about how many files you

3 review a year related to medical-legal issues?

4 A. It depends on what you think a

5 medical-legal issue is. It may have to do with a

6 credentialing of physicians, physician performance.

7 I'm not sure that you would consider those

8 medical-legal, so maybe you can tell me.

9 Q. I'm taking more specifically along the

10 lines of medical negligence cases.

11 A. Again, it depends on the year, but I would

12 say between five and ten.

13 Q. Can you tell me what percentage of your

14 income is related to your review of files in

15 medical-legal issues, medical negligence?

16 A. I can tell you that last year it was less

17 than ten percent, and I suspect it will be less than

18 that this year, too. I'll know better on the 15th of

19 August.

20 Q. Doctor, you're a Board certified

21 neurologist, correct?

22 A. I am.

23 Q. And you passed your Board certification in

24 March of 1972?

25 A. A great day it was, Mr. Landskroner.

1 Q. Since that time have you had another great

2 day when you were recertified?

3 A. This board has not dealt with

4 recertification, so I've been spared the embarrassment

5 and ardor of having to undergo preparation and then the

6 horror of facing yet another examination. At this

7 point in my life I've decided if anybody wants to give

8 me an examination for anything I won't take it. They

9 can have my driver's license.

10 Q. So you're not required to recertify under

11 your board?

12 A. God forbid.

13 Q. I see. If your Board

14 certification on the first attempt?

15 A. Yes, I did.

16 Q. I notice from your CV that you have a J.D.

17 as well as an M.L.

18 A. Yes.

19 Q. You did it for a Bar examination?

20 A. I did not.

21 Q. I understand now why.

22 A. Correct.

23 Q. Do you have any intention of taking the

24 Bar examination?

25 A. I don't know. I can't see myself doing

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

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

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

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

14 A. Again, it's a guess. A half a dozen,
15

16 Q. Can you give me a percentage of
17 the number of files that you've reviewed for the
18 plaintiff as opposed to the defendant?

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

24 Q. In that case you've been retained by
2 Meridia or the lawyers for Meridia Huron Hospital; is

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1 that accurate?

2 A. That's correct.

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

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

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

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

18 Q. Did you testify in trial in that case?

19 A. No.

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

22 A. Yes, it was.

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

25 A. I really can't.

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

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

5 Q. Was that also Cuyahoga County?

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

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

14 A. No.

15 Q. Have you ever authored any li ti i
16 joint effort with anyone in their office?

17 A. No, I haven't.

18 Q. How about done any presentations or sat on
19 any panels with anyone from the Reminger office?

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

24 Q. Did the office you a t out f law
25 school?

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1 A. No. They had more sense than that.

2 MR. MALONE: That's not
3 true.

4 BY MR. LANDSKRONER:

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

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

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

12 A. No, I don't.

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

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

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

21 A. No.

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

24 A. I believe I have.

25 Q. Have you ever done any work individually

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

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

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

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

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

19 Q. I know those long days.

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

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

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

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1 A. Yes.

2 Q. Are you on faculty at those
3 institutions?

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

5 Q. What classes do you teach?

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

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

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

10 Q. In a role as either a witness or as a
11 judge?

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

Classes in the various areas
including ethics?

1 A. Yes.

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

4 A. Yes.

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

7 A. Yes.

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

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

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

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

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

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

25 Q. Do you have those on file?

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1 [REDACTED]
2 ancient at this point.

3 Q. The documents that you have related to the
4 subject of families' liability their
5 ones, living wills and patients rights, I'd like you,
6 if you can, to screen through your materials and see if
7 you have any related to those teachings,
8 and provide them to counsel so I could access
9 those.

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

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

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

22 In your peripheral last
23 can tell where you might have taught and
24 the written materials related to it

25 te

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

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

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

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

19 A. Last February.

20 Q. And at Case Western?

21 A. Probably four months ago.

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

24 A. Yes, I'm certain I have.

25 Q. Anything in preparation for today's

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1 deposition?

2 A. No.

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

5 A. No, I haven't.

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

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

12 Q. Where is that at?

13 A. I hope you attend.

14 Q. I may very well do that.

15 A. It's some expensive downtown venue only
16 affordable by major law firms. I think it's at The
17 Forum. I think it's Friday and I think it starts at
18 9:00.

19 Q. Who is sponsoring that event?

20 A. The State Bar Association, I believe.

21 Q. What time are you scheduled to speak?

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

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

1 A. Which publication?

2 Q. The publication concerning experts in
3 neurology.

4 A. Yes, it is.

5 Q. What's the title of that one?

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

11 Q. That would be great.

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

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

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

25 A. My understanding was that I was asked to

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1 review records to come to some opinion as to what it
2 was that characterized Dewey Jones' neurologic state
3 and to offer a prognosis thereafter as to his continued
4 life and ill health.

