IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

SANDRA PAYNE, et al.,

Plaintiffs,

-vs-

JUDGE SUSTER
CASE NO. 315833

AKBAR KERAMATI, M.D., et al.,

Defendants.

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Deposition of A. ROMEO CRACIUN, M.D., taken as if upon direct examination before Juliana M. Lawson, a Notary Public within and for the State of Ohio, at the offices of 3619 Park East, South Building, Beachwood, Ohio, at 4:15 p.m. on Tuesday, March 30, 1999, pursuant to notice and/or stipulations of counsel, on behalf of the Defendants in this cause.

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On behalf of the Defendants.

A. ROMEO CRACIUN, M.D., of lawful age, called by the Defendants for the purpose of direct examination, as provided by the Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

DIRECT EXAMINATION OF A. ROMEO CRACIUN, M.D.

BY MR. O'DONNELL:

Q. Doctor, what is your name?

A. I'm Dr. Atanase Romeo Craciun. C-r-a-c-i-u-n.

Q. And are you a licensed physician in the State of Ohio?

A. Yes, sir.

Q. Are you also a surgeon?

A. No.

Q. How long have you been licensed in the State of Ohio?

A. Since 1982.

Q. And where is your office located?

A. In Park East, which is in Beachwood.

Q. Where did you receive your medical education and training?

A. I received my formal medical education in my native country in Romania, in Europe, and I graduated in September of 1973 with a degree of

M.D.

Q. And when did you come to the United States?

A. I come to the United States in July of 1977.

Q. And did you have further medical education and training after coming to the U.S.?

A. That's correct, sir. I, it took me one year to learn English, then I took my ECFG examination. Stands for Educational Commission for Foreign Medical Graduates. And I passed that. And after that I took my medical internship at Bethesda, Maryland and then formal training in neurology at, residence in neurology at Henry Ford Hospital in Detroit, Michigan and then at Cleveland Clinic Foundation, where I finish.

Q. And you finished your neurology residency when?

A. In 1984.

Q. Are you -- let me backup. Your specialty then is neurology?

A. That's correct, sir.

Q. What is the specialty of neurology?

A. It's medical branch, internal medicine dealing with the diseases involving brain, spinal cord and peripheral nerves, nerve coming from the spine to the extremities.

Q. Are you board certified?

A. That's correct, sir.
Q. How long have you been board certified?
A. Since 1984.
Q. Doctor, are you familiar with the spinal accessory nerve?
A. That's correct, sir.
Q. Where is that nerve located?
A. It's the eleventh cranial nerve. For the jury, the cranial nerves are 12 and 1 for each side of the face and the head. So we have number 1 nerve going with the sense of smell and nerve number 12 taking car'e of the innervation of the tongue. Number 11 is the nerve immediate before number 12 and involves primarily the innervation of two muscles, the sternocleidomastoid muscle, which is the most predominant muscle in the lateral side of the neck, and the trapezius muscle, portion of the trapezius muscle.
Q. What portion of the trapezius does it innervate?
A. Upper portion.
Q. Top of the shoulder here?
A. On top of the shoulder, yes. For the jury, the trapezius muscle is the muscle you see predominant under the collar of the shoulder and also the main muscle connecting the shoulder

itself with the neck.
Q. Are there nerves besides the spinal accessory nerve that innervate the trapezius?
A. Yes. The nerves innervate, in addition to the trapezius, are the nerves coming from the spine and the low neck area as well as in the upper dorsal area.
Q. What is the function of the upper trapezius muscle?
A. The upper trapezius muscles helps lifting of the shoulder.
Q. Anything else?
A. And also helps with the movement of the neck itself.
Q. Doctor, have you treated patients whose spinal accessory nerves --
A. Occasionally.
Q. -- are not functioning?
A. Yes.
Q. By the way, what is neuropathy?
A. Neuropathy is disease of nerve. Neuro is the nerve, opathy, from the Greek, means disease. Neuropathy means disease of a certain nerve.
Q. If someone's spinal accessory nerve is damaged during a surgical procedure, would you still say

it has a neuropathy?
A. That's exactly correct, sir. In other words, the term of neuropathy is somewhat journalized. I'm implies trauma, implies tumors, implies an involvement of a certain nerve.
Q. So if we use the term neuropathy, we're basically talking about damage to a nerve?
A. That's correct. A disease of a nerve. Yes.
Q. And the disease could have been caused by damage?
A. Oh, sure.
Q. What are some causes of spinal accessory nerve neuropathy?
MR. JACOBSON: Objection.
A. Some of them can be traumatic in nature. Some of them can be compressive secondary to a tumor and some of them can be of focal infectious process. Such as an abscess or localized infection deep in the muscle.
Q. Can a spinal accessory nerve be damaged during surgery?
A. Yes.
Q. Have you treated patients whose spinal accessory nerve has been damaged during surgery?
A. Yes.

