IN THE COURT OF COMMON PLEAS

OF CUYAHOGA COUNTY, OHIO

CHERYL OLA, et al.

Plaintiffs,

vs. Case No.

MICHAEL MACFEE, M.D., 152815

et al.,

Defendants.

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Deposition of MICHAEL WILLIAM DEVEREAUX, M.D., a Witness herein, called by the Plaintiffs for examination under the statute, taken before me, Donnalee Cotone, a Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel, at Mt. Sinai Medical Center, One Mt. Sinai Drive, Cleveland, Ohio, on Tuesday, November 27, 1990, at 5:00 o'clock p.m.

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ORIGINAL

APPEARANCES:

On behalf of the Plaintiffs:

Don C. Iler Co., L.P.A., by
NANCY C. ILER, ESQ. and
DON C. ILER, ESQ.
1640 Standard Building
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On behalf of the Defendants:

Jacobson, Maynard, Tuschman & Kalur Co., L.P.A., by
SUSAN M. REINKER, ESQ. and
DAVID T. MATIA, ESQ.
1001 Lakeside Avenue, Suite 1600
Cleveland, Ohio 44114
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MICHAEL WILLIAM DEVEREAUX, M.D., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF MICHAEL WILLIAM DEVEREAUX, M.D.

BY-MS. ILER:

Q. Doctor, would you please state your name for the record?

A. Michael Devereaux.

Q. And your office address?

A. Is division of neurology, Mt. Sinai Medical Center, Cleveland, Ohio, 44106.

Q. And is that your only office?

A. Yes, that's my only office. I see patients one day a week elsewhere, but it's a hospital office. This is where I'm located.

Q. Doctor, Susan Reinker has given me a curriculum vitae. Have you had a chance to look this over and is this current?

A. There's one that's being redone here that has a few more articles and stuff in it, but I don't know how old this is. It's good enough. It's been -- it's good enough.

Q. Okay. Are any of the articles that

you have written or any of the chapters of the books that you have written have anything to do with the issues here, femoral neuropathy.

Q. Have I written anything specific on femoral neuropathy, no.

Q. Are any of the new articles that haven't yet been added to this have anything to do --

A. No.

Q. Doctor, from your curriculum vitae I've seen that you're on several hospital committees. Can you list those for me?

A. Mt. Sinai committees. Let's see. I am on the utilization review committee. I'm chairman. Library committee. I'm on the medical advisory committee for the department of medicine, which is an elected position. I'm a treasurer of the Mt. Sinai Medical Society. What else?

Q. Would that help you?

A. Yes. I can keep all these things straight. Continuing education committee, medical ethics committee. I'm on the Haa's committee. Those are the main Mt. Sinai committees I'm on right now.

Q. And you're on some committees at some other hospitals, is that right?

A. Well, you know, I circulate on and off committees at University. I was on faculty counsel. I was elected to that. That just concluded. I was on the steering committee. That was just concluded. But yes, those are the main committees I'm on right now, uh-huh.

Q. Are you presently working on any research projects?

A. Yes.

Q. All right. Doctor, after you devote your time to the hospital committees that you've listed in your research and your teaching, what's the percentage of your time do you spend in direct patient care?

A. Percentage of my time would be probably 50 percent.

Q. Doctor, do you know Dr. Gerald McIntosh? He was a neurologist at University Hospital for a time.

A. Yes.

Q. And did you find him to be a competent neurologist?

A. I have no reason to believe that he

wasn't.

Q. Do you know Dr. MacFee?

A. No.

Q. Have you ever spoken with Dr. MacFee?

A. No.

Q. When were you first contacted about Cheryl Ola and about this case?

A. It was I think in February of 1989.

Q. Do you have some correspondence that documents that?

A. Yes.

MS. REINKER: Excuse me. I think there was older correspondence than that. I think there's other correspondence in there.

A. I think it was February of 89. Yes. Here, February of 89. February 16th.

Q. And was Susan Reinker the first person who contacted you about this case?

A. Yes. The only person I've talked with about this case that I can recall.

Q. And apparently you had a phone conversation before this letter was written?

A. Yes.

Q. And what did she ask you to do at

that time?

A. Well, according to her note it was that I agreed to review the case in hand.

Q. May I take a look at the materials that you reviewed on this case?

MS. REINKER: Just the things he reviewed?

Q. Let me take that back. First I'd like to look at your whole file and then we'll sort out what you reviewed. Thank you.

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(Thereupon, Devereaux Deposition Exhibits 1 through 8 were mark'd for purposes of identification.)

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Q. Dr. Devereaux, can you identify for me which materials you reviewed in preparation of your --

A. Can I have the records?

Q. They're right here.

A. All my letters and stuff.

Q. Sure.

A. Okay. Oh, this is, if I may, this is a secretary's note. It somehow got mixed up. If you want that you're welcome to it.

Don't I have something else from -- oh, here it is.

MS. REINKER: What was the question again?

A. Yes, would you please?

Q. The question was which materials did you review in preparation of your report?

A. It's listed on the initial page of my April 13th report. Do you want me to read it?

Q. Yes. I'd like for you to list to me the materials you reviewed.

A. Okay. To quote myself here, at your request -- well, I reviewed the inpatient and outpatient medical records and the medical/legal records regarding Cheryl Ola and her medical problems.

And what I reviewed were University Hospitals admission records, 11-17-86 to 11-21-86; Mt. Sinai Medical Center admission records, 6-16-87 to 6-20-87; records from Dr. MacFee's office chart, including some preoperative office notes, pathology notes and physical therapy reports from Alan Frey, PT; Sami Harik, M.D.'s neurological consultation

report, January 5, 1987; Howard Tucker, M.D.'s letters to Mr. Donald Iler dated April 6, 87, June 15, 87, October 6, 1987; Arthur M. Brickel, M.D.'s records, including a February 26th, 1988 neurological consultation report; and Gerald McIntosh, M.D.'s, August 19, 1988 consultation report; and M. Bashar Katirji, that's Dr. Katirji's September 7, 1988 office consulation report, October 18th, 1988 follow-up report, August 29th, 1988 EMG report.

And then I had some other information. Let's see. Robert S. Coplan, M.D., February 8, 1990 report on review of the records; Samuel Portman, M.D. report on review of records dated February 13, 1990; and Michael MacFee, Dr. Michael MacFee's discovery deposition, February 1st, 1990.