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

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

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

12 A. Yes.

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

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

19 Q. What do those records consist of?

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

22 Q. I figured you did when I saw the note of
23 35 pounds in the report.

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

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1 Q. I'll come back to that.

2 How much time have you spent reviewing
3 this file?

4 A. Altogether, probably 12 hours at this
5 point. There's just a lot of material.

6 Q. Is there anything else that you'd like to
7 review in this case that you haven't had the
8 opportunity to review?

9 A. Well, I've seen his current medical
10 records when I examined him. I believe it's from the
11 Heritage nursing facility. You know, as time goes on,
12 should this matter wind its way to resolution and
13 should I be called upon to speak again, I'd certainly
14 want to see up-to-date records.

15 Q. Of the records that you reviewed, can you
16 tell me what you recall seeing?

17 A. I can tell you what I've seen and I can
18 tell you what I've not seen. I've seen records from
19 University Hospitals of Cleveland; I've seen records
20 from MetroHealth Medical Center; I've seen records from
21 the Southwest Hospital; I've seen records from the
22 Aristocrat nursing facility and some other nursing
23 homes.

24 As I told you, I reviewed his records
25 from Heritage when I was there to examine him and I

1 Hospital admission?

2 A. Thank you, Mr. Malone. I could not have
3 said it better myself. My knowledge of him begins on
4 the day of his transfer to University Hospitals. I
5 know nothing of him before that in terms of
6 contemporary records.

7 MR. MALONE: we have not
8 asked him to evaluate, nor will we ask him
9 to evaluate or comment on any of the
10 so-called liability issues in this case.

11 MR. LANDSKRONER: Thank you,
12 Mr. Malone.

13 BY MR. LANDSKRONER:

14 Q. Doctor, did you undertake any literature
15 searches at any time related to your involvement with
16 this case?

17 A. Yes and no. I don't want to be vague
18 about it. During the time that I chaired and was a
19 member of the American Academy of Ethics Committee the
20 whole notion and concept of persistent vegetative state
21 ~~was really born and brought to maturity~~. So I am
22 familiar with that literature, I'm very familiar with
23 it, and, in fact, contributed to a number of the
24 committee reports and **so forth** to finding the **state** and
25 looking at prognosis, so I'm mindful **of** that literature

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1 have examined him and submitted a report. I've seen
2 the deposition of Dr. Winkler given on July 10, 1997
3 and I've seen the Life Care Plan that was previously
4 furnished by Dr. Winkler.

5 What I've not seen are the records of
6 Meridia Hospital; I've not seen anybody else's
7 deposition, nor do I know of the status of those
8 depositions, other than Dr. Winkler's; I've not seen
9 reports, other than his Life Care Plan. If there are
10 additional reports that he's furnished, I have not seen
11 those.

12 Q. Did you receive any summaries of medical
13 records along with the records themselves?

14 A. No, I have not.

15 Q. You have not been asked to render any
16 opinions concerning anything that happened prior to
17 October 20, 1994 and related to the care received by
18 Mr. Jones?

19 MR. MALONE: He hasn't seen
20 anything prior to November 21st when the
21 guy was transferred to University
22 Hospitals.

23 BY MR. LANDSKRONER:

24 Q. You have not been asked to render any
25 opinion about care rendered prior to the University

1 and I know what's in it, but in terms of precise
2 literature on the condition, no.

3 Q. I noted in at least one of the reports
4 that you've authored there's some reference to
5 statistical information.

6 A. That's correct.

7 Q. I'll get to the opinion a little bit
8 later, but can you tell me where that information is
9 pulled from?

10 A. That information was eventually published
11 in a variety of places, perhaps the best known is the
12 New England Journal of Medicine, I think in 1994. It's
13 a report of the task force on the determination of
14 persistent vegetative state, it has a title like that.

15 The information that went into it is
16 really a distillate of 20 years of looking into the
17 subject. That report was contributed to by
18 organizations of neurologists, neurosurgeons,
19 pediatricians, other medical organizations, so it
20 really involves two decades of work and hundreds of
21 people.

22 Q. Did you go back to that article, that
23 publication at the time you authored that report?

24 A. Well, I'm familiar, very familiar with the
25 article, so I really didn't have to go back to it.

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

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

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

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

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

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

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

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

3 A. Right.

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

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

12 Q. What year were those publications?

13 A. I believe 1994.

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

17 A. No.

18 Q. Did you li anything to t you in
19 coming back and writing reports at a later time?

20 A. never no.

21 Q. I t th th rt th tve s
22 marked. Are there any other reports that you've
23 authored besides the three that we have marked here
24 today?

