

1 IN THE COURT OF COMMON PLEAS
2 OF CUYAHOGA COUNTY, OHIO

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4 KARL J. YOST, etc., et al.,
5 Plaintiffs,

6 vs. Case No.

7 THE CLEVELAND CLINIC 449275
8 FOUNDATION,

9 Defendant.

10 - - - - -

11 VIDEOTAPED DEPOSITION OF GLENN E. DeBOER, M.D.

12 MONDAY, MAY 12, 2003

13 - - - - -

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

24 - - - - -

25

1 APPEARANCES:

2 On behalf of the Plaintiffs via telephone:

3 Becker & Mishkind, by
4 MICHAEL BECKER, ESQ.
5 Becker Haynes Building
6 134 Middle Avenue
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9 On behalf of the Defendant:

10 Reminger & Reminger, by
11 ALAN PARKER, ESQ.
12 LAURA J. AVERY, ESQ.
13 1400 Midland Building
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17 JOHN T. BULLOCH, ESQ.
18 The Cleveland Clinic Foundation
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23 -----

24 ALSO PRESENT:

25 Kevin Shahan, Video Discovery

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

6 EXAMINATION OF GLENN E. DeBOER, M.D.

7 BY MR. BECKER:

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

10 A. My name is Glenn Edward DeBoer.

11 Q. Would you spell your last name?

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

13 Q. D-E capital V as in victor?

14 A. B as in boy.

15 Q. DeBoer, I'm sorry.

16 A. DeBoer.

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

19 A. I'm a staff anesthesiologist.

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

22 A. No, I didn't.

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

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

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

8 A. 1973, I believe -- '74.

9 Q. Okay.

10 A. It was 1974.

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

13 A. Two, two years in the Army.

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

16 A. After my residency.

17 Q. Okay. So how many years at UH?

18 A. Four years.

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

22 A. Yes.

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

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

1 Kentucky.

2 Q. Both years?

3 A. Yes.

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

6 A. Yes.

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

9 A. No.

10 Q. -- general surgery?

11 A. I was chief of the operating room
12 service.

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

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

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

22 A. About 1976.

23 Q. Then what?

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

1 Q. Okay.

2 A. -- as an attending anesthesiologist.

3 Q. Okay.

4 A. And then I came to the Cleveland
5 Clinic.

6 Q. And you've been at the Clinic on a
7 full-time basis within the department of
8 anesthesia since 1978?

9 A. Yes, that's right.

10 Q. Have you ever been chair of the
11 department?

12 A. No.

13 Q. Do you have a subspecialty interest
14 within anesthesia?

15 A. At the present I do, predominantly
16 pediatric anesthesia.

17 Q. Back in the summer of 1996, did you
18 do predominantly pedes?

19 A. I was doing pediatrics, ENT and
20 neuroanesthesia.

21 Q. Is there a sub -- you're board
22 certified?

23 A. Yes.

24 Q. And did you pass your boards the
25 first time you took them?

1 A. Yes.

2 Q. Is there a subspecialty board within
3 pediatrics or neuroanesthesia?

4 A. There surely was not when I took my
5 boards.

6 Q. Okay. Is it possible for you to get
7 a copy of your -- complete copy of your current
8 vitae and get it to Mr. Parker so he can send it
9 along to me?

