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First Name	Edward
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IN THE COURT OF COMMON PLEAS

CUYAHOGA COUNTY, OHIO

TRICIA FORMICK,	)	CASE NO. 451559
Plaintiff,	)	JUDGE STUART A. FRIEDMAN
versus	)	
MADELEINE M. LENOX, M.D.,	)	**DEPOSITION OF**
Defendant.	)	**EDWARD FINE, M.D., Ph.D.**

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Deposition of **EDWARD FINE, M.D., Ph.D.**, a Witness herein, called by the Plaintiff for cross-examination pursuant to the Ohio Rules of Civil Procedure, taken before the undersigned, Denise Chulik, RN, a Registered Professional Reporter and Notary Public in and for the State of Ohio, at The Cleveland Clinic Foundation Westlake, 30033 Clemens Road, Third Floor, Westlake, Ohio, on Wednesday, July 9, 2003, at 2:40 p.m.

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APPEARANCES:

On Behalf of the Plaintiff:

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I N D E X

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WHEREUPON,

EDWARD FINE, M.D., Ph.D.,

after being first duly sworn, as hereinafter certified, testified as follows:

CROSS-EXAMINATION

BY MR. KULWICKI:

Q. Doctor, why don't you state your full name and spell your last name, and give us your current business address, where we're at today.

A. Edward Fine, F-i-n-e, 30033 Clemens Road, Westlake, Ohio 44145.

Q. And Doctor, you are a board-certified otolaryngologist; is that correct?

A. Yes.

Q. Do you hold any other board certifications?

A. No.

Q. All right. Now, in this case, Dr. Lenox has given the opinion that Ms. Formick's problems with regard to her spinal accessory nerve are related to an infection. Do you agree with that?

A. Yes.

Q. Tell me how many cervical lymph node dissections you've performed in the course of your career, roughly.

A. I'd say 50.

Q. And have you ever had this particular complication develop?
A. No.
Q. Have you ever had a complication develop wherein the spinal accessory nerve was compromised and the patient developed some type of palsy or injury related to that with the cervical lymph node dissection?
A. With a radical, more radical types of surgery, yes.
Q. As I understand it, there are varying degrees of lymph node dissection that you can do in this area, and the most radical would be one that involves the recovery of a number of lymph nodes, and then there's a modified radical, and then you've got what we have here, which would be the simplest of those procedures. Fair enough?
A. Yeah, that's pretty accurate; yeah.
Q. And with regard to the radical, you have had to sacrifice the spinal accessory nerve in the course of a radical dissection; correct?
A. Exactly.
Q. But you've never had this complication in the course of doing a simple resection of a single lymph node; correct?

A. True.
Q. I know what I wanted to ask you -- did you know Dr. Lenox before this case?
A. I know who she is.
Q. You trained at UH; she is affiliated with UH. Did you know her through that?
A. We had some vague interactions that, I think she trained at the clinic, mainly.
Q. Tell me about your vague interactions. What do you mean by that?
A. Well, I was a resident, and she was a -- maybe for a year or two, and I didn't really -- I don't know specifics.

She was an attending who was in the community, a community-based attending, which means she would do most of her surgeries, I believe out at that Green Road facility at this time.

Rarely, if she had a bigger type of case that she needed resident help with, she would do it at the University Hospitals main campus.

Q. Okay; and were there occasions when she had these bigger cases at the main campus that she would have, you would have been assisting her as a resident?

A. I would say rare. Maybe one; very rarely.
Q. Okay.
A. Typically she did most of her stuff out at Green Road.
Q. And then on either end of that, did you know Dr. Lenox before that interaction, or since then, have you had any interaction with her?
A. Well, because she works in Cleveland and I work in Cleveland, there's certain professional venues that we see each other at, but I don't socialize with her in any way or see her outside of the realm of those settings.
Q. Have you discussed this particular case with her?
A. No.
Q. Now, have you done any medical research with regard to any of the issues in this case?
A. Do you mean formal research on --
Q. Or informal. Have you looked at anything with regard to spinal accessory nerve injury as a result of cervical lymph node dissection?
A. Nothing recently. I mean, I didn't prepare per se.
Q. So specifically, with regard to this case, you didn't open up your computer or go into some books or whatever to look at anything?

