STATE OF OHIO,)
) SS:
COUNTY OF CUYAHOGA.)

IN THE COURT OF COMMON PLEAS

Kathleen M. Nabozny,
Plaintiff,
vs.
William E. Chepla, D.D.S.,
Defendant.

No. 131627

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Deposition of MICHAEL DEVEREAUX, M.D., a witness, taken as if under examination before Angelika P. Veres, a Notary Public within and for the State of Ohio, at Mt. Sinai Hospital, One Mt. Sinai Drive, Cleveland, Ohio, at 4:50 p.m., Wednesday, the 22nd day of March, 1989, pursuant to stipulations of counsel, on behalf of the Defendant.

APPEARANCES:

Kaufman & Cumberland, by
Mr. Frank R. DeSantis,

on behalf of the Plaintiff;

Kitchen, Messner & Deery, by
Mr. Eugene B. Meador,

on behalf of the Defendant.

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STIPULATIONS

It was stipulated by and between counsel for Plaintiff and Defendant that this deposition may be taken in stenotypy by Angelika P. Veres, that said stenotype notes may he subsequently transcribed into typewriting in the absence of the witness; that the reading and signing of the deposition by the witness are waived; and that all requirements of the Ohio Rules of Civil Procedure with regard to notice of time and place of taking this deposition are waived.

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MICHAEL DEVERAUX, of lawful age, a witness herein, called by the Defendant for the purpose of examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

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DIRECT EXAMINATION OF MICHAEL DEVEREAUX

BY MR. MEADOR:

Q Tell us your name, please?

A Michael Devereaux.

Q And you're a doctor; is that right?

A Yes.

Q Dr. Devereaux, my name is Gene Meador and I represent Dr. Chepla, who is a Defendant in this lawsuit, and you're well aware of that, I understand?

A Yes, sir.

Q You've been identified as a potential expert witness in this case and you prepared a report which I see is in front of you.

This is your deposition and my purpose is to find out what your opinions are and what

opinions you might render in connection with this lawsuit.

MR. MEADOR: The deposition here is being conducted by agreement of counsel; is that correct?

MR. DeSANTIS: It sure is.

MR. MEADOR: And I have provided you, Frank, with a copy of our expert's report by Dr. Mann; is that correct?

MR. DeSANTIS: Yes, you have.

Q Before we begin, might I look at your file to know what you have in it so I can save a little time?

A Okay. The only thing I would mention to you, Dr. Mann I think is the report you were just referring to, I just saw it a few minutes before, so I haven't had a chance to go over it in detail yet, but other than that --

Q Why don't you read Dr. Mann's report while I'm looking through your file?

A All right.

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(Discussion had off the record.)

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Q We're back on the record. Dr. Devereaux, I

just reviewed your file and I found -- this is your complete file that you gave me; is that correct?

A Absolutely, complete.

Q And in that file, I see the large portion of it is the Hillcrest Hospital record pertaining to the admission of Kathleen Nabozny?

A Correct.

Q With the date of admission being July 23rd, 1986 and the date of discharge being September 4th of 1986?

A Uh-huh.

Q There is also a copy of your report that you gave in this case?

A Yes.

Q And I assume that that's the only report that you authored in this case?

A Correct.

Q And that report contains your opinions --

A Absolutely.

Q -- in regards to this matter?

A Uh-huh.

Q Are there any other opinions that you have regarding this matter that are not contained in that report?

A None whatsoever.

Q I also have been given some correspondence from Kaufman and Cumberland, I believe there are two letters dated February -- if I could look at those letters-- February 27th, 1989, mother letter dated August the 17th, 1988; is that correct?

A Yeah, uh-huh.

Q And then there's a third letter dated October 20th, 1986 from Kaufman and Cumberland; is that correct?

A Yes. That's not to me, that's to Hillcrest Hospital, just. a *cony,*

Q And then there's a letter dated August 19th, 1988 indicating your fees for reviewing and preparing your report in this matter; is that right?

A Yes.

Q And then you also have a copy of Dr. Donald Mann's report which was given to you today; is that right?

A Right.

Q Now, there was also a two page -- one page with two sides to it, with your handwritten notes?

A Yes.

Q And if you could just tell us what that is, though?

A When I see a patient, I take a history, I sit down with the patient and I then will jot down some notes to remind myself to dictate some points, based on the patient's history. There may be some dates, and so forth, on it.

I then use it along with the hospital records when I sit down and dictate my full report after I see the patient, usually about an hour later.

For example, it lists the blood pressure reading I took and I have a rough drawing of the chin region, it shows an outline of the sensory disturbance the patient has, things of this sort. This is a handwritten note nearly --

Q In your handwriting?

A In my handwriting.

Q I notice it's in two different colors of ink. blue and black; is that correct?

A Yes.

Q When were those notes prepared?

A In the presence of the patient.

Q On the day that you saw the patient?

A Yes.
Q And --
A Not on the day I saw the patient, while I saw the patient.
Q Which would be on the day that you saw the patient?
A Yes.
Q Can you tell which notes were prepared first, the notes in black ink or the notes in blue ink?
A Well, probably what I did was I ran out of ink or left my pen in my office when I went back to get -- while the patient was disrobing, because the comments that are in blue ink indicate her blood pressure, which were done during the physical examination, and indicate the sensory loss.

There is also -- what I probably did was, and this is pulling it from way out, I couldn't remember the type of organism that she had. She didn't know, so I checked back in the notes while she was disrobing and reminded myself that it was staphylococcus and also I couldn't remember what kind of a catheter was used to administer the antibiotic

and I checked it out and it was a Hickman catheter, things that she wouldn't know.

And so those were then written with my pen in the office when I went back to look through the record.

So, these are just scratch notes to me to indicate to -- to mention a few points that I made my report from.

Q Do those notes indicate what the patient told you when you examined her?

A For the most part, yes, as does my report. I'm very clear in the report to indicate where the information was coming from, whether it was coming from the so-called original notes or whether it was coming from the patient.

Q I understand, you told me you want to use your August 19th, 1988 report.

A Absolutely.

Q And you do not want to refer to yowr notes?

A Scratch notes, right.

Q Scratch notes. My only concern is that oftentimes there is a -- sometimes a discrepancy between the handwritten notes that are prepared at the time that the patient is giving you that information and the dictated

letter which you've prepared shortly thereafter, and I'm wondering if you have compared your notes with your August 19th --

A At the time --

Q -- the dictation report to see whether there are any discrepancies?

A No, I have not looked at those scratch notes since I did the dictation and my only error, as I already told you, was not in destroying those notes so this kind of activity could be totally avoided, which I usually do.

Q Well, I would like to have a copy of your notes, just so that we might compare whether there are any discrepancies between your notes and the report.

I understand your feelings on that.

A No. I mean, this is just absurd.

Q You are going to destroy the notes and you're not going to --

A Yeah, they're my notes that I use to -- in the process of interviewing a patient, as I said, the same way that a lawyer will make notes, when he may be looking at an article in a journal or allow review and then will dictate from those notes.

My experience with this is simple. One time years ago when I testified in court, an eight page report which I had taken hours to prepare was not the subject of my cross-examination, but was the scratch notes which I couldn't even read and it was not a service to the court, a service to the patient, a service to anybody.

So, I have always torn those notes up so that that was never an issue, and I didn't do it this time and I just don't think that that serves -- there's nothing hidden here, no secrets. I stand by what I wrote here.

Q I understand. I'm not saying there is anything in your notes that would be different from your report.

All I ask you to do is let the judge at least decide, then --

A NO.

Q -- as to whether or not the notes --

A That isn't the judge's role to be involved in the practice of medicine. That is my role.

Q I absolutely agree with you.

A And what you have here is the practice of medicine. It is the same thing I do exactly

every time I see a patient, okay, whether it's legal or not legal, that means nothing to me, all right. I practice medicine.

It is not the judge's role to look at my notes and determine -- make any determinations like that. That's my role as a doctor.

It is his role, along with the jury's role, to determine whether or not the testimony I give is meritorious and I'll stand by that and I'll live with that.

Otherwise I wouldn't be -- I wouldn't have taken this case, but I don't think it's the role of the court to enter into how I practice medicine and this is how I practice medicine.

Q I tend to agree with what you say for the most part in terms of you consider this to be a medical role here.

A It is.

Q And that is your role.

The only difference is that the medical role here is interfacing with the legal role and Dr. Chepla, who happens to be a doctor, is not going to be necessarily judged in a medical setting, but he is going to be forced into a legal setting to decide these issues.

A And here I am and I'm ready for examination.
Q And you, being a witness in this case, you have to submit yourself to some of the legal roles that are placed upon you.
A Correct.
Q One of those roles involves being cross-examined on any of your notes.
A Okay.
Q Which would include the note that you intend to destroy.
A I've also -- let me make some other statements.

I've probably thrown out some other notes, too. The only reason I kept that is that it's a face sheet with the patient's address, and so forth.

Other notes are completely done away with because there's no reason to keep them. I do that generally.

That's only a one page sheet because that is the patient's address at the top and that's the way we do things in my office. We no longer do.

All nates axe thrown away now because the address sheets, the face sheets are placed on

the inside of the chart. So, as you can see, this contains her name, her age and whoever the referral was and that's why I usually keep that.

The rest of this, undoubtedly because there's no other information here about any other aspects of my physical examination, went onto the next page, so this is even a fragment of my notes, so it would be absurd.

Q How many other pages of other notes have been previously destroyed?

A Probably a couple. I probably threw them aut at the time I did my history and physical.

Q Can you do me this courtesy of reading your notes at least into the record, even though we're not going to have your original note because you're going to destroy it?

A See if I can read it.

MR. DeSANTIS: Let me interject. One of the problems he's having, Gene, he took these notes however long ago, they were handwritten, he prepared his report within a short time of taking these notes.

You didn't serve him with a

subpoena requiring him to bring these records. He has no legal obligation to maintain those records. It's a product of his ordinary --

MR. MEADOR: I understand.

MR. DeSANTIS: -- medical practice to get rid of handwritten notes after he's done dictating his typewritten report and I -

MR. MEADOR: As you and I both know, though, Frank, most all of the doctors in town take notes when they examine a patient, they are subject to discovery and they are ---

MR. DeSANTIS: That's not the issue here. There was no discovery served on Dr. Devereaux. There's no subpoena served.

I mean, as a courtesy, he brought his file here, but he doesn't want to provide this record.

MR, MEADOR: There wasn't a subpoena served on my expert witness, either.

MR. DeSANTIS: Nor on mine.

MR, MEADOR: And we produced those records.

MR, DeSANTIS: As I did,

MR. MEADOR: And you know darn well that I'm entitled to look at those records and if there's a page of notes that are in there, they should not be destroyed and they should be at least admitted to the court.

If the court decides they're not something that should be used for cross-examination, let the court decide.

MR. DeSANTIS: Well, right now, we're at an impasse.

A I can't even read all of this and your judge, no matter who he was, couldn't read it either.

I start out by making the comment "facial and mouth numbness, right side. Right mental region, feeling of drooling and wetness. Numbness" -- I don't say numbness.

I say, "right side of tongue, feels like Novocain. Face Eeels enlarged. Sensation of the area fecling hard, feeling firm, although it looks," quote, "okay," end quote.

When I was making comments under the tongue, "the tip tingles. The back of it feels fat and numb. Right lower gum and lower buccal mucosa" -- those aren't the patient's words, obviously -- "numb. External auditory canal tingling, feels like it's falling asleep only to the touch of a Q-tip.

"When pressing in the right TMJ region, tingling, right cheek. Some chronic pain, right TMJ region" and then I make a note to myself, question mark, "damage to the jaw joint from infection."