10 A. Yes. At this moment or -- no.

11 Q. Would you be willing to do that?

12 A. Sure.

13 MR. PARKER: At this moment? I
14 mean, his offices are in a different building
15 and the like, but --

16 MR. BECKER: No, not at this moment.

17 MR. PARKER: Okay.

18 MR. BECKER: Just in the near
19 future, within the next few days.

20 Q. Doctor, have you been deposed
21 before?

22 A. Never.

23 Q. This is the first time?

24 A. Yes.

25 Q. I just want to review the ground

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

8 A. Yes.

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

13 A. You bet.

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

19 A. Uh-huh.

20 MR. PARKER: Objection. You can
21 answer.

22 A. Yes.

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

25 A. I reviewed the anesthesia record,

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

4 Q. That's pre-op?

5 A. Pre-op evaluation.

6 Q. Okay.

7 A. Anesthesia record and his several
8 days of hospitalization.

9 Q. Okay.

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

12 Q. Okay.

13 A. And by the neurophysiology
14 technician.

15 Q. Linda Gagnon?

16 A. I'd have to see that --

17 Q. Okay.

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

20 Q. Okay. Do you remember Dr. Cheek?

21 A. Yes.

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

25 MR. PARKER: Objection to the

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

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

6 MR. PARKER: Okay.

7 A. Can you rephrase the question?

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

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

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

18 A. You're talking about a written
19 document?

20 Q. Yes, sir.

21 A. I don't remember any document --

22 Q. Okay.

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

25 Q. Do you recall Dr. Cheek ever

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

5 A. Not specifically.

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

8 A. Not at all.

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

13 A. No, I don't.

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

17 A. I do not.

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

25 A. Uh-huh. All right.

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

5 A. Uh-huh.

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

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

10 Q. Any particular reason why not?

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

13 Q. Okay. Would it be the preoperative
14 assessment?

15 A. Yes.

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

19 A. Yes.

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

23 - - - - -

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

1 of identification.)

2 - - - - -

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

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

8 Q. Okay. And what is it?

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

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

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

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

17 A. It's the anesthesiologist note.

18 Q. At the very bottom?

19 A. Yes.

20 Q. At the very bottom?

21 A. Yes.

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

24 A. That was Linda Skolaris.

25 Q. Okay. And what would her role be?

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

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

6 A. She worked for the anesthesia
7 department, yes.

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

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

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

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

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

1 responsible.

2 THE WITNESS: Yes.

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

6 A. It says.

7 Q. -- your interpretation of her notes?

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

14 Q. Okay. What does that mean to you?

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

18 Q. Okay.

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

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

23 A. I don't know what that means.

24 Q. You do not know?

25 A. I do not know.

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

4 A. Uh-huh.

5 Q. -- and then make your
6 recommendation.

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

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

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

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

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

21 Q. Oh, discussion?

22 A. Discussed, uh-huh.

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

25 A. Yes.

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

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

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

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

18 Q. And your experience is those are
19 lengthy operations?

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

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

24 A. Yes, and I think that --

25 Q. Now, as I recall --

1 A. Sorry.

2 Q. -- anesthesia --

3 A. Sorry.

4 Q. -- people --

5 A. Excuse me.

6 MR. PARKER: Mike --

7 A. Excuse me. I changed the ASA
8 classification from one to two I think based on
9 the patient being somewhat overweight.

10 Q. Okay. And I was going to talk about
11 ASA classification.

12 A. Good.

13 Q. Where is that on this form? Oh, I
14 see it. ASA class two.

15 A. Right.

16 Q. You changed it from class one to
17 class two?

18 A. One to class two, uh-huh.

19 Q. How do you know that? How do you
20 know that you've actually changed it?

21 A. Because I can tell from the color of
22 the ink here.

23 Q. So the ink is different?

24 A. Yep. It's my ink, or it's black
25 ink, and I would presume it's the same as what I

1 wrote the note in.

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

4 A. Yes.

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

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

10 Q. I gotcha.

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

14 Q. I'm with you.

15 A. Okay. So I presume --

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

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

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

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

1 disease.

2 Q. And a class three and class four?

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

5 Q. Yes.

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

11 Q. Okay.

12 A. That's very rough.

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

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

18 Q. All right.

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

21 MR. PARKER: Yes.

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

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

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

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

5 - - - - -

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

9 - - - - -

10 A. All right.

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

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

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

17 A. The signature at the top --

18 Q. Right.

19 A. -- and the number two behind it.

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

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

23 Q. What does the number two reflect?

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

1 personally responsible for administering the
2 anesthetic myself.