Q. Are those all the materials that you reviewed in preparation of that report?

A. Regarding the case, yes, I believe so.

Q. Did you review any medical literature before you wrote the report?

A. Yes.

Q. I have marked Devereaux three,

four, five, six, seven, and eight, some articles from the medical literature. Could you please take a look at those and tell me which ones you reviewed in preparation for your report?

A. Okay. I reviewed -- how would you like me to do this?

Q. I would like for you to refer to the number at the bottom.

A. I reviewed Deposition Exhibit No. 3, Deposition No. 4 or Exhibit No. 4, okay. I must have not quoted this. Now, what should I do, one that I didn't list in the bibliography that I must have looked for review but didn't quote? Do you want me to list that?

Q. Just identify it. That you looked at it and you --

A. Deposition No. 5.

Q. Okay.

A. Deposition No. 6, Exhibit No. 7. Deposition No. 6, Deposition Exhibit No. 7 and, again, Deposition Exhibit No. 8, yes.

Q. Doctor, I'd like to ask you about Deposition Exhibit No. 1 and No. 2, which are the same, your letter of March 13th, 1990.

A. Yes.

Q. This was written before your formal report on this case?

MS. REINKER: Objection to the phrase, formal report.

Q. Why was this letter written, this March 13th letter?

A. Because I wanted to sit down -- the way I approach these cases is to try to go through all of the records so that I have a ready reference for information, detailed information for my own review for some later date, and so it was written as much for me as for anyone else so that, again, I'd have detailed information.

Q. So you used some of the things or your notes from the March 13th letter in preparation for your April 13th letter, is that right?

A. Yes, which was a brief summary of the case.

Q. So the record is clear, doctor, so you have written three letters in this case, one dated March 13th, 1990, which is Deposition Exhibit 1 and 2, another one that is dated

April 13th, 1990 --

A. Uh-huh.

Q. -- which we have not marked yet as an exhibit and we will, and July 20th, 1990, which we'll also mark.

A. Yes, which is my physical examination.

MS. ILER: Would you please mark those?

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(Thereupon, Devereaux Deposition Exhibit 9 and 10 were mark'd for purposes of identification.)

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Q. For purposes of the record, your April 13th, 1990 letter is Deposition Exhibit No. 9 and the July 20th, 1990 letter is Exhibit No. 10.

A. Uh-huh.

Q. Have you reviewed anything else in preparation for your deposition today?

A. No, I don't believe so.

Q. Okay. You have conferred with Susan Reinker before this deposition?

MS. REINKER: Objection.

Q. I don't want to know what you said, I'm just asking you.

A. Yes. Uh-huh.

Q. And have you had several meetings with Susan Reinker before the case? Once again, I don't want to know the contents of what you said.

A. No.

MS. REINKER: Objection.

THE WITNESS: I don't believe we have.

Q. Dr. Devereaux, what do you understand the facts in this case to be?

MS. REINKER: Objection.

A. Yes. That's kind of a broad question there. The issue as I at least believe it to be is that the patient, Cheryl Ola, has some complaints, some -- that she attributes to having had an operation, the vaginal hysterectomy done on November 17th, 1986.

Q. Can you state for me in a little more detail what the events were that transpired during her admission to University Hospitals in 86?

MS. REINKER: Objection. Why don't you ask him a specific question?

MS. ILER: Susan, if you remember, this is the same question you asked Dr. McIntosh. I want to understand what the doctor understands the facts in this case to be.

MS. REINKER: Objection. All the facts in this case you want him to recite?

MS. ILER: Whatever facts he feels is important in rendering an opinion, those are the facts that I would like to know.

MS. REINKER: Note an objection. I don't think it's humanly possible for him to do that, but note my objection.

A. Well, basically, as I already stated, her problem, my parlance for saying that, the situation which got me involved with it is that she had ongoing symptoms, which she dated back to a November 17th, 1986 vaginal hysterectomy and that she had symptoms which included numbness of the medial aspect of her left leg, distal to the knee, low back pain beginning sometime after surgery and headache beginning at some point after surgery.

She basically was referred to Dr.

MacFee for evaluation of cervical carcinoma in situ, a small, if you will, beginning cancer of the cervix. After initial evaluation he -- it was decided to perform a vaginal hysterectomy and she was hospitalized at University Hospitals on November 17th, 19 --

Q. Excuse me, doctor, may I ask, you're referring --

A. To my report, yes.

Q. To your report of April 13. That's fine.

A. Okay.

Q. Continue. Thank you.

A. Sure. So she was referred to and hospitalized November 17th, 1986. She then underwent a vaginal hysterectomy. There were no initial problems noted. On November 18th, one day after surgery, she walked for the first time and then had a fall on the way to the bathroom or collapse. It's not clear which.

She basically -- then that led to a series of things that happened after that. She was ultimately seen by a neurologist. There was a question of whether or not she had blacked out. She was seen in consultation, as

I already mentioned, by the neurology service on the 19th, one day later, and there was a suggestion that she may have bilateral femoral neuropathy with symptoms greater to the right leg than the left leg.

Physical therapy was recommended and she was seen by a physical therapist on the 20th and was discharged from the hospital with instructions to do exercises at home, and then thereafter she was seen on follow-up by a series of neurologists among the next several years.

Q. And what do you understand her present condition to be?

A. On the basis of my July 20th examination, at that point she continued -- at least at that point she was having ongoing symptomatology in the right leg and as I outlined her complaints at that point were numbness along the medial aspect of the right leg from the ankle up to about the middle third of the leg, that's the lower leg, if you will.

She was complaining of tingling along the anterior thigh, the front of the thigh. She also had more generalized pain in

the right leg. That was basically what she was complaining of when she saw me. Those were the problems, I should say, that were confined to the leg.

She also had a chronic virtually daily headache that she complained of. I think at the time she saw me she was not having any significant back pain if I recall correctly. Those were the main things.

Q. Doctor, are you going to give a gynecological opinion as to the standard of care of Dr. MacFee in his treatment of Cheryl Ola concerning the vaginal hysterectomy on November 17th of 1986?

