IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO
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KARL J. YOST, etc., et al.,
Plaintiffs,
vs. Case No.
THE CLEVELAND CLINIC FOUNDATION, 449275
Defendant.
- - - - -

VIDEOTAPED DEPOSITION OF GLENN E. DeBOER, M.D.
MONDAY, MAY 12, 2003
- - - - -

The videotaped deposition of GLENN E. DeBOER, M.D., a Witness herein, called by the Defendants for examination under the statute, taken before me, Cynthia A. Sullivan, a Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel, at the offices of The Cleveland Clinic Foundation, 9500 Euclid Avenue, Cleveland, Ohio, on the day and date set forth above, at 3:00 p.m.
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APPEARANCES:

On behalf of the Plaintiffs via telephone:
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On behalf of the Defendant:
Reminger & Reminger, by
ALAN PARKER, ESQ.
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JOHN T. BULLOCH, ESQ.
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ALSO PRESENT:
Kevin Shahan, Video Discovery

GLENN E. DeBOER, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF GLENN E. DeBOER, M.D.

BY MR. BECKER:

Q. Doctor, good afternoon, sir. Would you please state your full name for the record?

A. My name is Glenn Edward DeBoer.

Q. Would you spell your last name?

A. Capital D-E, capital B-O-E-R.

Q. D-E capital V as in victor?

A. B as in boy.

Q. DeBoer, I'm sorry.

A. DeBoer.

Q. What is your current position at the Cleveland Clinic Foundation?

A. I'm a staff anesthesiologist.

Q. All right. By chance did you bring a copy of your curriculum vitae?

A. No, I didn't.

Q. All right. Could you just give me, sir, a thumbnail sketch of your background, your medical education and training?

A. Let's see. I did my medical school at Western Reserve University. I did my internship and residency in anesthesiology at University Hospitals of Cleveland. I was an anesthesiologist in the Army for two years.

Q. Well, when did you finish your residency, what year?

A. 1973, I believe -- '74.

Q. Okay.

A. It was 1974.

Q. So then after you finished your residency, did you do three years at UH?

A. Two, two years in the Army.

Q. How many years -- did you do the Army before or after UH?

A. After my residency.

Q. Okay. So how many years at UH?

A. Four years.

Q. Four years residency at UH, then two years in the Army, and when you were in the Army I'm assuming that you were an officer?

A. Yes.

Q. Okay. And where did you do your service?

A. U.S. Army Hospital, Fort Campbell,

Kentucky.

Q. Both years?

A. Yes.

Q. When you were in Fort Campbell, Kentucky, was it anesthesia?

A. Yes.

Q. Was it just any specific type of surgery or just --

A. No.

Q. -- general surgery?

A. I was chief of the operating room service.

Q. And did that cover things from general surgery to brain surgery?

A. Very occasionally. Only on an emergency basis did we do brain surgery, and that involved burr holes and nothing more. It was very similar to a small community hospital.

Q. All right. Sir, that would bring us up to what year at the time you finished your service to the country?

A. About 1976.

Q. Then what?

A. I spent two years at Cleveland Metropolitan General Hospital --

Q. Okay.
A. -- as an attending anesthesiologist.
Q. Okay.
A. And then I came to the Cleveland Clinic.
Q. And you've been at the Clinic on a full-time basis within the department of anesthesia since 1978?
A. Yes, that's right.
Q. Have you ever been chair of the department?
A. No.
Q. Do you have a subspecialty interest within anesthesia?
A. At the present I do, predominantly pediatric anesthesia.
Q. Back in the summer of 1996, did you do predominantly pedes?
A. I was doing pediatrics, ENT and neuroanesthesia.
Q. Is there a sub -- you're board certified?
A. Yes.
Q. And did you pass your boards the first time you took them?

A. Yes.
Q. Is there a subspecialty board within pediatrics or neuroanesthesia?
A. There surely was not when I took my boards.
Q. Okay. Is it possible for you to get a copy of your -- complete copy of your current vitae and get it to Mr. Parker so he can send it along to me?
A. Yes. At this moment or -- no.
Q. Would you be willing to do that?
A. Sure.
MR. PARKER: At this moment? I mean, his offices are in a different building and the like, but --
MR. BECKER: No, not at this moment.
MR. PARKER: Okay.
MR. BECKER: Just in the near future, within the next few days.
Q. Doctor, have you been deposed before?
A. Never.
Q. This is the first time?
A. Yes.
Q. I just want to review the ground

rules. This is a question and answer session under oath. It's important you understand the question that I ask. If the question doesn't make sense or is inartfully phrased, I want you to stop me and tell me so, and I would be most pleased to attempt to rephrase or restate the question. Fair enough?

A. Yes.

Q. It's very important that you answer verbally, particularly since we're conducting this deposition by phone. Please attempt to verbalize all your responses. Fair enough?

A. You bet.

Q. However, unless you indicate otherwise to me, I am going to assume that you fully understood the question that has been posed and you are giving me your best and most complete answer today. Fair enough?

A. Uh-huh.

MR. PARKER: Objection. You can answer.

A. Yes.

Q. Okay. Doctor, what did you review in preparation for today's deposition?

A. I reviewed the anesthesia record,

preoperative evaluation, recovery room record and some of the hospitalization early on within the first few days in the hospital.

Q. That's pre-op?

A. Pre-op evaluation.

Q. Okay.

A. Anesthesia record and his several days of hospitalization.

Q. Okay.

A. Okay. I reviewed the deposition by Dr. Mark Luciano.

Q. Okay.

A. And by the neurophysiology technician.

Q. Linda Gagnon?

A. I'd have to see that --

Q. Okay.

A. -- to make sure it was she, but that sounds familiar.

Q. Okay. Do you remember Dr. Cheek?

A. Yes.

Q. Okay. And when you were practicing at the Clinic, were you aware that Dr. Cheek had a drug and alcohol problem?

MR. PARKER: Objection to the

relevancy of this line of inquiry. The doctor can answer, but can I make the objection continuing?

MR. BECKER: Sure. A continuing objection, sure.

MR. PARKER: Okay.