At first, "slight right side of mouth," quote, "drawing," end of quote, "droop." Family noted that this went away four to five months afterwards," and then I put "staphylococcus, teeth extracted, July 8th, 1986, 7-26" -- I can't read my writing, it may be "drain abscess, pterygopalatine and intratemporal space abscess," but that was just an insert.

Then I had two to three days after the extractions, quote, "bad pain," end of quote, "couldn't open mouth. About seven days later, increased pain. One to two days later, face

started getting numb."

"Then numbness, fourth and fifth digits, right hand, followed by numbness, fourth and fifth toes, right foot," which she interjected went away during hospitalization.

July 18th, antibiotics. July 23rd, saw Monroe Cole.

I then outlined what -- no, I don't. I take that back. Then "hospitalization" and I kind of list some of the procedures, "right TM joint aspiration. Had a CT and MRI scan. Abscess drained. Hickman catheter placed. Seen by Ruch, Alperin, seen by Readerman.

"Anemia, question of PA," meaning pernicious anemia. Past medical history, she had right knee surgery -- oh, no. I take that back.

She had right knee surgery three weeks prior to my examination. She had had a C-section in the past. Blood pressure, 150, slash, 100.

Sensory loss, which I was referring to the face and then the rest of it is my notes later on, on other pages, which I just didn't include here.

A May I see the note again?

MR. DeSANTIS: Gene, for the record, Dr. Devereaux has allowed you an opportunity to examine the document.

MR. MEADOR: I'd like to get a copy of it so I really could examine it.

THE WITNESS: You couldn't read it. I can barely read it.

MR. MEADOR: I would say that it should be preserved as evidence and I don't see how it would hurt you in any way, Doctor, by preserving it.

THE WITNESS: Fine. I mean, this is just silliness really.

Q The notes here, I have a question regarding the top area here where you have reference to days, where the patient couldn't open her mouth, and I wonder if you could read that again, where it says --

A Yes, all right,

MR. DeSANTIS: If there's any doubt about what your writing reflects, you can refer to your report.

If you just can't read it, you

can't read it.

A I can't read my writing. I just say she had bad pain, couldn't open mouth.

Q Is there a time as to when the patient said that that occurred?

A Let's see. What did I say here?

A It was approximately -- she developed pain in the right side of her face. I say about three or four days later is what I put in my notes here that she developed difficulty opening her jaw, about the time the pain began.

Q That's what you have in your report?

A That's right. I stand by my report.

Q I understsand that. Is that what you have in your notes?

A I can't read my notes well enough to see if that's what I was saying. I just can't.

Q You also talk about numbness, I think, in your notes?

A Seven days later, she had a good deal of pain and perhaps I think I said one to two days after that, she started developing numbness.

Q Okay. The seven days later is meaning seven days after she developed the pain, which was three or four days after the extractions; is

that what your notes mean?

A No. I'm going from the time of the extractions.

Q Okay. So, the seven days later, which is referenced in your notes, goes to seven days after the extractions? If you don't know --

A I can't read my notes, I just don't know. I live by this is what she told me right here. Okay.

I just can't read scratch notes to me, that I may have? made some points, I may have asked her questions latex on which I didn't write down here that then led to my final report, This is what I believe she told me.

There's no ulterior motive in this,

Q Well, my point is, I'm not saying there is, but why destroy whatever evidence you might have of your notes?

A I usually don't, I don't keep scratch notes in my charts, whether it's legal or not legal. I just don't do it.

Q You do know that a lot of doctors keep the notes that they use when they examine --

A A lot of doctors don't write seven page single space notes.

Q That's true, I agree with you.
A Including your own expert.
Q That's true.
A That's the difference. That's -- this is not a legal -- this is what I normally do. You can go into my charts and you can see. I write very lengthy notes.
Q The other notes that you had regarding your examination, you said, were destroyed?
MR. DeSANTIS: He said he thought they were destroyed.
A Well, I can't recall how many pages I kept.
Q When were those notes destroyed?
A When I did the dictation. The only reason I kept this is because it's my face sheet.
Q Okay. Can I have copies, then, of everything else that I've laid out in front of you?
A Absolutely.
Q Besides the one page note which I'm not going to get a copy of apparently?
A You may.
Q Okay. You indicated that you have testified before in court; is that correct?
A Yes.
Q How many occasions have you testified in court

before approximately?

A It's -- by "in court," do you mean actually in a court of law or including depositions?

Q First I'm going to ask you about in the court of law?

A I've done it once this year, this calendar year. I would guesstimate that in the eleven years I've been in Cleveland, almost twelve, I've probably gone to court six, seven times maybe. Maybe eight.

Q And there was one occasion on which *you* were cross-examined off of your notes and it was not a very good experience, I take it?

A It was a disservice.

Q And you believe that's --

A It didn't help him either. He lost.

Q And you believe that your report would have been a more accurate --

A Absolutely.

Q -- method for the attorney to question you on?

A Yes.

MR. DeSANTIS: Objection. Go ahead.

A Uh-huh.

Q Your answer is yes?

A Yes.
Q Which case are you referencing that you had this difficulty with?
A Oh, it's been --
Q The cross-examination?
A -- eight years ago, nine years ago, in a court hearing or a court case that was probably in Geauga or Lake County on a patient with purported thoracic outlet syndrome.
Q Do you remember the name of the patient?
A No, I quite honestly don't.
Q Who did you review the case for, the plaintiff or the defendant?
A I was the -- for the defendant.
Q And you don't recall the name of the defendant either; is that correct?
A No.
Q Do you recall the name of the defense attorney?
A No, I couldn't tell you to save my soul.
Q How many depositions have you given testimony in?
A Well, I probably have averaged, over again the twelve years I've been here, two or three a year. That's a guess.

Q Bo you know the names of any of the cases in which you gave depositions?

A Of the individuals?

Q Yes.

A The patients?

Q Yes.

A I don't know that it would be appropriate to mention them if I could.

I mean, I can name some of the attorneys, but I bluntly can't -- I just can't sit here and remember the names of the people involved frankly.

If you want the names of some of the attorneys --

Q Do you keep a record of the cases in which you review?

A They're in my files.

Q Is there a way that you could find out the names of the cases in which you testified in?

A Probably.

Q Would you be willing to prepare a list of those cases?

A Of all the cases that I've done legal?

Q We'll, we're talking about two or three depositions per year and I don't know whether

or not you keep your records for the eleven or twelve years you've been in Cleveland. We're talking about 20 to 25?

A It would mean going through a series of charts -- I mean, all of my case records, pulling them out, checking to see if there was a deposition involved or if it was just a case that I rendered an opinion on and it never came to court. It's going to take a lengthy amount of time.

Q Can it be limited in a way so that you would only look back, say, to the last couple of years?

A No. We don't keep records by year. We are now, but we didn't tken. so, I would have to go through the charts in alphabetical order.

The charts do have a different color when they're legal, so that they could be pulled out, and then we'd have to check and see which cases I did depositions on.

Q Would it be too much trouble to ask you for the names of two or three cases in which you've done depositions instead of asking you all the cases?

A I think that can be done, but I'd be curious

to know, first of all, if that was appropriate to release the names of people to you, even though I realize this is a legal setting, I don't know whether that would be appropriate, and I'd like to be advised about the appropriateness of that and the acceptability of that, number one.

Q I give you that opportunity. I don't want you to do something that you feel that you're releasing confidential information.

A I don't know.

Q If a lawsuit has been filed, it's a public record at that point, A versus B, and what I would like to do is just get the names of a couple of those cases in which you gave depositions and to make it easy on you and your office, I'm asking you for the names of, say, two or three different cases where you've given depositions.

A May I ask why? I've never had that asked of me.

Q Well, I'll tell you after we're done with the deposition, I'll be glad to tell you.

A All right. I think that that can be arranged. It's going to take sometime.

Q Well, you can get back to me or get back to Frank.

A It will involve some expense on your part.

Q Well, you can let me know what kind of expense it will be and we can go from there.

MR. DeSANTIS: Let me, just for the record, so it's clear, Doctor, you're not agreeing to do that, you're agreeing to look into whether there's any legal impediments to doing it or whether you have any legal obligation to do it, neither of which will I advise you, but I would encourage you to seek that kind of legal advice on your own. Is that accurate?

THE WITNESS: Fine.

Q How many cases have you reviewed over the last -- you say you've been reviewing cases for eleven or twelve years; is that correct?

A Oh, I've been here for almost twelve years, twelve years next July and I certainly didn't do anything initially, so I can't really remember when it was that I started seeing cases and I've seen cases in a rather modest trickle since then.

I try to keep it to a minimum. So, I really can't tell you how many because I don't keep records like that.

As you know, many cases don't come to court, don't come to deposition.

Q Well, my question has to do with cases you're asked to review, not so much the number of depositions or the number of times you've testified in court because you've already told me that you've given approximately two or three depositions per year?

A I'm guessing.

Q Since the eleven or twelve years you've been here and when I -- when you say been here, I'm assuming you mean in the Cleveland area; is that correct?

A Yes, sir, Mt. Sinai Hospital.

Q And you indicated that you've testified in court maybe six, seven or eight times?

A Something like that.

Q And my question really had to do with how many times you've been asked to review a case for attorneys in connection with litigation?

A That would be more than two or three times a year. Probably, as a guess, six or seven

times a year.

For example, I reviewed the first case for an attorney this year today. That's the first case I've done in 1989 was today. Just happened to turn out that this deposition was the same day.

So, at that rate, it would be four this year. I don't do a great deal of legal work. I keep it under -- keep it to an appropriate minimum so it doesn't look like I'm doing too much quite consciuosly. I also make a conscious effort to do both defense work and plaintiff's work.

Q Can you give me a percentage?

A I probably do about, oh, three out of four cases I see are for the defendants. Probably 75 percent defense, 25 percent for the plaintiff.

If that's an error, it's probably an error that would be more than 75 percent for the defense.

Q Of the twelve years that you've been in this area, you said you didn't remember when you first started reviewing cases?

A It was probably several years, I would guess.

Q After you had been here three or four years is when you started roughly?

A Well, I don't -- it's not the kind of information I store, so I'd have to check and I honestly don't know. I wouldn't want to mislead you.

Q Since you've given depositions before, I'm not going to go through all of the ground rules, but, of course, if you don't understand one of my questions, feel free to tell me because I really don't want you to answer any questions that you don't understand.

In addition to that, if you are giving me a guess on something --

A I will tell you.

Q -- or kind of speculating without being able to say to a reasonable degree of medical certainty, I'd appreciate it if you could let me know that we're in that sort of an area.

A Absolutely.

Q How did you come about to be contacted to review this matter?

A That I really can't recall. I must have been contacted through the law firm, however, and not by the patient.

Sometimes a patient comes to me and I find out later it's a legal case. Because of my initial face sheet, I'd say the patient was referred by a law firm. That is your law firm.

Q That would be Kaufman and Cumberland?

A Yes. And it would have been the letter that I wrote to Mr. Richard Zeiger, but I cannot recall whether they just called my office and asked if I could see a case, that's what frequently happens, and if I'm not doing too much work, I'll say yes and if I am doing too much work, I'll say no and it was probably something to that effect.

Q Prior to your reviewing this ease, had you ever reviewed a case for Kaufman and Cumberland before?

A I honestly don't know.

THE WITNESS: Have I?

MR. DeSANTIS: It's not my deposition.

A I honestly don't know,

Q Do *you* know any of the attorneys at Kaufman and Cumberland on a -- for any other reason other than this particular lawsuit?