A. Are you asking specifically about an opinion whether or not the surgery should have been done and that kind of thing? The answer is no. I'm not an obstetrician and gynecologist.

Q. And you don't perform vaginal hysterectomies?

A. No.

Q. So what are you going to give a standard of care on?

MS. REINKER: Objection.

A. Well, most of her complaints fall in the neurologic arena, not in the gynecologic arena. I suspect that's why I was consulted by Miss Reinker to review those symptoms since they are predominately neurological and most of her follow-up care she has had has been by neurologists not gynecologists.

Q. So do I understand you're going to confine your opinion to her injuries?

MS. REINKER: Objection. If you ask him if he has an opinion as to Dr. MacFee's standard of care, just ask him that. Don't play games with him.

A. I'm going to discuss those things in which I am qualified to discuss and that has to deal with her neurologic symptomatology and my opinions about the meaning of that neurologic examination and so forth.

Q. I'm still a little unclear, doctor. Are you going to give an opinion on the standard of care insofar as Dr. MacFee is concerned?

A. Well, I'm not quite sure what that question means.

Q. Uh-huh.

A. I am going to discuss what I've just said I'm going to discuss, neurologic aspects of her clinical problem. I'm not sure where you draw the line between what is gynecologic expertise and neurologic expertise, but I don't plan to go beyond my area of expertise. But I don't know quite what you mean by your question. But that's as I plan to deal with this, as a neurologist.

Q. What opinions are you going to render insofar as Dr. MacFee's care?

MS. REINKER: Objection.

A. Well, I suppose my opinions will be based on the questions that you ask me.

Q. Can you tell me what the standard of care is for a gynecologist in performing a vaginal hysterectomy?

MS. REINKER: Objection.

A. Not in terms of specifics, no. I'm not sure quite what even that question entails. The general statement would be that does the patient need the operation, that the operation would be done well, and that the patient be appropriately followed-up on the basis of what that -- of requirements or

referred to other people on the basis of what needs to be done following the surgery.

Q. Was a standard of care for Dr. MacFee is to insure that nobody, either himself or anybody else is leaning on Cheryl Ola's legs during the vaginal hysterectomy?

MS. REINKER: Objection.

A. Well, again, it's kind of -- I'm sorry -- but a rather vague statement. I suppose it is certainly his duty to make sure his patient is not unduly injured by the surgery and that means everything. That means anesthesiologic care, nursing care, the care provided by the people around him. He's the captain of the ship.

MS. REINKER: Move to strike.

Q. Doctor, is it below the standard of care for the doctor to allow somebody else or himself to lean against the patient's leg during the vaginal hysterectomy?

MS. REINKER: Objection. Your question is calling for a legal conclusion. Dr. Devereaux is not an expert as to whose duty it is to do what with regards to hospital employees and I'm not going to permit him to

answer that question.

Q. Is it below the standard of care for Dr. MacFee to have allowed someone, either himself or someone else to have leaned on Cheryl Ola's leg during a vaginal hysterectomy?

MS. REINKER: Objection. The doctor is not qualified to answer a question which calls for a legal conclusion.

MS. ILER: Excuse me. The doctor just told me he was giving a standard of care opinion.

MS. REINKER: The question goes beyond standard of care. Your question has to do with a legal conclusion as to whose obligation it is to do what in an operating room. Dr. Devereaux is not in a position to answer as to who's responsible for who.

MS. ILER: Why don't you have the doctor answer it and then we can take it up with the judge?

MS. REINKER: Please read the question.

(Record read.)

MS. REINKER: Note an objection. Also, I'm objecting to the conclusions you draw

in your question which are unsupported by any evidence.

A. I would say no.

(Record read.)

Q. No, it's not below the standard of care?

A. No. I mean, I can't ever imagine a vaginal hysterectomy ever having been done where the legs aren't touched if one is familiar with the anatomy of where the vagina is and where the legs are. It would be a matter of degree.

Certainly the legs are going to be touched in any vaginal operation. It's a matter of degree and that would then be determined -- that would be the role of the -- I would think the surgeon to make sure that excessive degrees are not -- excessive degrees of pressure are not employed.

MS. REINKER: Move to strike.

Q. So that last statement is the standard of care that the surgeon --

A. I've given you my opinion as a neurologist. I don't know what standards of care are established by gynecologists. I'm

giving you my opinion as a neurologist and that's common sense more than specific expertise.

MS. REINKER: Move to strike.

Q. Doctor, in Exhibit No. 9, your April 13th letter, I'd like to refer you to page three where you state, "In summary, from my review of the available information surrounding the surgery of Cheryl Ola by Dr. Michael MacFee, there were no unusual circumstances such as prolonged surgery, indications of unusual pressure on the thighs or any description of any unusual positioning." Are those your reasons in support of Dr. MacFee?

A. Sure.

Q. Are there any other reasons besides these three that you have set forth here?

MS. REINKER: Objection.

A. No. I can't imagine what they would be right off the top of my head.

Q. Okay. I'd like to go over each of those reasons with you.

A. Okay.

Q. Your first reason is that there was

no prolonged surgery.

A. Correct.

Q. Are you referring to surgery time?

A. Yes.

Q. What was the surgery time in this case?

A. The time I quoted -- and it's also difficult to know -- was an hour and 35 minutes taken from the anesthesiology report which listed the operative time. The actual time of surgery was perhaps less, but it's difficult to know for sure.

Q. What is the normal time for a vaginal hysterectomy?

MS. REINKER: Objection.

A. My understanding is -- of course, that's going to reflect the case and that's what I can't specifically know, complications and so forth that deal with the surgery. My understanding is that this is a standard, about a standard length of time.

Q. And where did you get your understanding that this is a standard time?

A. My general medical knowledge. I actually did about a hundred vaginal

hysterectomies in my younger years. I was going to go into OB at one point, and also just from general reading at that point.

Q. So your opinion that this is a normal surgery time is based upon --

A. My general knowledge of obstetrics and gynecology is it's about standard time. As I say, it may even be less because operative reports generally -- or operative times are started from the very, very beginning to the very very end.

Q. What is a prolonged surgery time?

A. Well, that's a very qualitative statement and it's going to depend on the situation that you run into and sometimes is not an absolute factor. It would have to do with complications, size of the patient, other issues. But when you're getting into cases that run longer than two, two and a half, three hours, you're getting into prolonged time.