A. No.
Q. Are you aware of any literature, based on your general knowledge, that specifically talks about nerve injury as a result of infection?
A. If you ask me to quote specific articles or chapters, I would be hard pressed to identify one or two things. There's a certain number of standard, you know, textbooks that usually we refer to.
Q. What would those be?
A. There's one called Bailey, which is sort of a standard ENT/head-neck surgery type textbook.
Q. Any others that come to mind?
A. Not off the top of my head.
Q. Now, when you in one of your 50 or so cases, when you do that, remove cervical lymph node, do you make yourself available for patient emergencies by carrying around a beeper and having a paging service where your patients can call if there's some postop complication?
A. Yes.
Q. And based on your training and experience, is that a standard practice for surgeons or ENTs who do this type of operation?
A. Yeah.

Q. And can we agree that it would be reasonably safe or careful to respond to a patient's complaints of inflammation or infection in the surgical site during the five-day period following this surgery?
A. Yeah, I would say it's reasonable for, you know, me or -- I mean, I've got a partner.
Q. So in other words, either you or your partner will cover?
A. Somebody's responsible, absolutely.
Q. Okay. With regard to the mechanism of injury, why don't you just tell me, if you would, what you think happened, and what led to this lady's injury.
A. As far as I can tell from reading what was -- the information that was provided to me, she had this biopsy done under what they call MAC, which means she wasn't completely paralyzed.

She was breathing spontaneously, which would key you into any concerns about injury to the nerve, usually, while the procedure's going on.

It sounded like from what I read that there was -- let me check and see -- but not immediately, but a day or two later, when there was a call made to Dr. Lenox's office indicating

that there might be some drainage from the wound and some weakening of the arm on that side. That's the crux of what I saw or, you know, read about what was going on here.

Q. Okay.

A. That's the left side of the neck.

Q. And in terms of your opinions that you'll give at trial, are you planning to explain how the infection led to damage of the nerve?

A. Well, the way I would put it together is, first of all, by history, this area of the neck had been operated on before, and that can result in some scarring.

You don't have the normal tissue planes that can separate freely, and if there's an infection that develops postoperatively, that could impair functioning of the nerve. That's how I put together what happened here.

Q. And tell me, if you would, specifically how an infection would impair the functioning of the nerve.

A. Well, infection usually causes inflammation, and what is called the host response, which is the body's attempt to wall off and fight the infection.

If that whole process occurs adjacent to the nerve, it could potentially impair the functioning of the nerve.

Q. So it would actually be inflammation of surrounding tissues compromising the nerve or pressing on the nerve, somehow causing --

A. Impaired function.

Q. -- impaired function; okay. It wouldn't be something like the infection actually eating away at the nerve itself, would it?

A. That would be very rare. Depending on what type of bacteria it was, there's some unusual bacterias that can do that, but I think that would be unusual, very unusual.

Q. Like the so-called flesh-eating bacteria?

A. Exactly.

Q. And there's no evidence that those were present in this case, is there?

A. Not that I can see.

Q. Now, let me back up: You talked about MAC, and can you tell me what that stands for?

A. I'm sorry. MAC stands for monitored anesthesia care. There's usually -- and again, I'm not an anesthesiologist; this is my perception.

There's usually three components of

anesthesia: One is amnesia, one is pain control, and one is muscle paralysis; and if you're going to operate in an area that you are concerned about the nerve and nerve functioning, you want to be able to monitor that nerve during the course of your procedure.

And monitored anesthesia care means you can have amnesia and anesthesia, but you don't necessarily have to have muscle paralysis.

So if you're getting near a nerve, stimulating it or irritating it, you would expect a sign of that specifically; the arm to move or the patient to twitch or something like that.

Q. Now, in reading the records myself, I don't see specifically any reference to MAC. Is it specifically referred to as monitored anesthesia care or MAC in the records?

A. Give me a moment.

Q. I guess you looked at the operative note. I do see it now.

A. Yeah.

Q. Do you see the operative note? Actually, underneath where it says "Anesthesia," I see MAC there now.

A. Right.

Q. Now, even with MAC, there is a local anesthetic in the area where the incision is being made; is that correct?
A. Exactly. You're right.
Q. And can that cause some anesthesia of the nerve?
A. Usually that anesthetic that's injected is injected very superficially; if it wasn't injected superficially, and by "superficially" to actually numb the skin, most of the sensory nerves in this area are in the skin, and once you get through the skin, pretty much anything under that is not real sensitive to pain.
Q. Okay.
A. And -- but you're right; if you were to inject it deep, you could have some numbness of or anesthesia of the nerves.
Q. And might that impair its response to being compromised intraoperatively?
A. That's a possibility.
Q. Now, in Dr. Lenox's description of the surgery, does she describe any unusual anatomy in this patient?
A. Let me just review it for a moment just to be sure.
Q. You bet.