3 Q. Who would be?

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

7 Q. So a doctor in training administered
8 the anesthesia?

9 A. Under my direction, yes.

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

13 A. Yes, I was.

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

16 A. I haven't the slightest idea.

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

20 A. I --

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

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

1 Q. Okay. Do you know what year
2 resident this particular person was?

3 MR. PARKER: Objection. What he
4 was, what do you mean?

5 THE WITNESS: Yes.

6 Q. At the time of this operation, was
7 he a first-year resident, a second-year
8 resident?

9 A. I'd have to speculate.

10 Q. All right. I see a number two
11 circled --

12 A. Uh-huh.

13 Q. -- Doctor?

14 A. Uh-huh.

15 Q. What's the significance of that?

16 A. That's the ASA status.

17 Q. Okay.

18 A. The resident wrote it down as one
19 also, and I changed it to two.

20 Q. Fair enough. Where it says induce
21 hypotension, do you see that right next to the
22 two?

23 A. Oh, yeah. It's way in front, yes.

24 Q. There's a number 18 next to it?

25 A. Yes.

1 Q. What does that mean?

2 A. I think that stands for the IV that
3 was placed in the induction room.

4 Q. The size of the IV?

5 A. Yes. And if you go down one line,
6 there's an X in the box that says induction room
7 precare, TCI IV is circled.

8 Q. Uh-huh?

9 A. And above that is written 18, and
10 that's all in the same color ink, so I presume
11 that's what it stands for.

12 Q. Okay. Any other entries on this
13 page by you?

14 A. I believe just beyond the 10:45
15 marking, time mark in the squared area, there's
16 a note of neo 100 plus 100.

17 Q. What does that mean?

18 A. That means that I gave or was --
19 there were two doses of Neosynephrin given.

20 Q. For blood pressure?

21 A. For blood pressure. That's at the
22 point when the blood pressure was about 85, 89
23 systolic.

24 MR. PARKER: Doctor, it looks to me
25 like that's at the 9:45 mark rather than the

1 10:45 mark.

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

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

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

10 A. That's just what --

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

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

23 Q. Okay. Continue to read, please.

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

1 Q. All right. Continue.

2 A. And then there's another mark, a
3 check with a circle, 1 gram Vancomycin per
4 surgeon's request at 9:25.

5 Q. Vancomycin is a type of antibiotic?

6 A. Yes.

7 Q. Yes?

8 A. Yes. Yes, it's a type of
9 antibiotic.

10 Q. Can you tell whether or not -- can
11 you tell me what agents were utilized during
12 this induction, drugs?

13 A. For the induction of anesthesia?

14 Q. Yes.

15 A. The patient got two-tenths of a
16 milligram of Robinul, I think 200 micrograms of
17 Fentanyl in divided doses, 300 milligrams of
18 Pentothal, oxygen, and then nitrous oxygen and
19 oxygen, and then Zemuron 40 milligrams.

20 Q. Can you tell how long this person
21 was under anesthesia by this form?

22 A. Well, we say that anesthesia started
23 at 8:20 and that it was finished, meaning the
24 patient was left in the recovery room, at 1630.
25 Now, that is on the next page.

1 Q. All right. And --

2 A. Which I'm not sure --

3 Q. Is there anything on that next page
4 that's in your handwriting?

5 A. Yes. I see two things.

6 MR. BECKER: All right. And we're
7 going to have to -- Alan, off the record.

8 (Discussion off the record.)

9 - - - - -

10 (Thereupon, Plaintiff's Deposition
11 Exhibit 3 was marked for purposes
12 of identification.)

13 - - - - -

14 Q. All right. Doctor, would you
15 identify what's been marked as Plaintiff's
16 Exhibit 3?

17 A. Yes. I have -- that's the second
18 page of this anesthesia record.

19 Q. Okay. And why don't you go ahead
20 and tell me what's in your handwriting on this
21 page?

22 A. In the far left column, the last
23 note in the upper set is D-E-S-F-U-L-R which is
24 Desflurane.

25 Q. I'm sorry. I can't find that.

1 Where?

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

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

11 Q. Where it says EBL, estimated blood
12 loss?

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

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

16 A. -- an echelon up.

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

19 Q. Where I see Pavulon?

20 A. Just below Pavulon.

21 Q. Where it says F102?

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

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

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

5 MR. BECKER: Right.

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

9 MR. BECKER: Excuse me.

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

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

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

17 MR. PARKER: Okay.

18 Q. And what does that mean, Doctor?

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

22 Q. What does that mean?

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

25 Q. And for what reason?

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

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

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

9 Q. Okay.

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

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

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

18 Q. Where is the circle on the graph?

19 A. It's --

20 Q. Oh, I see it. It's under about
21 1300?

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

24 Q. Okay.

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

1 there's --

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

4 A. It's a steroid --

5 Q. Okay.

6 A. -- anti-inflammatory --

7 Q. Okay.

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

10 Q. Okay.

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

13 Q. Okay.

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

18 Q. Okay. Anything unusual about that?

19 A. No.

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

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

25 Q. Okay. And that corresponds to what

1 time?