Q. And if you do run into a prolonged surgery time, what type of complications would arise?

MS. REINKER: Objection. Prolonged surgery for what kind of procedure?

Q. For a vaginal hysterectomy.

A. In terms of actually -- for the most part I'm not, again, qualified to speak on that because of the fact that that is a surgical issue and I'm a neurologist.

Q. Well, let me get a little more specific. How does prolonged surgery time during a vaginal hysterectomy, how does that cause a femoral neuropathy?

MS. REINKER: Objection.

A. Well, I don't know how it goes to a femoral neuropathy. There is an association between femoral neuropathy in some studies in prolonged surgery.

Q. Can you explain that a little bit for me?

MS. REINKER: Objection.

A. In what regard?

Q. How does a prolonged surgery time during a vaginal hysterectomy become associated with a femoral neuropathy?

A. Don't know.

MS. REINKER: I don't think there's any indication --

A. It's not clearly understand.

Q. And you've reviewed the literature on this particular point?

A. As much as I can. It's not understood. It's a statement of observations.

Q. Does it have to do, doctor, based upon your training and certainly your expertise on the compression of the femoral nerve?

A. I'm sorry. You mean, my opinion in terms of prolonged?

Q. Yes.

A. No, it's really based more on looking at it from the literature, and that is what the literature reports say, that that's a factor, an important factor was very extensive prolonged surgery.

Q. And the exact mechanism of injury of the femoral nerve you're saying is not known by the literature?

A. Well, it's not clearly known. Compression in prolonged surgeries has been described in the literature as being a factor.

Q. Yes. Could a prolonged surgery time on November 17th could have caused femoral neuropathy in Cheryl Ola?

A. That's a conjecture. I just don't

know. Since the surgery wasn't prolonged by my prior statement, it would be, you know, real conjecture.

Q. So you have no opinion on that?

MS. REINKER: Objection. He just testified that there was not prolonged surgery on November 17th.

A. Well, I mean, how can you have an opinion on a conjecture? Prolonged surgery may be a factor and, therefore, if she had undergone prolonged surgery, as any patient might have undergone prolonged surgery, then there might have been an increased risk of femoral neuropathy. I suppose you can say that, but it's just a conjecture.

Q. Doctor, your second reason in your letter was -- the letter of April 13th --

A. Uh-huh.

Q. -- was there was no indication of unusual pressure on the thighs.

A. Uh-huh.

Q. What records did you base that opinion on?

A. Operative reports and so forth. The only records that anybody else would ever

have available that I'm aware of. And there was no indication that there was any unusual posturing and positioning of the patient or any unusual pressure placed on the thighs by any of the records that I reviewed.

Q. And is that usually something that's noted on the records to your experience?

A. Well, I can't say that I've reviewed enough operative records from vaginal hysterectomies to know that it is or isn't. I can't answer that question. I can only say in this case it wasn't noted and there's no other source that I know of.

Q. Doctor, how does unusual pressure on the thighs cause for neuropathies?

MS. REINKER: Objection.

A. Well, the theory would be that in the nerve or if the thighs are pressed on or postured in a funny way, that the nerve, the femoral nerve could suffer compression in a sense I suppose from being kinked by the inguinal ligament.

Q. And doctor, that unusual pressure, does that take just a few minutes?

A. No.

Q. What is your opinion as to how long that takes?

A. Well, it --

Q. Or do you have an opinion?

A. Yes, I do. From, again, my review of the literature it's generally associated with prolonged surgeries lasting more than two hours.

Q. You're certainly not saying that you can't have unusual pressure resulting in a femoral neuropathy in a surgery that's under two hours?

A. I would have to answer no, I'm not saying that. If you can demonstrate that that happened.

Q. That question, doctor, is that when there's pressure on the thighs, how long does that pressure have to be maintained in order to cause a femoral neuropathy?

MS. REINKER: That's been asked and answered. Objection.

A. Several, more than several hours. Again, the word unusual is a very difficult word to define, but I would answer several hours or more.

Q. Could an unusual pressure have been exerted on Cheryl Ola's thighs during her vaginal hysterectomy to have caused her femoral neuropathy?

MS. REINKER: Objection.

A. That's -- I mean, the word could, I don't know what to even say with that. Could it have happened, I guess it could have, if you want me to limit myself to something like that. There's no evidence that it happened.

Q. Doctor, in your review of the literature, did you find articles where there was a femoral neuropathy as a result of unusual pressure on the thighs during surgery?

A. Mainly with abdominal hysterectomies there were studies that have shown that certain examples that were used in abdominal hysterectomies showed femoral nerve compression.

Q. Well, that's a little different.

A. She had a vaginal --

Q. Unusual pressure on the thigh --

A. Yes, she had a vaginal hysterectomy. Again, we get into the whole issue of unusual, and I'm not quite sure what

unusual pressure is. I mean, it's a very nonspecific term.

I can't as we sit here right now speak to any articles I read where patients will put -- how can I answer that question? It's just an open-ended question. There's probably somewhere in other -- there are probably articles in the literature where unusual pressure was documented that could produce femoral neuropathies.

MS. REINKER: The question was did you see any such article.

A. No. I can't recall as we sit here. I can't recall it.

Q. Well, when you wrote --

A. I'd have to look at --

Q. Doctor, these are your words, unusual pressure?

A. All right.

Q. When you wrote this in this report, what were you talking about, unusual pressure on the thighs, were you talking about somebody leaning against a thigh?

A. Yes. I'm talking about some defined pressure where people say this patient

was found in an unusual position, that it was -- someone documented pressure on the leg. By unusual, as I just was saying, you're going to in a vaginal hysterectomy, you're going to touch the thighs. That's why they gown the thighs. If no one ever touched the thighs, they wouldn't need to gown them. So you're going to come in contact with thighs. I'm talking about unusual pressure, something that is documented.

Q. In the case studies -- and you're saying --

A. That's my definition of unusual, okay.

Q. When you reviewed the literature, did you find a case of a femoral neuropathy resulting from unusual pressure of the thighs?

A. Yes. Well, let me rephrase that. I found case reports of femoral neuropathy related to prolonged vaginal surgery, vaginal hysterectomies, yes.