A. No, it doesn't sound like there was anything unusual done, or unusual anatomy described.
Q. Does she describe encountering any difficulty in dissecting the spinal accessory nerve away from the lymph node that was removed?
A. No.
Q. Now, in your practice, do you typically identify the spinal accessory nerve during this particular type of surgery?
A. I would not, as a routine.
Q. All right. Would you typically describe it in your note, either as being not identified or identified and isolated?
A. I might describe it as not being identified; not as a routine, though.
Q. Now, in the 50 or so cervical lymph node dissections that you've performed, did you use a local anesthetic as opposed to general anesthesia?
A. Usually, yeah. You use this MAC; is that what you mean?
Q. I guess so. I guess what I'm referring to is local as opposed to general, and I assume MAC is a form of local anesthesia?
A. Yeah, it's sort of an attended local, which means you have an anesthesiologist by. Yeah; this is,

in my mind, the preferred technique, because you do have concerns about injury to that nerve.

Q. Okay. In fact, have you ever done a simple single lymph node resection in the cervical region under general anesthesia, or has it always been with local or MAC?

A. No, I have done it under general anesthesia, too.

Q. And under what circumstances would you do that?

A. Usually if it's a kid -- a child, someone who may not be able to sort of handle some of the stress associated with sort of being in the twilight sleep, you just put them to sleep. It sort of helps you control the surgical situation.

Q. Now, you made a statement earlier that when there's monitored anesthesia care, that if there's injury to the nerve intraoperatively, the response of the associated muscle usually keys you in to an injury to that nerve, and the way you said it was, it usually keys you in; and I want to focus on the qualifier of "usually."

A. Uh-huh.

Q. And ask if it's possible that you can cause injury to the nerve and not have some physiological response in the associated, the enervated muscle.

A. At the time of surgery?

Q. Yes.
A. Well, if you had infiltrated, or injected would be a better term, lidocaine into the area, you could anesthetize the nerve, and then if you came close or stimulated it and were expecting motion or some sign, you might not get it.
Q. Now, in terms of draping the surgical area, what's your typical practice? How much draping do you do, and what would you expect to be exposed on the patient?
A. Typically, I would put a shoulder roll under the patient to extend the neck, turn the head, in this case to the right so the left neck was exposed, and drape an area that's probably three or four inches on a side.
Q. And would you expect, for instance, the shoulder area to be covered in draping during this procedure?
A. I typically would do that.
Q. Now, are there techniques that you use during cervical lymph node dissection to protect against injury to the spinal accessory nerve?
A. For an isolated lymph node that you're concerned with like this case?
Q. Yes.

A. Besides using the monitored anesthesia care and being sure or trying to be sure that I inject superficially so you don't impair the ability of the nerve to function, I routinely don't use -- there's some monitors that you can use for more extended types of dissection. That isn't usual for me, what I would do.

Q. But in terms of the actual procedure itself, I've heard it described as gently teasing the lymph node away from the surrounding tissue so as not to cause injury to the nerve.

A. Okay.

Q. Is that something that you would employ as a safe practice?

A. Yeah.

Q. Okay.

A. Trying to stay right on the surface of the lymph node so once you've identified the superficial surface, stick close to it so that you don't unintentionally injure any surrounding tissue is a good strategy.

Q. And speaking of that, one of the goals of the surgery would be to preserve the tissues around the lymph node as best as possible; correct?

A. Exactly.

Q. And in terms of the posterior triangle, that's the area where the surgery's taking place; correct?
A. Um-hum.
Q. Oh, by the, way you have to say "yes" as opposed to "um-hum."
A. Sorry. Yes. Thank you.
Q. In terms of that area, the posterior triangle, the only vital structure that runs through there would be the spinal accessory nerve; correct?
A. Yeah, you could say that. I mean, there's some pretty significant-sized blood vessels that run through there, and there's some nerves that run deep to that, but for all intents and purposes, the spinal accessory nerve is the major structure that you want to try to preserve.
Q. And I further understand that when doing this procedure, one of the techniques that you would use would be to place a suture in the lymph node itself to assist you in teasing it away or pulling it away from the surrounding tissues. Is that something that you do?
A. No, I usually don't do that.
Q. Okay.
A. My experience is the lymph node is too friable, and sticking a suture in there, you would just

pull the suture out, so you might have to use a gentle forceps, which is a grasping tool, or blunt dissection, which means small pieces of gauze wrapped around your finger, or other real blunt dissecting techniques.