2 A. To the end of the procedure. I
3 don't think that there is any mark on the chart.

4 Q. Okay. Generally, there's a circle
5 with a number in it, and then the number is
6 referenced in the graphing?

7 A. In the comment line.

8 Q. But there's no --

9 A. I don't see it.

10 Q. You can't tell what time that refers
11 to?

12 A. No.

13 Q. What are those drugs --

14 A. Those --

15 Q. -- reverse the anesthesia?

16 A. -- reverse the muscle relaxant.

17 Q. Okay. Can you guesstimate or
18 approximate what time those muscle -- that
19 reversal was instituted?

20 A. Well, I'd have to look at the
21 recovery room. He arrived --

22 MR. PARKER: Just before you answer
23 it, I'd like to object to the extent that it's
24 calling for a guess.

25 Q. Give me your best estimate, Doctor.

1 A. Yeah. I would say somewhere near
2 4:00 o'clock.

3 Q. Okay.

4 A. I'd have to look at the recovery
5 room and see what time he arrived. That was
6 4:30, but 4:00 o'clock roughly.

7 Q. Next entry under comments?

8 A. It says 50 and 50 Fentanyl in PACU
9 for post-op pain.

10 Q. Okay.

11 A. Patient has some tape allergy, and I
12 think that's skin abrasion around the eye, tape,
13 comma, mouth, for ET, period.

14 Q. Okay. Next entry?

15 A. Some Neosporin oint, that may be
16 ointment, at the abrasion site.

17 Q. All right. Have we covered all your
18 entries in this chart?

19 A. Those are not my entries, the last.

20 Q. I appreciate that, but have we
21 covered all the entries that you've created in
22 this chart?

23 A. As far as I can see or tell at
24 present. It's possible, if we go back up into
25 the drug administration area, there's a note

1 with Zemuron 10 --

2 Q. Uh-huh.

3 A. -- Fentanyl 50 and 75.

4 Q. Uh-huh.

5 A. Those might be my notes.

6 Q. Doctor, are any of the drugs used
7 during this anesthesia what one might consider a
8 neuromuscular blockade?

9 A. Neuromuscular blockers?

10 Q. Yes.

11 A. Yes.

12 Q. Would you tell me which drugs they
13 are?

14 A. Zemuron and Pavulon.

15 Q. Would you spell Zemuron for me?

16 A. Z-E-M-U-R-O-N.

17 Q. And would you spell Pavulon?

18 A. P-A-V-U-L-O-N.

19 Q. All right. Can you tell me over
20 what period of time those neuromuscular blockers
21 were likely in effect during this surgery?

22 MR. PARKER: To the extent you can,
23 Doctor, please answer, but I'm going to object
24 to the form of the question and -- because it's
25 vague. Likely in effect is a vague term when it

1 comes to anesthetic agents.

2 But go ahead and answer it,

3 Doctor --

4 Q. Do the best you can, Doctor.

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

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

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

13 Q. Uh-huh.

14 A. And about hourly to
15 hourly-and-a-half he got additional doses of
16 about 10 milligrams until about I would say
17 sometime after 3:00 -- sorry -- sometime after
18 1:00.

19 Q. 1:00 p.m.?

20 A. Yeah, sometime between 1:00 and
21 1:15. And near 9:45 in the morning he got 2
22 milligrams of Pavulon, and he got another dose
23 at about 2:45.

24 Q. P.m.?

25 A. P.m., yes.

1 Q. All right. And is it appropriate to
2 talk about the phrase half life with anesthetic
3 agents, or is that inappropriate?

4 A. Well, with some agents, but --

5 Q. What I'm trying to get an
6 understanding, Doctor, and maybe you've already
7 answered this, would it be fair to state that
8 there are likely neuromuscular blockers on board
9 from the beginning of this surgery until the
10 end?

11 A. There were some.

12 Q. Well, there were two.

13 A. But we're -- I'm talking about
14 amounts.

15 Q. Okay. Have you heard of the
16 expression train of four?

17 A. Yes.

18 Q. What does it mean?

19 A. It's the way we monitor
20 neuromuscular function.

21 Q. And how do you do that?

22 A. We have an instrument that --

23 MR. PARKER: Well, one second.

24 You're going to answer the question, but it's
25 not -- it's not you, it's not Dr. DeBoer that

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

3 THE WITNESS: (Indicating.)

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

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

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

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

14 A. Yes.

15 Q. Let's start over.

16 A. Uh-huh.

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

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

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

25 A. That's to know the percent or

1 degree, I guess, of paralysis.