A No, although I can't swear to you that I haven't spoken to them before, involved in another case before. I know I never met you before today, Mr. DeSantis, so, no, I haven't had any close contact with their firm and I wouldn't be a bit surprised if this is the first case I've seen for them. I just don't know.

Q You look at the letterhead here and you see the attorneys listed in that firm?

A Yes.

Q None of them are recognizable to you; the name, that is?

A No, not right off the top of my head.

Q What about Charles Young? He's not on there, but I think he was with that firm. Did you know Mr. Young?

A I can't recall right at this moment.

Q Do you know when you were first asked to review this case?

A Well, it would have been sometime probably -- I saw the patient August 19th, 1988.

It would have been sometime probably several months before that because my waiting list to see patients is usually several

months, particularly for non-emergent cases and so, I would imagine sometime in the early summer or spring of 1987.

Q Do you believe you were contacted by phone by an attorney at that time; as far as you can tell?

A As far as I can recall. They may have called -- that's often what happens. Sometimes my secretary will then tell them, "Well, send a note and we'll look at the case," because I generally will not see every patient. If it doesn't look like it has any merit, I will not become involved.

a Did you also review records when *you* prepared your opinion?

A I absolutely did.

Q And the records that you've reviewed are contained on your report dated August 19th, 1988?

A Correct.

Q Can we mark your report so that we've it clearly identified on the record?

A Sure.

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(Defendant's Exhibit A marked for

identification purposes.)

- - -

A One thing that would be worth noting, perhaps, since we're into a lot of technicalities, I made a few penciled in corrections because of some punctuation errors, and so forth, which I have checked here.

Did not change the report in any way, just changed the tense of a few verbs and if that's an issue, I'll let you know,

Q Does that -- that shows up on the copy that you have?

A Yes.

Q We can make a copy of that and I can see what your changes are.

Maybe I should just look at them and see if there is anything I would think would be noteworthy. Otherwise we can just go on.

A Mainly the kind of things that my 7th grade English teacher, Miss Butz, would like me to correct.

Q Thank you, According to your report, which we've marked Defendant's Exhibit A, you said %hat was your only report and that contains a11 of your opinions that you'll be giving in

connection with this lawsuit; is that correct?

A Correct.

Q Your report indicates you reviewed the Hillcrest Hospital chart, the report and notes from Dr. Cole, the office records from Dr. Chepla and the office records from Dr. Sangrik?

A Uh-huh.

Q Are there any other records that you reviewed or any other materials since you prepared your report?

A The only other thing that's already mentioned was the report that was handed to me today from Dr. Donald Mann, a neurologist in the community who I know well.

I don't believe any other information has been sent to me since this initial packet was received.

Q How is it that you know Dr. Mann?

A He is a neurologist in the community, associated with University Hospitals, as am I, and I have seen him from time to time.

I have even sent him cases for legal work when I have felt that I shouldn't take anymore, and other cases as well.

Q What is his reputation in the community?
A He's a competent neurologist.
Q And you know Dr. Cole, I take it?
A Very well.
Q And how do you know him?
A Again, he is a neurologist who's had a strong association with University Hospitals and Metropolitan General Hospital for years; again, he was here when I came here.

I'm not quite sure how long he's been here, but he is a highly regarded neurologist in the community.

Q Do you know either of those doctors on anything more than just a business level?
A Both of them have been to my house on occasion for social gatherings of the Department of Neurology, things of that nature.
Q You don't -- you never knew Kathleen Nabozny prior to seeing her; is that correct?
A Absolutely correct. I seen her one time.
Q I assume you don't know anyone else in her family?
A Not to my knowledge.
Q Do you have a current resume of your academic --
A Curriculum vitae, sure.

Q -- credentials and your work experience?
A I do,
Q so, to save time, could we --
A I'll be more than happy to send you a copy.
Q Do you have a copy of it here that I might look at to see if there's anything that I have to ask you about it?
A Not with me and, frankly, my secretary, now that it is six o'clock, is gone. Almost six o'clock, and I don't know where they file them.

If it's important, I could take a break and go to the office and see if I can find a copy.

Q Well, I think to expedite matters, maybe if you would just send it to me, if you could just give me a general overview of your academic credentials and your work experience without going into every detail since I will have your resume, but I would like you to particularly emphasize anything that you believe to be particularly helpful to you when you reviewed this case.

For example, if there's a particular publication that you were responsible for, you

worked on or some kind of a project that you were involved in, I would like you to emphasize that, please.

MR. DeSANTIS: Off the record.

- - -

(Discussion had off the record.)

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A You'd like me to give you my CV starting basically with college?

Q Yes, please.

A I graduated from Stanford University, California in 1964. I graduated from medical school from the Baylor College of Medicine in Houston, Texas in 1968.

I did an internship in medicine at U.S.C. Los Angeles County General Hospital in '68, '69. Three years of neurology residency at the same institution, and then an additional year of neurooptholmology fellowship at the same institution.

I then spent two years at the Philadelphia Naval Hospital where I was chief of neurology, fulfilling my obligation in the military from '73 to '75 and in '75, I went to the Neurologic Institute of Columbia College of

Physicians and Surgeons in New York where I was a fellow in clinical neurophysiology.

I spent two years there, the last year as assistant professor of neurology at Columbia. I then came to Cleveland in July of 1977, I came as the chief of the Division of Neurology at Mt. Sinai, the assistant professor of neurology at Case Western University.

I have been here now for almost twelve years. I am now the chief of the Division of Neurology at Mt. Sinai, the associate director of the Department of Medicine and associate professor of neurology at Case Western Reserwe University.

I have published, most of my publications deal with neurooptha lmology, opthalmology and disturbances of the eye.

I have not specifically published on dental neurologic disturbances, if you will.

I have indeed lectured a good deal to dentists, mainly through our residency program in dentistry and oral surgery at Mt. Sinai.

I made videotapes of physical examinations, and so forth, for them for meetings. That's probably my main interaction

with dentists through the teaching program here and also through referrals between myself and dentists over the issue of temporomandibular joint syndrome and other kind of conditions which exist somewheree between neurology and denistry.

Q Do you have a board certification?

A I'm board certified in neurology. I am board certified by the American Board of Qualification in EEG.

I am board qualified, but not certified in EMG.

Q Do you have a private practice?

A Yes, I see patients in private.

Q Where is your private practice?

A At Mt. Sinai, in the Division of Neurology, in the Department of Medicine at Mt. Sinai.

Q How much of your time is devoted to private practice versus --

A Teaching?

Q Teaching.

A Oh, I would estimate 25 -- well, no, probably a third. Probably 33 percent, if I were to give you a rough figure.

Q Thirty-three percent of your time would be

spent in --

A Pure private practice, yes. The other is involved in indigent care and teaching, and so ≤or h.

Q How much of your time, percetage wise, would be involved with teaching?

A Probably a third.

Q Then the other third would be the indigent care?

A Well, that's involved really in the teaching, to a great extent.

The other third would be in administrative work, lecture preparation. Of course, that would be included in teaching, that sort of thing.

Q Your private practice, what kind of patients do you see?

A Patients with neurological problems.

Q And the teaching, what areas do you teach in?

A Neurology -- depends on where I'm teaching.

At the medical school, to the sophomore class, most of my lecturing is in the area of epilepsy and related problems.

To medicine residents, it's general neurology. To neurology residents, it would

be general neurology, epileptology and neuroophthalmology, areas that I have training, and it depends pretty much on the audience.

Q During the course of your private practice, have you treated any patients with the same kind of problem that Kathleen Nabozny developed?

A A facial abscess following dental extraction?

Q Yes.

A No, not that particular situation, as far as I can recall.

Q Have you ever seen a patient who was diagnosed with the same diagnosis that Kathleen Nabozny was eventually found to have?

MR. DeSANTIS: Objection. Go ahead, Doctor.

A I genuinely can't recall that. I have certainly seen patients with facial abscesses. That's not rare. Although it's relatively uncommon, the reason it is not rare is that a significant percentage of the patients I take care for, the teaching services are indigent and do not receive good dental care and so I've seen a modest to moderate number of

patients over the years with dental abscesses of one type or another, producing headache and other general problems.

So, from the neurologic perspective, I can assure you that there have been many a patients I have seen with headaches I have referred to dentists for evaluation, some of whom have turned out to have abscess; certainly not all, but it is something that I am familiar with.

Q With facial abseesses?

A In association with neurological problems, it is something that I have seen, but primarily in my indigent population, but not solely.

Q Have you seen any patients with a pterygopalatine abscess after a dental extraction?

A Probably not.

Q Have you seen any patients with a pterygopalatine abscess, regardless of what the --

A Yes.

Q -- prior procedures might have been?

A Yes.

Q On how many occasfons have you seen a patient?

A I couldn't tell you. Infrequent.
Q Less than five patients?
A Probably. And those were -- if I recall correctly, I don't think any followed dental extraction.

Most of those were related to cancers and other situations, facial tumors and what have you.

Q Would you agree with the statement that a pterygopalatine abcess infection is rare?
A Of course rare is a nonspecific term. It is certainly not a common problem.
Q It's not common, you're not going to say that it's rare, though?
A Well, I'm just -- what's the difference between -- when you define the difference between uncommon and rare, I'll answer that.

These are nonspecific terms. I have told you that in twelve years, I've seen less than five patients, certainly Eess than five patients with pterygopalatine abseess.

That's a fairly, you know, direct statement, that it's a very uncommon problem. It's probably safe to say it's a rare problem, whatever rare means.

E Q You wouldn't --
2 A It's not unheard of.
3 Q You wouldn't be surprised if in the 31 years
4 of Dr. Cole's practice, he has never seen a
5 patient other than Kathleen Nabozny with a
6 pterygopalatine abscess infection?
7 A No.
8 MR. DeSANTIS: Objection.
9 a I wouldn't be surprised at all. Actually that
10 speaks to his skill.
11 Q Did you review or rely on any medical
12 literature when reviewing this case?
13 A No, not in -- well, not in the initial
14 eparation. I did rely on the literature
15 when I reviewed some of the subdivisions of
16 the mandibular division of the trigeminal
17 nerve in terms of the names of some of those
18 divisions, and so forth. Yes, I did rely on
19 the literature for that.
20 Q That was for the purpose of identifying those
21 subdivisions of the mandibular division of the
22 trigeminal nerve?
23 A Yes. Specifically I had to recheck the names
24 of the nerves from the posterior division that
25 innervated the auricular region, the ear.

Q That would be --
A The auriculotemporal division of the posterior division of the mandibular division of the trigeminal nerve.
Q If I understand what you're saying, you needed to look it up in the book for your impression, which is on page six, where you identified all of the various divisions and subdivisions of the nerves that you believe may be affected; is that correct?
MR. DeSANTIS: Objection. Go ahead and answer.
A Yes, the specific names.
Q But other than for looking up those names, you didn't have to refer to any other medical literature to review this case and prepare your opinions; is that correct?
A I believe that that is correct.
Q Okay. Looking at page one of your report, the hospital chart from Hillcrest Hospital was one of the items that you reviewed?
A Correct.
Q Is there anything that you are aware of that was particularly significant that was found in the Hillcrest Hospital record?

MR. DeSANTIS: Objection. Go ahead and answer, if you understand the question.

A I frankly can't recall, as I sit here today, anything that dramatically comes to mind from that record.

Q What about the second item that you reviewed, Dr. Cole's report and his follow-up notes?

A Uh-huh.

Q What was significant in Dr. Cole's report and notes which impressed you?

MR. DeSANTIS: Objection. Go ahead and answer.

A Well, the thing that impressed me more than anything was his -- more or less, I guess, indicated in his notes was the fact that he was smart enough to recognize a problem when a patient called him blindly who was not referred, since neurologists, including Dr. Cole, do predominantly referral work from other physicians, have the patient seen at five o'clock in the afternoon and admit her to the hospital prompt.