Q. Okay. Now, in terms of achieving hemostasis after the lymph node's been removed, it's my understanding that typically you can do that simply by putting pressure on the area where the vessels are bleeding at. Is that your experience?

A. That's reasonable, very reasonable, yeah.

Q. Okay, and I further understand that if you do have excessive bleeding you can control that through the use of sutures right on the bleeding vessel; correct?

A. That's an option, yes.

Q. And the other option would be the use of electrocautery; correct?

A. Right.

Q. Now, of the three options, is the electrocautery the most, for lack of a better word, the most dangerous, or it carries the most risk; would you agree with that?

A. Yeah, I think that's reasonable to say.

Q. Now, in your experience in the 50 or so cervical lymph nodes that you have dissected, have you had occasion to use electrocautery?
A. Yes.
Q. And under what circumstances would you use it?
A. Failure of those other prior two ways to control bleeding, either pressure or suture.
Q. So let's say in your note, would it say something to the effect that uncontrolled bleeding or excessive bleeding, or bleeding not being able to be or not able to be controlled with pressure or sutures, and therefore, electrocautery was used?
A. Right.
Q. Okay.
A. I would typically say, yeah, excessive bleeding or was controlled with cautery.
Q. So you would spare the use of electrocautery in a case where there was mild or easily-controlled bleeding?
A. Right, and that's a judgment sort of a thing, depending on how big the lymph node is. Ideally you try to do this without putting a little drain in, and that's why you want it reasonably dry.
Q. Okay.
A. And so there's some focus on keeping things dry.

Q. Yeah, I would be.
A. It's pretty dry stuff.
Q. I'm a pretty dry guy, so maybe I'll like it. Now, we can certainly agree, then, that in this case we're not talking about radical neck surgery; correct?
A. Right.
Q. And Doctor, in terms of your medical-legal involvement, again dealing with cases where you've been asked by one party or the other to render opinions or review records involving medical care, in other words, like a medical-negligence action, have you looked at cases or testified in cases involving medical care in the past?
A. Yes.
Q. And how many times would you say you've looked at records on behalf of lawyers in a medical case?
A. One or two.
Q. And have those been always where you've been asked on behalf of the lawyer representing the doctor to look at records?
A. No.
Q. Have you looked at records on behalf of a patient or a patient's lawyer?
A. Actually, I did. I actually worked with Howard

Mishkind on some case.

Q. That was actually, I think, was it a car accident case?

A. Right.

Q. But in terms of cases where a doctor's care of a patient is called into question --

A. Yeah.

Q. -- have you ever looked at records on behalf of a lawyer who's representing the patient?

A. I don't think.

Q. And on the occasions, a couple of occasions where you've looked at records on behalf of the attorney representing the defendants, do you remember who the defense lawyers were that you assisted or looked at records on behalf of?

A. Besides what I mentioned?

Q. Right.

A. I've done some looking at insurance -- on behalf of state insurance companies; just a couple.

Q. Okay.

A. That's about it.

Q. Have you done any work with Ms. Mitchell or Mr. Auciello, either of them or their law firm in the past, Gallagher Sharp?

A. Never.

Q. Do you know how they got your name in this case?
A. I don't.
Q. Have you actually testified in what we call a deposition; that's this setting here, where one lawyer asks you questions and a court reporter takes down your answers?
A. Once.
Q. Was that with Mr. Mishkind?
A. Twice.
Q. Okay; and what was the second one?
A. I was involved in a suit where someone was -- a lawsuit against me.
Q. And what was generally the facts that were involved in that case?
A. The facts were, there was an elderly woman who ultimately had an unrecognized esophageal perforation following a procedure.
Q. And was that case ultimately dismissed?
A. It was -- it went to mediation, and it was settled.
Q. Besides your medical practice and a couple of case that you've looked at in the past couple of years, do you do any, do you have any other professional activities?
A. No. Do you mean, do I do anything outside of what

is apparent here to use my medical degree or whatever?

Q. Yes.

A. No, none.

Q. You note in your CV that you had some dealings with Dr. Shuck at UH. Are you familiar with Dr. Shuck's opinions regarding medical negligence and his sort of negative philosophy about lawyers and lawsuits and that sort of thing?

A. No, I'm not.

Q. Okay.

A. I was -- the only reason I had any dealings with him is when I did my general surgery year, which is an internship year, he happened to be the chairman of the department.

