IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

KARL J. YOST, etc., et al — NO. 449275
Plaintiffs
VERSUS — JUDGE TIMOTHY J. McGINTY

THE CLEVELAND CLINIC FOUNDATION
Defendants

Videotaped deposition of DR. BRUCE FISCH, 1542 Tulane Avenue, Conference Room 219 A, New Orleans, Louisiana, 70112, taken in his offices, on Tuesday, the 13th day of May, 2003.

APPEARANCES:

(Via telephone)
BECKER & MISHKIND CO., L.P.A.
(By: Michael F. Becker, Esquire)
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ATTORNEYS FOR THE PLAINTIFFS

REMINGER & REMINGER CO., L.P.A.
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ATTORNEYS FOR THE DEFENDANT

REPORTED BY:

NANCY LAPORTE
Certified Court Reporter
State of Louisiana

S T I P U L A T I O N

It is stipulated and agreed by and between counsel for the parties hereto that the deposition of the aforementioned witness is hereby being taken pursuant to Rule 30 of the Ohio Rules of Civil Procedure;

That the formalities of reading and signing are specifically not waived;

That the formalities of sealing, certification, and filing are specifically waived;

That all objections, save those as to the form of the question and the responsiveness of the answer, are hereby reserved until such time as this deposition, or any part thereof, may be used or sought to be used in evidence.

NANCY LAPORTE, Certified Court Reporter, in and for the Parish of Orleans, State of Louisiana, officiated in administering the oath to the witness.

DR. BRUCE FISCH,

after having been first duly sworn by the above-mentioned Certified Court Reporter, was examined and testified as follows:

EXAMINATION BY MR. BECKER:

Q. Good morning, Doctor.

A. Good morning.

Q. Would you tell me your full name please?

A. Bruce Jeffrey Fisch.

Q. And you don't sound like you are from New Orleans.

A. No. I grew up in Indiana.

Q. Okay. Doctor, have you ever been deposed before?

A. Yes.

Q. Many times or a few times? Give me a sense.

A. Probably less than ten.

Q. I just want to review the ground rules here. This is a question-and-answer session under oath.

A. Yes.

Q. It's important that we communicate, and it's important that you

understand the question. If the question is ineptly phrased or confusing to you, I don't want you to answer. I want you to stop me and tell me so, and I would be most pleased to attempt to rephrase or restate the question; fair enough?

A. Fair enough.

Q. Because I am conducting this deposition by telephone, it's critically important that you be sure I have completed my question before beginning your answer so we don't speak over one another; fair enough?

A. Okay.

Q. It's also important that you answer verbally; obviously I cannot appreciate any type of a head nod. So as I may have indicated to you, unless you indicate otherwise to me I'm going to assume that you fully understood the question that I posed and you are giving me your best and most complete answer today; fair enough?

A. Okay.

Q. Doctor, do you have a copy of your curriculum vitae handy?

A. Yes, I do.

Q. Would you hand that to the court reporter so she can mark it as Plaintiff's Exhibit Number 1?

THE COURT REPORTER:

The document is marked.

EXAMINATION BY MR. BECKER:

Q. What we're handing you has been marked as Plaintiff's Exhibit 1. Would you identify that document for us?

A. This is my curriculum vitae. It's a summary of my career path and publications and other academic activities.

Q. Is it current?

A. Yes.

Q. Are there any articles that you have authored or co-authored or textbook or journal articles or chapters in textbooks that do not appear on that vitae?

A. There may be because it's a summary, as far as publications go, of more recent publications. But if you want I can certainly supply you with a complete list.

Q. Would you give -- is that something you could tender to Mr. Parker at the end of this deposition?

A. Yes, I could.

Q. What I am interested in, Doctor, is whether -- let's talk about invited lectures, first of all. Have you provided -- have you done any invited lectures that would be relevant to the subject matter of this case?

A. I don't think directly, but in the field of clinical neurophysiology, yes.

Q. Which invited lectures would they be?

A. My last lecturing activity was with the American Academy of Clinical Neurophysiology, where I chaired an all-day course in electroencephalography, from technical aspects to clinical applications. Before that, I believe, would be my presidential address to the American Clinical Neurophysiology Society that had to do with the electrophysiology of epileptiform activity.