Q. Are you familiar with a so-called traction injury on the spinal accessory nerve?
A. Yes.
Q. What, can you describe that for me?
MR. JACOBSON: Let me just make a standing objection here. Any of this testimony that relates to standard of care, and that's what we're getting into right now, I'm going to voice a continuing objection here, with counsel's permission, so I don't have to continue to object.
MR. O'DONNELL: That's fine. I don't expect to go into standard of care. I'm not going to make you object each time.
MR. JACOBSON: All right.
A. Yeah. By traction neuropathy, when we are talking about traction, we implicit, we suspect that a portion of the nerve or the fibers of the nerve have been stretched. And by stretching, we assume the possibility of malfunction of some nerves. Talking for the jurors, whenever you have a wire, because you have to imagine the nerve as a wire, and you have that wire damaged in one area or another, that creates a malfunction. That can be equivalent to the

traction.

Q. So in layman's terms, a traction injury to the nerve would be like a stretching of the nerve?

A. That's correct. Beyond the tolerance of the neck.

Q. Have you treated patients with traction injuries to the nerve?

A. Yes.

Q. Excuse me. Spinal accessory nerve?

A. Yeah.

Q. Have you treated patients whose spinal accessory nerve has been surgically dissected and removed, cut?

A. Yeah.

Q. Is there a difference in clinical presentation between patients whose spinal accessory nerve has been stretched or damaged by traction injury and patients whose spinal accessory nerve has been cut or removed?

A. The only difference is time-wise in a sense that the symptoms can present initially the same, but the prognosis and the evolution is different.

Q. What is the prognosis and evolution where it's a traction injury?

A. When you have a traction injury, you assume,

depends on the degree of the traction, you assume that you have maintained the skeleton of the nerve. That's very important. Because if you imagine the skeleton of the nerve, like tubular stem, you expect the nerve to regrowth and reconstruct the damage which has created before. Having a transection of the nerve, you eliminate the architecture of the nerve, which may still present, which in turn can create malfunction and healing defect. In other words, you may end up having a different structure of the nerve as regenerates.

Q. When a person's spinal accessory nerve is injured, whether it's by traction or transection or some other reason, does a person experience some loss of use or function of their upper trapezius?

A. That's correct, sir.

Q. Is that loss of use or function of the upper trapezius more significant or different when the nerve has been cut as opposed to damaged by some other means but essentially left intact?

A. Again, it depends on the prognosis. Usually, in the person who has a transection of the nerve, the muscle will be atrophic. The muscle will

melt, the muscle will not regenerate.

The person who has a traction of the nerve and implicit, does not have complete destruction of the nerve, there is a chance that a portion of the muscle would still function.

Q. So a traction injury patient can experience recovery, but a transection injury patient probably would not experience recovery?

A. That's correct, sir. In majority of the cases.

Q. Some traction injury patients won't have recovery?

A. That's correct, sir.' That depends on the anatomical description, which, for the whole purposes we don't -- I mean, the exceptions would be very rare. So we are talking about most of the people, majority of the people.

Q. Is the neurologist able to tell when the patient presents in the office with their clinical symptoms and situation whether the spinal accessory neuropathy was caused by a traction or a transection?

A. Only by history, sir.

Q. And if the history is indefinite, is there anything in the clinical symptoms that can point you to one cause or the other?

A. No.
Q. Did you see Sandra Payne, the plaintiff in this case, as a patient?
A. That's correct, sir.
Q. And do you have a chart or a file concerning her?
A. Yes, I do, sir.
Q. And I think we talked earlier, that's the complete chart you have before you today?
A. Yes.
Q. When did you first see Sandra Payne?
A. I saw her first on June llth of 1996.
Q. What subject of complaints did she have on June llth, '96?
A. She was complaining of pain involving left shoulder.
Q. Anything else subjectively on that date?
A. That was, that was the only subjective complaint.
Q. By the way, I'm not sure if I asked you this before. If I did, I apologize.
A. No problem.
Q. What are the signs and symptoms of a spinal accessory nerve neuropathy?
A. Weakness primarily of the muscle innervated by

the nerve, which is overwhelming the motor nerve, means a nerve dealing with motion and the muscles.