That was the most impressive thing about his --

Q Is there anything else in his notes that was particularly impressive to you in connection with your preparation for your opinions in this case?

A Well, the other thing, I mean good neurology always impresses me and this is excellent neurology. He made on the basis of a history and physical examination a diagnosis that was correct.

Q I believe that on page two of your report, you indicate that Dr. Cole correctly diagnosed a extracranial infection on the right side of the face?

A Uh-huh, extracranial.

Q And I was wondering if that was Dr. Cole's diagnosis?

A At the time he saw her --

Q At the time he saw her or was that something that was later on found by him?

A That is correct, that is probably something that was found later on and in reality, what he stated was that it is imperative to rule out an infection and he had -- he did say, which *is* probably extracranial rather than intracranial.

So, from that, I just made the point that he correctly diagnosed an extracranial infection, but in reality, he said that's probably what she had. He didn't say an absolute diagnosis. I still give him an A.

Q Was there anything particularly impressive about Dr. Chepla's notes that you reviewed regarding the opinions that you've prepared in this case?

A Nothing that comes to mind as I sit here.

Q What about Dr. Sangrik's notes, the other dentist?

A No, nothing that I can recall specifically.

Q Let's look at page two of your report. You start with a subtopic called "Present Illness," and you have the first paragraph of information, and I'm wondering where that information came from in that first paragraph of page two.

A From the patient.

Q So, in other words --

A That's a very traditional introductory statement in the present illness of a history and physical examination, which is a way of stating that the patient's problem began on

July 8th, 1986, at least this is -- this was my impression of when the problem began, so that there was nothing in her history of conseqence prior to that time and that's when I begin my discussion,

Q Okay. And that's your first sentence that "The patient was in her usual state of health until July" --

A Stable health.

Q "Stable health until July 8, 1986 when she underwent multiple tooth extractions," parenthesis, "ll because of sensitive dental caries and periodontal disease."

Then you go on to state that "The patient states in three to four days, (4 days according to Dr. Cole's report,)" close parenthesis, "she developed pain in the right side of her face."

That is something that the Plaintiff told you, three or four days?

A She told me that, and then I looked at Dr. Cole's, and that's why as I say, I try, although I don't consider it terribly important, you obviously do, I try to keep it separate.

The patient told me as best as she could remember about three or four days later and when I went to Dr. Cole's report, I see it's four days later, so her recall is pretty good on that point.

Q Then she told you about that time or shortly thereafter that three or four day period, she also developed difficulty opening her mouth; is that correct?

A Yes.

Q And difficulty opening one's mouth is called trismus?

A Trismus, yes.

Q Is that your definition of trismus?

A That is the way I use the term, yes.

Q Do you have a different definition of trismus when it pertains to a neurological matters?

A No. I'm using it the way I would normally use the term here.

Q Okay. I don't want to put words into your mouth as to the definition of trismus.

What would be your definition in your own words?

A Well, that it refers to difficulty in opening one's mouth.

Q Okay. Then it says in your report, "Approximately ten days after surgery, she developed numbness in the right cheek and she was started on Keflex."

Is that also something that was told to you by Kathleen Nabozny?

A No, I don't believe that would -- she probably wouldn't have recalled the word Keflex. She --

Q Let's break up the sentence. "Approximately ten days after surgery" --

A "Approximately ten days after surgery, she developed numbness in the right cheek."

Q Where did you get that information from?

A From her.

Q And she used her word for -- she used the word numbness?

A Yes.

Q What is your definition of numbness?

A It's a difficult word to define, but it usually suggests a feeling of a lack of sensation that normal tactile stimuli are not felt. The tactile stimuli are not felt normally, that there's a decreased appreciation.

Q How does that term differentiate from the term

paresthesia?

A Paresthesia suggests a more positive sensation. Probably the best way I can explain that would be if you're talking about anesthetizing a nerve, the numbness is what one feels initially after the anesthesia takes place, when you can't feel much.

As the anesthesia wears off, there's often a tingling sensation, which at times can be uncomfortable. That would refer to the -- or would represent a paresthesia.

Q And the paresthesia would be synonymous with the tingling?

A More of a tingling sensation.

Q Are you critical of Dr. Chepla in his administering of Keflex at that time --

MR. DeSANTIS: Objection.

Q -- to the patient, that antibiotic?

A Yes, Keflex. Well, it's -- Keflex is a broad spectrum cephalosporin, which covers a number of organisms.

To specifically say that I am critical of him using Keflex would not -- would be wrong, I think.

Q Okay.

A I'm not specifically critical of him using Keflex.
Q What kind of bacteria did this patient become infected by?
A It was later proven that she had a staphylococcus.
Q Is Keflex an effective antibiotic to fight staphylococcus?
A It is not an antibiotic that you would use for staphylococcus. Once you identify, there are synthetic penicillins, and so forth, that you would use if you knew the organsisms.
Q Okay. I guess my question --
A I think that would be better directed to an infectious disease expert, but I think all of them would agree with that.
Q This patient was allergic to penicillin?
A Okay. Then you -- again, Keflex would not -- there would be other --
Q More effective antibiotics. What I'm asking you is whether or not you know whether or not Keflex does have an effect on this particular --
A It would have some effect on --
Q And I imagine --
A -- some effect --

MR. DeSANTIS: Gene, let him finish.

A It would have some effect on a staph infection.

Q And what effect would it have on a staph infection? A positive effect I assume we're talking about?

A Yes, it would be of some value, bud it would not --

Q Be the most effective antibiotic.

Then your report reads on, "About two weeks after the surgery, she noted numbness in the right half of the tongue and over the tight lower lip to the midline."

That information was from the plaintiff, Kathleen Nabozny?

A Yes.

Q Then it says, "Also about this time she developed tingling in the 4th and 5th digits of the right hand, and 4th and 5th toes of the right foot."

That information you also received from Kathleen Nabozny?

A Yes.

Q And do *you* understand that at the two week

period after the surgery, at approximately that time, that that's when she first noted numbness in the tongue, lip, hand and toe areas that are referenced here, about two weeks after?

A That's what I reported in my note.

Q Then your next paragraph is in regards to information that I assume you received from Dr. Cole's records; is that correct?

A Yes.

Q And that includes recitation of Dr. Cole's neurologic examination?

A Yes.

Q There are seven findings that you have chosen from Dr. Cole's examination.

If you would look at those seven findings that you chose and tell me the significance of each to you and why you decided to list these findings?

A Well, it isn't that they're so significant to me, it's that they were noted by Dr. Cole; so, that's why I listed them here. Do you want me to read the things?

Q No, I can read them. I was wondering if you could tell me what was significant, why?

I mean, Dr. Cole's records are about two pages of notes regarding this matter, and I was wondering why you decided to pick out those seven findings?

A Well, they're probably -- I'd have to look at his note again.

Q I'm going to hand you what's been marked as Defendant's Exhibit 3, which is Dr. Cole's typewritten note.

A His note is written in a paragraph form and so what I did was I went through and picked out what I call the positives, significant positives.

I don't list things like the blood pressure and that's olfaction, smell was intact, pupillary functions were normal. In other words, all of the things that were normal, and I went down and outlined the things that he found that were outside the range of normal, and those are listed here.

That's interesting reviewing my notes. I see there's one thing here that is not quite correct that he wrote down, but it's not important to the case, but these are basically the things that he listed as being positive

findings.

Q What were you referencing?

A I wrote in my note "absent deep tendon reflexes" and really it was absent deep tendon reflexes at the knees. Not a real issue here. She's obese and it's difficult to elicit reflexes.

Q These seven findings that Dr. Cole found, did you find any evidence in the records that you reviewed or in talking with the patient that any of these seven things were found prior to July 23rd, when Dr. Cole examined her? She was never given a neurologic examination prior to that time, I understand?

A That's my understanding, yes.

Q But I mean, is there any evidence that you've seen in the records to indicate that these seven findings were present prior to July 23rd?

MR. DeSANTIS: Objection. Go ahead, if you can answer.

A I don't list any of this having been present before that. It is conceivable in reviewing -- it might be an error there in terms of what the dentist may or may not have found in his

fallow-up exams that he had, but I don't recall.

She probably had some fullness in the face, and I'm not even sure of that.

Q Do you know whether Dr. Cole found any evidence of a fever on July 23rd?

A I do not recalf him recording a temperature. I would have been remiss if -- I don't think there was a temperature listed here, so I didn't make a comment one way or the other.

Q Is the finding of a temperature significant if it was found?

A Yes, it would be significant.

Q Why would it be significant?

A Well, it could be a sign of infection.

Q What about malasia, what is that?

A Malaise. Malaise is a term that is used to describe a patient having a lack of energy.

Probably the best definition is -- description for anybody reading this wauld be the kind of feeling you have when you have the Elu, you just feel lousy, lack of energy, lack of get up arid go, a lot of colloquialisms that people use and doctors use.

Q Would that be a significant finding that you

would have listed?

A It's not a finding so much as it is a physical examination. It really is more a descriptive term far a complaint that a patient would have.

Q And Dr. Cole's records did not indicate that complaint?

A I can't specifically recall whether he used the word malaise in his report at this point.

Q Now, Dr. Cole apparently was puzzled about the numbness that was apparently found in the right fingers and toes. Are you also puzzled by that?

A Yes.

Q Why is that so puzzling?

A Because it doesn't make sense,

Q Is that because there are different sets of nerves that would affect those regions of the body?

A Correct, and that is the art of good medicine, sorting through the things that are unimportant or as we say in the trade, the red herrings to get to the crux of the matter and that's what he did, Because that would suggest actually a problem in the high spinal

cord OK in brain and what it meant in reality, I cannot say.

Q You don't have any explanation for that today?

A No. I'm sure it was real and I'm sure it was there. I just can't explain it.

Q Take a look at page three of your report; you indicate in the second complete sentence on that page, "In addition, there was complete opacification of the right maxillary antrum due to sinusitis."

What is a complete opacification of the right maxillary antrum?

A The maxillary sinus on the X-rays appeared cloudy, meaning that it contained En this case material which would have suggested that the sinus wasn't draining, it was obstructed, and probably that there was pus in the sinus.

Q And you know that when Kathleen Nabozny was admitted to the hospital, she was administered Clindamycin; is that correct?

A ClEndamycin.

Q Is that an appropriate antibiotic for the kind of abscess that the patient had?

A Well, frankly, at that point, let me see -- yes, it was.

Q And why do you say that?
A Because she was seen by obviously skilled physicians who maintained her on the drug for 42 days and she got better.
Q We don't know whether another antibiotic would have worked quicker, do we?
MR. DeSANTIS: Objection.
A That is outside my area of expertise and I won't comment on that.
Q Very good. Let me ask you about the third paragraph on page three, in the middle of that paragraph, you have a parenthesis where you say, "I am not clear from his note as to whether she had objective findings of loss of sensation within the mandibular division of the right trigeminal nerve at that time."
Why don't you review that paragraph and tell me what it was that you were not clear about?
A Yeah. It was just from -- and again, this would have to be a question that would be addressed to Dr. Cole and it may have been brought up in his deposition. Just looking at his physical examinations, following -- in follow-up, I wasn't clear just from reading

his report whether there was loss of sensation in the area to his examination; i.e., he would have done a pin prick examination to see if there was a loss of sensation and I just wasn't clear on that point from his notes.

Q This is his note from September 22nd of 1986 you're referring to?

A He just wrote in his note, yes, that his neurological examination was otherwise normal and I didn't know, just reading it, what exactly that meant and that's why I put in "I am not clear from his note as to whether she had objective findings of loss of sensation," et cetera, meaning the results of his pin prick test which he didn't make absolutely clear at that point to another reader.