A. Can you rephrase the question?

Q. Certainly. While Dr. Cheek was at the Clinic, did you ever become aware that he had a drug or alcohol problem?

A. Not during the time he was at the Clinic practicing.

Q. Okay. Doctor, do you -- do you recall Dr. Check ever generating or developing any protocols for anesthesia as to what should or should not be done during -- by anesthesia relative to his intraoperative patients?

A. You're talking about a written document?

Q. Yes, sir.

A. I don't remember any document --

Q. Okay.

A. -- of that nature, and I don't have one, obviously.

Q. Do you recall Dr. Cheek ever

lecturing to the department of anesthesia relative to what should or should not be done for purposes of his patients that he is engaged in intraoperative monitoring?

A. Not specifically.

Q. I'm assuming you don't recall this case?

A. Not at all.

Q. And I'm assuming that you don't recall any conversations you may have had with either Dr. Gerson, Dr. Cheek or Dr. Luciano relative to this case?

A. No, I don't.

Q. And I'm assuming you don't have any recollection of conversations with this young man nor his parents?

A. I do not.

Q. All right. The balance of this deposition, Doctor, is -- other than the very tail end is going to be relative to you interpreting your notes, and I want you to know that you're more than free at any time before responding to any of my questions to look at the chart. Please, feel free to do so.

A. Uh-huh. All right.

Q. What I would like to do, sir, and I'm really particularly interested in things written by you personally, and I'd like to address that in a chronological fashion.

A. Uh-huh.

Q. Could you tell me based on the chart when your first entry is; the date, the time?

A. The first entry that I have in the chart is not dated nor timed.

Q. Any particular reason why not?

A. No. I'm not sure. We usually don't time our preoperative note.

Q. Okay. Would it be the preoperative assessment?

A. Yes.

Q. Where it says in the upper left-hand column, general anesthesia preoperative assessment?

A. Yes.

MR. BECKER: Okay. Cindy, would -- would you mark that as Plaintiff's Exhibit 1 for me, please, and let me know when you're ready.

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(Thereupon, Plaintiff's Deposition Exhibit 1 was marked for purposes

of identification.)

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Q. Doctor, hopefully in your hand is what's been marked as Plaintiff's Exhibit No. 1. Would you identify that for the record?

A. I'm looking at the original, but they both seem to be the same.

Q. Okay. And what is it?

A. It's the Cleveland Clinic Foundation general anesthesia preoperative assessment.

Q. Okay. On that -- is it a one- or two-page document?

A. It's a one-page one-sided document.

Q. Okay. And on that, what's been marked as Plaintiff's Exhibit 1, could you tell me what is actually in your handwriting?

A. It's the anesthesiologist note.

Q. At the very bottom?

A. Yes.

Q. At the very bottom?

A. Yes.

Q. Can you tell me whose -- who completed the upper portion of that entry?

A. That was Linda Skolaris.

Q. Okay. And what would her role be?

A. She was the registered nurse that was doing preoperative evaluations it looks like on 6-24-96 -- I'm sorry, 6-21-96.

Q. Now, would she be within the anesthesia department?

A. She worked for the anesthesia department, yes.

Q. So she would be considered an anesthesia nurse? I appreciate not -- not necessarily within the operating suite, but within your division?

A. I presume that she was an employee of the anesthesia department, but she may be an employee of the Clinic. She was -- she is not a nurse anesthetist.

Q. Okay. By that answer, to me that implies that some people that work at the Clinic are not employees of the -- employees of the Clinic. Are you an employee of the Clinic?

A. Yes. I'm talking about her direct superiors, if I can say that.

MR. PARKER: Yeah. I don't think -- I don't think he's drawing the distinction that you are drawing from that answer. I think he's just trying to answer to whom she reports and is

responsible.

THE WITNESS: Yes.

Q. Doctor, let's look under neurologic on her notes. My copy I can't read too well. Can you tell me what it says --

A. It says.

Q. -- your interpretation of her notes?

A. Yeah. There's an arrow down, decreased strength left ankle that began in 1 -- and I can't read all of that -- of 90-something. Left is greater than right leg. And I can't read the next note, and it says, starts -- starts back, goes to legs.

Q. Okay. What does that mean to you?

A. That he had at least decreased strength in his left ankle that began sometime, and as I say, I can't tell 1-90, 1-91, 1-92.

Q. Okay.

A. And that the left leg is worse than the right.

Q. Okay. Where it says starts back, goes to leg, what does that mean?

A. I don't know what that means.

Q. You do not know?

A. I do not know.

Q. Okay. I'm assuming, Doctor, that -- that one of the reasons the nurse completes this form is so you can read it --

A. Uh-huh.

Q. -- and then make your recommendation.

A. Uh-huh. Yes, that's true.

Q. Okay. Why don't we just proceed down to your notes, and I would like you to interpret your handwriting verbatim, and if you use abbreviations, please, explain what it means.

A. Yeah. It's PT, or patient, seen, examined, chart reviewed. And then in parentheses it says, somewhat overweight, plan GA endo, risks, benefits, DIS or DIC, and my signature.

Q. Okay. I follow the risk, the word risk and the word benefit. What is after that?

A. D-I, I think S-C, or D-I --

Q. Oh, discussion?

A. Discussed, uh-huh.

Q. Okay. That would be the risk of anesthesia discussed?

A. Yes.

Q. And what generally would you tell the patient or in this case the patient's family?

A. I'd try and find out what their questions were, what they were anxious about. I would discuss the procedure or procedures that I was going to do, in this case that I would put the patient to sleep with medications in the intravenous, that I would be doing endotracheal intubation, that the patient would be positioned in a prone or on his tummy, and that I would expect it would be a long operation.

Q. Why would you expect it to be a long operation?

A. Because it's scheduled as a tethered spinal cord laminectomy with release and resection or debulking of a cord lipoma.

Q. And your experience is those are lengthy operations?

A. They usually are quite lengthy. I would say greater than four hours.

Q. Okay. Have we covered all your entries on Plaintiff's Exhibit 1?

A. Yes, and I think that --

Q. Now, as I recall --

A. Sorry.
Q. -- anesthesia --
A. Sorry.
Q. -- people --
A. Excuse me.
MR. PARKER: Mike --
A. Excuse me. I changed the ASA classification from one to two I think based on the patient being somewhat overweight.
Q. Okay. And I was going to talk about ASA classification.
A. Good.
Q. Where is that on this form? Oh, I see it. ASA class two.
A. Right.
Q. You changed it from class one to class two?
A. One to class two, uh-huh.
Q. How do you know that? How do you know that you've actually changed it?
A. Because I can tell from the color of the ink here.
Q. So the ink is different?
A. Yep. It's my ink, or it's black ink, and I would presume it's the same as what I

wrote the note in.