Q. And can you point which article?

A. It is Hopper and Baker.

Q. You're referring to your March letter, is that right?

A. I think I have the Hopper -- I'm referring Hopper C, Baker J: Bilateral femoral neuropathy complicating vaginal hysterectomy, Volume 32, pages 543 to 547, 1968.

Q. Is this the one you're talking about, doctor?

A. Yes.

Q. That's Exhibit No. 7. Doctor, the third reason stated in your April 13th letter was there was no description of unusual positioning.

A. Right.

Q. Is that right?

A. Correct.

Q. And what records did you base that on?

A. The surgical reports.

Q. And when you say surgical reports, doctor, can you tell me --

A. Well, the operative reports, the anesthesiology reports, all that material. There was nothing in the hospital record from that hospitalization that indicated that there was any unusual -- that there was any unusual problem met in surgery.

Q. So when you said unusual positioning, you meant something --

A. That somebody would have defined as being out of the ordinary. That she was in some way, shape or form had certain body deformities, scoliosis of the spine, that she was positioned on the table in an unusual way. That she -- they used a unusual position to do the surgery, for whatever reason the anesthesiologist or others noticed something atypical.

Q. What was Cheryl Ola's position during the vaginal hysterectomy on November 17th, 1986?

A. My understanding is that she was in a routine lithotomy position.

Q. Can you be any more specific than that?

A. Using leg stirrups. No, that's about as specific.

Q. Do you know what type of stirrups she was using?

A. No, I don't remember the name of the stirrups.

Q. Could unusual positioning during

Cheryl's vaginal hysterectomy have caused her femoral neuropathy?

MS. REINKER: Objection. Asked and answered. You've answered it already.

A. Okay.

MS. REINKER: He's answered it already. The exact same question.

Q. You can answer it.

MS. REINKER: He can't answer it again. You're asking him to speculate as to something --

MS. ILER: Excuse me. I don't remember asking you the question, Susan. I remember asking the doctor.

MS. REINKER: Go ahead. Since you remember asking it, you don't need another answer to it.

Q. Excuse me. Can you answer my question?

THE WITNESS: Could I have that again?

MS. REINKER: Are you saying could it happen? What exactly is your question?

MS. ILER: We'll find out.

(Record read.)

MS. REINKER: Now, my question, Nancy, for some clarification, is your question if this patient were in an unusual position could she develop a femoral neuropathy or is your question this patient has a femoral neuropathy, could that have been caused by unusual positioning?

MS. ILER: I like both your questions. I'll take the first one first.

MS. REINKER: If this patient were in an unusual position could she develop a femoral neuropathy, is that your question?

Q. That's my first question.

A. Well, I'll give a hypothetical answer to a hypothetical question and the answer would be yes, if you could document some unusual position or surgical duration, I suppose the answer would be yes based upon literature.

MS. ILER: And Susan, what was your other question? That was good.

MS. REINKER: You come up with one of your own, Nancy. You were doing a fine job.

Q. Doctor, from your review of the

literature and your experience, how does this unusual positioning cause femoral neuropathy during vaginal hysterectomies?

MS. REINKER: Objection.

A. Well, again, in my review of the literature it would be associated with very prolonged surgery, what seemed to be the major factor in most of the articles I reviewed, and the conjecture was that somehow the nerves are compressed if the surgery is prolonged or if there's underlying nerve damage already, diabetes, something of that sort that might make the nerve more susceptible to injury.

Q. So are you saying that you can't -- that you can only have a femoral neuropathy from unusual positioning when there's a prolonged surgery time?

A. That seems to be the major factor from my review of the literature. I mean, you're getting into situations of only's and this's and that's, and most of the case reports were small case reports. There isn't a large experience with this condition that's been published in the literature, so it's hard to give you a scientific evaluation in terms of a

large series of cases.

Q. But certainly understanding the mechanism of the injury, you certainly aren't prepared to state that a femoral neuropathy can't occur in a surgery that's less than two hours?

MS. REINKER: Objection.

A. No, I didn't say that. I'd say that if you were to find some other explanation for compromised nerve function already if the nerve is damaged -- again, there have been some case reports of diabetes making nerves more susceptible to injury and that might then lead the nerve to be more easily traumatized, which might occur, then that might mean that the time could be less.

I'm saying that you're trying to find evidence in the literature of what the factors are. Prolonged surgery seems to be a factor.

Q. But it's not a determining factor?

MS. REINKER: Objection. Well --

A. Well, it is a determining factor in one particular report I've shown you already.

Q. Right.

A. It is a determining factor, and shorter duration cases I would -- I'd have to presume that there'd have to be other factors that you would come up with some intraoperative process where the patient had a funny body posturing or was positioned funny on the table or something else happened or there was a obvious direct surgical mishap somehow lacerating the nerve by a -- which would be very difficult to do from a vaginal approach.

Q. Doctor, back to your April 13th letter, have we discussed all your reasons, doctor, concerning your opinion that -- and I'll quote from the letter -- there is no evidence of malpractice on Dr. MacFee's part?

A. That was my opinion, yes.

Q. And we've discussed all your reasons for that, have we?

MS. REINKER: As contained in the letter, yes.

A. As contained in the letter.

Q. I want to know outside the letter, do you have any other opinions outside of the letter or reasons in support of Dr. MacFee?

A. Gee, I just can't recall anything

specific right now. If you want to ask me some questions that might probe that further I just can't think to an open-ended question. If there's something else that I -- but nothing that comes to mind right now.

Q. Okay. Because doctor, I don't -- I'm going to use this to get ready for trial. If you have a new reason in support of Dr. MacFee -- in support of your opinion that Dr. MacFee, there was no evidence of malpractice in his care and treatment of Cheryl Ola, I would like to know about that. I asked you that question and you've now told me you've discussed all of your opinions?

MS. REINKER: As he can think of here today.

A. Yes, that I can think of.

MS. REINKER: You've answered.

Q. If you come up with any new reason before trial, can you tell Miss Reinker and Miss Reinker will tell me so I can re-examine you on those particulars?

MS. REINKER: Objection. There's no obligation for me to disclose to you my witness's thought processes.

MS. REINKER: Dr. Devereaux and I have agreed to that.