Q. I didn't hear the end of your answer.

A. It had to do with the physiology of something called epileptiform activity.

It's an electrical discharge that occurs from the brain in people who have epilepsy.

Q. I noted you have a particular interest in epilepsy.

A. Yes, I do.

Q. Have you given any lectures on the topic of intraoperative monitoring via EMG and/or the use of neuromuscular blockers during intraoperative monitoring?

A. No.

Q. In the journal article, could you tell me which journal articles or textbooks would be relevant to the subject matter of this case?

A. Give me one moment to take a look.

Q. Take your time.

A. In looking through the articles that I have in the current CV, I don't see any that would be directly relevant to the case.

Q. When you say "articles," would that include book chapters as well?

A. That's correct. In one book that I author, the -- it's called the EEG Primer -- there is some discussion of evoked

potentials --

Q. Right.

A. -- that would have some relevance, I suppose, to this case. But not -- there isn't any in-depth discussion about intraoperative monitoring.

Q. Let's talk a little bit about if you know how Mr. Parker happened to contact -- or how the law firm of Reminger & Reminger happened to contact you in this case.

A. No. I don't know at whose advice they contacted me.

Q. Do you know any doctors at the Cleveland Clinic?

A. Yes, I do.

Q. Who do you know?

A. Well, I know Dr. Luders, who is the chairman of the department there. He shares some similar interests with me. I know Dr. Dudley Dinner, who is also a clinical neurophysiologist and epileptologist and sleep expert. Dr. Elaine Wyllie, who is a pediatric epileptologist and whose textbook of epilepsy I contribute to.

Q. Okay. Ever been to the Cleveland

Clinic?

A. No.

Q. Of the three or four physicians you've just delineated, who do you know the best? Likely Luders?

A. It would be hard to say. I have had similar exposure to each of them, I believe, over the years.

Q. I am assuming you have not talked to any doctor at the Cleveland Clinic regarding this case?

A. No, I have not.

Q. Let's talk about your medical-legal work, Doctor. How long have you been reviewing cases?

A. Since around 1990 or '91.

Q. And would that be just maybe one or two cases a year?

A. At most.

Q. And do you keep a list of the cases you have reviewed?

A. I don't specifically keep a complete list; however, I might be able to reconstruct such a list.

Q. Well, have you ever reviewed a

case from the Cleveland Clinic before?

A. No.

Q. Ever reviewed a case for the law firm of Reminger & Reminger before?

A. Not to my knowledge.

Q. How did your work break down between cases -- the context -- plaintiff and defendant? What is the percentage?

A. I don't think I understand the question.

Q. What percentage of the contacts that you get per year or in total, let's say in the last 10, 12 years, have been on behalf of the patient, and what percentage have been on the behalf of the medical provider?

A. I would say the majority have been on the behalf of the defendants or the medical provider.

Q. Okay. How many cases have you actually reviewed on behalf of the plaintiff and you found it meritorious where you would be willing to give a deposition and testify, if any?

A. I don't think any.

Q. Of the depositions you have given

it's been on the behalf of the medical provider, correct?

A. To the best of my recollection, almost exclusively.

Q. And, Doctor, have any of those cases involved any type of similar subject matter involving whether there was valid and reliable intraoperative monitoring done during spinal cord surgery?

A. No.

Q. Have any of them involved any type of intraoperative monitoring in those other cases?

A. No.

Q. No?

A. No.

Q. Do you have any notes as a result of your review of this case?

A. I have two pages of typed comments.

Q. Okay.

A. Just some of the information.

Q. Is that something that -- Alan, could we facilitate the fax of those two pages? Let's mark them as exhibits --

Plaintiff's Exhibit 2A and 2B right now. And then, Alan, would you make inquiry if someone could fax them to my office immediately?

A. Excuse me. I'd have to dig them out of my office. They were outline notes that I used in making my statement that I had submitted.