Q. Right.

A. We all avoided him as much as we could.

Q. Doctor, I assume your medical license has never been restricted, revoked, suspended or called into question in any way; correct?

A. Correct.

Q. And I also assume that your staff privileges at any hospital have not been restricted, suspended, revoked or called into question in any way. True?

A. True.

Q. Would you agree that if proper care is taken in dissecting an inflamed lymph node that is non-cancerous and doesn't have any other pathology attached to it, like cat-scratch fever, that being careful, you can avoid injury to the spinal accessory nerve?

A. Yeah, I think that's usually how it works out. I agree.

Q. Do you have any plans to do any research relative to the facts of this case?

A. None.

Q. Let's talk about the injury involved here. First of all, can we agree that a healthy shoulder with proper enervation has a dynamic equilibrium of muscle forces that keep the shoulder in place?

A. Yes.

Q. And that when there is injury to the spinal accessory nerve, that dynamic equilibrium of muscle forces it, or that dynamic equilibrium is disrupted?

A. Potentially.

Q. It's my understanding that normally, the spinal accessory nerve is the sole nerve enervating the trapezius muscle?

A. True; it's my understanding.

Q. And that one of the features of injury to the spinal accessory nerve is pain; would you agree with that?
A. I'd have to check on that.
Q. Okay.
A. I thought it's mainly a motor nerve, not necessarily sensory, so I'd have to see.
Q. Yes, I agree with that, and I should clarify my question, but that when the motor function of the trapezius muscle is affected through injury to the spinal accessory nerve, that disruption of this balance of muscles around the shoulder can lead to a pain syndrome?
A. I think that's my understanding.
Q. All right. Do you have any opinions with regard to the prognosis for this patient currently?
A. As it relates to recovery of nerve function or trapezius muscle function?
Q. Right.
A. Well, there were some nerve studies that Ms. Formick had undergone which, to the best of my interpretation, show that there was a partial injury of that 11th cranial nerve.

And I'd have to retest the rechecking, which I believe was recently done, but it did show

that there was improvement in the functioning of the nerve. Again, the actual -- I'll have to rely on the interpretation by the neurologists.

Q. Right. Assuming that to be the case, would you anticipate that she has any permanent injury as a result of this initial problem that she had?

A. Well, I would -- she could possibly have some permanent injury. I think the fact that there has been some improvement is encouraging, and the ultimate, final outcome may be seen in the future.

Q. Sitting here today, you don't have an opinion to a reasonable degree of medical probability as to what her future holds, do you?

A. In terms of ability to move her arm?

Q. Correct.

A. Or raise her arm above 90 degrees? Yeah. I don't have; I don't have a specific opinion as to the amount of function that she will regain.

Q. If, in fact, Ms. Formick did have disability or pain associated with the injury to the spinal accessory nerve in the immediate postoperative period, could we agree, then, that the infection was probably not the cause of her spinal accessory nerve injury?

A. Okay; I'm sorry, can you repeat it? I was

distracted.

Q. Sure; fair enough. If you were to assume that, in fact, her problems with pain and dysfunction in the shoulder occurred immediately in the postoperative period, could we then agree that the injury to the spinal accessory nerve was not caused by the infection?

A. My interpretation of what you're asking me is if she woke up in the recovery room or that night or the next day and called and said, "Look, I got this problem. I can't raise my arm," then in my mind, there was an intraoperative injury to the nerve.

Q. And in terms of in the postoperative period, she was on, she was prescribed, I believe Tylenol 3's; I think that's right. What is Tylenol 3, by the way?

A. Tylenol 3 is a combination of codeine and acetaminophen that is commonly used in the immediate postoperative period.

Q. So would that have an effect of being both a sedative and a pain reliever?

A. The shouldn't have much sedative effect. It should mainly be a pain reliever.

Q. Okay.

A. Analgesic.
Q. And following this procedure, would you expect there to be some discomfort in the neck area that would be a natural part of the surgery itself?
A. I would expect a day or two of pain that would require a narcotic to help get a person through that period.
Q. Now, if a patient does experience some compromise of the spinal accessory nerve but not total compromise of the spinal accessory nerve intraoperatively as a result of one of these surgeries, what would you expect the postoperative course to be like?
A. In my mind, some of it would depend on the mechanism of injury; then there's potential options in terms of a little bit of crush.
Q. Right.
A. Where you would immediately notice some impairment, but if there wasn't too much damage, you would get progressive improvement of the functioning of the nerve.
Q. Okay.
A. The scenario that we're kind of looking at, where initially her arm was all right, but then a day or two later she started to notice drainage and pain,

which again is an infection, that shows a different time course.