MS. REINKER: Well --

Q. Doctor, back to your April 13th letter, in that same paragraph you state several examining neurologists have felt that she had a probable right femoral neuropathy, although an EMG and nerve conduction study revealed no evidence of femoral damage.

A. Correct.

Q. Would you please tell me what are the names of those neurologists when you say several. Can you tell me?

A. Let's see.

MS. REINKER: Objection.

A. Sami Harik, Gerald McIntosh, Bashar Katirji thought she had femoral neuropathy. Several others did not.

Q. Which others didn't?

A. Howard Tucker and Arthur Brickel.

Q. Doctor, do you have an opinion as to whether or not Cheryl Ola has or had a femoral neuropathy?

A. Do I have an opinion? Yes. In reviewing the information I think she had a

femoral neuropathy.

Q. Can I stop you for a moment? At what point in time are you talking about?

A. When she was examined by the neurologist after surgery.

Q. Are you referring to the neurologist at University Hospital?

A. Yes.

Q. Who examined her on November 18 and November 19 of 1986?

A. Yes. It would be my deduction from the information available that she had a mild bilateral femoral neuropathy. Whether she continues to have that or not is unclear.

Q. Why is that unclear to you?

A. Well, there's no EMG documentation of femoral nerve damage. There's no objective physical findings that I can measure, changes in reflexes, muscle strength and so forth of femoral nerve damage, neither lower extremity.

The only problem is decreased pin appreciation in the medial aspect of the right leg, which is -- again, sensory examinations lack objectivity because they require subjective involvement. So there's nothing

that I can clearly measure and reproduce that shows ongoing femoral neuropathy.

Q. Do you have an opinion as to what the cause of a femoral neuropathy is?

MS. REINKER: Is or was?

Q. Was.

A. Was. Well, no, I'm not really clear what happened and that's the truth. That's not something being said here across a legal table. Obviously there's a temporal relationship between her neurologic disturbances and the surgery.

Q. I don't understand temporal.

A. Temporal, time relationship. That she had some problems after the surgery, and therefore, it seems reasonable to suspect that there may have been -- something happened in surgery. That's all I can say. But the mechanism of action I do not know. It is unknowable.

Q. Doctor, for the purposes of the record, what is a femoral neuropathy?

A. A neuropathy refers to disorder of nerve. Femoral refers to a specific nerve in question. So it basically means dysfunction of

the femoral nerve or disturbance of the femoral nerve.

Q. And what are the physical signs or symptoms of a femoral neuropathy?

A. What do you want, symptoms or signs?

Q. Symptoms.

A. Symptoms. They can be variable. They can from the standpoint -- the major symptom would be weakness of the femoral nerve-innervated muscles, which are the muscles that cause hip flexion and knee extension. That's the primary role of the femoral nerve.

Q. And for the purposes of the record, those muscles are?

A. The major muscles then would be the iliopsoas, the quadriceps, femoris, pectineus, sartorius, those are the major muscles. There's also sometimes a contribution to the adductor group, the thigh adductor group. But the major muscles and the ones that I mentioned -- I don't think I left any out.

Q. What other physical -- is that all physical?

A. So the weakness I mentioned

predominately of the hip flexors, the knee extensors and possibly, but not much weakness of the thigh adductors diminish or absent -- I'm sorry -- knee reflexion, patella reflexion. I'm sorry. You asked for symptoms. Excuse me. I was giving you a sign.

So the weakness that I mentioned and then varying degrees of sensory disturbances and complaints ranging from pain in the leg, which could have difficult distributions, but would be in the thigh predominately, in the front of the thigh and maybe even into the medial aspect of the leg.

And then she might experience, a person would experience some numbness in those same distributions. Those would be the major complaints or symptoms that a person might have with femoral neuropathy.

Q. Which means by sensory disturbance is pain or numbness, is that right?

A. Sensory complaint. Maybe I should mention, maybe I should use that word disturbance. That could be pain, numbness, tingling.

Q. What are the signs of a femoral neuropathy?

A. Signs on examination would be weakness of the hip flexors to individual muscle group testing, weakness of the knee extensors, which looked like -- functionally would express itself primarily by difficulty walking, climbing stairs and so forth. You would also expect to see absent ankle -- I keep saying ankle -- absent knee or patella reflexion, and then you might see varying degrees of sensory loss on examinations.

Q. And where would those varying degrees of sensory loss be?

A. Could involve the anterior thigh and the distribution of the medial and intermediate cutaneous nerves, which are branches of the femoral nerves and the distribution of the saphenous nerve along the medial aspect of the leg distal to the knee.

Q. And for purposes of the record, the saphenous nerve is a branch of the femoral nerve, is that right?

A. Correct.

Q. Is it a sensory branch or a motor

branch?

A. Sensory.

Q. Have you treated patients with femoral neuropathy before?

A. Yes.

Q. Had any of your patients had a femoral neuropathy following a vaginal hysterectomy?

A. I've had one after a vaginal delivery. I honestly can't recall. I believe I had one maybe ten or 15 years that I recall seeing. But I honestly can't document that.

Q. How do you make diagnoses in your patients of femoral neuropathies?

A. History, physical examination, and then where warranted ultimately EMG and nerve conduction study.

Q. Is an EMG and a nerve conduction study definitive in your diagnosis?

MR. ILER: Of what?

Q. Of femoral neuropathy.

A. Oh, dear, how do I state that? It is -- it offers strong support, the diagnosis.

Q. But certainly the history and the physical exam are also important components of

your --

A. Absolutely.

Q. Did any of your patients with femoral neuropathy have permanent deficit?

A. Including all femoral neuropathies I've ever seen?

Q. Right.

A. Sure. Yes.

Q. So not all of the patients or the cases of femoral neuropathies that you know of have completely recovered?

A. Oh, no. Gunshot wounds and things like that you wouldn't expect for recovery.

Q. Doctor, back to your report of April 13th of 1990. You state in your report that Mrs. Ola's symptoms of numbness right lower leg -- I'm sorry -- numbness in her right lower leg and low back pain and headaches began after the vaginal hysterectomy of November 17, 1986?

A. Okay.

Q. Is that true?

MS. REINKER: Objection. Is it true?

Q. That's bad. Let me strike that.

Is that the information you have from your review of the records?