Q. Where are you situated in relation to your office?

A. It's down the hall.

Q. Can we go off of the record a moment, Doctor, while you retrieve that, please?

A. Sure.

THE VIDEOGRAPHER:

We're going off of the record. It's 11:31 a.m.

(Brief recess.)

THE VIDEOGRAPHER:

We are back on record. It's 11:40 a.m.

EXAMINATION BY MR. BECKER:

Q. Doctor, handing you what's been marked as Plaintiff's Exhibit 2A and 2B, would you identify those for the record, please?

A. Yes. These are some notes I took on the records I reviewed.

Q. Okay. For example, under Luciano Deposition, you are simply quoting what he says?

A. That's correct. I made these notes some time ago, partly for the purpose of submitting my opinion --

Q. Right.

A. -- to Mr. Malone.

Q. For example, under Luciano, pages 33, 34, it says, "Doesn't know that monitoring and excludes bladder FX." What does FX mean?

A. FX means function.

Q. And what is the significance of that?

A. I am not sure. I have got to take a look back at the deposition.

Q. Does that surprise you that he didn't know that monitoring excludes bladder function?

A. I think what happened was -- yeah. It first, when I read that, I got the impression that he wasn't aware that the monitoring being performed would exclude

bladder function. But at that time I was also unaware that the anal sphincter had been monitored.

Q. One second. I have got to put you on hold just for 15 seconds.

A. Okay.

Q. I'm back. So when you have Dan Schwartz so -- Dan Schwartz's opinions are from his deposition and they start at the bottom of the first page. And everything on the second page is your interpretation of what he says?

A. Yeah. For instance, when I say "He guesses that this or that," the second paragraph from the top --

Q. I'm not talking about your report, I'm talking about your --

A. I'm not either.

Q. -- your notes.

A. That's what I am talking about. Second page of my notes, the second paragraph, for instance, I use the term "He guesses."

Q. Right.

A. That's, you know, my opinion of what he is trying to say in his deposition.

Q. Okay. So these are your comments on what he says. But there are no notes that reflect your review, what you found from your impressions from looking at the medical records; is that correct?

A. Well, I am not sure if I could put it that way, because these are my impressions from reviewing the depositions and records.

Q. Okay. Clearly, they are your impressions from looking at the depositions. Is there anything that references or reflects your impressions from the records?

MR. PARKER:

Other than his report?

MR. BECKER:

I am talking about in his notes.

THE WITNESS:

No. I don't believe so.

EXAMINATION BY MR. BECKER:

Q. Okay.

Doctor, is it your opinion that the intraoperative monitoring by Dr. Cheek was prudent and careful and met all of the standards applicable in 1996?

A. I think it was appropriate for what was being done for intraoperative monitoring in 1996.

Q. Okay.

So as far as you are concerned, the Cleveland Clinic and their intraoperative monitoring -- in this case they met all of the reasonable, prudent, and careful standard of care?

MR. PARKER:

Objection to form. You can answer, Doctor.

THE WITNESS:

As far as I can tell, what they did was appropriate for the case.

EXAMINATION BY MR. BECKER:

Q. As far as your opinions, Doctor, that they -- that there was -- clearly you feel they complied with the standard of care for intraoperative monitoring by competent neurophysiologists, correct?

A. Well, what do you mean by "standard of care"? In other words --

Q. Well, what is your definition of "standard of care," doctor?

A. If you are talking about written guidelines, then I am not sure we could -- we could have a reasonable answer, because this practice of intraoperative monitoring is somewhat locality based. There is a lot of difference from one place to another. Even today, as shown in one of these depositions, there's a center where they don't use intraoperative monitoring at all. There is a lot of variation in practice, is what I am trying to say. So if you are trying to get me to say he met the standard of practice, standard of practice was -- wasn't clearly defined then and it's still evolving now.

Q. Here's my question, Doctor.

A. Okay.

Q. Can we agree that if one is to engage in intraoperative monitoring then those professionals that conduct the intraoperative monitoring have to do it in a prudent and careful way. Do you agree with that?