25 A. No.

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

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

6 A. I chaired it.

7 Q. What did the committee undertake?

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

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

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

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

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

1 Q. We t l y d ft of t l s reports?

2 A. No.

3 Q. d you at any p t in time review the
4 complaint and answer filed in this case?

5 A. I believe not.

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

9 A. No, I don't.

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

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

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

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1 A. It's abundant.

2 Q. Can you tell me how many patients that
3 you've actually been the attending physician for who
4 have been in that state?

5 A. In persistent vegetative state?

6 Q. Yes.

7 A. Probably two dozen over the years.

8 Q. Can you tell me when the last time you
9 were the attending physician for a patient in a coma or
10 if you're presently --

11 MR. MALONE: Do you

12 distinguish attending from consulting?

13 There is a difference between being an
14 attending and being a consultant. I'm not
15 sure if the doctor is mindful of it when
16 he answers your question or if he's being
17 expansive.

18 BY MR. LANDSKRONER:

19 Q. Let me ask it in terms of your active
20 involvement in the care of a patient in a persistent
21 vegetative state.

22 A. I have to think back. Probably a couple
23 of months ago. You mentioned coma and a few other
24 things. Again, I'm talking about persistent vegetative
25 state only, not coma.

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1 Q. That's a good point. Can you define for
2 me persistent vegetative state?

3 A. Yes, I can. It might be useful to turn to
4 one of the reports, if you wouldn't mind. It's report
5 No. 3. The criteria for persistent vegetative state
6 are listed under the bullets, and save for one, that is
7 the issue of time, it is an accepted medical standard
8 that the use of persistent vegetative state is not
9 applied in general to a child or an adult unless
10 they've shown evidence of unawareness for a period of
11 at least 30 days.

12 Now, having said that, there are a
13 number of other things that are essential to the
14 diagnosis of that condition. One is evidence of
15 person, self-awareness or awareness of the environment
16 as evidenced by some ability to interact with that
17 environment in a meaningful way, in a way that shows
18 understanding or learning. Dewey Jones has none of
19 that.

20 The next is the absence of voluntary or
21 purposeful behavioral responses. He has none. Now,
22 does this mean he's unresponsive, no, he has lots of
23 responses, but the problem is that they're not
24 purposeful, not linked to the stimulus, they tend to be
25 generic, predictable, stereotyped kinds of things.

1 Let me give you an example. A

2 purposeful response to sticking a pin in your nose
3 would be alert, to look at me as an overly aggressive
4 and cruel individual, to get your head out of the way
5 and grab the pin and my hand and push it out of the
6 way. That's a natural response on the part of an
7 infant or child or adult.

8 A stereotyped response would be to arch
9 your head, arch your neck, stiffen your arms and
10 stiffen your legs and snort. It would matter little
11 whether the pin stick is in your nose, on your cheek or
12 somewhere else, the response is stereotyped, it's not
13 purposeful.

14 Q. If I can interrupt you for just a second
15 and ask, withdrawal from painful stimuli as in turning
16 your head away or withdrawing from the actual pain, the
17 stimulation, moving back away from the painful
18 stimulation, is that a natural response?

19 A. It's natural, but you can do it with your
20 brain stem and your spinal cord, it doesn't require
21 participation in cerebral hemispheres.

22 Let me give you an example. You in the
23 course of a beautiful weekend are walking barefoot
24 along the glistening, expansive beach at Edgewater
25 Park. Some buffoon has left his Macanudo cigar still

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1 lighted in the sand and, as poor fortune would have it,
2 your foot comes to rest on the lighted cigar butt.
3 Your nervous system is organized in such a way that
4 before you can register and say ouch your foot has
5 moved.

6 The initial withdrawal of your foot
7 does not require participation of anything except the
8 organization of normal spinal cord function, it's not a
9 conscious act. The ouch part or looking down and
10 knowing it's a cigar butt and knowing your foot is
11 burned are complex behavioral responses and they do
12 require an awake brain to do, but before any of that
13 has gone into place there's been a mechanical or
14 reflexive part. Turning a head or getting your foot
15 out of the way or snorting does not require conscious
16 participation, it's reflexive activity.