A. Correct.

Q. Okay. Doctor, I'd like to move to your exam of July 20th, 1990.

MS. REINKER: Can we go off the record for a minute?

(Short recess taken.)

Q. Okay. Doctor, I'd like to question you on your July 20th 1990 letter which is Exhibit No. 10.

MS. REINKER: Ten.

MR. ILER: What exhibit is that?

MS. ILER: Number ten.

Q. You examined Cheryl Ola at the request of Susan Reinker, is that right?

A. Correct.

Q. Is your history and exam and findings of Cheryl for your exam of that day contained in Exhibit No. 10?

A. Yes.

Q. I'd like to direct your attention to page number four under impression.

Q. Okay. You state number one, sensory disturbance, right lower extremity in a

distribution between the L4 dermatome and saphenous nerve distribution?

A. Correct.

Q. And I may have asked you this before, but if you wouldn't mind repeating it, what is a sensory disturbance or what did you mean when you wrote that?

A. That I found some disturbance in her ability to sense a pin, to appreciate pin prick and temperature and light touch in the area in question.

Q. As a neurologist are those clues that there is an injury or problem with the saphenous nerve?

A. It could be related to the saphenous nerve.

Q. What happens to the nerve to cause a sensory disturbance?

MS. REINKER: Objection. Are you referring to any nerve in the body?

Q. Talk about the saphenous nerve.

A. If the saphenous nerve -- if there's some insult to the saphenous nerve that might result in sensory disturbance and the insult could be many things.

Q. What is a L4 dermatome?

A. Dermatome refers to the sensory map that relates to nerve roots.

Q. Can you describe for us the L4 dermatome?

A. If you -- L4 dermatome is very nearly the same as the saphenous nerve. They virtually overlap.

Q. So we're talking about what part of the anatomy?

A. Well, the L4 root is on the back. If you have a pinched nerve in your back it happens to be the fourth lumbar root, the things that you could see would be a sensory loss in this same distribution.

Q. Doctor, you're referring to a specific area when you describe that disturbance, aren't you?

A. Yes.

Q. Which area is that?

A. It is along the medial aspect of the leg distal to the knee and essentially proximal to the malleolus, M A L L E O L U S, I think.

Q. And does that also cover the

anterior portion of the thigh?

A. Well, if you look at the thigh -- the thigh you said?

Q. That's right.

A. The -- no, there is no L4 distribution to speak of in the thigh.

Q. Did Cheryl Ola have the sensory disturbance that you described in your report in her right leg before the vaginal hysterectomy?

A. No, not that I can recall.

Q. Do you know what the cause of this -- isn't the cause of Cheryl Ola's sensory disturbance in her right leg the vaginal hysterectomy performed on November 17, 1986?

A. Well, I've already answered.

MS. REINKER: Objection. I think, you know, assuming she has such a disturbance.

MS. ILER: Well, the doctor just said there was a disturbance.

MS. REINKER: Well, he's describing what the patient tells him.

MS. ILER: Just a minute, Sue, because I think these talking objections are sounding like testimony to me and the doctor is

certainly capable to tell me what he found in Cheryl.

MS. REINKER: Just note my objection to the form of your questions.

Q. Okay.

THE WITNESS: Would you reread the question for me, please?

(Record read.)

MS. REINKER: Objection.

A. I don't know.

Q. Do you know what the cause is?

MS. REINKER: Objection.

A. I can't find any objective disturbance in her femoral nerve or in the L4 distribution. My examination -- she has some sensory complaints and some disturbances on examination, but I'm not even absolutely certain that there is an ongoing femoral neuropathy. So that I can't say for sure, that this sensory disturbance that she has now, her complaints is definitely related to the vaginal hysterectomy.

Q. Is the sensory disturbance that you noted in your examination of July 20th, 1990 related to the femoral neuropathy that you say

that she had at the time of her hospitalization at University Hospitals?

MS. REINKER: Objection.

A. It could be.

Q. Have you found any other cause for the sensory disturbance besides a femoral neuropathy?

MS. REINKER: Objection.

A. Can't even find any definite evidence of a femoral neuropathy. I've already said her EMG is normal. She has no motor findings and as I -- honestly, as I could report there's a sensory disturbance in her right lower extremity within the L4 dermatome and saphenous nerve distribution. That's all I can tell you for sure.

I do think I've already reported that she had a femoral neuropathy. I'm not even sure if she does anymore.

By the way, can I make you aware of a mistake I forgot to tell you? The very first word on page four where I said examination on the July 20th letter, that should read radiculopathy.

Q. I'm not sure where you are,

doctor. Can you point?

A. Page four, the very first word.

MS. REINKER: It's five.

A. I'm sorry. Page five. I stand corrected.

Q. Instead of examination it should be radiculopathy?

A. Right.

Q. Doctor, when you use the word impression, what does that mean to you?

A. That is -- I suppose my conclusion would be.

Q. That's your diagnosis?

A. That's my -- yes.

Q. Okay. Doctor, from your review of the records and examination of Cheryl Ola, she did not have any metabolic disturbance that would have caused a femoral neuropathy, did she?

A. No.

Q. From your review of the records and your examination of Cheryl, she was not a diabetic?

A. I have no evidence that she's a diabetic.

Q. From your review of the records and your examination of Cheryl, she had no lumbar disc that would cause a femoral neuropathy?

A. None was found.

Q. Nor did --

A. Well, lumbar disc would not cause a femoral neuropathy.

Q. Would some disturbance in the lumbar column cause a femoral neuropathy?

A. No.

Q. Would any type of disc cause a femoral neuropathy?

A. No.

Q. Okay. What's a radiculopathy?

A. Opathy means disorder of, radicular means root, so it's a disorder of the root in the back, what is often referred to as a pinched nerve in the back.

Q. You didn't find any evidence from your examination and your review of the records that Cheryl Ola had a pinched nerve or radiculopathy, did she?

A. No.

Q. Nor did you find any evidence of any vascular event during the surgery that

caused her femoral neuropathy?

A. None that -- from the reports available to me.

Q. Nor did Cheryl Ola have a tumor mass that would have caused her femoral neuropathy?

A. No.

Q. Okay. Doctor, back to your July 20th -- I'm sorry -- yes, July 20th, 1990 report of your examination also under impression is chronic headaches, probably muscular contraction in type?