MR. PARKER:

Objection.

EXAMINATION BY MR. BECKER:

Q. Do you agree with that, Doctor?

A. Well, I think the people who engage in monitoring have to be competent to do monitoring.

Q. So the answer to my question would be yes?

MR. PARKER:

Objection. It mischaracterizes. You don't want me saying what I think, so I will keep my mouth shut, but objection to the form.

MR. BECKER:

I would rather you not give speaking objections, Alan.

MR. PARKER:

Right, and so I'm not. Objection to form.

THE WITNESS:

I think what they did was reasonable.

EXAMINATION BY MR. BECKER:

Q. Okay. And as far as you are concerned what they did did not violate any prudent or careful practice?

MR. PARKER:

Objection to form.

EXAMINATION BY MR. BECKER:

Q. Correct?

A. What -- see, again, because there is no global standard for intraoperative monitoring, certainly wasn't then, I am not sure what practice you are talking about violating or not violating. Can you be more specific?

Q. Well, I am going to try, Doctor. I'm assuming you've been brought into this case to give an expert opinion that the Cleveland Clinic and Dr. Cheek met the appropriate standard of care for a neurophysiologist during this surgery.

A. I think I was brought into this case to give my opinion, one way or the other.

Q. Well, they didn't bring you into this case to give an opinion that Dr. Cheek violated the standard of care. That's not your opinion, is it?

A. Well, I am sure they are hopeful that I would give an opinion that would support them, just as you would be hopeful I'd give an opinion that would support you. All I'm trying to say is: My understanding coming

into this case is that I am supposed to give my opinion, what I truly believe my objective -- as most objective it can be -- opinion.

Q. Right, you are supposed to give an objective opinion, correct?

A. To the best of my knowledge.

Q. And let me ask it this way. Will you be rendering an opinion at trial that Dr. Cheek's and -- Cheek's and/or his colleagues who were engaged in the intraoperative monitoring of Karl Yost met the standard of care? Are you going to be rendering an opinion on that issue?

A. I'll -- I will be willing to say that they gave adequate care.

Q. Okay. And when you say "adequate care," did they meet -- please understand or assume that "standard of care" in Ohio is defined as what a reasonably prudent and careful person would do, a specialist in like or similar circumstances.

MR. PARKER:

We are going to disagree on that definition. I object to the form.

THE WITNESS:

You are putting me in a somewhat difficult position because I am not thoroughly familiar with precise definitions of "standard of care," particularly as it would apply to Ohio.

EXAMINATION BY MR. BECKER

Q. Okay. Well, I am going to ask you to assume it's true that that's the definition, the definition that I just gave you what a reasonably prudent or careful person would do in like or similar circumstances of the same specialty. Okay?

A. Okay.

Q. Now, is it your opinion that Dr. Cheek met the appropriate standard of care in this intraoperative monitoring of Karl Yost?

MR. PARKER:

Objection. You can answer it.

THE WITNESS:

Okay. Back in 1996 when this took place, I would say he probably met whatever standard of care there was in Ohio at the time for intraoperative monitoring.

EXAMINATION BY MR. BECKER:

Q. I didn't hear the answer, sir.

A. Back in '96 when this was performed, I would say that he probably met whatever standard of care there was --

Q. Okay.

A. -- for intraoperative monitoring --

Q. Okay.

A. -- at the time.

Q. And what's the basis of that opinion?

A. The basis of that opinion is that motor function was monitored and sensory function was monitored, that function of the anal sphincter, which we all hope will cover function also of the bladder, was monitored.

Q. Okay. And since there was monitoring, you felt that was sufficient to meet the standard of care, as I defined it?

A. I think they did an adequate job of supporting the surgeon with monitoring.

Q. Okay. Are you making any assumptions for that conclusion that they met the standard of care?

A. Such as?

Q. I don't know.

A. Well, I am assuming that they performed the monitoring. I am assuming that the monitoring was -- was monitored by someone --

Q. Competent to interpret?

A. Correct.

Q. Any other assumptions?

A. No. I think that's about it.

Q. Well, let's go on and talk a little bit further about this -- medicine in this case, and we may discover some other assumptions.