Q. Yeah, but how do you know -- or did she classify it as one and you made it two?

A. Yes.

Q. I'm not following you. How do you know that you changed anything?

A. Because I can see that the color of the ink on the second upright bar of the Roman numeral two --

Q. I gotcha.

A. -- is black, and the color of the first bar is blue, and she made her note entirely in blue.

Q. I'm with you.

A. Okay. So I presume --

Q. What was the reason you increased the ASA classification?

A. I think, looking back at the case, that it was because the patient was somewhat overweight.

Q. Okay. And would you -- would you distinguish for me the difference between an ASA class one and a class two?

A. Class one is a healthy patient. Class two is a patient with mild systemic

disease.

Q. And a class three and class four?

A. Uh-huh. It depends upon what -- how you review those today?

Q. Yes.

A. Class three is incapacitating systemic disease that's not a constant threat to life. I'd have to think about this a minute. Class four is incapacitating, that is, a threat to life.

Q. Okay.

A. That's very rough.

Q. Going chronologically now, when would your next entry be in this chart?

A. I presume that the next entry would be my staff signature on the top of the anesthesia record.

Q. All right.

MR. BECKER: And Cindy, did we make a copy of that?

MR. PARKER: Yes.

THE NOTARY: All we have is the one you faxed.

Q. Doctor, is that the same exhibit that you're referring to?

A. Yes. That's a copy of what I have in hand.

MR. BECKER: Okay. Let's mark that as Plaintiff's Exhibit 2.

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(Thereupon, Plaintiff's Deposition Exhibit 2 was marked for purposes of identification.)

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A. All right.

Q. All right. Doctor, would you identify Plaintiff's Exhibit 2 for the record?

A. Yes. It's the first page of the anesthesia record.

Q. Okay. And what part of Plaintiff's Exhibit 2 is in your handwriting?

A. The signature at the top --

Q. Right.

A. -- and the number two behind it.

Q. Okay. And what does that mean? That's his ASA classification?

A. No. That's down several lines more.

Q. What does the number two reflect?

A. That -- it reflects my staffing position that day. That means that I'm not

personally responsible for administering the anesthetic myself.

Q. Who would be?

A. That means I'm supervising probably, and I have below my signature the name of the resident who was Salama.

Q. So a doctor in training administered the anesthesia?

A. Under my direction, yes.

Q. When you say under your direction, would you have been in the operating room at the time?

A. Yes, I was.

Q. How many operating rooms were you covering at that time?

A. I haven't the slightest idea.

Q. Can you give me a range as to how many you could be covering, from one to three or one to six or --

A. I --

MR. PARKER: Objection to the extent it calls for speculation. If you can answer it with a reasonable estimate, feel free, Doctor.

A. I would very seldom ever cover more than two, if ever.

Q. Okay. Do you know what year resident this particular person was?
MR. PARKER: Objection. What he was, what do you mean?
THE WITNESS: Yes.
Q. At the time of this operation, was he a first-year resident, a second-year resident?
A. I'd have to speculate.
Q. All right. I see a number two circled --
A. Uh-huh.
Q. -- Doctor?
A. Uh-huh.
Q. What's the significance of that?
A. That's the ASA status.
Q. Okay.
A. The resident wrote it down as one also, and I changed it to two.
Q. Fair enough. Where it says induce hypotension, do you see that right next to the two?
A. Oh, yeah. It's way in front, yes.
Q. There's a number 18 next to it?
A. Yes.

Q. What does that mean?
A. I think that stands for the IV that was placed in the induction room.
Q. The size of the IV?
A. Yes. And if you go down one line, there's an X in the box that says induction room precare, TCI IV is circled.
Q. Uh-huh?
A. And above that is written 18, and that's all in the same color ink, so I presume that's what it stands for.
Q. Okay. Any other entries on this page by you?
A. I believe just beyond the 10:45 marking, time mark in the squared area, there's a note of neo 100 plus 100.
Q. What does that mean?
A. That means that I gave or was -- there were two doses of Neosynephrin given.
Q. For blood pressure?
A. For blood pressure. That's at the point when the blood pressure was about 85, 89 systolic.
MR. PARKER: Doctor, it looks to me like that's at the 9:45 mark rather than the

10:45 mark.

THE WITNESS: I'm sorry. That's what I meant to say.

Q. That's all right. You're doing fine for your first deposition.

Doctor, the comments in the lower left-hand corner where anesthesiologists generally make comments about complications or unusual events --

A. That's just what --

Q. -- can you -- can you interpret that for me since I suspect that's not in your handwriting?

A. Yeah. That's the resident's notes as we start the case. He says, patient seen, chart reviewed 7:55. There's an X there, and that's the time the patient was brought into the OR which looks like about -- refers up to the bottom of the hatched area, and that says, patient to the room, monitored, pre-something, preoxygenated, and at marking I, smooth induction.

Q. Okay. Continue to read, please.

A. And it says, patient turned to prone position, care given to ears, eyes, nose.

Q. All right. Continue.
A. And then there's another mark, a check with a circle, 1 gram Vancomycin per surgeon's request at 9:25.
Q. Vancomycin is a type of antibiotic?
A. Yes.
Q. Yes?
A. Yes. Yes, it's a type of antibiotic.
Q. Can you tell whether or not -- can you tell me what agents were utilized during this induction, drugs?
A. For the induction of anesthesia?
Q. Yes.
A. The patient got two-tenths of a milligram of Robinul, I think 200 micrograms of Fentanyl in divided doses, 300 milligrams of Pentothal, oxygen, and then nitrous oxygen and oxygen, and then Zemuron 40 milligrams.
Q. Can you tell how long this person was under anesthesia by this form?
A. Well, we say that anesthesia started at 8:20 and that it was finished, meaning the patient was left in the recovery room, at 1630. Now, that is on the next page.