But again, I would expect improvement spontaneously after the infection was controlled. Is that sort of along the lines of what you're asking me?

Q. Yes, but if, in fact, the nerve was lacerated intraoperatively -- not completely cut in half, but lacerated -- what sort of postoperative course would you expect?

A. Well, I would expect immediate, partial paralysis, paresis.

Q. And what would you expect if the nerve was burnt through with electrocautery; what would you expect postoperatively?

A. Well, then I would expect a scenario similar to being cut, where there would be immediate inability for the nerve to function.

Q. Okay.

A. But depending on the level of burn, progressive improvement.

Q. And in terms of the patient recognizing this immediate paralysis, there would not be a loss of sensory function in the trapezius; correct?

A. Usually. I would say no, yes.

Q. So in other words, the patient wouldn't feel a paresthesia or anything; right?
A. Numbness, right.
Q. Okay, and they wouldn't feel pain either, would they?
A. Immediately?
Q. Right.
A. Nothing more than associated with the incision.
Q. Now, are you familiar with any of the risks associated with injury, the long-term complications associated with spinal accessory nerve injury?
A. Only in very general terms. I don't deal with it routinely.
Q. Would you agree that one of the long-term risks associated with spinal accessory nerve or complications associated with it would include thoracic outlet syndrome?
A. No, I'd have to defer to a neurologist or somebody who has more experience.
Q. Well, let me ask it this way: What's your understanding of what would be the potential complications or risks of spinal accessory nerve injury over a long period of time?
A. Well, you would have an inability to raise the

arm; pain, as we sort of alluded to earlier; there's an asymmetry of the shoulder girdle, based on the -- the name of the bone is slipping my mind now, but the bone, the bone sort of cants out and becomes bat-winged.

Q. The scapula?

A. The scapula, thank you -- on that side, long-term; secondary, to the best I know, loss of tone of the trapezius.

Q. Besides being able to do overhead work, have you heard of complications associated with spinal accessory nerve injury that make it difficult to do activities that involve forward extension such as cutting meat, driving, or writing?

A. That may be. Again, because I haven't really delved into it, I would feel uncomfortable saying one way or the other.

Q. Doctor, do you agree that the follow-up care that Mrs. Formick has received has been appropriate; in other words, are you critical of any of the surgeons or physicians that treated her after she discovered that she had this injury?

A. No. She was started on an antibiotic expeditiously orally, and a cream to apply to the area.

Q. Okay.
A. So in terms of controlling the infection, I think that was a real reasonable thing to do.
Q. How about in terms of going to see a neurologist, going to see Dr. Hardy? And I think that's about all that she did in terms of when she learned that she had damage to her spinal accessory nerve; that's pretty much what she did.

Were the actions of Dr. Mann, the neurologist, and Dr. Hardy, the surgeon, were they appropriate and reasonable, in your opinion?

A. Yeah, I think they were very appropriate.
Q. Okay.
A. She also went to see a -- went to see Dr. Esclamado, which is a second opinion, somewhere along those lines. Yeah, that's exactly what I would have done if this happened to me.
Q. And his care was appropriate under the circumstances?
A. I think so.
Q. And Tricia's follow-up in terms of trying to get this repaired and going to Dr. Esclamado and Dr. Mann was appropriate?
A. I think so, yes.
Q. Are you critical of her in any respect with regard

to her follow-up of this condition?

A. Not at all. I'm sure it's very frustrating for her to have that kind of difficulty, given what she does for a living.

Q. Yes. Now, Doctor, assuming that Ms. Formick does have a pain syndrome associated with her spinal accessory nerve injury, first of all, would that type of presentation be consistent with this injury; in other words, a pain syndrome?

A. Yeah, I'd have to refer to my neurology colleagues.

Q. And here she is now about five years postop. Would you expect that if she does have a pain syndrome associated with this injury, that it would be permanent in nature?

A. Again, I'd just have to refer to them.

Q. Okay.

A. I couldn't really give you a good, informed opinion about that.

Q. Are you aware of any treatments that were available to --

A. She's about four years out, excuse me.

Q. Fair enough. Are you aware of any treatments available to her that may improve her condition or that she hasn't tried yet that may assist her in

recovering from this injury?

A. Again, I think that's more the realm of the neurologist. In terms of exercises, things along those lines?

Q. Surgeries, exercises, anything.

A. Part of the problem that I see is there is a -- and it's not a problem; it's fortunate that she does have some re-enervation, and that's encouraging.