17 Q. That's not a purposeful response?

18 A. That in itself is not purposeful.

19 Q. Continue on.

20 A. He has no access to language. Now,
21 there's no discrimination between language and noise
22 and, in fact, there's no predictable response to either
23 one. In Mr. Jones' examination whether his name was
24 whispered to him, whether it was shouted to him,
25 whether there was ambient noise in the room or some

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1 sudden noise, shouting, banging things, there's no
 2 no to
 3 Q. Was there any reaction to it?
 4 A. It's really hard to link it in time. From
 5 time to time he will do such things on his own as
 6 twitch his cheek or move his eyes, but he does that
 7 whether or not there's anything going on in the room.
 8 So it takes a process of imbuement or attribution to
 9 say yes it's linked to that. In my opinion, then, is
 10 no predictable linkage of environmental activity and
 11 his response to it at all, they are random events and
 12 not linked in time.
 13 He has intermittent wake/sleep cycles
 14 that are really quite striking. They're not entirely
 15 regular, they're irregular. He will appear to be in
 16 repose for a couple of minutes and then appear to wake
 17 and his eyelids will retract and he will appear to look
 18 off into the space around him not focussing on
 19 anything, his eyes will rather wander, and that will be
 20 kept up for a couple of minutes and then he'll happen
 21 to go to sleep again. The cycle tends to repeat itself
 22 at variable lengths, the length of each apparent
 23 sleeping or waking being brief rather than long.
 24 Intact wake/sleep cycles are characteristic of
 25 persistent vegetative state.

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1 He has the ability to maintain his
 2 heartbeat, his blood pressure, the kinds of things that
 3 are done as part of the intact activity of the
 4 autonomic or vegetative nervous system. He can cause
 5 oil to be secreted on his skin; his gastrointestinal
 6 track is motile; he can secrete mucous and other
 7 secretions in his lungs. Those are nervous system
 8 mediated but not muted by parts of the nervous system
 9 that deal with wakefulness or learning or
 10 consciousness.
 11 He is doubly incontinent, his bowel and
 12 bladder. He has preservation of certain reflexes that
 13 do not require again the participation of the cerebral
 14 hemispheres, eye movements, respiration, pupillary
 15 reactivity to light and the like. Those are criteria
 16 that are established clinically to determine that a
 17 person is persistent vegetative state. That is a
 18 clinical diagnosis.
 19 Q. Are there other clinical signs which could
 20 be looked for that also encompass persistent vegetative
 21 state?
 22 A. There are, but these are the essential
 23 requirements.
 24 Q. Can you tell me what the others are?
 25 A. You may see a person in a persistent

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1 vegetative state yawn or tear, grimace, giggle. He
 2 didn't display those. They can be seen. They are not
 3 essential to the diagnosis.
 4 Q. Anything else
 5 A. No.
 6 Q. What's the definition of coma?
 7 A. Coma differs from this. First of all,
 8 coma is used to designate acute states. It may be
 9 prolonged, but in general it connotes an acute state.
 10 Persons in coma frequently require support of vital
 11 functions, like their blood pressure and so forth.
 12 Now, Mr. Jones requires the use of a
 13 respirator to keep him alive. He has respirations
 14 without a respirator, the problem is they're not very
 15 effective and may fail, so with him it's an assistive
 16 rather than a required device. Persons in coma lose
 17 their brain stem reflexes of which he has in abundance.
 18 Those are the fundamental differences
 19 Now, coma frequently blends into persistent vegetative
 20 state. In it it all of the time.
 21 Q. How about semi-comatose state?
 22 A. to me
 23 Q. Is there a clinical diagnosis for a
 24 sen con state that you're aware of?

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1 A. There are lots of definitions. That is
 2 not a particularly useful definition. It's too much
 3 like beauty.
 4 Q. I guess in response to the question there
 5 is no clinical diagnosis that you're familiar with that
 6 defines --
 7 A. That's not what I said. There's plenty.
 8 You can find the word semi-coma appearing all over the
 9 medical literature. It's like beauty, you don't know
 10 if it's a lot or a little bit.
 11 If I were to define the basic unit of
 12 beauty as one millennium it would at least give me a
 13 start. That amount is sufficient to launch a single
 14 ship. What a little bit of semi-coma is I haven't the
 15 slightest idea.
 16 MR. MALONE: I have to run,
 17 so Mr. Casey will stay, but I have to
 18 excuse myself, I have another commitment
 19 that I've got to get moving on.
 20 BY MR. LANDSKRONER:
 21 Q. Dr. Conomy, we were talking about
 22 comatose state and I was going to inquire if
 23 Mr. Jones is in what you would deem at this point a
 24 comatose state.
 25 A. No, he's not.