2 Q. And when you utilize and engage in,
3 quote, a train of four, end of quote, do you
4 generally chart it?

5 A. No, we do not. And we -- I'm
6 talking about the Cleveland Clinic or we in the
7 group here at the Cleveland Clinic -- I don't
8 think I have ever seen it charted.

9 Q. You have never seen it charted?

10 A. Nowhere that I've ever worked.

11 Q. Okay. And do you do it all the
12 time?

13 A. Do I use a nerve muscle stimulator?

14 Q. Yes.

15 A. Yes.

16 Q. Do you use the train of four?

17 A. All the time, yes, anytime I give a
18 muscle relaxant.

19 Q. And you're saying you don't chart
20 it?

21 A. We chart that we do it, okay?

22 That's --

23 Q. You do chart that you use it?

24 A. We use it, yes.

25 Q. And when you do use it, what does it

1 refer to? You just put T4 or train of four?

2 A. No.

3 Q. What's your abbreviation?

4 A. Under this -- in this anesthesia
5 record under monitoring, five squares from the
6 bottom --

7 Q. Which page?

8 A. I'm sorry, first page or second
9 page. It says NB BLK monitor and then site.

10 Q. All right. Wait a minute.

11 A. Sorry.

12 Q. I can't find it here. I'm looking
13 at the -- at Plaintiff's Exhibit 2. Where is
14 it?

15 A. Yes, on the right-hand side.

16 Q. Right. Under regional?

17 A. No. Just above regional is airway.

18 Q. Yes.

19 A. And above airway is monitoring.

20 Q. Above in the monitoring section?

21 A. Right.

22 Q. Yes.

23 A. It's the fifth box from the bottom.

24 Q. And what does it say there?

25 A. It says NM, space, BLK, space, and

1 then monitor site.

2 Q. Okay.

3 A. And that box is checked.

4 Q. Okay. And what's the line next to
5 it for?

6 A. Behind?

7 Q. Yes, sir.

8 A. Yeah. That would -- if we had
9 listed where we had monitored, that would be
10 written there.

11 Q. Well, why didn't you list where you
12 monitored?

13 A. I'm not sure why it's not there.

14 Q. Well, just give me some examples of
15 where you could monitor that, what sites.

16 A. In a patient prone, we would
17 probably have both arms extended on arm boards
18 so that the hands would be somewhere about the
19 same level as the head, and I would expect we
20 would monitor the ulnar nerve on the hand
21 closest to the anesthesia machine.

22 Q. Okay.

23 A. And that's typical. Two EKG pads
24 would be placed on the nerve, and it would be
25 hooked up to the neuromuscular stimulator.

1 Q. For the ulnar nerve?

2 A. In this case, yes, more than likely.

3 Q. And would you normally write ulnar
4 nerve there?

5 A. You could. You could write left
6 arm. You could -- lots of things could be
7 written.

8 Q. Okay. Is that generally where you
9 do the monitoring?

10 A. Yes.

11 Q. Left arm?

12 A. Left or right ulnar nerve is the
13 most common historically and was the most common
14 as far as early research is concerned.

15 Q. How many times would you do this
16 during the course of the procedure?

17 MR. PARKER: Objection to form. Do
18 you understand the question, Doctor?

19 THE WITNESS: Yeah. I have some
20 understanding.

21 MR. PARKER: Okay.

22 A. That's a little bit difficult to
23 answer because the -- I'm not sure how often or
24 how much the resident had the monitor on. If I
25 was behaving as my usual self, it would have

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

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

6 A. Was it --

7 Q. Was that his job?

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

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

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

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

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

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

1 would do, correct?

2 A. Oh, I'm -- I can't be certain but --

3 Q. Okay. Well, why would you delegate
4 this responsibility to a resident rather than
5 you do that yourself? Hello?

6 A. Yeah. Ask me the question again.

7 Q. Why would you delegate the
8 responsibility of train of fours to a resident
9 rather than do it yourself?

10 A. Why? Well, I do delegate some
11 degree of many parts of the anesthetic to the
12 resident, but at those times that I would be
13 speaking with him about the case and evaluating
14 what he has done, then I would -- that's one of
15 the things that I would ask about and look at,
16 and --

17 Q. What would you be looking for?

18 A. How many twitches there were.

19 MR. PARKER: Were you finished with
20 your answer, Doctor?

21 Q. I'm sorry, sir. I don't mean to cut
22 you off.

23 A. That's fine. Right.

24 Q. Were you done?

25 MR. PARKER: Let me just say this,

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

6 THE WITNESS: Okay.

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

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

11 (Record read.)