He probably knows well looking at his own notes, but I just wasn't sure. I suspect there was objective loss of sensation, but --

Q But you were confused because he said in there, "her neurological examination is otherwise normal"?

A Right. And I didn't want to read anything into the examination that would have been inappropriate for me to do, so I basically

just left it as a question.

Q I want to hand you what I'll represent to you is Dr. Cole's September 22nd, 1986 office note and I'd like you to take a minute to look at that, please.

A Yes.

Q Is it also confusing to you as to the apparent recurrence of the numbness?

MR. DeSANTIS: Objection.

A Well, see, this was the issue, she is complaining of bouts of numbness. Dr. Cole just does not list a neurologic examination of findings and that's why he says "her neurological examination is otherwise normal," and I don't know by that if he means that there was decreased pin appreciation over the same region that I found when I examined her.

I don't know what other comment that I could make. What she feels subjectively and what he sees objectively are two different things.

The patients may complain of bouts of numbness with objective findings of constant numbness and other patients may complain about numbness with no objective findings, so I

don't know the exact time course.

As near as I can tell, she had sensory loss before. Obviously, the question is did it get better and come back or did it continue.

I suspect it continued, but I can't be sure of that, so I made that very clear in my note.

Q Is that how you interpreted his notes, then, even though it seems to say in here, for example, the second paragraph on Dr. Cole's note says, "She is being sent for a CT scan of the paranasal sinuses"?

A Yeah.

Q "The recurrence of numbness" --

A Is a bit bothersome.

Q Is a bit bothersome and --

A What he is worried about is that the patient has some more complaints and his concern obviously by what he did was could she be -- could the abscess be reaccumulating, could she be developing a new problem or a recurrence of the problem. Again, I --

Q You did not interpret this note to mean that she had a period of time prior to this where

there was no numbness and then it came back?

A I suspected that that was not the case, but I was not sure. That's why I made it very clear so that there would be no confusion for anybody reading this about that.

The patient herself reported that she had had constant numbness to me.

Q Are your opinions regarding the permanency of her condition and the -- on causation as to her condition, are they based upon a continuous --

A No, not necessarily.

Q -- series of numbness?

A That would frankly not be my opinion. My opinion would be that her findings that I saw when I examined her were related back to the abscess.

Q What I'm asking you, is it important for you to have a continuous sequence of numbness without any periods of no numbness?

A Well, it would be nice to know that for sure, okay, it would be nice to know that for sure. That would be absolute proof positive that there was a cause and effect relationship, if it didn't get better, it didn't get worse.

But as I say, I'm not absolutely sure of that.

Q What if there had been a period from the time of her discharge until September 22nd, or shortly before that date, when Dr. Cole saw her again, where she did not experience any numbness?

A It wouldn't change my opinion. I still think that there is a one to one relationship between the abscess that she has and the numbness and subjective symptomology and objective findings when I saw her August 19th.

Q Is there any plausible explanation why she would have a period, if she were to have a period, without numbness?

A Well, since numbness is such a subjective phenomenon, I can only say that that kind of thing can happen, that symptomatology may become apparent to a patient when there was a time where it wasn't quite so apparent, both in the legal setting and outside the legal setting.

So, I didn't consider that a key issue in the meaning of her symptomatology when I saw her and her signs when I saw her with relationship to her original problem.

Q I take it the last paragraph on page three is where you start your findings based upon your examination of her; is that correct?

A Yes. That -- not my findings on examination, but that is basically, that's where I begin the statement about the symptoms that she had when I saw her.

Q And those symptoms that she had when you saw her were based upon your examination of her?

A Well, this is based upon my history. This part of the examination is where she is telling me about her problems, the neurologic examination begins at the bottom of page four.

Q So that all of the paragraphs starting with the last paragraph on page three and going up to where it says "Neurological Examination" on page four, those were all subjective information that was given to you by the patient?

A This is the history as is listed under the history of the present illness, into that category.

Q And that history was given to you by the patient?

A Correct.

Q In the patient's past medical history, is there anything in there of significance to you regarding your findings or opinions in this case?

A In the past medical history? I'm sorry.

Q Yes.

A No. It is -- the pernicious anemia, of course, was interesting, if you will, curiosity, but I don't think it has any relationship with her focal sensory complaints.

Q Why is it interesting to you?

A Well, it can produce neurologic phenomenology.

Q What kind of neurologic phenomenology?

A Generally it begins with problems in the lower extremities. The exact pathophysiologic disturbances are in dispute.

It may produce a peripheral neuropathy, as some would say, with numbness, tingling, loss of sensation in the lower extremities, impairment or loss of the deep tendon reflexes in the lower extremities.

It can also present as a spinal cord disturbance, so-called subacute combined degeneration and can produce disturbances,

again, which are characteristically seen in the lower extremities.

There also may be associated with it changes in cognitive function, sometimes referred to as megaloblastic madness associated in pernicious anemia with the changes in thought.

But there was no evidence of any of this in here and in fact, as I understand it, she was being treated with B-12, although at the time I saw her, I'm not sure if the diagnosis had ever really been established because there was suspicions on a first Schilling test, but I was not aware if this had ever been done.

It was supposed to have been repeated and I don't know that it was ever repeated and I just don't know if the diagnosis was fully established or not.

She was being treated for it, and B-12 is routinely administered to patients in our society.

I don't know what that -- it doesn't by any means prove that she has pernicious anemia.

Q Under your neurological examination, why don't

you tell me what you did when she saw you, what your examination consisted of?

A Well, it's a traditional examination. It would have been probably quite similar to the examination that Dr. Cole performed and perhaps that Dr. Mann performed and what I did was examined the cranial nerves, those are the nerves that exit directly from the brain to innervate the face, of which there are twelve pairs; her motor function, strength and tone in the extremities, coordination, this is pretty much self-explanatory, reflexes; namely, t e deep tendon reflexes, sensation.

Q Let's start with the cranial nerves; how do you test the cranial nerves?

A Well, it depends on which nerve. You begin, if you test cranial nerve one, which isn't routinely done, that's olfaction.

Q You didn't test cranial nerve one?

A No. It's frequently not done. If the patient has no complaints of loss of olfaction or smell, it's a pure subjective test and often people who smoke or have colds can't really be tested adequately.

So, it frequently isn't done unless

there's some reason you're looking for a problem with olfaction.

Q Let me ask you this. How did you test cranial nerve five?

A It is --

Q That's the only nerve I understand that's affected in this particular case; is that right?

A At the time of my examination. At the time of Monroe Cole's examination, there was a suggestion tht the 7th cranial nerve was also involved, but at the time of my examination, there was no evidence of involvement.

So, the only nerve in which I found any abnormalities was the fifth cranial nerve, trigeminal nerve.

Q How did you test that nerve?

A It is tested in several ways.

One looks, first of all, for sensation over the face. That's probably its major function, although it has some other very important functions.

It is responsible for sensation over the entire face, the -- to a certain extent, the top of the head, if you will, the mouth and

contents of the mouth, the gum, the tongue, the side of the mouth and buccal mucosa, the lips, to a point roughly down to the chin line, you know, along the undersurface of the mandible. That is its major function or one of its major functions I suppose is more accurate.

It also innervates the muscles of mastication, muscles that are involved in chewing, the temporalis muscle and the pterygoids.

It also is involved with the reflex of the cornea, referred to as a corneal reflex.

That's if you touch the cornea, someone will blink reflexly and that as in part monitored through the trigeminal nerve.

So, those were the kinds of things I checked, facial sensation, sensation in the mouth.

Q Is the trigeminal nerve another name for cranial nerve five?

A Right. That is the name, The numbers are really based on nerves as they exit from the brain, from the most rostral or top part of the brain to the most caudal or base of the

brain, roughly speaking, but each one of those nerves has an individual name.

Q Okay. You were telling me how you tested -- how you did your neurological examination of cranial nerve five.

A Right. The main thing I tested on her, because it's probably the most precise, in that it's a hard nerve to test all sensation, sensory modalities, is pin prick.

I often test face, so the main thing that I was testing was appreciation of the pin, how she felt the sensation, comparing side to side, looking at areas that would be the subdivisions of the trigeminal nerve.

Q As a practical matter, how do you do it? Do you have the patient stand in front of you, do you hold the pin, tell me?

A The patient is generally seated on an examining table and I use a safety pin and one begins then by comparing side to side, area to area.

Q What do you do, push the pin up against different areas of the face?

A Exactly.

Q Are the patient's eyes open at that time?

A I may test with eyes open or eyes closed.
Q Do you know how you tested Kathleen Nabozny?
A Usually both ways.
Q And do you cover all of the areas that the trigeminal nerve would --
A Correct.
Q You said the entire face is served by that nerve?
A Uh-huh.
Q So, you test at different portions of Kathleen Nabozny's face?
A Yes.
Q You did it on both sides?
A Correct.
Q And what did you find?
A The major finding was that there was a marked decrease in pin appreciation in the right mental region.

That corresponds roughly to the right side of the chin, the right lower lip, to the midline or to the middle of the mouth, the right side of the tongue and the right lower buccal mucosa, which is the inside of the cheek, if you will, and also the right gum to the midline.

That actually should read the right lower gum.

Q What should read the right lower gum?

A I just say right gum to the midline. That's the right lower gum. The right upper gum was not involved.

Q You say sensation was normal in the right mandibular region over the ramus of the jaw.

What area was that that was normal? I'm referring to the second sentence.

A The ramus of the jaw really refers to an area - how stall I describe this -- that is lateral to the mouth, what some people might refer to as the angle of the jaw, so that the ramus anatomically speaking would be this area right in here, looking at a skull.

So, along the mandible, along the jawbone, her sensation was normal until one got to the front of the jaw, if you will, in the chin region.

Q I'm going to ask you to do something that is not normally done in doctor's depositions, but maybe you could just draw a schematic of the face and the areas that you found to be affected adversely?

A The mouth is pretty self-explanatory, but if we're talking about the --

Q Draw a circle around the area, maybe we can shade it in, the area that you believe has been affected by the -- the areas that you believe to be a permanent problem for Kathleen Nabozny?

A Sure.

Q Would you put today's date and your initials on there so we know that is your creation?

MR. DeSANTIS: I presume you're going to mark it?

MR. MEADOR: Yes.

Q That will show the exterior areas that are affected. Obviously it doesn't show the right side of the tongue or the right interior gum line or the inside of the right cheek?

A Correct.

Q But are we saying that those areas -- would those be the areas internal to the exterior areas that you have drawn here on this sketch and let's mark this Exhibit B?

- - -

(Defendant's Exhibit 3 marked for identification purposes.)

- - -

Q Take a look at page six of your report. Can you tell me what an abscess is?

A Yes. An abscess is a localized, often somewhat walled off area containing what is commonly referred to as pus, which is usually a collection of white blood cells, often bacteria or whatever the infecting organism is, necrotic issue that was in the area that's been damaged by the inflammatory process that's involved with the formation of the abscess.

Q How would an abscess be differentiated from cellulitis?

A Cellulitis is a more diffuse process. There is -- itis meaning inflammation of the tissues, and one would not find frank pus if one stuck a needle in it.

One might find an area of inflammation and localized cellular response; frequently one might see, in fact, cellulitis before the formation of an abscess.

So, it has a less, well-defined -- it's a less, well-defined entity of no demarcations of pus, but usually it's seen by all of the

classic manifestations of an inflammatory process, rubor, tumor, calor and dolor; redness, swelling, heat and pain.

Q Those four symptoms are classic symptoms of an abscess?