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

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

8 Q. No functions whatsoever?

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

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

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

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

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

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

6 Q. They are able to comprehend to some
7 extent?

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

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

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1 A. In general, no. Now, there is the very
2 rare, the very odd case of some recovery after
3 persistent vegetative state. One case in New York, a
4 young man I think was in PVS around two years. One
5 published from Houston, Texas, a young woman who had
6 been in a persistent vegetative state for a period of
7 15 to 18 months, she wrote as she recovered I love you
8 mom.

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

15 Q. What is the longest situation you're aware
16 of where a patient was in PVS and recovered at least
17 partially?

18 A. Probably two years or thereabout.

19 Q. What's the best that you're aware of
20 that has happened in a PVS state?

21 A. I can even give you names.

22 Q. Just if you can give me --

23 A. I can give you names.

24 woman named Elaine Esposito survived for 41 years, she
never recovered. Another one named Rita Green for, I

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

4 Of all of the persons in the United
5 States in PVS today, that number is not known for sure
6 largely because of definitional problems, it's between
7 10,000 and 25,000. Of that there may be one with
8 prolonged survival and there may be three with some
9 recovery after several months of PVS. Again, I think
10 numbers are very important here and the numbers you're
11 talking about are vanishingly small, they are close to
12 zero.

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

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

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

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

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

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

18 Q. Conversely, have you ever encouraged a
19 family to upgrade the care for a patient in a PVS
20 state?

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

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

5 Q. Have you had the opportunity to read
6 Dr. Winkler's deposition?

7 A. Yes.

8 Q. Did you note in the deposition that
9 Dr. Winkler referred to a patient of his who recovered
10 from what he deemed a comatose state after nine years
11 in the hospital and is now an active member of
12 society?

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

16 Q. Do you have any reason to believe that
17 that is not the case?

18 A. I'd like to see more data about it. I'd
19 like to know what he is doing or where the

20 value. He believes he knows such an individual. I
21 don't know such an individual.

22 Q. Dr. Winkler, I think, also referred
23 later in his deposition that he had a patient that was
24 also in a coma that was in for three years that also

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1 Q. You're not critical of the Jones family in
2
3 brother, are you?

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

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

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

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

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

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

1 came out of the comatose state and, although did not
2
3 improvements and was aware --

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

11 Q. Balance the checkbook.

12 A. No, I know of no such person.

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

15 A. Yes.

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

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

21 I find that you would agree that
22 plan depicts the extent that accurately
23 depicts what the type of care could be for Mr. Jones in
24 a home setting?

25 A. I believe it does, yes.

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1 Q. Do you have any question as to the
2 qualifications of Dr. Winkler to prepare such a plan?

3 A. No. I'd have an additional quarrel or
4 question about the home setting. Clearly Mr. Jones can
5 be cared for in a home provided the home is turned into
6 a hospital, that's what it would take. I don't think
7 it's best suited to a home because of the burden of his
8 care.

9 Q. Is that what, in essence, the Life Care
10 Plan sets forth?

11 A. Yes.

12 Q. You, I think, have referenced in one of
13 your reports that Mr. Jones is exposed to some risks, a
14 variety of dire health threats which include repeated
15 septicemia, infection; is that accurate?

16 A. Yes, it is.

17 Q. Is Mr. Jones at greater risk for these
18 infections in a hospital setting than he would be in a
19 home setting?

20 A. I don't believe so. Most of the trouble
21 he's going to get into has to do with aspiration, bed
22 sores, urinary track sepsis. He in a nursing home
23 setting is really not going to be victimized by the
24 same kind of nosocomial infections that go on in
25 hospitals.

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1 Would they be present in a home to the
2 same degree they're present in a rehabilitation
3 facility or nursing home, probably not, but the level
4 of care that he requires, as I said, would literally
5 convert his home into a hospital or nursing home with
6 staffing and the like which would then contain the same
7 kinds of risks that are present where he is.

8 Q. Isn't he exposed to greater risks where
9 he's at now because of exposure to other patients and
10 other nosocomial infections?

11 A. I don't believe he is. I think that one
12 can raise that possibility. His exposure is not as
13 open as it would be, say, in an intensive care unit
14 where he's surrounded by other very ill or septic
15 people or immunosuppressed people and so forth.

16 Q. Dr. Winkler said in his deposition that
17 it's his opinion that the nursing home facility
18 increases the likelihood of him experiencing increased
19 morbidity, particularly in terms of infections from
20 cross-contamination being in a health care facility
21 such as that. Do you agree or disagree with that?

22 A. Yes, I agree with that. If you bring
23 three or four health care workers into his home then
24 his exposure goes up even though he's at home. I don't
25 think you've saved anything. When this is weighed

1 against the burden of medical care that he requires, I

2 don't think there is an advantage to that.

3 Q. Is there an advantage to having family
4 members close by who care for his well-being in a home
5 setting as opposed to in a hospital?