Q. All right. And --
A. Which I'm not sure --
Q. Is there anything on that next page that's in your handwriting?
A. Yes. I see two things.
MR. BECKER: All right. And we're going to have to -- Alan, off the record.
(Discussion off the record.)
- - - - -
(Thereupon, Plaintiff's Deposition Exhibit 3 was marked for purposes of identification.)
- - - - -
Q. All right. Doctor, would you identify what's been marked as Plaintiff's Exhibit 3?
A. Yes. I have -- that's the second page of this anesthesia record.
Q. Okay. And why don't you go ahead and tell me what's in your handwriting on this page?
A. In the far left column, the last note in the upper set is D-E-S-F-U-L-R which is Desflurane.
Q. I'm sorry. I can't find that.

Where?

A. In the column which starts with nitrous oxygen/oxygen or that starts with time.

MR. PARKER: It's about one-third of the way down the page, Mike. It begins with D. It's handwritten. It's -- it's part of the graphic chart. There's a column that says time. Underneath that is nitrous oxide O2 LPM, and then there's handwritten entries. That last handwritten entry is what he's referring to.

Q. Where it says EBL, estimated blood loss?

A. No. That -- it's --

MR. PARKER: You're too far down about seven lines.

A. -- an echelon up.

MR. PARKER: You're about seven lines too far down.

Q. Where I see Pavulon?

A. Just below Pavulon.

Q. Where it says F102?

A. It says -- no, it's above F102. Right underneath Pavulon.

Q. I don't have anything on mine underneath Pavulon.

MR. PARKER: I think you might be looking at Plaintiff's Exhibit 2 where it drops from Pavulon and there's one blank space and then there is F102.

MR. BECKER: Right.

MR. PARKER: The page we're looking at that's been marked as Plaintiff's Exhibit 3 --

MR. BECKER: Excuse me.

MR. PACKER: -- it says Pavulon. Then the next entry is -- what is it, Doctor? I can't read it.

THE WITNESS: It's D-E-S-F-U-L-R.

MR. BECKER: I see it now. I'm sorry. You were correct, Alan. I was looking at the wrong exhibit.

MR. PARKER: Okay.

Q. And what does that mean, Doctor?

A. That stands for Desflurane, and over some time, about 1530, you can see the percentages.

Q. What does that mean?

A. That means that that drug was added at that time.

Q. And for what reason?

A. To add to the depth of anesthesia because of -- or to supplement, I guess I would say, the anesthesia because the Isoflurane had been turned off which you can see.

Q. All right. Let's go ahead and read the bottom comments by the resident.

A. Well, the first comment on the bottom is mine.

Q. Okay.

A. That's at about 1300. That's the circle. Decadron 4 milligrams IV/surgeon request or REQ. That's the first note under comments.

Q. I see that, but what is that referencing?

A. That's representing the circle and comment number --

Q. Where is the circle on the graph?

A. It's --

Q. Oh, I see it. It's under about 1300?

A. Yes, but in the comment line, which is just below the graphic representation.

Q. Okay.

A. All right. Also, let's see,

there's --

Q. What does that mean, Decadron per surgeon's request? What is Decadron?

A. It's a steroid --

Q. Okay.

A. -- anti-inflammatory --

Q. Okay.

A. -- and the surgeon had asked that we give some.

Q. Okay.

A. It wasn't part of the anesthetic as such.

Q. Okay.

A. Also, at the 2:45 -- 12:45 time mark, there's a urine measure, and that was 14 cc's for a total of 314 cc's, and that's also my note.

Q. Okay. Anything unusual about that?

A. No.

Q. All right. What's the next note under Decadron?

A. That's Neostigmine three-and-a-half milligrams, .3 Robinul, reversed, extubated, awake to PACU.

Q. Okay. And that corresponds to what

time?
A. To the end of the procedure. I don't think that there is any mark on the chart.
Q. Okay. Generally, there's a circle with a number in it, and then the number is referenced in the graphing?
A. In the comment line.
Q. But there's no --
A. I don't see it.
Q. You can't tell what time that refers to?
A. No.
Q. What are those drugs --
A. Those --
Q. -- reverse the anesthesia?
A. -- reverse the muscle relaxant.
Q. Okay. Can you guesstimate or approximate what time those muscle -- that reversal was instituted?
A. Well, I'd have to look at the recovery room. He arrived --
MR. PARKER: Just before you answer it, I'd like to object to the extent that it's calling for a guess.
Q. Give me your best estimate, Doctor.

A. Yeah. I would say somewhere near 4:00 o'clock.
Q. Okay.
A. I'd have to look at the recovery room and see what time he arrived. That was 4:30, but 4:00 o'clock roughly.
Q. Next entry under comments?
A. It says 50 and 50 Fentanyl in PACU for post-op pain.
Q. Okay.
A. Patient has some tape allergy, and I think that's skin abrasion around the eye, tape, comma, mouth, for ET, period.
Q. Okay. Next entry?
A. Some Neosporin oint, that may be ointment, at the abrasion site.
Q. All right. Have we covered all your entries in this chart?
A. Those are not my entries, the last.
Q. I appreciate that, but have we covered all the entries that you've created in this chart?
A. As far as I can see or tell at present. It's possible, if we go back up into the drug administration area, there's a note

with Zemuron 10 --
Q. Uh-huh.
A. -- Fentanyl 50 and 75.
Q. Uh-huh.
A. Those might be my notes.
Q. Doctor, are any of the drugs used during this anesthesia what one might consider a neuromuscular blockade?
A. Neuromuscular blockers?
Q. Yes.
A. Yes.
Q. Would you tell me which drugs they are?
A. Zemuron and Pavulon.
Q. Would you spell Zemuron for me?
A. Z-E-M-U-R-O-N.
Q. And would you spell Pavulon?
A. P-A-V-U-L-O-N.
Q. All right. Can you tell me over what period of time those neuromuscular blockers were likely in effect during this surgery?
MR. PARKER: To the extent you can, Doctor, please answer, but I'm going to object to the form of the question and -- because it's vague. Likely in effect is a vague term when it

comes to anesthetic agents.

But go ahead and answer it, Doctor --

Q. Do the best you can, Doctor.

MR. PARKER: -- to the extent you can.