A Well, of an inflammatory process.

Q Whether it be an abscess or cellulitis?

A Or cellulitis.

Q What is neoplasm?

A Neo meaning new, plasm meaning in this case cells. It is a term often used in association with cancer.

So, it really refers to the development of and growth of cells that are outside the normal cell lines.

It's again usually manifestation of a tumor, cancer.

Q I want to hand you an MRI report that is dated July 25th, 1986, regarding a scan that was done and there's a conclusion on there that -- which reads, "The MRI study is highly suggestive, if not diagnostic, of an abscess or inflammatory cellulitis in the pterygopalatine fossa on the right."

Is there any doubt in your mind that as of

that date, Kathleen Nabozny had an abscess or do you believe that because of this report, July 25th, 1986, or do you believe that there's also room to say that there may have been a cellulitis at that point?

MR. DeSANTIS: Objection.

A Well, I suppose --

Q Is that a distinction without any meaning?

A I think so, frankly. I think that really in this case is -- it's as much as a radiologist can say on the procedure and really it's, I would think, just difficult for him to say more than that.

So, he was careful enough to not say more than he should on the basis of the MRI scan results.

I don't think the distinction is terribly important to support it, from my perspective anyway.

Q Where is the pterygopalatine region and how does that affect the trigeminal nerve or how do the two interface?

A That's going to be difficult to put on paper.

Q Do the best we can.

A The word fossa suggests cavity, The

pterygopalatine fossa is an area --

Q And for the record, you have been nice enough to bring a skull?

A Human skull.

Q And you're going to point out as you testify, I imagine, these areas; is that right?

A Yes. It is an area that lies underneath and slightly lateral to the orbital socket, the eye, and --

Q How large of an area is it in most humans; give yourself a range, if you care to?

A I would say that you could -- we're talking in perhaps one to two centimeters in this area.

Q The fossa that we're talking about, the pterygopalatine fossa, then, would be on most humans beings an area of approximately one to two centimeters in size?

A Right. Probably the easiest thing to say, it's deep to the cheekbone.

If an individual puts his finger on the cheekbone and were to push that finger in, oh, perhaps four or five centimeters, an inch and a half or two, one would come in close proximity to the pterygopalatine fossa.

As I was saying, it is sort of to the

outside, underneath, if you will, inferior, slightly lateral and to the posterior part of the orbit, the eye socket. And that would place it in an area that would be again an inch or two, perhaps three or four or five even centimeters superior to the wisdom teeth, the back molars in the upper gum, if that makes any sense.

Now, haw does that relate to the trigeminal nerve? The trigeminal nerve again is a three part nerve, tri meaning three; geminal nerve.

The first division is not in question, that's the ophthalmic division, It leaves the skull through the -- into the back of the eye, the back of the orbit, to the superior orbital fissure.

The maxillary division, which is a second division to the trigeminal nerve, leaves the inside of the skull through the foramen rotundum, okay, the round hole, and that exits into the region of the pterygopalatine region, the fossa.

Q When you say exits --

A It enters through that region, it enters

through the floor of the skull.

Q That's where it exists and passes through the fossa that we are talking about?

A Passes near the fossa, right. It can be seen very deep to that fossa. Then --

Q How close does it pass through that -- to that fossa?

A Well, it's in -- it's hard to say. It's hard to place precise definitions on the boundaries, but it would be really at the medial aspect of the fossa, past the foraminal valley.

The mandibular division exits through the floor of the middle fossa of the skull through the foramen ovale, or the oval frame, and that one is clearly visible. It's a little easier to show, through here, and then the nerve then exits into the deep face, through the floor of the skull and then undergoes a series of subdivisions, branches, and so forth, so we have the --

Q Does it pass through the fossa, the pterygopalatine fossa?

A Not really through it. It passes out somewhat posterior to it and then branches come up

PAGE **85 MISSING IN ORIGINAL**

was purchased from.

Q And those pipe cleaners are supposed to represent the various branches of the nerve?

A No. These actually refer to other things. There's other foramina there, involved there. The carotid artery is represented by one of them. They're really not -- in fact, most of them have nothing to do with what we're talking about.

I brought this one in because it has a jawbone in place, a mandible; this other one does not.

Q Let's see if we can put this in even simpler terms.

The fossa, without using medical terminology, the fossa is like a cavity, right?

A Right.

Q And it's sort of a roundish sort of area?

A Correct.

Q It's in the deep spaces in the right cheekbone, if you'd go --

A Deep to the cheekbone.

Q -- if you go one and a half to two inches deep, you would be in the area of that fossa;

is that correct?

A Correct.

Q And there are two divisions of the trigeminal nerve that pass in the area --

A Region.

Q -- or the region of of this fossa; is that correct?

A Correct.

Q And the two divisions are the maxillary division and the mandibular division?

A Correct.

a And neither one of these divisions actually pass through the fossa itself, but they either themselves or their branches go in the region of that fossa; is that correct?

A Well, the -- there would be some branches, the greater petrosal nerve would be actually involved with the maxillary division five and that would come close to being in the pterygopalatine fossa.

Q The petrosal nerve?

A Is not involved here.

Q I'm only asking you about the nerve that is involved here, which is the trigeminal nerve and all of its -- some of its divisions; is

that right?

A Correct.

Q Can you tell me how close the maxillary division of the nerve passes to the fossa itself?

A Well, we're dealing in terms of millimeters, very small area.

It is along, again, the medial surface. One thing that needs to be stated here is we're not -- we're talking about multiple branches that immediately start spreading out, so this whole area is covered with a number of branches of both the mandibular and the maxillary division, which really can only be appreciated in anatomical drawings.

In some of those branches, probably, frankly, more from the maxillary division than the mandibular division, which is a little bit more lateral to this area, would come closer to passing through the pterygopalatine fossa.

Q Okay. And it's your opinion that there is permanent damage to the maxillary and the mandibular divisions of the trigeminal nerve for this patient?

A No. I thought that objectively, the major

involvement was in the mandibular division. The maxillary division was spared.

Q That's why your impression, which is on page six, only talks about neuropathy to the mandibular division?

A Yes.

Q Then you've indicated that you looked up all the various subdivisions within that division that were affected?

A I reviewed, yes, some of the anatomy of the mandibular division, some of it particularly with regard to the ear.

I was less familiar with them than with the jaw.

Q And it's your opinion that these nerves were affected because of an abscess in the pterygopalatine fossa; is that correct?

A It's difficult to say precisely because there was infection outside of the pterygopalatine fossa. The temporomandibular joint appeared to be inwolwed.

Q How do you know the temporomandibular joint was involved?

A Well, at least from what I gathered, surgeons were called in to aspirate the jaw, the TMJ

joint.

My feeling is that there was probably abscess formation, but then the term that you brought up, cellulitis, probably evidence of inflammation and infection that were located beyond that area.

For example, the maxillary sinus, we've already talked about, was opacified and had to be subsequently drained, as I understand it, and that there was probably involvement back into the region of the temporomandibular joint, which is near the ear, so that whole area was involved and so its difficult, if not impossible, to define the exact margins.

The actual area of pus was, from the information I have, localized to the pterygopalatine fossa, but there were other areas of involvement outside of that.

Q Were you also aware of fluids and pus-like materials in the sinus?

A Yes, in the maxillary sinus.

Q Do you know which came first, the fluids in the sinus or the pus and whatever materials were in the abscess?

A No, no way of knowing. I don't think -- that

would be impossible to know.

Q So, you don't know if this infection started in the sinus region and then affected the fossa region?

A No, I don't know how it spread.

Q Are you knowledgeable with respect to what kind of infection the staphylococcus bacteria will cause?

In other words, the progress of that sort of an infection?

MR. DeSANTIS: Objection. Go ahead and answer, if you can.

A You mean whether it's rapid or not so rapid?

Well, it would frankly depend on a series of things that could happen. It could be relatively indolent and stay around for a long time before becoming evident or it could be a rapidly progressive. It depends on the host, resistance and it depends on whether or not the patient becomes septic, it gets into the bloodstream.

I mean, something like this can go to the meninges and produce meningitis, so it's a very difficult question to answer why some people have an organism that stays localized,

or maybe even a host that kills it off, and other people die faced with the same organism.

It's probably some chance how it spreads when it gets into the -- into the blood vessels and spreads throughout the body, a host of factors.

Q That question would be better directed to, say, an infectious disease specialist; is that correct?

A Certainly.

Q Do you know where the source of Miss Nabozny's infection came from?

A Well, again, the presumption is that it is related to the dental procedures that she had.

Q And I'm not sure where you got that presumption?

A It's my presumption, cause and effect relationship on the basis of her having the dental procedures and then over a relatively short time developing problems which subsequently led to the diagnosis of an abscess in the region of the work that was done, so it's strictly, as is the case often in medicine, observational cause and effect.

Q Let me ask you this. Did you know that

Kathleen Nabozny also was found to have a sinus infection when she was admitted to the hospital?

A Oh, you mean the maxillary infection that we already talked about?

Q Yes.

A Yes, absolutely.

Q What I'm asking you, is that a cause of the dental extractions?

MR. DeSANTIS: Objection. You can answer.

A My presumption is that the infection throughout the right side of the face was related to the dental extractions, including the abscess into the sinus or the infection, I should say, into the sinus, as well as the facial infection.

My impression from the information I reviewed, that was all related to the same process.

Q But if you don't know what came first, the sinus infection or the fossa abscess, how can you rule out the possibility of there being a sinus infection then carrying over into the other regions that were affected?

MR. DeSANTIS: Objection. Go ahead and answer.

A Well, there was no clinical symptomatology before that.

Quite frankly, had there been, the dentist should not have been doing dental extractions in the face of a sinus abscess.

He himself -- and that would not have been in the best interest of good medical care.

So, my presumption is that even her dentist didn't recognize any problem like that before because one would not want to remove teeth in the face of an infectious process.

Q Because of all of the factors involved that you talked about regarding a staphylococcus infection, you're not able to say with certainty, then, how quickly it progresses; is that a fair statement?

MR. DeSANTIS: Objection.

A You mean in all cases?

Q Well, in Kathleen Nabozny's case, for example? Are you able to say when she was infected and to the day what occurred after that, with respect to her infection?

A Oh, I see what you're saying. No, I can't say

when the first staphylococcus organism entered into the tissue and began to multiply.

Q Can you say when she had the abscess, when the abscess developed?

A When it would be defined as an abscess versus cellulitis? No, not precisely.

Q Can you say when it was cellulitis?

A You mean how soon after the dental procedure did she --

Q Or before the dental procedure. I'm not going to limit you to time after the dental procedure.

A I suspect that is correct, on the basis of her history, probably began to have manifestations of the infection, in retrospect, probably about three to four days after the dental extractions,

Q Okay. And how are you able to say that?

A On the basis of the patient's complaints.

Q What specifically would this patient have had three or four days after the dental extractions?

A She would start to develop pain.

Q What's happening inside, though? Is that when she had cellulitis three or four days after

the extractions?

MR. DeSANTIS: Objection. You asked him two questions. Which one do you want him to answer?

A The -- well, let me just try to answer it anyway.

I am surmising that when she began to complain of increased pain, that being one of the manifestations of the inflammatory response, when she started to have increased pain three to four days after is when she started -- when her infectious process started to manifest itself.

Now, I cannot tell you that at that point, she had abscess or cellulitis or what. My presumption would be that she would not have had a frank abscess three to four days after the dental procedure, assuming the association, that that probably would have taken somewhat longer and that there was a period of generalized tissue inflammation, and that probably at a point somewhat further down the line that there was there the development of a frank localized pocket, if you will, of pωΞ, an ΞPscess.