6 A. I don't know the capacity of his family to
7 take care of him. My understanding from the nursing
8 home is they haven't been around in a while. I don't
9 know what their propensity for care giving or their
10 skills in care giving may be whatever they are.
11 Mr. Jones clearly requires professional help and lots
12 of it to get by.

13 Q. What is your understanding of Mr. Jones'
14 family's attendance at the nursing home facility?

15 A. I don't have an understanding.

16 Q. You mentioned that you --

17 A. It was mentioned to me, I think by one of
18 the nurses, that people from his family had not been
19 there in a while. I don't know what a while is and I
20 didn't pursue it.

21 Q. Did you review any documentation at the
22 nursing home aside from his medical charts?

23 A. No.

24 Q. You had a conversation at your visit With
25 the head nurse, nurse manager of the facility?

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1 A. I believe so. I talked to the charge
2 nurse and to the head nurse, yes.

3 Q. Tell me about what those conversations
4 entailed.

5 A. I wanted to know about his current vital
6 signs. I reviewed his record as to temperature, blood
7 pressure and so forth. I wanted to see his medication
8 list, which I did go over. Charted notes about his
9 level of reactivity response and the like. Basically
10 that was it.

11 Q. Is that true of both conversations?

12 A. Yes.

13 Q. Doctor, let's look, if we can, at your
14 report concerning -- I believe it's the July 17th
15 report marked as Exhibit 3. In that report you've
16 indicated that you believe that Mr. Jones will not
17 continue to live beyond the year's end, correct?

18 A. Yes.

19 Q. Can you tell me what the basis for that
20 opinion is?

21 A. Well, it really rests on medical
22 probabilities. He's suffered this state, the
23 beginnings of this state since October of 1994. If one
24 looks at persons such as Mr. Jones -- and I put
25 Mr. Jones in the sickest of this group because of his

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

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

9 (Thereupon, there was a brief recess.)

10 BY MR. LANDSKRONER:

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

14 A. It was a him.

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

17 A. No, I don't.

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

21 A. No, I don't.

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

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

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

7 A. They have, yes.

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

11 A. No.

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

15 A. No.

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

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

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

24 A. I guess. I don't know. I don't know. I don't know.
25 his chart. I can tell you this, he has a problem with

1 infection all the time.

2 Q. Aside from the preventative maintenance
3 from infection, do you know how many times since he's
4 been in that facility he's run into a problem where
5 there's an ongoing infection?

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

11 Q. Can you know if he's been transferred at
12 any point in time since he's been in the new facility
13 to the hospital for treatment and care?

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

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

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

22 Q. How many beds were in the room?

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

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

3 A. I don't know.

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

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

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

19 A. That's not what I said.

20 Q. That's what I'm asking.

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

25 Q. So it would not affect or increase his

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1 likelihood or risk of infections with more persons?

2 A. I wouldn't put him in a room with two
3 lepers and a tubercular, but in general, no.

4 Q. Let's jump back to the basis of the
5 opinion that Mr. Jones will not survive through the end
6 of the year. You mentioned you put him in the highest
7 risk group because of his other health concerns. Are
8 presently his other health concerns, including his
9 cardiac status and diabetic status, controlled with
10 medication?

11 A. Well, they're controlled at times and not
12 controlled at other times. They require ongoing
13 management with skilled care and multiple drugs.
14 They're controlled to the degree he can survive with
15 them. They are very substantial burdensome illnesses.

16 Q. Nonetheless, with medication and care,
17 they are controlled?

18 A. Presently they're controlled. There's no
19 guarantee they're going to stay that way.

20 Q. Now, when you talk about Mr. Jones' life
21 expectancy, again, you said with probability, that is,
22 with 51 percent medical probability he will not survive
23 through the end of the year, correct?

24 A. Correct.

25 Q. So you're not guaranteeing that Mr. Jones

1 vegetative state that he's presently in, correct?

2 A. Correct.

3 Q. Again, you're not suggesting that he could
4 not live to 69 years old as set forth by Dr. Winkler,
5 but just within reasonable probability that he will not
6 live until he's 69 years old?

7 A. That's correct.

8 Q. Doctor, how many times have you been
9 called upon to give a probability as to life expectancy
0 for one of your patients?

1 A. I really don't know the number of times.
2 It's more than a score I would think.

3 Q. And in every instance you were not correct
4 in terms of predicting life expectancy, were you?

5 A. I've never been entirely correct in
6 predicting anything.

7 Q. Of course, I assume you're very happy when
8 your patients exceed the life expectancy that you may
9 have to render for their future care?