A. Uh-huh.

Q. What is a muscle contraction headache?

A. Tension headache.

Q. Do you have an opinion as to the cause of those muscle contraction headaches?

A. In her?

Q. Yes.

A. Yes.

Q. And what's your opinion?

A. I think she's anxious and depressed.

Q. Why is she anxious and depressed?

MS. REINKER: Objection.

A. I don't know fully.

Q. Isn't it true that she's anxious and depressed because she can no longer do the things that she could do before the vaginal hysterectomy and that has caused her anxiety and stress?

MS. REINKER: Objection.

A. I'm not sure I can answer that question in any meaningful way.

Q. Doctor, do you have an opinion as to whether or not the sensory disturbance that you documented in Cheryl Ola in her right lower leg is permanent in nature?

MS. REINKER: Objection.

A. I don't know at this point. I'm not sure. It would depend on the generator. I'm not sure just what the generator is.

Q. More likely than not, is it permanent?

MS. REINKER: Objection. He just answered that.

A. I honestly don't know. I genuinely don't know.

Q. In your experience with femoral

neuropathies --

A. If I knew the exact cause I might be able to give you a better answer.

Q. -- isn't it true that in the case of femoral neuropathy if you're going to see recovery you would have done so?

A. By two to three years out, yes.

Q. Doctor, what is a chronic pain disorder?

A. That's a person who's got pain for a long time.

Q. Have you made that medical diagnosis in your patients?

A. Yes.

Q. And what does that diagnosis entail?

A. Patient's history of having ongoing pain.

Q. That's the only criteria that you need?

A. It's a major factor, yes. Most patients with chronic pain do not have specific findings for that pain or a specific etiology.

Q. And what is your treatment for patients with chronic pain?

A. Avoidance of addictive drugs and a general, if you will, holistic approach to the pain, dealing with psychiatric organization, tricyclic antidepressants, which are very helpful in the treatment of the pain, and then depending on the -- specifically on the type of pain we're dealing with, physical therapy sometimes is useful, exercise, antiinflammatory drugs may be used for -- depends on the circumstances. Also, for the treatment of chronic pain is counseling, use of tricyclic antidepressants, biofeedback, those kinds of things.

Q. And that counseling is part of behavior modification to help a patient deal with the chronicity of the pain, is that right?

A. That and possibly if it's involved with the generation of the pain to deal with the etiology.

Q. Could I just have a few minutes -- I think I may be done -- to look over my notes?

A. Sure.

(Short recess taken.)

Q. Just a few more questions, doctor.

A. Sure. Please.

Q. Is there a connection between the femoral neuropathy that was documented in University Hospital records by the neurologist on the 18th and 19th of November and the sensory disturbance that you noted in your report of July 20th, 1990?

A. I'm not totally sure. There could be.

Q. Doctor, in the last ten years how many medical negligent cases have you reviewed?

A. Now, does that mean just looking at records or going to court?

Q. That means just looking at records.

A. I do this so sporadically it's difficult for me to give you a precise answer, but I would guess --

MS. REINKER: Don't guess, doctor. If you don't know, you don't know.

A. I would say perhaps on average three a year, something like that. Maybe four. I honestly am not sure.

Q. And you review those on behalf of the defendant doctor or on behalf of the

patient?

A. Both. I've been on both sides of the fence.

Q. And what percentage of medical negligent cases did you review for the patient?

A. I can't give you precise percentages, but I would guesstimate somewhere around a third. That would be a guess.

Q. In the last ten years, about how many depositions have you given in relation to medical negligence cases?

A. Medical negligence in the last ten years?

Q. Yes.

A. I would guess probably one a year on average.

Q. And of those cases that you gave depositions in, were those on behalf of the patient or on behalf of the doctor?

A. Both.

Q. What percentage were for the defendant doctor?

A. Maybe two thirds.

Q. In the last ten years about how many times have you appeared in court or

testified for trial in medical malpractice cases?

A. Medical malpractice?

Q. Yes.

A. One, two -- medical malpractice probably four, five that I've testified, something like that over the last ten years. Well, actually over the last 12 years, 13 years since I've been here.

Q. Of those cases that you testified at trial, what percentages of those were on behalf of the defendant doctor?

A. In court. I've gone to court for some on the plaintiff's side, but those have been against companies. I don't remember going up against one or being on the plaintiff's side that has gone all the way to court against a physician. So I can't recall having gone to court on the side of the plaintiff.

Q. So it's been on the side of the doctor when you've testified in court?

A. Yes. Usually when I testified for the plaintiff it doesn't get past the deposition.

Q. Yes. I'll have to remember that.

Have you testified for the firm of Jacobson, Maynard, Tuschman & Kalur before?

A. In court? Have I gone to court?

Q. Have you gone to court?

A. That's a question.

Q. That's a question.

THE WITNESS: Do you know?

MS. REINKER: I don't remember any.

A. I can't recall. I can only tell you if I have, it's been like one or two. I can't remember specifically. I might have, I just don't know.

Q. Have you reviewed cases for the firm of Jacobson, Maynard, Tuschman & Kalur before?

A. I was actually trying to recall that for you and I can't -- I think I looked at some cases one time at a meeting downtown about seven or eight years ago. Two or three of us met as a panel.

Q. That's when you sat on the review board of the Physician Insurance Exchange, isn't it?

MS. REINKER: Objection.

A. You know, I really can't remember under what capacity, but I think I've done that once, and my guess is that I have looked at some other cases, but I can't really specifically remember.

Q. Okay. Are you an insured of Physician Insurance Exchange?

MS. REINKER: Objection.

A. Yes.

Q. Are you going to testify live at trial next week?

A. I've been asked to. I'm prepared to.

Q. You're prepared to, okay.

MS. ILER: We would ask for a waiver of signature.

MS. REINKER: I suggest that you review the deposition since there are medical terms involved, that you not waive your signature and have a chance to review it.

THE WITNESS: Oh, okay.

(Deposition concluded at 6:50 o'clock p.m.)

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CERTIFICATE

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

I, Donnalee Cotone, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, MICHAEL WILLIAM DEVEREAUX, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 30th day of November, 1990.

Donnalee Cotone

Donnalee Cotone, Notary Public
within and for the State of Ohio

My commission expires January 14, 1992.