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

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

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

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

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

24 Q. Right.

25 A. And if that wasn't the case whenever

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

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

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

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

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

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

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

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

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

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

5 MR. PARKER: Objection.

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

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

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

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

18 MR. PARKER: Objection.

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

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

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

6 Q. I understand that.

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

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

14 A. No.

15 Q. So is this something in a verbal
16 discussion?

17 A. At least as far as I know.

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

20 A. Yes, right.

21 Q. Right?

22 A. Correct.

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

25 A. Verbal discussion.

1 Q. -- between Dr. Cheek and Dr. Luciano
2 or --

3 A. No.

4 Q. -- and you --
5 This would be --

6 Q. -- or whom?

7 A. This would be between me and someone
8 from the department of neurology.

9 Q. And can you tell us from the chart
10 who that likely would be?

11 A. No, not for sure. There were three
12 people involved, I think. I'd have to look.
13 There was Dr. Gerson.

14 Q. Right.

15 A. Dr. Cheek.

16 Q. Uh-huh.

17 A. And I think the monitoring
18 technician.

19 Q. Well, is it likely since Dr. Gerson
20 was in training that the discussion would have
21 occurred, if it did occur, between you and
22 Cheek?

23 A. It's possible.

24 Q. Is it likely?

25 A. I can't say.

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

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

6 Q. Give me an example of such a
7 discussion.

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

13 Q. Right.

14 A. And we're going to monitor EMG.

15 Q. Uh-huh.

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

21 Q. Give me an example of expectations.

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

1 Q. Okay.

2 A. And that would be an expired
3 concentration.

4 Q. Okay.

5 A. And we want the patient to at least
6 have two twitches on a train -- his train of
7 four.

8 Q. Two twitches on a train of four?

9 A. Right. At least two twitches on the
10 train of four.

11 Q. That's for EMG monitoring?

12 A. Yes.

13 Q. Based on the chart, we can't tell if
14 there were one, two, three or four twitches,
15 correct?

16 A. That's true.

17 Q. And you wanted -- if the neurologist
18 said to you, I want at least two twitches, if
19 the intraoperative monitoring specialist said I
20 want you to have at least two twitches on the
21 train of four, what would that mean to you as to
22 what you would have to do relative to the degree
23 of neuromuscular blockers used?

24 A. You would titrate them
25 appropriately.

1 Q. Give me an example.

2 A. You would see how many twitches the
3 patient had. There's a fair period of time
4 before I would presume the neuromuscular
5 monitoring was commenced by the neurology
6 people, and you would give a dose of drug and
7 see what the result was.

8 Q. Would you expect the titrating of
9 those drugs and their responses to be charted
10 somewhere?

11 A. As I said, that is not something
12 that I have ever done or seen done.

13 Q. Well, let me ask you this, is there
14 any evidence in this two-page anesthesia record
15 that there was titrating of neuromuscular
16 blockers?

17 A. Well, I can see the amounts used,
18 and I know the weight of the patient.

19 Q. Okay. What was the weight of the
20 patient?

21 A. 70 kilograms.

22 Q. Which equates to how many pounds
23 approximately?

24 A. About 150, just roughly.

25 Q. 150, did you say?

1 A. Roughly. 70 kilograms is what's
2 listed.

3 Q. That's about 150 pounds?

4 A. Roughly.

5 Q. Correct?

6 A. Yes, roughly.

7 Q. And you -- you felt 150 pounds was
8 overweight?

9 A. He was five feet three inches tall,
10 and my note said, I believe, somewhat
11 overweight.

12 Q. Okay.

13 MR. BECKER: Cindy, can you go back,
14 please, and read my question before I asked him
15 about what was the weight?

16 (Record read.)

17 Q. Okay.

18 A. And I had an answer, I believe, or
19 started an answer.

20 Q. What was your answer, sir? Well, I
21 may have cut you off.

22 MR. PARKER: Yeah. Let's -- let's
23 read the answer and see whether it was complete.

24 MR. BECKER: Go ahead.

25 (Record read.)