20 A. In general, yes.

21 Q. Can you tell me the last time you had a
22 patient exceed the medical life expectancy that you
23 based your opinion on?

24 A. Yes. A person who lived to be 103 years
25 old was a patient of mine, very famous and has a local

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1 is going to pass on before the end of the year?

2 A. I would hardly guarantee that.

3 Q. And in terms of the basis for the
4 statistical information, I believe you referred me to
5 the articles that gave you the numbers that you've
6 referenced in Exhibit 3 as to the 3.3 year life
7 expectancy for a person in a vegetative state.

8 A. Yes.

9 Q. You've also rendered the opinion that
0 Mr. Jones within reasonable medical probability, again,
1 51 percent, will not come out of coma, correct?

2 A. Correct.

3 Q. And you cannot say --

4 A. Excuse me, he's not in coma, persistent
5 vegetative state.

6 Q. PVS, thank you for correcting me.

7 So you're not saying that Mr. Jones
8 absolutely positively will not come out of his
9 vegetative state?

0 A. Well, there's a possibility that he may
1 live life eternal, it's not probable that he will.

2 Q. And that's what I'm getting at. The
3 probability we're dealing with is in terms of him
4 passing on before the end of the year and in terms of
5 his not living, coming out of coma or coming out of the

1 automobile museum named after him. I was a guest at
2 his 100th birthday party. I never thought he would
3 live that long or stand up to do it, but he did. I was
4 not only surprised, I was delighted to see that occur.
5 He made it to almost 103.

6 Q. Have you had that happen with patients who
7 are in their 30s and 40s?

8 A. Have what, have them live to be 103, not
9 in my experience.

0 Q. Live beyond what the medical expected life
11 expectancy would be.

12 A. A few do, a lot don't unfortunately.

13 Q. Your CV mentioned an award you received
14 for quantization of cutaneous sensation. What is that
15 award?

16 A. Well, that was a study to apply
17 mathematics and statistics to describe the ability of a
18 person to feel stimulation on their skin.

19 Q. And was there a publication that was
20 related to that, as well?

21 A. Several.

22 Q. What were the results in short form of
23 that study?

24 A. Well, the threshold is age dependent,
25 sight dependent and has to do with predictable

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

5 Q. Does Mr. Jones feel?

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

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

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

17 Q. What year was your contribution?

18 A. Again, I don't know precise year. That
19 work began in the early 1970s. The Uniform Brain Death
20 Act started to get legislative activity sometime around
21 1980.

22 Q. Does Ohio recognize that act?

23 A. Yes, it does.

24 Q. It's still in effect?

25 A. Yes.

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

3 A. Not to that act, no.

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

6 A. No, they're not dead.

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

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

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

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

21 Q. He has an apparent alertness?

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

2 have

3 a senescent mummy for that reason.

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

6 A. Now you are.

7 Q. What is the senescent mummy?

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

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

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

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

25 A. We can know what we know according to the

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

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

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

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

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

16 Q. Did she take any notes?

17 A. No.

18 Q. Did you take any notes during the exam?

19 A. No.

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

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

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1 cerebral hemispheres are awake.

2 Q. And, in fact, Mr. Jones' brain stem
3 appeared to be intact?

4 A. Yes.

5 Q. And what else did you glean from that test
6 that you performed?

7 A. I gleaned exactly that.

8 Q. I think you mentioned during the
9 examination that if Mr. Jones were awake and conscious
10 he would have a gazed fixation and the eyes would move
11 away from the cold.

12 A. When you get -- his eyes moved very
13 rapidly away from the cold stimulated side. Persons
14 who are awake and conscious develop a particular kind
15 of nystagmus with very rapid movement away from the
16 cold stimulated side. Persons in coma develop tonic
17 gaze deviation or no deviation at all, may be
18 completely unresponsive to cold stimulation.

19 The quality of his responses suggests
20 an intermediate position; namely, that those
21 connections to the brain stem that subserve this are
22 intact, but those centers above that level are not
23 participating. It's a test in that sense for the
24 integrity of the cerebral hemispheres. His don't work.

25 Q. You indicated that prior to performing

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1 that test you expected different results, correct?

2
3 Persons with PVS have some degree of responsiveness in
4 this test, some more than others. The character of the
5 nystagmus may vary from person to person depending on
6 just how intact the brain stem is. His is the quality
7 of response that you see in persistent vegetative
8 state, not what you see in wakefulness and not what you
9 see in coma.

10 Q. I think you indicated though that you
11 expected before the test that his eyes would move
12 towards the cold, which indicated that he was not
13 wakeful, correct?