Q. If you don't understand my question, I'll be happy to rephrase it, but go ahead.

A. Well, we've described some of the difficulties with that, but the patient got his first dose of Zemuron at about 8:30 in the morning.

Q. Uh-huh.

A. And about hourly to hourly-and-a-half he got additional doses of about 10 milligrams until about I would say sometime after 3:00 -- sorry -- sometime after 1:00.

Q. 1:00 p.m.?

A. Yeah, sometime between 1:00 and 1:15. And near 9:45 in the morning he got 2 milligrams of Pavulon, and he got another dose at about 2:45.

Q. P.m.?

A. P.m., yes.

Q. All right. And is it appropriate to talk about the phrase half life with anesthetic agents, or is that inappropriate?
A. Well, with some agents, but --
Q. What I'm trying to get an understanding, Doctor, and maybe you've already answered this, would it be fair to state that there are likely neuromuscular blockers on board from the beginning of this surgery until the end?
A. There were some.
Q. Well, there were two.
A. But we're -- I'm talking about amounts.
Q. Okay. Have you heard of the expression train of four?
A. Yes.
Q. What does it mean?
A. It's the way we monitor neuromuscular function.
Q. And how do you do that?
A. We have an instrument that --
MR. PARKER: Well, one second. You're going to answer the question, but it's not -- it's not you, it's not Dr. DeBoer that

does that during the procedure, but in terms of --

THE WITNESS: (Indicating.)

MR. PARKER: Oh, it is, yes. I'm sorry. I apologize. I misspoke. I just -- I thought that the question was in error.

MR. BECKER: I didn't hear all that objection, Alan, but I know you don't mean to testify for the doctor.

MR. PARKER: I don't, and I withdraw the objection as well.

Q. Okay. Doctor, the concept of train of four?

A. Yes.

Q. Let's start over.

A. Uh-huh.

Q. In real basic lay terms, what does it mean?

A. It means we provide or apply an electrical stimulus to a peripheral nerve and watch the twitch response of the enervated muscle or muscle groups.

Q. Okay. And what's the purpose of that?

A. That's to know the percent or

degree, I guess, of paralysis.
Q. And when you utilize and engage in, quote, a train of four, end of quote, do you generally chart it?
A. No, we do not. And we -- I'm talking about the Cleveland Clinic or we in the group here at the Cleveland Clinic -- I don't think I have ever seen it charted.
Q. You have never seen it charted?
A. Nowhere that I've ever worked.
Q. Okay. And do you do it all the time?
A. Do I use a nerve muscle stimulator?
Q. Yes.
A. Yes.
Q. Do you use the train of four?
A. All the time, yes, anytime I give a muscle relaxant.
Q. And you're saying you don't chart it?
A. We chart that we do it, okay? That's --
Q. You do chart that you use it?
A. We use it, yes.
Q. And when you do use it, what does it

refer to? You just put T4 or train of four?
A. No.
Q. What's your abbreviation?
A. Under this -- in this anesthesia record under monitoring, five squares from the bottom --
Q. Which page?
A. I'm sorry, first page or second page. It says NB BLK monitor and then site.
Q. All right. Wait a minute.
A. Sorry.
Q. I can't find it here. I'm looking at the -- at Plaintiff's Exhibit 2. Where is it?
A. Yes, on the right-hand side.
Q. Right. Under regional?
A. No. Just above regional is airway.
Q. Yes.
A. And above airway is monitoring.
Q. Above in the monitoring section?
A. Right.
Q. Yes.
A. It's the fifth box from the bottom.
Q. And what does it say there?
A. It says NM, space, BLK, space, and

then monitor site.
Q. Okay.
A. And that box is checked.
Q. Okay. And what's the line next to it for?
A. Behind?
Q. Yes, sir.
A. Yeah. That would -- if we had listed where we had monitored, that would be written there.
Q. Well, why didn't you list where you monitored?
A. I'm not sure why it's not there.
Q. Well, just give me some examples of where you could monitor that, what sites.
A. In a patient prone, we would probably have both arms extended on arm boards so that the hands would be somewhere about the same level as the head, and I would expect we would monitor the ulnar nerve on the hand closest to the anesthesia machine.
Q. Okay.
A. And that's typical. Two EKG pads would be placed on the nerve, and it would be hooked up to the neuromuscular stimulator.

Q. For the ulnar nerve?
A. In this case, yes, more than likely.
Q. And would you normally write ulnar nerve there?
A. You could. You could write left arm. You could -- lots of things could be written.
Q. Okay. Is that generally where you do the monitoring?
A. Yes.
Q. Left arm?
A. Left or right ulnar nerve is the most common historically and was the most common as far as early research is concerned.
Q. How many times would you do this during the course of the procedure?
MR. PARKER: Objection to form. Do you understand the question, Doctor?
THE WITNESS: Yeah. I have some understanding.
MR. PARKER: Okay.
A. That's a little bit difficult to answer because the -- I'm not sure how often or how much the resident had the monitor on. If I was behaving as my usual self, it would have

been on continuously, and I like to see changes in train of four when I'm giving neuromuscular blockers.

Q. Well, was it up to the resident then to do the neuromuscular -- the train of four?

A. Was it --

Q. Was that his job?

A. Well, to -- how can I say that? To evaluate it on a minute-to-minute basis, I would say yes, under my direction.

Q. All right. But is this something that was going on continuously, or could it have been done once in the beginning and once at the end of the surgery?

A. Oh, no, not with me as his boss.

Q. Well, when did you expect them to monitor it; every hour, every 20 minutes?

A. Oh, no. As I said, when I do it, I do it regularly. In this case or continuously, they have to change batteries for me sometimes. In this case I expect that he would have done it both before and after every time he gave a muscle relaxant or added to the muscle relaxant.

Q. Okay. When you say you would expect, that's what you would have hoped he

would do, correct?
A. Oh, I'm -- I can't be certain but --
Q. Okay. Well, why would you delegate this responsibility to a resident rather than you do that yourself? Hello?
A. Yeah. Ask me the question again.
Q. Why would you delegate the responsibility of train of fours to a resident rather than do it yourself?
A. Why? Well, I do delegate some degree of many parts of the anesthetic to the resident, but at those times that I would be speaking with him about the case and evaluating what he has done, then I would -- that's one of the things that I would ask about and look at, and --
Q. What would you be looking for?
A. How many twitches there were.
MR. PARKER: Were you finished with your answer, Doctor?
Q. I'm sorry, sir. I don't mean to cut you off.
A. That's fine. Right.
Q. Were you done?
MR. PARKER: Let me just say this,

Mike, because he says that was fine, but because of the phone, there may be occasions that Mike inadvertently stops you. If that's the case, let Mike know. He'll be happy to let you finish your answer.