1 A. Yes, and that I would relate to some
2 degree of titration.

3 Q. You think there was some degree of
4 titration here?

5 A. Absolutely. I know there was.

6 Q. Okay. And what do you base that on?

7 A. The patient's weight and the drugs
8 used.

9 Q. I mean, how do we tell that from the
10 chart, whether there was some degree of
11 titration used?

12 A. The first dose of Zemuron that was
13 given was 40 milligrams. An intubating dose in
14 a patient of this weight would have been
15 approximately 1 milligram per kilogram or 70
16 milligrams, so that's a very low dose of the
17 drug. Following that it's almost -- it's over
18 an hour before he gets another dose of
19 10 milligrams which is a very small dose.

20 Q. Doctor, going back to this form
21 where we have under monitoring this NM block
22 monitor site --

23 A. Uh-huh.

24 Q. -- do you see that?

25 A. Yes.

1 Q. Does that mean neuromuscular
2 blockade?

3 A. Neuromuscular block monitor --

4 Q. Who does that mean?

5 A. -- site. That's the electrical
6 instrument and the wires that we use to monitor
7 neuromuscular function.

8 Q. And does that monitor neuromuscular
9 function just in the arm, and then you make the
10 assumption if it works in the arm, what we see
11 in the arm is what's happening in the spinal
12 cord?

13 MR. PARKER: Objection to form.

14 Q. I didn't hear your answer, sir. Did
15 you say yes?

16 A. No. I didn't answer. This is the
17 stimulus given to a peripheral nerve, and we are
18 measuring the response of a peripheral muscle.

19 Q. Uh-huh.

20 A. This is not a direct stimulus to the
21 nerve.

22 Q. Maybe I'm not making myself clear.
23 If you're monitoring the arm, are you making the
24 assumption that what's happening in the arm is
25 also what's happening in the nerve roots in the

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

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

5 Q. It does not?

6 A. No.

7 Q. Did you say no?

8 A. Yes, I said no. Sorry.

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

11 A. Neuromuscular blockers.

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

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

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

18 A. Yes, it could.

19 Q. And bladder, correct?

20 A. Yes, they could.

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

1 A. No.

2 Q. Have you ever seen that written
3 there?

4 A. No.

5 Q. If the -- if the only sites you use
6 is the ulnar nerve, what's the reason for the
7 blank -- for the line next to it?

8 A. That's not the only site we use.
9 It's the most common site.

10 Q. Well, what are the other sites?

11 A. One could use a branch of the facial
12 nerve.

13 Q. Okay. Any other sites?

14 A. Those are the most common sites that
15 I know of. One could use some of the nerves in
16 the leg, posterior tibial, and watch flexion in
17 the foot.

18 Q. Is there any indication from this
19 chart which nerves were utilized for this
20 neuromuscular block monitoring?

21 A. No, there's not.

22 Q. And if you had to make a best
23 estimate, you would say it was the ulnar nerve?

24 A. That's what I said to begin with,
25 yes.

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

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

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

11 MR. PARKER: Objection.

12 Q. Correct?

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

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

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

20 Q. His being --

21 A. The resident's --

22 Q. -- the resident?

23 A. -- response.

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

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

5 But answer, if you can.

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

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

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

1 Q. For what to happen?

2 A. For them -- there to be less than
3 two twitches during the period of time that
4 they're doing their resection.

5 Q. I'm sorry, sir. I didn't hear you.

6 A. For there to be less than two
7 twitches during the period of time they're doing
8 their resection, and I guess I'd add and their
9 monitoring.

10 Q. Well, all right. Do you have an
11 opinion based on this child's weight and the
12 neuromuscular blockers utilized whether or not
13 there was at least a two out of four during the
14 critical periods of time in this surgery, or
15 would that be speculation on your part?

16 A. Well, it would be speculation, but
17 looking at the drugs that are used, I expected
18 he had at least two twitches.

19 Q. Do you recall any -- since Dr. Cheek
20 has left the Clinic and someone has taken over
21 the intraoperative monitoring, do you recall
22 whether there has ever been any written policies
23 and procedures as to what type of neuromuscular
24 blockades are to be used and in what quantity
25 during intraoperative monitoring?