14 A. If they move toward the cold stimulated
15 side you're dealing with profound coma. He developed
16 some slow irregular wide amplitude sustained nystagmus
17 to that, and that's what you see in PVS.

18 Q. Prior to doing that test on the patient I
19 think you stated as you were preparing to do the test
20 that you thought that his eyes would, in fact, move
21 towards the cold stimulus.

22 A. It's hard to predict until you did it. He
23 did have some slow movement away. I'm not sure what a
24 surprise it was.

25 Q. Was that prediction based on your review

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1 of the medical records?

2 A. Pardon me?

3 Q. Was that prediction that he would not --

4 A. No, it's based on my examination of him.

5 Q. I *think* you made reference during your
6 examination to the significance of the response of his
7 hand pulling when you put your hand in his hand, What
8 is the significance of that response?

9 A. Well, it's a traction response. It's of
10 that category or classification of responses that tends
11 to incorporate a stimulus into the body. They're very
12 old responses and they have a teleological meaning.

13 I don't mean to be personal, but have
14 you any children?

15 Q. No.

16 A. If you take a young newborn infant whose
17 cerebral hemispheres are not working, not myelinated,
18 you can take that baby, take their hands and they'll
19 pull back on you as, you know, look, the baby is
20 standing and he's only two days old type of thing.
21 That class of response tends to incorporate stimulation
22 into the person.

23 It's the same class as sucking
24 responses, it allows small babies to survive, allows
25 small monkeys to cling to the back of their mother and

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1 allows small possums to find their mother's pouch.
2 Very primitive reflexes and not themselves evidence of
3 learning or friendliness.

4 The normal response in a conscious
5 awake individual given my fingers scraping their palm
6 is to pull their hand away and wonder what kind of a
7 fellow they're dealing with.

8 Q. Along the same lines, the response that
9 you elicited by using the pin around the facial area is
10 significant of what?

11 A. Withdrawal, grimacing, reflexive stuff.
12 It's not a purposeful form of response.

13 Q. To clarify, Mr. Jones had both cranial
14 nerve reflexes and spinal reflexes?

15 A. That's correct.

16 Q. He also had his gag reflex present?

17 A. Well, it's not an also. That is a brain
18 stem reflex mediated by cranial nerves.

19 Q. You indicated Mr. Jones had spontaneous
20 respirations?

21 A. Yes, he does.

22 Q. Doctor, in your report of July 14th you've
23 noted at the end of the first paragraph under
24 impression, the lack of distal reflexes may suggest
25 superimposed diabetic neuropathy. What is that?

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

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

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

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

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

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

1 here today?

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

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

13 A. I don't believe so, no.

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

17 A. I have not.

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

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

23 A. Only if I'm asked.

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

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

3 A. Correct.

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

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

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

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

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

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

21 Q. I understand.

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

1 indicated earlier today?

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

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

9 A. If asked, yes.

10 Q. Have you been asked yet?

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

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

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

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

21 MR. LANDSKRONER: I wish I
22 knew.

23 BY MR. LANDSKRONER:

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

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

4 A. Where is that?

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

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

8 Q. No recollection of that statement?

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

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

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

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

20 MR. CASEY: NO questions,
21 Susan?

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

25 MR. CASEY: I think they

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

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

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

12 MR. LANDSKRONER: Just inquiring.

13 I think that's all I have, Doctor. I
14 thank you for your time. I just would
15 want to get a copy of that one publication
16 that you referenced.

17 THE WITNESS: you're welcome
18 to.

19 MR. CASEY: Read or waive,
20 Doctor?

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

23 (DEPOSITION CONCLUDED.)

24 (SIGNATURE WAIVED.)

25 - - -

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1 may just have a few. They're talking
2 amongst themselves.
3 (Thereupon, there was a discussion off the
4 record.)

5 BY MR. LANDSKRONER:

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

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

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

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

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

25 A. No, we do not.

1 STATE OF OHIO,)
2 COUNTY OF CUYAHOGA,) SS:
3 CERTIFICATE
4 I, LAUREN I. ZIGMONT-MILLER, Registered
5 Professional Reporter and Notary Public within and for
6 the State of Ohio, duly commissioned and qualified, do
7 hereby certify that the within-named witness, JOHN PAUL
8 CONOMY, M.D., J.D., was by me first duly sworn to tell
9 the truth, the whole truth and nothing but the truth in
10 the cause aforesaid; that the testimony then given by
11 him was reduced to stenotypy in the presence of said
12 witness, and afterwards transcribed by me through the
13 process of computer-aided transcription, and that the
14 foregoing is a true and correct transcript of the
15 testimony so given by him as aforesaid.

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

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

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

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

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