Q. So weakness of the upper trapezius?

A. And the sternocleidomastoid.

Q. And I'm sorry. I didn't ask you this. What is the function of the sternocleidomastoid?

A. The muscle holding mandible, the lower jaw and helping the head with the forceful movements in one side or the other, lateral or circular.

Q. Besides weakness then, what other signs and symptoms do you see with injury to the spinal accessory nerve?

A. Sometimes pain and tingling sensation.

Q. Anything else?

A. Those are the main symptoms.

Q. Have you observed degrees of spinal accessory nerve neuropathy, in other words, some worse than others?

A. Oh, yeah. Yes.

Q. And I'm sorry, but getting back to Sandra Payne. Did you perform a physical exam on June llth?

A. That's correct.

Q. Did that exam cause you to suspect a left spinal

accessory nerve neuropathy?
A. That's correct, sir.
Q. And what degree of a neuropathy did you suspect existed?
A. At that time, I didn't comment, but I suspected that it was probably mild to moderate degree.
Q. The symptoms -- excuse me. Were the complaints and the history and the physical exam consistent with a transection of the spinal accessory nerve?
A. As I say before, I do not know that. I cannot say that.
Q. How much function of the shoulder had Sandra Payne lost by the time that you saw her on June 11th of '96?
A. When I saw her June llth, she has had -- first of all, for the jury, I would like to explain to them that we estimate the strength of the muscle as 5 to 5 when you have full strength and you are in normal strength and zero when nothing is moving. This classification is an international classification, except for the Royal College of Physicians from UK.

And what I saw on her, the estimated weakness was, I mean, the estimated strength was

4, 4.5, involving the trapezius, supraspinatus muscle and probably the deltoid as well.

Q. And what were your recommendations then to Sandra Payne?

A. Usually when I see these patients and they have enough time from the time of the alleged injury, the best examination would be an EMG examination. Because I saw some muscles which have had involvement for a reason or another, such as deltoid muscle and the prominence of the scapular bone. I elected to suggest also an MRI of the cervical spine.

Q. So your main suspicion was a spinal accessory nerve injury, what, you were trying to rule out something else?

A. That's correct, sir. Additional disk herniations or anything.

Q. So you recommended an MRI, an EMG. Anything else?

A. Yeah. Those were the two. And the physical therapy, of course.

Q. Why did you recommend physical therapy?

A. In order for the muscle to be preserved, in order to save a bulk of muscle, as much as possible, you to have start active motion,

active range of motions in those muscles. By doing that, you hope to prevent two things. You hope to prevent further atrophy and loss of use of the muscles. And also, you hope that you are going to enhance the fibers of the muscles which will survive to be able to compensate for the ones that are lost.

Q. So some fibers in her upper trapezius were still being innervated?

A. Judging from the strength, those muscles, those fibers of the muscle were still present and functioning. I did not know the degree of the damage, but I certainly hoped that by doing that I would prevent further loss of the muscle.

Q. Okay. Would you expect that some fibers of the upper trapezius would still be innervated even if the spinal accessory nerve was cut or transected?

A. See, we are using the word transected. I don't know if the nerve was transected. What I can say is that the nerve might have been damaged in, judging on the fact that she did not have complete loss of strength in those muscles. Certainly you assume indirectly that muscles are still functioning and you have to hang on to

that and try to push it.
Q. Well, if the nerve is cut, aren't you cutting off the nerve supply to that muscle and all of its fibers?
A. Indeed we are talking about on speculative grounds. If the nerve is cut, it depends on how much the nerve is cut. In other words, you can have only a portion of the nerve being cut as opposed to totally being cut.
Q. If it's totally cut, would you expect there to be any strength left in the upper trap?
A. Very unlikely. Because when I saw her 6-11, and she has had surgery on April, so we are talking about six to eight weeks, at that time, certainly you hit the bottom in most of the times. And in other words, at that time you have the maximum deficit picture going to see.
Q. What were your thoughts on what kind of outcome she might have as of your first visit with her?
A. Well, I waited for the EMG examination. On the basis of the EMG examination, you can assume, properly done, and the EMG examination was done at Cleveland Clinic, because I wanted to have a totally independent, unbiased examination. And certainly what you expect, you expect

indirectly, properly done, to see, number one, if you have complete loss of the muscle. Number two, they will try usually to give you an expectation to what degree of nerve was damaged and indirectly you can make some assumption.