But the exact time course I don't think -- I'm not capable of telling you exactly what the course was.

- - -

(Recess taken.)

- - -

Q Let me refer you to page six where you start with your comments. I assume, Doctor, that that's where more or less your opinions come into play in this report; is that correct?

A Observations, opinions.

Q Conclusions?

A Whatever the word comment means, but it has some of all of that,

Q And in your first paragraph under "Comments," you basically are saying that you don't have any doubt about the organic basis of the patient's symptom complex?

A Correct.

Q Which means what?

A Well, if we were just talking about a subjective complaint, a patient who comes in with a headache, there's no way of prooving or disprooving that on the basis of the history and physical examination.

The next step in my mind would be a situation where a patient comes in with a sensory disturbance. The patient could see they don't feel the pin in one area and they do feel it in the other, that's a very subjective experience. That's one of the reasons why I don't often routinely check olfaction. They say they can smell the chemical or they can't.

In this particular situation, I was impressed with her examination for very simple reasons. I don't think most individuals know anywhere near enough of their neuroanatomy to make this up.

I know medical students that don't know enough neuroanatomy to make this up, and so, that was one of the things that impressed me. Not only would she have to know the division, the mandibular nerve distribution, she would have to know the specific distribution, such as the mental nerve. Not many people would know that. This is not a lady that is medically sophisticated.

So, that was my observation and that is opinion in the first paragraph of the comments

that I truly believe that this is a sensory disturbance that is organically based.

Q Okay. How soon after the extractions did the first evidence of sensory disturbance manifest itself?

A Well, some of this was evident to Dr. Cole, I believe. Let me just peripherally look at my notes again.

Q I think you have it in your next paragraph, it says here the patient did not have any sensory disturbance on the right side of her face until approximately ten days after the dental extractions.

A Right.

Q Is that the first time, then, as far as you know, that the patient had sensory disturbance on the right side of her face?

A Correct.

Q And what do you mean by sensory disturbance?

A By that, I mean a complaint, something other than pain and this is where we get into the issue of numbness, which has a more -- more specific to nerve involvement than just pain.

Q And where did you get this information that it was ten days after?

A The patient's history that she said when she started to feel numbness.
Q And did you notice that Dr. Cole's notes also indicated that ten days after the extraction, the patient complained of tingling?
A I can't recall noting that. Actually -- and even that's not totally accurate, because as I mentioned in my initial impression, the patient was complaining of -- I'm sorry, my initial history --
Q Well --
A Let me put this back together if I may.
Q Let me show you what I'm referring to. Defendant's Exhibit 1, which is an exhibit that was marked at Dr. Cole's deposition, indicates on here Friday, July 18th, patient began with tingling feeling inside of face?
A Yes.
Q You saw this before, this report or this record from Dr. Cole?
A Is this his initial exam?
Q This is his record.
A Yes, I presume that I saw that, then.
Q It wasn't in your file here. Is there a reason why it's not in your file?

MR. DeSANTIS: Well, for the record, we took Dr. Cole's deposition long after a lot of this material was provided to Dr. Devereaux.

I don't know if some of the stuff you're referring to is some of the material that came into both of our possessions from Dr. Cole subsequent to the time it was transferred to Dr. Devereaux.

Q Well, I gues my question is I didn't see any material from Dr. Cole in your report.

MR. DeSANTIS: Other than the records that we already talked --

A His initial consultation report, what I have is listed in the first page here.

Q Okay. I stand corrected. There is -- you do have the typewritten page. Okay.

A Okay, yeah.

Q In any event, what I'm leading to is that Dr. Cole also had in his notes a tingling that was reported by the patient ten days after the extractions?

A Yeah.

MR. DeSANTIS: I'm going to object

to that. You're mischaracterizing. Those aren't Dr. Cole's notes. He testified that somebody else other than him took those notes and he didn't know who,

MR. MEADOR: That's something you and I can argue about, I guess,

Q In any event, that information was either given to you -- it was given to you by Kathleen Nabozny, though, ten days after?

A Yes, correct.

Q And you believe the reason why there was sensory disturbance at that time was because the -- you say the abscess -- it says, "Presumably the abscess had reached a size by that time to produce compression"?

A Yes, I did say that, And probably that's a little presumptuous on my part because, again, to presume the exact mechanism of nerve involvement, whether it: is compression, direct inf1ammatian and damage to the nerve from the inflammatory response is really unclear.

So, what the exact pathophysiologic process is, whether it's mechanical, I really don't know, I probably should have made that

more clear.

Q You're not saying for sure there was an abscess at that time, that's just one hunch of what may have caused the sensory disturbance at that time; is that correct?

A Yes.

Q Okay. And I mean, you said reached a size, but you can't size anything at that point?

A Correct.

Q So, if I asked you what the size of the abscess was at that time, you'd say you don't know?

A I think it would be frankly difficult for anyone to know, even the physicians who were working on the abscess at that point. It's not something that you can measure with a ruler.

Q So, whatever it is, you do believe that it is some sort of a compression, though?

A Well, I believe more accurately that it is part of the process and whether it's compression, inflammation, direct damaged nerve, I really can't say and I probably should have been a little more clear about that in this note.

Q What is the process we're talking about?
A The infection in her face.
Q Can you give me a chronology of how it follows along, what do you start with and --
A Okay. It would be a general chronology of the inflammatory process, and what would happen would be that there -- the organisms that would have escaped into the tissue, there then is a host response, which involves white blood cells and other areas coming to the area to phagocytize and other ways to try to fend off the organism.

The organism at the same time is multiplying and I suppose very simplistically stated, it becomes somewhat of a race between what the organism can do and can't do and what the host doesn't respond to, which includes the initial phagocytosis, the white blood cells coming in to consume the bacteria and ultimately even certain antibiotics and other kinds of, I guess, chemical and hormonal defenses.

The fever itself is a general response because raising the body temperature tends to inactivate organisms, although there was no

fever here.

Then this process spreads with resultant necrosis, tissue damage. That, in combination, as I already mentioned before, with the white blood cells and with the bacteria, forms actual pus, that leads to the formation of the abscess and then around that abscess certainly there would be abnormal tissue; i.e., inflammation, cellulitis.

So, that would have gone beyond the confines of the abscess into the tissues of the face and whether the nerves were damaged again by the actual compression of the abscess being consumed by the abscess, necrosis, other --

Q Consumed?

a Well, with the abscess corning around and literally destroying the nerve or whether it would be just the cellulitis with inflammation and death of the axons and Schwann cells which surround the axons and the nerve itself by compromising blood supply or what have you, I don't know.

I don't think anybody can be certain of that. So, as I say, that probably is not a necessarily incorrect statement, but it's

probably overly simplistic.

Q Can we say to a reasonable degree of medical certainty that the -- when the compression started on the nerve?

A No, I can't say.

Q You can't say that it started ten days after the dental extractions?

A Well, I would say there was involvement of the nerve ten days after the dental extractions and that was what was producing her numbness.

a But you're not going to say to a reasonable degree of medical certainty that the compression started on the nerve itself ten days after the dental extractions?

a I probably shouldn't say that because I'm presuming a mechanism that I can't really defend.

Q I understand, So, you can't say that the compression started ten days after the extractions to a reasonable degree of medical certainty?

A Or whether it was with inflammation or what, that is correct,

Q Okay. Take a look at the last page of your report, page seven.

I believe the first full paragraph on that page, you basically indicate the symptomatology and you also indicate in so many words that, "I believe that this is a permanent condition"?

A Yes.

Q Okay. Now, you are willing to give that opinion without examining her again, you're able to give that after your one examination?

A Well, obviously that opinion would be strengthened by repeated exams. No question about it.

But for the reasons I listed on the basis of one examination, that was my impression, yes.

Q Okay. And then the next paragraph -- the next paragraph where it says, "Although I admit to the ease of practicing medicine by hindsight, I do believe that had the problem been recognized sooner than 15 days postoperatively, she might not have been left with permanent damage to the mandibular division of the trigeminal nerve."

Now, with respect to that sentence, you say, I think you are assuming that the problem

was recognized 15 days postoperatively, being that that's the time that Dr. Cole examined her; is that correct?

MR. DeSANTIS: Objection. Go ahead and answer.

Q Is that your assumption, though, by that? I'll be glad to show you Dr. Cole's records.

A I just need the dates. That's all I would answer.

July 8th was the surgery, Monroe Cole's examination was the 15th -- I'm sorry, the 23rd and that's 15 days later,

Q Okay. That's what you're basing that on, then?

A Yes.

Q So, Dr. Cole recognized the problem 15 days after surgery.

You're saying that the permanent damage that she had might not have occurred if it had been recognized earlier; is khat correct?

A Yes, that is correct,

Q You're not saying as to when Dr. Chepla should have recognized the problem?

MR. DeSANTIS: Objection. Go ahead and answer.

Q I'm not asking you for that, if you don't have an opinion on that, but he's an oral surgeon and you're a neurologist and --

A It is difficult to say within, you know, a precise date the problem should have been recognized.

Q Okay.

A To say whether it should have been recognized in four days or six days or seven days --

Q Right, I understand that. Are you able to say, though, to a reasonable degree of medical certainty that if, say, for example, he would have recognized the problem 14 days after the surgery, that this permanent damage would not have occurred?

A I can't say that.

Q Okay. I'm just going to use another number, instead of going all the way down the numbers from 15 down to zero, but are you able to say to a reasonable degree of medical certainty whether if this problem had been recognized, say, ten days after the surgery, whether or not Mrs. Nabozny would or would not have suffered permanent injury?

A Okay. My suspicion is or my impression is

that had this been recognized around nine to ten days after the dental extractions, that permanent injury may well have been avoided.

What do I base that opinion on? Because about ten days afterwards is when she developed numbness. So, that's when there is neurologic compromise.

So, it is a relatively safe presumption that had she been treated, we'll say, before the onset of numbness, that she may well not have developed neurologic problems.

Q So, if this would have been -- the problem would have been diagnosed before nine or ten days after the surgery, then you believe to a reasonable degree of medical certainty that she would not have experienced this permanent damage?

A I think that's a safe statement. Again, it's not a guarantee because had treatment begun nine days before, it doesn't mean that the abscess and inflammation would have responded so immediately that she wouldn't have gone on to develop a problem.

Q That's what I thought. I'm asking you whether or not it's more probable that she would not

have had permanent injury, if, say, for example, it was discovered nine days after the extractions?

A Yes, it's more probable that she would not have had injury if it was discovered nine or ten days afterwards versus fifteen.

Q You're not going to say nine days, you're going to say nine or ten days?

A Well, these -- you know, to give an hourly, almost, course doesn't -- isn't fair to either side. You just can't be that precise.

Q Right.

A I can't give you a point in time, presuming that everything is stated here absolutely correctly about onset of times, and so forth, when treatment would have prevented neurologic compromise. I can't say with absolute certainty.

It is obvious that the sooner treatment began, the less likely she would have developed neurologic problems. No one will dispute that.

If she had been treated the day after surgery, no one disputes that the neurologic problems could have been avoided, as long as

we're playing with days and numbers. Where in that continuum after that that treatment of the infection would have guaranteed or almost guaranteed that there wouldn't have been a development of a neurologic problem is so hard to --

Q I'm not asking for guarantees. When does it go over the 50 percent mark in terms of what day, if you can do that? If yaw can", that's --

A You, yourself, have already, early on in this deposition given one of the problems. This is a rare situation and when you're dealing with a rare situation, it is difficult to talk in terms of what is precise.

If it had happened thousands of times, then you could say with greater certainty. I'm telling you that it would be my impression or that I think with probability that had this been treated nine to ten days out, somewhere in that vicinity, that you very likely could have avoided neurologic compromise.