1 MR. PARKER: Objection. You can
2 answer.

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

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

10 MR. PARKER: Objection.

11 A. Not to the best of my memory.

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

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

17 A. I can't tell you.

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

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

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

1 A. I do not remember.

2 Q. Could it have been as late as '96 or
3 '97?

4 A. Well, I was involved in '96 or '97.
5 This case occurred in '96.

6 Q. Right.

7 A. Right.

8 Q. Could it have been as late as '97?

9 A. That's possible. I don't remember.

10 Q. And why is it that you're not
11 involved in these kinds of cases anymore?

12 A. My, what, interest has shifted more
13 predominantly to general -- excuse me -- general
14 pediatrics.

15 Q. When you say general pediatrics,
16 what does that mean?

17 A. That means my, what, specialty is
18 not at the present neuroanesthesia nor ENT, so I
19 would have less occasion to do those cases than
20 people who have more interest.

21 Q. Do you recall working with Dr. Cheek
22 where he would maybe set something up and then
23 once -- leave the room when the operation
24 started? Do you have any recollection of his
25 practice?

1 A. Not really. I know that I saw him
2 and spoke with him fairly regularly.

3 Q. Uh-huh.

4 A. But the specifics of his practice I
5 can't say.

6 Q. Just to recap, Doctor, the
7 neuromuscular block monitoring site or the train
8 of four, that was the responsibility of the
9 resident that assisted you with anesthesia,
10 correct?

11 A. That's my responsibility. He
12 carries that out under my direction.

13 Q. Right. But you don't do that; he
14 does that, correct?

15 A. I don't know that. I have to think
16 about the question. I guess you'd have to
17 define the word do because it may be that I
18 placed the electrodes myself. That's after the
19 patient was rolled over that I turned on the
20 stimulator and checked the train of four at that
21 time. But for ongoing monitoring, for following
22 that parameter, that is his job.

23 Q. And you expected him to do that
24 every 20 minutes or so?

25 A. I said if I were there and if he was

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

3 Q. Right.

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

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

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

11 Q. Were there any -- would there be any
12 records that would reflect how many other
13 surgeries you were overseeing, or I should say
14 how many different anesthetics you were
15 overseeing?

16 A. You mean like a schedule, written
17 schedule?

18 Q. Right.

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

22 Q. The entry by you, Doctor, roughly at
23 9:45, do you see that? We talked about it, the
24 Neosynephrin for the hypotension.

25 A. Yes.

1 Q. Could that be the first time that
2 you made an appearance on this case?

3 A. Absolutely not.

4 Q. Why do you say that?

5 A. Well, because I had to start the
6 case to begin with. I saw the patient
7 preoperatively. I was there when the patient
8 went to sleep. I was there when the patient was
9 rolled prone and positioned.

10 Q. Why do you have to be there when the
11 -- when the case starts, that is, when
12 anesthesia starts?

13 A. That's my responsibility.

14 Q. To be present at the time --

15 A. Of induction.

16 Q. -- that induction begins?

17 A. You bet.

18 Q. Okay. So the other timing that we
19 have besides what you have just indicated as
20 well as the 9:45 is at roughly, oh, 1:30 or so,
21 correct?

22 A. That's the time that I made a note
23 on the chart. I think it's about 12:45.

24 Q. Okay.

25 A. Uh-huh. And I have some other notes

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

3 Q. And that was at --

4 A. About 1:15.

5 Q. -- roughly 3:30?

6 A. 1:15.

7 Q. 3:15, did you say?

8 A. 1:15.

9 Q. 1:15?

10 A. 1:10, 1:15.

11 Q. And 3:15?

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

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

21 A. At what time?

22 Q. During the surgery.

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

25 Q. Does it matter?

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

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

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

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

11 A. The surgeon --

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

14 A. You bet.

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

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

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

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

23 Q. Okay.

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

1 criteria.

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

6 A. No. You're talking about everybody?

7 Q. Right.

8 A. No.

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

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

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

15 THE WITNESS: All right.

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

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

20 THE NOTARY: Yes.

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

23 THE WITNESS: You bet.

24 THE VIDEOGRAPHER: Would you like a
25 videotape as well?

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

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

6 THE WITNESS: I'd like to see it.

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

9 MR. PARKER: No.

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

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

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

19 MR. PARKER: Okay.

20 THE VIDEOGRAPHER: Okay. This
21 concludes our deposition.

22 - - - - -

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

24 (Signature not waived.)

25 - - - - -

1 AFFIDAVIT

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

5 PAGE LINE REQUESTED CHANGE

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20 Subscribed and sworn to before me this

21 _____ day of _____, 2002.

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Notary Public

25 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.

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