Q. After getting the EMG results then -- let me back up. What did the EMG show?

A. The EMG examination was done on 6-17-96. And the results are most consistent with left spinal accessory mononeuropathy, axon loss in character and severe in degree electrically in upper trapezius.

Q. What does that mean in layman's terms?

A. Well, we have three portions of the trapezius muscle. And what has happened is you have a portion which is located in the upper portion of the shoulder, a mid portion, which is sort of the intermediary, and lower portion, which is responsible for inferior aspect of the shoulder blades participating in moving of the shoulder blade in the inferior aspect.

What he mentioned here was clearly on the upper portion of the trapezius muscle.

Q. So that's consistent with damage or neuropathy of the spinal --

A. That's consistent with the branch of the spinal accessory muscle. We know that indirectly because he comment himself by no definite abnormalities were identified in the mid trapezius or in sternocleidomastoid.

So in saying that we clearly localize, number one, the portion of the nerve responsible for the trapezius muscle, and number two, not only that, but only fragment of the trapezius muscle was involved. So fragment of the nerve was involved. So indirectly we know that not all nerve was compro'mised.

Q. At that point then, after reviewing the EMG, what was your prognosis?

A. Well, I consider her prognosis cautiously good. Certainly it was early to make a final conclusion about that. And I strongly encourage her to consider physical therapy.

Factors which need to be considered in the recovery from those are things like age, conditions which involves the peripheral nervous system, such as diabetes, kidney failure, other major medical problems, which she did not have.

Q. Had you reached any conclusion by that point whether the spinal accessory nerve was cut out

completely, cut somewhat or --
A. Again --
Q. -- stretched?
A. Again, I'm going to refresh to that and I'm going to say what I can say is the nerve was damaged for a reason or another and was probably damaged about 75. The branch was damaged 75. Not the nerve. The branch of the nerve responsible for the upper trapezius muscle. And that was by his statement, because he did a compilation study on the right side and he estimated the loss to the one side in the compilation.
Q. Are you familiar with nerves known as cervical rootlets?
A. Yes.
Q. Where are those located?
A. Those are nerves piercing or emerging from the spinal canal and they are located immediately at the exit of the nerves from the spinal canal.
Q. Would cervical rootlets be located in the area of the spinal accessory nerve?
A. Yes.
Q. What's the function or purpose of cervical rootlets?

A. In that area, most probably will be a sensory. In other words, for the lay people, feelings such as pain, tingling, numbness.
Q. In what part of the body?
A. In the upper portion of the neck.
Q. So you began physical therapy, correct?
A. That's correct, sir.
Q. Did you continue to see her from time to time?
A. Yes. She came to me back in a follow-up visit, which is the customary way of taking care of those people, on 7-15, which is roughly one month.
Q. And how was she recovering?
A. At that time, there was prominence, the same degree of weakness was present involving the trapezius muscle as well as the rest of the muscle. As I mentioned, supraspinatus and infraspinatus was present from before. And I made the comment that she started to compensate with a portion of deltoid muscles and also having some function, provided by the mid and lower portion of the trapezius muscle, compensating for the one lost in upper portion.
Q. Is that what normally happens in cases like this where the accessory nerve is damaged?

A. In general, this happen with everybody's nerve. Because, as I mentioned, as the time necessary for the nerve to recover is invariably long, muscle who survive, the muscle unaffected, those fibers will get larger and will try to take over the function which the muscle, the fibers which the muscle lost.

Q. So nothing was happening in July to change your belief that this was a spinal accessory nerve neuropathy?

A. No, not at all.

Q. In fact, those findings would confirm that conclusion?

A. Endorsed by the EMG.

Q. Did you refer Sandra Payne to a neurosurgeon?

A. I discussed with her the option. Usually what happens is the fact that if you have let's say a nerve injury for a reason or another, there are some people in our medical world who dedicate themselves to restructuring or helping the nerve continuity and the function. And those usually are osteopaths, physicians dealing with the fractures and bones, and also neurosurgeons. And I have discussed with her the possibility of referring her to Dr. David Klein, who is a

professor of neurosurgery at Louisiana State University, for the simple fact that he is one of the most prominent figures in the world taking care of the peripheral nervous system. That was an option in case her nerve did not show signs of healing.

Q. Did she ever go see Dr. Klein, to your knowledge?

A. No.

Q. Did she see any other neurosurgeons?

A. Yes. She refer herself apparently to Dr. Joseph Hahn, who is a neurosurgeon, and also at the time, if I'm not mistaken, head of the department of neurosurgery at Clinic.