Q Treated nine or ten days, or are you talking about diagnosed, because there is a delay here? You notice that even Dr. Cole, as astute as he was, he found the problem or had

a preliminary idea of what it might be 15 days postoperatively, but it wasn't until the 17th day that they actually started with an antibiotic?

A But that's the problem that one would face in his institution. He probably couldn't get an MRI scan for two days.

Hillcrest does not have an MRI scanner. Patient had to be sent off premises, scheduling and that sort of thing. Had he been working at University Hospitals, Mt. Sinai, the Cleveland Clinic, diagnosis very probably would have been made the same day. That's just the way that things are.

It's not his fault. It's the circumstances of the time of 19, what, '86 when this took place. MRI was a relatively new procedure and not so easily available.

So that the two days really comes down to he made the diagnosis in his office and then he started the wheels rolling of trying to prove the diagnosis and that is a function of radiology, the individual hospital, how fast you can get tests done, all those kinds of things. That's why it took so long.

There was no delay in the diagnosis in terms of him having to think of new things to do. He knew right where he was going, he just kept throwing tests at her until he proved the diagnosis and that did take two days in his setting where, in another setting, it may have been taken hours,

Q What was the first step that was taken here to fight this infection?

A In terms of treatment?

Q Yes.

A Oh, boy, I'm not sure I know without looking over the notes, but the very first step was -- I honestly don't know what the exact orders of treatment, how it took place. I really didn't address myself too much to that.

It was sort of outside my area of expertise. I can look at the notes as well as you and tell you -- try to piece together from the progress notes what he did step by step if that's what you want me to do.

Q No, that's all right. Let me see if I understand your opinion,

If nine or ten days after the extractions Kathleen Nabozny had gotten whatever the first

step of treatment was, she would not have had, more probably than not, she would not have had any permanent injury?

MR. DeSANTIS: Objection. Go ahead and answer that if you agree to the characterization.

A We11, what you're saying, if the diagnosis had been made and treatment started a week earlier than was the case, would she have developed her problems and the answer is: My suspicion is no.

Q And your suspicion is more than 50 percent?

A Yes.

Q Okay. Why, when you wrote your report, you indicate that had the problem been recognized sooner than 15 days postoperatively, she might not have been left with permanent damage, why did you use the terms "might not" instead of "probably not"?

A Well, we're getting into semantics, aren't we, semantics of the legal system and semantics of the medical system.

I am -- outside this deposition, there might not -- I would doubt that "might" and "probably" have much specificity and

difference between them, so I'm not really -- I'm using -- I don't want to get into a semantics argument between "might not" and "probably not" and what that relates to.

You define it in court. It's not really defined outside of the courtroom.

Q Is that the extent of your opinions, then, in connection with this matter?

A Yes.

Q You're not going to testify that Dr. Chepla committed malpractice or failed to comport with the standard of care?

A I basically will testify --

MR. DeSANTIS: Well, I'm going to object and let you go ahead and answer.

A I will stand by what I wrote and I avoid terms like malpractice, frankly, in a report because that's really a legal terminology, frankly, from my perspective and I stand by what I say and that is that I do think that there was a delay in the making of this diagnosis and that there may be room for debate and that's why we're here, but my impression from my standpoint as a neurologist is that this diagnosis should not have been made by a

neurologist.

Much power to Dr. Cole for making the diagnosis, but the situation had gone too far at that point.

Q When do you think that the diagnosis should have been made?

A Well, okay. This is going to be a difficult issue and I suspect will become the crux of the debate that will go on in court.

The thing that bothered me was that this woman had chronic complaints -- started developing complaints three to four days, in that vicinity, after her procedure, and was having problems throughout that time, was treated at one point with antibiotics, but nobody sat down and said, "What's going on here? This lady is not getting better, she's developing more symptomatology. Let's take a look at this."

That's what I think should have happened in the best of all possible worlds.

Q And you think that nine or ten days after the extractions, that had she gotten these -- the treatment, and we haven't said what the treatment is because you're not that familiar

with what the first line of treatment was, it probably was the antibiotic that she was given?

A Well, I presume. I didn't really --

Q Why don't we make sure we know what we're talking about here? Look at the hospital record, then, and tell me what the first course of treatment was.

A Okay. 7-25.

MR. DeSANTIS: Let me interject. Are you talking about the first course of treatment after the MRI pinpointed --

MR. MEADOR: No, after her --

MR. DeSANTIS: Let me finish. Are you talking about after the MRI pinpointed the pterygopalatine fossa infection or at the time she saw Dr. Cole on the 23rd?

MR. MEADOR: After her admission to the hospital, what was her first course of treatment?

A Probably the best thing to do is not look at the progress notes. Look at the order sheets. The very first treatment was nonspecific and that was some pain medications, and so

forth, to help reduce her pain.

Q What was the next treatment she received?

A She was given some Motrin on the 24th, which is an anti-inflammatory drug, primarily for pain.

Q Do you think if the Motrin or the pain medication were given nine or ten days after the extractions, that it would have made any difference?

A No. Probably the first treatment that I can see here, unless they gave her something -- was the Clindamycin that was started on 7-25. I had no other information in my chart or my letter and it's the first thing I see written here on 7-25 as a specific, nine hundred milligrams IV qh.

Q So, if Mrs. Nabozny had gotten that Clindamycin nine or ten days after the extractions, then it's your opinion that it's more probably --

A If treatment --

Q -- than not she would not have had the permanent injury?

A Yes, I think that's a safe statement.

Q And that's the sort of the treatment that you

are saying she should have gotten nine or ten days after the extractions, the Clindamycin?

A What I am saying is the process should have begun before it began is what I'm saying.

My problem with this case is pure and simple and that was that she was left to seek out a neurologic opinion and that a neurologist should not be making a diagnosis of an abscess in the face after a dental extraction, okay, that the process was not begun before.

My problem with this case, I cannot guarantee you that she would not have developed these problems, okay, even if treatment was begun earlier.

I suspect there would have been a much less likely chance of that happening, as I already testified, but the problem, the situation was delayed.

This woman should have gotten involved in the process of trying to figure out what was going on four or five days afterwards, okay.

If all the tests would have turned out negative and the diagnosis could not have been made, that happens. It's happened to me.

Nothing you can do about that.

The situation is it was delayed in terms -- she doesn't get the specific treatment until the 25th and I think that is *too* long,

I think this should have been -- there should have been efforts to uncover this before the 15th, other than giving nonspecific antibiotic therapy for somebody who has evolving symptoms of the face.

Q You've had a chance to read Dr. Mann's report regarding this matter?

A Yes.

Q How do you differ with his report?

MR. DeSANTIS: Let me interject. Once again, he just received that report.

MR. MEADOR: I understand that.

MR. DeSANTIS: And perused through it. If he's willing to comment on it --

MR. MEADOR: Well, just object. I would appreciate it if you'd just object.

MR. DeSANTIS: WeIf, I just want it clear on the record that if you're going to ask him questions about a

report that he hasn't had a chance to study, that you're going to get answers that are going to be based on that short duration, and if he doesn't want to answer, I don't think he has to.

MR. MEADOR: Well, I think it's improper for you to give that kind of objection, Frank. I'm surprised that you would coach the doctor that much.

MR. DeSANTIS: I'm not coaching. I feel real uncomfortable having you ask him questions about a report he has not seen.

MR. MEADOR: Well, he can say that.

MR. DeSANTIS: I can instruct him not to answer.

MR. MEADOR: No, you can't. I don't believe you can.

I don't think that's fair to say that you can do it. The doctor can do that. If he hasn't had enough time to study it or --

MR. DeSANTIS: That's what I just said.

MR. MEADOR: He can say that. You don't have to say that for him.

MR. DeSANTIS: I sure do. What do you think I'm here for? I'm here to protect the record and one of those things is to advise him that he doesn't have tu answer your questions about a report that he hasn't had an opportunity to study --

MR. MEADOR: He's a witness. He's not your client.

MR. DeSANTIS: I don't care if he's a witness or my client. I'm here to represent my client and if part of that is to instruct him that he doesn't have to answer questions about a report that he hasn't had a chance to study, I'm going to do that.

A I will comment, first of all, if I may say something. I'm not his witness, from my perspective, as a neurologist. I am making the opinion and I would be making the same opinion if he calls me or if you call me.

If I can't say that, then I better not come to court again.

What I am saying is that Dr. Mann is a neurologist and I am a neurologist, and when it comes to the diagnois of facial abscesses, I made a point already, that is not a neurologic diagnois.

Dr. Mann makes the point that the diagnosis was subtle. For a neurologist, that's true. Monroe Cole was smart enough to pick it up.

And his, even though the findings may seem subtle, they were definite enough that he makes an emergency hospital admission and begins an emergency workup, most of the studies are ordered ASAP, and he proves the diagnosis he made on his initial impression. Yes, the --

Q Let me ask you about what you just said.

Are you saying that when this patient started to develop sensory problems, that that was not the thing to do, to refer that person to a neurologist?

A Oh, yes, absolutely, that was the thing to do at that point.

I'm just telling you it should have never gotten that far, that ideally, this should not

have happened, that this patient goes to a neurologist and has some sensory symptoms and also ends up having some involvement with the 7th nerve, some motor phenomenonology as well.

After she had had some complaints for a period of time and for, what, approximately ten days before, she goes to a neurologist or is asked to see a neurologist. I don't think she was referred to a neurolcgist. That -- Dr. Mann is correct that the neurologic phenomenonology on that was probably quite mental before that. This woman had pain, this woman had problems in her face and they were not being addressed.

I would hope at that point she had no neurologic phenomenonlogy. If she did, then there really is an egregious problem.

My presumption is the neurologic findings are late in their findings, but that the infection had gune too far by the time she developed the neurologic problems.

I disagree with Dr. Mann, as much as I've had the opportunity to review his report, in that I think that this should have been identified and the process of trying to figure

out what was the matter with this lady before what he reports being relatively minor neurologic or minimum neurologic findings or subtle neurologic findings, 15 days after when Monroe Cole saw her.

This lady had pain and numbness before that and the problem should have been addressed. This lady should never have seen a neurologist. Never should have seen a neurologist, in my opinion. A neurologist should not be making the diagnosis of a facial abcess.

Q You're saying the oral surgeon should have made the diagnosis?

A The diagnosis should hawe been made before that.

Q Are you saying when?

A Well, I am being somewhat vague about that, admittedly, because I wasn't involved in the process.

She did have symptoms three to four days after and her symptoms were getting worse, as I understand it, from the information that I have.

Something should have happened, okay.

Now, had she been referred to a neurologist in three or four days, I don't know that Monroe Cole could have made the diagnosis. Knowing him, h probably would have.

I can't be sure about that, that's pure speculation on my part, but something should have been going on to try to stop this or at least try to get to the bottom of this.

Nothing was done, there were no diagnostic procedures instigated.

Q You're not going to say when, but you just think something should have been done?

A Yeah, I think it's difficult to precisely say whether the fourth day or the fifth day or the sixth day or the third day, but I am bothered by the information that I have, three to four days out, she developed pain and other symptoms and she should have -- those symptoms should have been addressed.

Q What other information have you had regarding preparing your opinion, other than the materials you reviewed here?

You just referenced a comment that Mrs. Nabozny was talked to about seeing a neurologist at an earlier date than when she

PAGE 128 MISSING IN ORIGINAL

Q Okay.

A No, I didn't mean to suggest that.

MR. MEADOR: Well, we finally ended this, I think. Thank you very much. You have a right to read it, if you'd like to.

THE WITNESS: Thank you, no.

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(Signature waived.)

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