THE WITNESS: Okay.

A. We could go over the question again, I guess, and --

MR. BECKER: Cindy, what was my last question?

(Record read.)

A. Yeah. How many twitches there were or are.

Q. Okay. That's what you would expect the residents to be looking for?

A. No. That's what I would check the resident on every time I was reviewing and working the case with him.

Q. Okay. But if you're out of the room or in another operating room at another anesthesia, how are you supposed to check that?

A. I would have given him directives to begin with, what I wanted.

Q. Right.

A. And if that wasn't the case whenever

I was in the room, he'd hear about it.

Q. I understand that, but how do you check on what the response is to the train of four?

A. Well, as I say, I visualize it when I'm in the room myself.

Q. Okay. But he's not supposed to record that anywhere, correct?

A. He does not record it anywhere, no. And I have some idea of what the effect of the drugs were during the time I saw them given, so one has, can I say, an on-running history in my mind of what's going on clinically.

Q. Well, is it likely, Doctor, that there was a neuromuscular blockade during the actual dissection of the -- or resection or untethering of this lipoma?

A. I'd have to know what time that was, if you're talking about time.

Q. Okay. Based in your experience with -- with untethering of lipomas, does that generally occur towards the last third of the surgery, or is it generally in the middle?

A. Yeah. That's very hard to say. I really can't say.

Q. Do you know what the effect of neuromuscular blockers are on the accuracy and efficiency of intraoperative spinal cord monitoring?

MR. PARKER: Objection.

A. I -- I think you'd have to be a little more specific with the question.

Q. Do you know whether or not a neuromuscular blockade can result in a false negative during EMG monitoring of a lipoma resection?

A. I guess I'd have to say it would depend upon the degree of blockade.

Q. Okay. Based on the anesthetic agents, what degree of blockade would you expect to have an impact on the -- where it can create a false negative?

MR. PARKER: Objection.

A. Yeah, that's -- I would have to say that that was or is part of the protocol that was developed by the department of neurology, neurophysiologists, and they've given us the guidelines regarding that.

Q. When did they do that? Was it after this case?

A. Oh, no, no, no, no, no. No, the -- at some time as we start the case and during the case there is a discussion, at least to begin with, about what sort of monitoring is going to be done.

Q. I understand that.

A. All right. And what the expectations are or what the requirements are, and --

Q. Well, when you say -- first of all, I don't want to misunderstand you. When you say protocol, do you mean there was something in writing?

A. No.

Q. So is this something in a verbal discussion?

A. At least as far as I know.

Q. Is that what you meant by the term protocol?

A. Yes, right.

Q. Right?

A. Correct.

Q. So you're assuming there was a verbal discussion --

A. Verbal discussion.

Q. -- between Dr. Cheek and Dr. Luciano or --
A. No.
Q. -- and you --
This would be --
Q. -- or whom?
A. This would be between me and someone from the department of neurology.
Q. And can you tell us from the chart who that likely would be?
A. No, not for sure. There were three people involved, I think. I'd have to look. There was Dr. Gerson.
Q. Right.
A. Dr. Cheek.
Q. Uh-huh.
A. And I think the monitoring technician.
Q. Well, is it likely since Dr. Gerson was in training that the discussion would have occurred, if it did occur, between you and Cheek?
A. It's possible.
Q. Is it likely?
A. I can't say.

Q. Are you -- are you assuming there was a verbal discussion about what type of neuroblocking agents we want and to what degree?

A. Sorry. There always is. And when it comes to --

Q. Give me an example of such a discussion.

A. When it comes to a point -- well, first of all, you know, the question is what are we going to monitor today when one sees the technician show up, and she would give you some information. We're going to monitor SSEPs.

Q. Right.

A. And we're going to monitor EMG.

Q. Uh-huh.

A. And sometime during that pre-op or pre-preparation discussion, someone from the department of neurology is always -- I can't say always, but is very often there, and one would discuss with them their expectations.

Q. Give me an example of expectations.

A. And one would say that in this case since they are doing SSEPs that we don't want the potent agent to be at a higher concentration than .4 percent.

Q. Okay.
A. And that would be an expired concentration.
Q. Okay.
A. And we want the patient to at least have two twitches on a train -- his train of four.
Q. Two twitches on a train of four?
A. Right. At least two twitches on the train of four.
Q. That's for EMG monitoring?
A. Yes.
Q. Based on the chart, we can't tell if there were one, two, three or four twitches, correct?
A. That's true.
Q. And you wanted -- if the neurologist said to you, I want at least two twitches, if the intraoperative monitoring specialist said I want you to have at least two twitches on the train of four, what would that mean to you as to what you would have to do relative to the degree of neuromuscular blockers used?
A. You would titrate them appropriately.

Q. Give me an example.
A. You would see how many twitches the patient had. There's a fair period of time before I would presume the neuromuscular monitoring was commenced by the neurology people, and you would give a dose of drug and see what the result was.
Q. Would you expect the titrating of those drugs and their responses to be charted somewhere?
A. As I said, that is not something that I have ever done or seen done.
Q. Well, let me ask you this, is there any evidence in this two-page anesthesia record that there was titrating of neuromuscular blockers?
A. Well, I can see the amounts used, and I know the weight of the patient.
Q. Okay. What was the weight of the patient?
A. 70 kilograms.
Q. Which equates to how many pounds approximately?
A. About 150, just roughly.
Q. 150, did you say?

A. Roughly. 70 kilograms is what's listed.
Q. That's about 150 pounds?
A. Roughly.
Q. Correct?
A. Yes, roughly.
Q. And you -- you felt 150 pounds was overweight?
A. He was five feet three inches tall, and my note said, I believe, somewhat overweight.
Q. Okay.
MR. BECKER: Cindy, can you go back, please, and read my question before I asked him about what was the weight?
(Record read.)
Q. Okay.
A. And I had an answer, I believe, or started an answer.
Q. What was your answer, sir? Well, I may have cut you off.
MR. PARKER: Yeah. Let's -- let's read the answer and see whether it was complete.
MR. BECKER: Go ahead.
(Record read.)