And the last study that she had, which looks like it was March of 2002, by Dr. Katirji, shows that she had significant re-enervation with marked improvement of the right spinal accessory neuropathy, which is sort of an encouraging thing; and I don't know -- I would again have to defer to them whether there's any value to retesting her now a year, year and a half after that.

Q. In general, can we agree that EMGs do have their limitations?

A. Again, I'm going to have to defer to one of the neurologists.

MR. KULWICKI: I think that's all the questions I have. Why don't you give me a few minutes to confer with my co-counsel and we'll come back and wrap up.

THE WITNESS: Sure.

Q. I know what we should do -- why don't we mark your report as Exhibit 2, and if you could, just for the record, identify this report; in other words, confirm that it is, indeed, your report in this case.

(Plaintiff's Deposition Exhibit No. 1, Curriculum Vitae of Edward Fine, M.D., Ph.D., and Plaintiff's Deposition Exhibit No. 2, Dr. Fine's report of May 20, 2003, marked for identification.)

Q. I'll give you that, Exhibit 2.

A. Yeah, I think that's mine.

Q. Have you prepared any other reports or drafts of this report?

A. No.

Q. Do you have any notes relative to your investigation into this case?

A. Just what you've sent to me.

Q. Okay, very good. Doctor, one of the things in a medical negligence case that you may be asked to opine about is what the standard of care is, or what you consider to be the standard of care in this case. How do you define that term, standard of care?

A. I may be able to opine?
Q. Yes. Opine, give opinions?
A. Oh, opine. Do I think this is standard of care?
Q. No, what I was asking you to do is define "standard of care."
A. Define the term "standard of care"?
Q. How do you define that?
A. In my mind, that's something that going to a, I'll say community-based physician, you would have the expectations of having a certain level of treatment provided.

And by a certain level, I mean, aggressiveness, work-up, things they usually do that usually go into a normal interaction with a patient.

Q. So I guess maybe to clarify, are you saying that it's what you would expect a physician in a particular community to do in terms of evaluation or treatment of a particular patient?
A. Yeah, that's a good summary.
Q. Have you had a chance to read Dr. Barnes' deposition?
A. I did.
Q. And other than the basic opinion about what caused this spinal accessory nerve injury, do you have

any other specific areas of disagreement with Dr. Barnes?

MS. MITCHELL: Dave, can I interject for a second -- I think the doctor thought you were referring to the report.

MR. KULWICKI: Oh, okay. All right.

Q. So you've read his written report, but not his deposition transcript?

A. Right.

Q. Okay.

A. Yes.

Q. And again, in terms of differences between you and Dr. Barnes, the obvious one is that Dr. Barnes feels that this was an intraoperative injury, and you feel that it was as a result of the infection,

A. Yes.

Q. But other than that difference, are there any other areas that you differ with Dr. Barnes as far as his report is concerned?

A. Well, I don't necessarily agree with a lot of the stuff he put in this report; and, you know, I don't know how detailed we want to get.

Q. Did you make any notes, by any chance, on his report?

A. I did make some notes, yeah.

Q. If I could just ask you about those?
A. Sure. Do you want a copy of that?
Q. Well, why don't you just run through it?
MS. MITCHELL: May I see it when you're done?
MR. KULWICKI: Sure.
Q. Why don't you just run through your notes and just tell me what you've written.
A. Okay. Well, I wrote -- paragraph by paragraph?
Q. Why don't we start with right here? You have a question mark, and you say "not at all." Can you just tell me what you were thinking when you wrote that?
MS. MITCHELL: That's at the bottom of the second paragraph?
MR. KULWICKI: Correct, yes.
A. Well, I had a question after that. I just wonder how well -- here he indicates that from the records -- this is my understanding -- that he gleaned that she could not move the arm.
Q. And you didn't think that was quite --
A. Well, no. My question to him would be, could she not move it at all; okay?
Q. Oh, okay.
A. Okay? And that's a much different scenario than

what we're talking about.

Q. Okay.

A. I mean, all this is in the left neck. Minor stuff, but --

Q. So he had the wrong side of the neck in his report?

A. He's got the wrong side of the neck throughout this. He indicated that things were pretty prominent, but the lymph node is barely a half-inch in size, and so -- one centimeter by one centimeter by one and a half.

So again, they're just minor things. It's just when I look at this, I'm just trying to sort of figure out what he's talking about.

Q. Incidentally, a centimeter would be about, what -- the size of a dime or something? Is that what we're talking about; maybe a little smaller?