Q. Other than any communication you had with him in this case, are you familiar with him?

A. No. I received, if I'm not mistaken, somewhere here, but nothing else besides that letter. I did not speak on the phone and I did not --

Q. And what were his findings in his letter?

MR. JACOBSON: Objection.

Continuing line of objection to this line of questioning, with counsel's permission.

MR. O'DONNELL: No problem. You don't have to keep jumping in. That was

for the record.

A. Apparently he, we are more or less at the degree of first line, because I was trained at the Cleveland Clinic so we know each other. So basically he reviewed the case, he reviewed the EMG. And what he felt, there is a spasm in her trapezius muscle on the left. However, I really cannot document any weakness associated with that. And I reviewed the MRI brought along, and I do not see anything of surgical significance.

So I also reviewed the EMG with Kerry Levin and I'm not sure if "this is, really confirms a lacerated nerve.

Q. Did he have any more conclusions in there?

A. In any event, I told her we need to repeat the EMG and we see her in the pain clinic to try to get her, short of trying of preventive intervention. And he concludes, his conclusion, this will certainly not be an easy nerve to find and, therefore, I think we should try to see if recovers on its own. Bear in mind, I never ask him opinion about if it's easy or hard to find the nerve.

Q. Other than his comment on whether surgery might or might not be appropriate, were his

conclusions essentially the same as yours?

MR. JACOBSON: Objection.

A. At this point, he explained, he expressed himself, he made two statements. One of them, he assumed that the nerve was lacerated and, secondly, he felt that there was no need for a surgical option at this point.

Q. In his comment there where he says that this is not, I'm paraphrasing, but he says essentially he doesn't necessarily know whether this represents a lacerated nerve, was that pretty much consistent with your conclusion?

A. No, no. I never say lacerated. I made the statement the nerve was cut. And I'm going to be more specific regarding that. See, whenever you have surgery, you can have little hematoma, little blood clot form in there. You can have a number of traumas to the muscles, to the fat under the skin, to the skin itself, which can represent a compression to that nerve.

MR. JACOBSON: Objection. Move to strike.

A. I didn't see, when you make that assumption that the nerve was lacerated, you have to see the specimen and the nerve was cut.

Q. Did you ever tell Sandra Payne that the nerve was sliced or the nerve was cut or something to that respect?
A. I never mentioned that in my --
Q. When was the last time you saw Sandra Payne?
A. I saw her the last time in March -- I'm sorry. In April of 1997.
Q. And what findings, if any, did you make on examination then?
A. At that time, I say that the motor system reveal a most symptomatic confirmation of her neck. I could not see further focal atrophy or funiculation in the deltoid muscle as well as the rest of the girdle muscles are entirely normal.
Q. Had she made a good recovery up to that point?
A. From my point of view, certainly, sir. I did not know the intention what she wanted to, how she wanted to pursue, particularly after I was faced with her self-referral to the Cleveland Clinic. So it's a matter of choice.
Q. What degree of functional disability, if any, did she have when you saw her last on April 15th, 1997?
A. She has had some limitation in her endurance in

doing different activities involving lifting of the arm, both of shoulder, as she stated.

Q. Did you find any other functional limitations?

A. No, sir.

Q. In patients with spinal accessory nerve injury, do you often observe drooping or sagging of the shoulder?

A. It depends on the degree. Yes.

Q. Do you know whether she was exhibiting any drooping or sagging of the shoulder?

A. Not at the time that I saw her.

Q. Would you put that in your note if she had it?

A. Oh, yeah. I would make a note of that.

Q. Do these patients with spinal accessory nerve neuropathy occasionally experience a winging of the scapula?

A. Again, winging of the scapula belongs to another nerve. It's called long thoracic nerve. The only way for them to experience that would be to have a muscle atrophy of the upper portion of the trapezius muscle, which in turn may create a false impression that the scapula is winging, because you automatically compare with the opposite side.

Q. Did you find a winging of the scapula in this

case?
A. No.
Q. What is contracture?
A. Contracture, involuntary permanent muscle straightening.
Q. Is that essentially where the muscle sort of shrinks up?
A. That's correct.
Q. Have you observed contracture in patients with spinal accessory nerve injury?
A. It depends when you examine them.
Q. Well, so in other words, yes, you have seen it in spinal accessory nerve cases?
A. Sure. If you see them in say six months, one year or more than that, yes.
Q. That was my next question. How quickly or slowly would you expect contracture to develop?
A. Not sooner than six months properly treated with physical therapy.
Q. What do you mean, if there's proper physical therapy, it would not develop before six months?
A. Would prevent or mitigate the contracture to a significant degree.
Q. How late would expect contracture to develop, if it's going to develop at all?