A. Yes, and that I would relate to some degree of titration.
Q. You think there was some degree of titration here?
A. Absolutely. I know there was.
Q. Okay. And what do you base that on?
A. The patient's weight and the drugs used.
Q. I mean, how do we tell that from the chart, whether there was some degree of titration used?
A. The first dose of Zemuron that was given was 40 milligrams. An intubating dose in a patient of this weight would have been approximately 1 milligram per kilogram or 70 milligrams, so that's a very low dose of the drug. Following that it's almost -- it's over an hour before he gets another dose of 10 milligrams which is a very small dose.
Q. Doctor, going back to this form where we have under monitoring this NM block monitor site --
A. Uh-huh.
Q. -- do you see that?
A. Yes.

Q. Does that mean neuromuscular blockade?
A. Neuromuscular block monitor --
Q. Who does that mean?
A. -- site. That's the electrical instrument and the wires that we use to monitor neuromuscular function.
Q. And does that monitor neuromuscular function just in the arm, and then you make the assumption if it works in the arm, what we see in the arm is what's happening in the spinal cord?
MR. PARKER: Objection to form.
Q. I didn't hear your answer, sir. Did you say yes?
A. No. I didn't answer. This is the stimulus given to a peripheral nerve, and we are measuring the response of a peripheral muscle.
Q. Uh-huh.
A. This is not a direct stimulus to the nerve.
Q. Maybe I'm not making myself clear. If you're monitoring the arm, are you making the assumption that what's happening in the arm is also what's happening in the nerve roots in the

lower spinal cord as to whether or not there has been an impact by the neuromuscular blockers?

A. This drug does not affect the nerve roots in the spinal cord.

Q. It does not?

A. No.

Q. Did you say no?

A. Yes, I said no. Sorry.

Q. Which drugs don't affect the spinal cord?

A. Neuromuscular blockers.

Q. Well, do they impact the -- the nerves that feed the anal sphincter?

A. They are blocking drugs. They work at -- at the neuromuscular junction.

Q. Which would impact the nerves that feed the anal sphincter?

A. Yes, it could.

Q. And bladder, correct?

A. Yes, they could.

Q. Doctor, have you ever seen on this line here where it says NM block monitor site where you see one out of four or someone has written one out of four or three out of four or two out of four?

A. No.
Q. Have you ever seen that written there?
A. No.
Q. If the -- if the only sites you use is the ulnar nerve, what's the reason for the blank -- for the line next to it?
A. That's not the only site we use. It's the most common site.
Q. Well, what are the other sites?
A. One could use a branch of the facial nerve.
Q. Okay. Any other sites?
A. Those are the most common sites that I know of. One could use some of the nerves in the leg, posterior tibial, and watch flexion in the foot.
Q. Is there any indication from this chart which nerves were utilized for this neuromuscular block monitoring?
A. No, there's not.
Q. And if you had to make a best estimate, you would say it was the ulnar nerve?
A. That's what I said to begin with, yes.

Q. And explain to me one more time, what's the difference between four out of four and two out of four?

A. That's the degree of block. Four out of four infers that there is no block. Two out of four means that there is some degree of block.

Q. So you want -- the goal is not to gain a four out of four; the goal is to have at least a two out of four?

MR. PARKER: Objection.

Q. Correct?

A. The goal is at least -- to have at least two.

Q. Right. And should the resident be charting anything if he doesn't have at least two?

A. I suppose if that would happen, it would depend upon I suppose his response.

Q. His being --

A. The resident's --

Q. -- the resident?

A. -- response.

Q. What do you mean, the resident's response?

MR. PARKER: You just asked about what the resident's response should be. He's trying to -- he's trying to answer a question that I think has him speculating.

But answer, if you can.

A. Yeah. It surely is speculation. It depends -- it would depend upon the time during the anesthetic and during the procedure.

If, for example, you know, the technician had said or the surgeon had said, now is the time we're going to begin manipulating the nervous structures and so forth, we need to have two twitches or more, often or regularly, I'd have to say I guess always they come over and look and see what we're doing, how many twitches there are. They look at if we have end-tidal monitoring, what the end-tidal agent is, and at least that's on some occasions I've seen them write those down.

And if at some time following that time he had less than two twitches, either he would let me know or let them know or let the surgeon know. But how can I -- how can I say that? I think it would be very unlikely for that to happen. I have not seen it happen.

Q. For what to happen?
A. For them -- there to be less than two twitches during the period of time that they're doing their resection.
Q. I'm sorry, sir. I didn't hear you.
A. For there to be less than two twitches during the period of time they're doing their resection, and I guess I'd add and their monitoring.
Q. Well, all right. Do you have an opinion based on this child's weight and the neuromuscular blockers utilized whether or not there was at least a two out of four during the critical periods of time in this surgery, or would that be speculation on your part?
A. Well, it would be speculation, but looking at the drugs that are used, I expected he had at least two twitches.
Q. Do you recall any -- since Dr. Cheek has left the Clinic and someone has taken over the intraoperative monitoring, do you recall whether there has ever been any written policies and procedures as to what type of neuromuscular blockades are to be used and in what quantity during intraoperative monitoring?

MR. PARKER: Objection. You can answer.

A. If there are, I haven't read them.

Q. And since Dr. Cheek has left, do you recall ever receiving -- hearing a lecture from anyone, any type of neurophysiologist specializing in intraoperative monitoring, about the types of anesthesia agents and neuromuscular blockers used?

MR. PARKER: Objection.

A. Not to the best of my memory.

Q. Do you know who is in charge of neuromuscular -- strike that.

Do you know who is in charge of intraoperative monitoring, spinal cord monitoring, today at the Clinic?