A. Probably a little smaller. I usually have a ruler here.

Q. That's all right. You don't have to give it exactly.

A. A little less than half an inch.

Q. Okay. All right; and then at the bottom of the page, you have some writing here. Can you just run through that briefly and tell me what you

wrote?

A. Sure. Well, there's no mention of postoperatively, I didn't see where she was seen by Dr. Rosenberg.

Her surgery, I believe, was done -- and let me get these correct -- let me figure out the specific date -- I'm sorry -- that this was done; the 16th of November. I'm sorry, it looks like October 20th.

Q. I believe October 20th was the date of surgery. Okay, so he got the date of surgery wrong in his report?

A. Let me be sure. I'm sorry I'm not better organized. Do you have a copy of that operative note?

Q. The op note? It's really not that important, Doctor. I think, in fact, he did get it wrong in his report, and corrected it in his deposition.

But just really for our purposes, I'm just trying to understand what your notes say here, so it's really not important for us to clarify that. I can find it if you really want to see it.

A. The op note?

Q. Yes.

A. Sure.

Q. In terms of when you give your patients antibiotics postoperatively for this particular procedure, have you had any problems with them developing infections?

A. I've had more problems with them developing upset stomachs. That isn't uncommon. To answer your question -- I'm sorry -- I haven't had any difficulty with infection, but that's my own particular -- how I was trained.

MR. KULWICKI: Why don't we take a quick break, and I think I may be done.

THE WITNESS: Of course.

(A short recess was held.)

MR. KULWICKI: Let's just wrap up here.

Q. Doctor, when we first began the deposition, you had mentioned something about operative scarring and how that may have affected the outcome.

And I don't want to put words in your mouth, but you mentioned something about her not having normal tissue planes or something. Tell me what you meant by that.

A. Usually if you enter a virgin neck, native neck, one that hasn't been operated on, all the paths or planes that divide the muscles from the overlying soft tissue or muscles from each other are easily

spread apart, usually with just a finger, or what I would call bluntly.

If somebody has entered the neck for whatever reason, then there's sort of the natural body's response to heal, and with that you get some scarring; and that can cause adhesions or sort of attachment of these normally unattached muscles or tissues together.

Q. So if she had surgery in the same area as this surgery that we're talking about here, that might have made it more difficult to do the dissection; is that what you're saying?

A. Yeah, I think it would, definitely.

MR. KULWICKI: Okay. That's all the questions I have, and you have the right to review the transcript; and Ms. Mitchell may, or Mrs. Mitchell may have some advice for you in that regard.

MS. MITCHELL: I know you've only been deposed twice before. You do have a right to review the transcript to make sure that your words were taken down accurately -- obviously, you can't make any changes to the testimony you've given -- or you can trust the court reporter that she took everything down.

Since this was a fairly short deposition, it's a comfort level for you. I don't see any problems in waiving, but you're entitled to read.

THE WITNESS: Okay.

MS. MITCHELL: What would you like to do?

THE WITNESS: If I read, what does that mean? That means I get a copy of the transcript before?

MS. MITCHELL: Right. That means that the court reporter, who will most likely be providing an expedited transcript if possible, will forward a transcript within seven days of its preparation.

And since trial is next week, it would be a problem. You can read through it and correct any errors on what's called an errata sheet --

THE WITNESS: Yeah.

MS. MITCHELL: -- and then report that to me, and I'll return that to her. Really, it's your own comfort level. This wasn't --

THE WITNESS: Well, I guess I can waive this.

MS. MITCHELL: Okay. So just for the record, if you want to say you wish to waive signature?

THE WITNESS: For the record, I wish to

waive signature.

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(Deposition concluded at 3:42 p.m.)

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C E R T I F I C A T E

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

I, Denise Chulik, a Registered Professional Reporter and Notary Public in and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within-named Witness, **EDWARD FINE, M.D., Ph.D.,** was first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony so given by him was by me reduced to Stenotype in the presence of the witness, and that the foregoing is a true and correct transcription of the testimony so given by him as aforesaid.

I certify that this deposition was taken at the time and place in the foregoing caption specified.

I certify that I am not a relative of, employee of or attorney for any of the parties in the above-captioned action, that I am not a relative of or employee of an attorney of any of the parties in the above-captioned action, that I am not financially interested in this action, and that I am not, nor is the court-reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28 (D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Akron, Ohio, on this 10th day of July, 2003.

Denise Chulik, RN, RPR & Notary Public
My Commission Expires August 9, 2005