A. That depends on the degree of injury and the length of the nerve damage. For the jury and for yourself, you have to realize that once you have -- let's go back to the cutting of the nerve. If you have a nerve cut, the nerve itself will continue to be generated for a period of weeks. After which the proximal portion, means the portion closer to spinal cord, will start to regenerate. And that regeneration takes unfortunately one millimeter a day or one inch a month. So, therefore, it depends on the length of the injury to see exactly how much time you have to allow.

Q. So everyone, if a nerve is totally cut out, there may be some regeneration?

A. Yes.

Q. Will there always be regeneration or just sort of depends?

A. Again, assuming that the nerve is not completely cut, the chances to regenerate are great. If the nerve is completely cut, you may have regeneration defect.

Q. If contracture is going to develop, would you normally expect to see that develop somewhere along the lines of 20 months or more after the

injury?
A. That is very variable. It's unfair to make a journalized statement, but, you know, that should be something that would be very fluctuating.
Q. Can contracture develop even after the shoulder has been drooping for a long time?
A. Yes.
Q. And are there physical therapy exercises or regimen which can decrease the severity of the contracture?
A. Physical therapy exercises would be very important in a sense that by doing the physical therapy you will mobilize the joint. By mobilizing the joint and maintaining a joint mobile, you will have function of the muscle. Therefore, you will prevent further contracture.
Q. Can that kind of physical therapy be done on a home-exercise basis or does it have to be with a physical therapist?
A. See, the things are changing in healthcare industry now. Used to be that this has been monitored by the physical therapist a number of times per week with a number of minutes or half an hour or whatever dedicated. Now, the things

may be just instructed to do a number of exercises and see me in a week or something like that. It's very variable. It's almost impossible to compare.

Q. Are patients with spinal accessory nerve neuropathy normally prevented from participating in gainful employment?

A. I doubt.

Q. Now that we are roughly three years after her surgery where the damage may or may not have occurred, does anything in the case tell you one way or the other how the damage to her spinal accessory nerve occurred?

A. No. The only thing which I have in the long range is the second EMG examination. The second EMG examination say marked reinnervation in the left upper trapezius muscle has occurred and evoke motor amplitude has clearly improved. Means when you do the EMG exam, you do two things. You stimulate the nerve, you measure the time and the amplitude of the response and you measure the nerve and you measure the motor response, which means you measure the state of the muscle. So what he says here, he says that he has, she has had substantial improvement in

comparison to 6-17-96; however, there is still some motor units, means there's still some fibers in the upper trapezius muscles which are not completely recovered at this point. But he doesn't say that it's hopeless.

Q. Based on everything you have in your chart and everything that we've talked about today, there is, can you, as a neurologist, say one way or the other whether this nerve was stretched or cut?

A. No.

MR. O'DONNELL: I don't have any more questions for you. Thank you.

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CROSS-EXAMINATION OF A. ROMEO CRACIUN, M.D.

BY MR. JACOBSON:

Q. Doctor, I'm Bill Jacobson and I represent the plaintiff and I just have a few questions for you today.

A. Yes, sir.

Q. Dr. Keramati is a friend of yours, correct?

A. He's a colleague, yes. Absolutely, yes.

Q. He referred this patient to you initially; is that correct?

A. That's correct, sir.

Q. In your file, I noticed a letter from Mr. O'Donnell, defense counsel for Keramati, to you requesting that he speak with you on the phone regarding this claim.

Did you have an opportunity to speak with Mr. O'Donnell prior to this deposition?

A. No.

Q. Now, one thing that you said to Mr. O'Donnell in his direct examination I would like to follow up on.

A. Please.

Q. And that is in the determination of whether or not this was a traction injury or a transection injury. You said you would have to see the specimen?

A. That's correct.

Q. Now, you are referring to the pathology specimen; is that correct?

A. That's correct.

Q. Did Mr. O'Donnell ever supply you with the report of the pathologist that he retained to review the specimen, Dr. Al Casey?