A. I can't tell you.

Q. Do you know if there is anyone in charge?

A. I'm sure it's being done. I'm not often involved with this -- those procedures at this time.

Q. Well, when was the last time you likely were involved with an untethering of a spinal -- of a lipoma on a cord?

A. I do not remember.
Q. Could it have been as late as '96 or '97?
A. Well, I was involved in '96 or '97. This case occurred in '96.
Q. Right.
A. Right.
Q. Could it have been as late as '97?
A. That's possible. I don't remember.
Q. And why is it that you're not involved in these kinds of cases anymore?
A. My, what, interest has shifted more predominantly to general -- excuse me -- general pediatrics.
Q. When you say general pediatrics, what does that mean?
A. That means my, what, specialty is not at the present neuroanesthesia nor ENT, so I would have less occasion to do those cases than people who have more interest.
Q. Do you recall working with Dr. Cheek where he would maybe set something up and then once -- leave the room when the operation started? Do you have any recollection of his practice?

A. Not really. I know that I saw him and spoke with him fairly regularly.
Q. Uh-huh.
A. But the specifics of his practice I can't say.
Q. Just to recap, Doctor, the neuromuscular block monitoring site or the train of four, that was the responsibility of the resident that assisted you with anesthesia, correct?
A. That's my responsibility. He carries that out under my direction.
Q. Right. But you don't do that; he does that, correct?
A. I don't know that. I have to think about the question. I guess you'd have to define the word do because it may be that I placed the electrodes myself. That's after the patient was rolled over that I turned on the stimulator and checked the train of four at that time. But for ongoing monitoring, for following that parameter, that is his job.
Q. And you expected him to do that every 20 minutes or so?
A. I said if I were there and if he was

following my usual practice, it would have been continuous. Some people do not --

Q. Right.

A. Some people do not follow that, but to say that it was how often or how short, I can't tell you at this juncture.

Q. Well, can you even tell me how -- how often you were there during this surgery?

A. I can't document that from the anesthesia record.

Q. Were there any -- would there be any records that would reflect how many other surgeries you were overseeing, or I should say how many different anesthesias you were overseeing?

A. You mean like a schedule, written schedule?

Q. Right.

A. I doubt whether there's a written schedule. That's -- it's purely speculation, but since '96.

Q. The entry by you, Doctor, roughly at 9:45, do you see that? We talked about it, the Neosynephrin for the hypotension.

A. Yes.

Q. Could that be the first time that you made an appearance on this case?
A. Absolutely not.
Q. Why do you say that?
A. Well, because I had to start the case to begin with. I saw the patient preoperatively. I was there when the patient went to sleep. I was there when the patient was rolled prone and positioned.
Q. Why do you have to be there when the -- when the case starts, that is, when anesthesia starts?
A. That's my responsibility.
Q. To be present at the time --
A. Of induction.
Q. -- that induction begins?
A. You bet.
Q. Okay. So the other timing that we have besides what you have just indicated as well as the 9:45 is at roughly, oh, 1:30 or so, correct?
A. That's the time that I made a note on the chart. I think it's about 12:45.
Q. Okay.
A. Uh-huh. And I have some other notes

that -- where I've written in some drugs, I think.

Q. And that was at --

A. About 1:15.

Q. -- roughly 3:30?

A. 1:15.

Q. 3:15, did you say?

A. 1:15.

Q. 1:15?

A. 1:10, 1:15.

Q. And 3:15?

A. 1:30 maybe, and I have another note in the chart at about 3:30, but that is no measure of the number of times I was in the room.

Q. Okay. What would you -- assuming you weren't in the room, what would you have expected your resident to do if he tried the train of four and it came in less than two out of four?

A. At what time?

Q. During the surgery.

A. Yeah, but at what time during the surgery?

Q. Does it matter?

A. Yes. If they're manipulating the lipoma or doing EMG monitoring, it's very important.

Q. Okay. Well, let's assume that it's during EMG monitoring.

A. Right. Then he would have told people that were there and probably would have called me. I mean --

Q. And when you say he would have told people that were there, that's what you would --

A. The surgeon --

Q. -- what you would have expected of your resident?

A. You bet.

Q. And that would include, obviously, the surgeon?

A. Right, and whoever was there doing the monitoring.

Q. Well, who did you understand was capable of doing EMG monitoring, if you have an opinion?

A. I'm not an expert in that area.

Q. Okay.

A. That's done by the department of neurology. You know, they have their own

criteria.

Q. Do you generally indicate the people that were involved in the presence in the operating room somewhere in the anesthesia records?

A. No. You're talking about everybody?

Q. Right.

A. No.

Q. Any indication on the anesthesia records that a Dr. Gerson was present?

A. No, not on our records that I know of.

MR. BECKER: Okay. Doctor, I think that's all the questions I have for you.

THE WITNESS: All right.

MR. PARKER: Thank you very much. We'll reserve the right to read and sign.

MR. BECKER: Okay. I'll order this depo, and can I have it within five days?

THE NOTARY: Yes.

MR. BECKER: Okay. Doctor, thank you for your time.

THE WITNESS: You bet.

THE VIDEOGRAPHER: Would you like a videotape as well?

MR. BECKER: Yeah. Send me a copy of the videotape.

THE VIDEOGRAPHER: Doctor, you have the right to view this videotape, or you can waive that right at this time.

THE WITNESS: I'd like to see it.

THE VIDEOGRAPHER: Okay. And you said you wanted to have this filed?

MR. PARKER: No.

THE VIDEOGRAPHER: Or are you willing to waive filing and signature?

MR. PARKER: I'm willing to waive filing and signature on the videotape, but I reserve the right to sign the transcript. Mike, are you willing to waive filing of the videotape?

MR. BECKER: Sure. I could barely hear you, Alan, but sure.

MR. PARKER: Okay.

THE VIDEOGRAPHER: Okay. This concludes our deposition.

- - - - -

(Deposition concluded at 4:20 p.m.)

(Signature not waived.)

- - - - -

AFFIDAVIT

I have read the foregoing transcript from page 1 through 68 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

_____

Subscribed and sworn to before me this _____ day of _____, 2002.

_____
Notary Public

My commission expires _____.

CERTIFICATE

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

I, Cynthia A. Sullivan, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named GLENN E. DeBOER, M.D. was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action. I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 15th day of May 2003.

Cynthia A. Sullivan

Cynthia A. Sullivan, Notary Public
Within and for the State of Ohio

My commission expires October 6, 2006.

INDEX

DEPOSITION OF GLENN E. DeBOER, M.D.