A. No.

Q. Did he ever supply you with the report of Dr. McCarty, the pathologist retained by the

plaintiffs to look at the specimen?
A. No.
Q. Doctor, would the existence in the pathology specimen of a five millimeter length of normal appearing nerve of two millimeter diameter be something that would be important in determining whether or not there was a transection or a traction injury?
A. Oh, yeah. Definitely.
Q. Doctor, let me just go briefly through your notes with you. When you first saw this patient on June 17th, you did some --
A. June 11th.
Q. Pardon me. June 11th. You did an examination. You took a history. And you immediately came to the conclusion that this patient probably had a problem with her left spinal accessory nerve, correct?
A. Uh-huh.
Q. That's a yes, doctor?
A. I'm sorry. Yes.
Q. You used the term neuropathy. Neuropathy could mean a transected nerve or a nerve injured by traction, either one, correct?
A. Correct. Very general term.

Q. And your exam, doctor, and I don't doubt that you have excellent technique, but that's something of a subjective exam when you evaluate the strength of the shoulder, correct?
A. That's correct, sir.
Q. And, however, on July 17th, at your order, this patient underwent an objective test known as an EMG; is that correct?
A. Uh-huh. I'm sorry. Supposed to be objective. And let me explain in this way. The objectivity implies 100 percent of cooperation.
Q. Did you find this patient ever, doctor, to be less than cooperative?
A. No, absolutely not. The issue is the amount of pain and discomfort which the patient is willing to take, you know, when they have the examination.
Q. I understand. And that EMG demonstrated a severe neuropathy electrically, correct?
A. That's correct. That's correct. Exactly.
Q. The second EMG that was done sometime later, doctor, demonstrated some reinnervation, but that could occur whether the nerve was transected or damaged by traction injury, correct?

A. Correct.
Q. Now, doctor, you commented with respect to the first EMG that the sternocleidomastoid muscle was unaffected, correct?
A. Uh-huh.
Q. But if you are doing surgery in the area of the posterior triangle, or what is sometimes referred to as the lateral triangle, you would expect that portion of the spinal accessory nerve is already below that portion which innervates the sternocleidomastoid, correct?
A. That's correct. Minus the anatomical variation in which more or less for a reason or another different branches can occur randomly.
Q. Doctor, you also referred her for an MRI because you wanted to rule out any significant problems with the spinal nerves causing this and you were able to rule that out, correct?
A. That's correct.
Q. But you felt that that treatment and expense was necessary here, correct?
A. Yes. Considering the objective findings and considering the, you know, age of the patient and everything else.
Q. Doctor, on the office visit of July 15th, you

discussed with her the EMG results and the severe problem that the EMG had shown, correct?

A. That's correct.

Q. Doctor, your notes indicate that she was getting, pardon me, notes indicated her job apparently is giving her a hard time. She is working at a desk, papers and you made it very clear that she is unable to sustain vigorous activity, correct?

A. That is correct.

Q. Doctor, you also wrote a letter to her employer on June llth?

A. Yes. To whom it may concern. Yes.

Q. Indicating that she is being seen by you and it is your professional opinion that she should not be involved in any activities that require lifting, pushing, pulling or carrying anything over five pounds until further notice, correct?

A. Uh-huh. Yes.

Q. You wrote a letter to Dr. Keramati on June 15th indicating that you suspected her outcome would be favorable; is that correct?

A. That's correct.

Q. That was prior to the time that you had seen the EMG results, correct? The EMG was done June

17th, two days later. Is that correct, doctor?
A. That's correct.
Q. On July 15th, you wrote another letter for her employment indicating Sandra Payne is under my care, she suffered nerve damage to the left and, pardon me, left neck and shoulder area and, therefore, it is my professional opinion that she should not lift, push or be involved in any strenuous activities until further notice or approximately three months?
A. That's correct.
Q. At which time you had intended to reevaluate her and see if she could --
A. That's correct.
Q. This was indeed a motivated young lady, she wanted to work, correct, doctor?
A. She says she wanted to work. And from what I understand, to a certain extent, the employer tried to accommodate her.
Q. Doctor, briefly, explain to the jury, if you would, you use the term of the nerve supplying the muscle or innervating the muscle.

Would you explain briefly how that works?
A. The nerve itself comes like a wire from the spinal cord, which is the major trunk. And this

wire goes like a branch of a tree with small buds approaching different group of muscles. And what they do, they synchronize the action or the contraction of different group of muscles, gaining the command from the brain.

Q. Doctor, you haven't seen this patient in two years?

A. No. Absolutely correct.

Q. Do you know Dr. John Conomy?

A. Very well.

Q. And what is your opinion of Dr. Conomy professionally?

A. I'm very biased because Dr. John Conomy was my mentor, teacher and many other things.

Q. Putting that bias aside, as best you can?

A. He is one of the prominent neurologists in the country.

Q. Of course, Dr. Conomy has seen her much more recently than you have?

A. That's correct. I suppose.

Q. Well, assuming that he has, doctor, has seen her more recently, would you defer to him regarding her prognosis at this time?

A. Well, certainly he's more, you know, acquainted with this situation than me considering the

facts. Yeah.

Q. Now, doctor, this patient has had a relatively good recovery from this injury, correct?

A. That's absolutely correct, sir.

Q. But once again, we're talking about, as a relative thing, you would not expect a complete recovery under these circumstances, would you?

A. See, the problem is what I expected is considering the way in which the second EMG was done, I consider functionability to be very acceptable.

What you have to take in account is the fact that for a period of time she probably misused different muscle groups creating a strain in the joint, creating the pain. So we are dealing with a more or less indirect or vicious cycle related to the function of the joint itself.

And other things which I would like you to take into account is the vanity. You are dealing with a young woman who likes to wear dresses or whatever and certainly will be somewhat frustrated by perhaps some isometric features of her shoulders.

Q. Doctor, are you suggesting that because in her

effort to stay working and keep working and in an effort to compensate for this she may have contributed to the problem? Is that what you are suggesting?

A. No. What I suggest is the fact that because of the use of the joint itself, the joint can create further trauma. That's the reason. Because I wrote those letters to the employer to try to avoid strenuous activity and the process of working on the joint waiting for the nerve to recover.

Q. So, doctor, I think,'if I can understand what you are saying here, and you mentioned it to Mr. O'Donnell, that certainly that somebody with a spinal accessory nerve injury is employable, but the probability is they shouldn't be doing heavy work; is that a fair statement?

A. Yeah. To a certain extent, yes. In other words, let's put it this way, she will not be probably as competitive as her co-workers with respect to the endurance among other things. Yes.

Q. Dr. Conomy has seen her, she does have a significant degree of contracture. Now, doctor, once again, what causes the contracture?

A. Again, the contracture itself can be a result of multifactorial problems. And to be more explicit to the jury, I would like to explain to them that once you have a pain in a joint, you don't use the joint, not using the joint, you create more loss of the muscle, which in turn will predispose other groups of muscles to contracture.

Q. I see. So the contracture, doctor, is some subjective evidence of the pain and the disability that she's had in the muscle over the years, correct?

A. And probably misuse of the shoulder itself, yes.

Q. I'm still not sure I understand what you mean by misuse. Overuse, is that what you mean?

A. Well, let's put it this way: When we lift our hand in one direction or another, 90 percent of us are using specific group of muscles. Now, when we have some weakness for a reason or another, we try to compensate with the other group of muscles at the price of straining the joint.

Q. And that's something that somebody who has a loss of the function of one muscle group would

have to do?
A. Yes.
MR. JACOBSON: I have no further questions, doctor.
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REDIRECT EXAMINATION OF A. ROMEO CRACIUN, M.D.
BY MR. O'DONNELL:
Q. Are there exercises and physical therapy that she can do to reduce that sort of misuse of the muscle and get the muscle more closer back to a normal state?
A. Yes, sir.
Q. Could she --
A. In the long range, this would be very important, because the physical therapy, again, will maintain, will preserve the mobility of the joint. Therefore, it will create function in the joint and help the muscles stay functional.
Q. Assuming she's experiencing this contracture now, which is again, roughly three years after the injury, can physical therapy still help her?
A. Yes.
Q. By physical therapy at this time, you try to prevent further damage?
A. You do not know how much damage she can have in

the future.

Q. Can it help her regain some of the use that she has lost?

A. Sure. An injury at this time can be predisposed to many things. Arthritis, calcium deposits which will further damage the joint. By doing physical therapy, you prevent that.

MR. O'DONNELL: I have no more questions for you. Thank you.

MR. JACOBSON: Thanks very much, doctor. Off the record.

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

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THE WITNESS: Yes, I waive.

(Signature waived.)

C E R T I F I C A T E

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and seal of office, at Cleveland Ohio, this 1 day of April A.D. 19 99.

Juliana M. Lawson

Juliana M. Lawson, Notary Public, State of Ohio
1750 Midland Building, Cleveland, Ohio 44115
My commission expires March 10, 2000

W I T N E S S I N D E X