I am assuming that you are in charge of the intraoperative monitoring at LSU down there?

A. I am the head of the section of clinical neurophysiology. I don't directly do the intraoperative monitoring.

Q. You don't?

A. No.

Q. Who does?

A. Dr. Lee Happel and some --

Q. How do you spell his last name?

A. H-A-P-P-E-L. He performs about

500 cases a year.

Q. Is he a neurologist?

A. He's a clinical neurophysiologist. He's a Ph.D.

Q. Similar to Dr. Schwartz?

MR. PARKER:

Objection.

THE WITNESS:

Well, except, I guess, he's a full-time employee at a university.

EXAMINATION BY MR. BECKER:

Q. Other than that, his training is similar, to your knowledge?

A. Oh, I have no knowledge of Dr. Schwartz's training.

Q. You don't actually engage in intraoperative monitoring? Dr. Lee Happel does?

A. That's correct.

Q. Do you know whether Dr. Lee Happel was contacted on this case to act as an expert?

A. No. He wasn't, to my knowledge.

Q. Did you ever recommend to Mr. Malone or anybody around you in the office

that they hire a clinic neurophysiologist that actually does monitoring?

MR. PARKER:

Objection. That would be work product.

EXAMINATION BY MR. BECKER:

Q. I'm not asking you what -- I am asking you if you ever made that recommendation?

MR. PARKER:

That would be work product. That would be communication between expert and attorney.

Don't answer that, Doctor.

EXAMINATION BY MR. BECKER:

Q. Do you know, Doctor, whether Lee Happel does any medical-legal work?

A. I don't.

Q. Have you talked to Dr. Lee Happel about this case, by chance?

A. I haven't talked to him specifically about this case, but I have asked him some questions that might be relative -- relevant to it.

Q. Okay. Tell me what questions

you've asked him that would be relevant to this case. What kind of questions?

A. Okay. Well, I am going by memory and this is months ago.

Q. Go ahead.

A. But the question I recall asking him was about how often we use a neuromuscular blockade in a tethered cord surgery, and if that is used how adequately can the monitoring be performed?

Q. You asked him that question?

A. Correct.

Q. You asked him that question because you didn't know the answer?

A. I wanted to check my own knowledge against his.

Q. I see.

Did he -- was this a verbal or was this, like, an e-mail transmit, or --

A. It was just a verbal exchange.

Q. Okay.

A. Pretty brief.

Q. Do you recall his comments specifically?

A. Well, it's a little fuzzy now.

But in general, his response was that it would be appropriate to use a neuromuscular blockade in such a case, as long as the blockade didn't completely prevent a muscular response from a direct neuro stimulation.

Q. How do you insure that the blockade doesn't block the neuromuscular response? How do you insure that, Doctor?

A. Well, first of all you get the response if you --

Q. Sorry?

A. You get the response to begin with. If there is any question you can also take a look at the train of four that the anesthesiologist usually performs.

Q. When you say "take a look at it," you mean take a look at the printout to the sheets?

A. No. Just see what the response is to the train of four.

Q. Okay. And what kind of documents support the anesthesiologist on train of four?

A. You mean in general?

Q. In general.

MR. PARKER:

Objection. You can answer.

EXAMINATION BY MR. BECKER:

Q. What do the documents look like? What are they called?

MR. PARKER:

Objection.

THE WITNESS:

Well, it can be on a monitor, it can be on a printout --

MR. BECKER:

Okay.

THE WITNESS:

-- and if it's gross enough it can be direct observation.

EXAMINATION BY MR. BECKER:

Q. Okay.

Well, based on what you are saying to me, I am wondering if you -- have you ever witnessed a surgery on tethering of a lipoma?

A. No.

Q. Can we agree, Doctor, that if in fact the Cleveland Clinic's surgeon told the parents that there would be intraoperative monitoring, the parents had the right to rely

on that representation by Dr. Luciano and the right to rely on the belief that the intraoperative monitoring would be done in a valid and reliable manner?

MR. PARKER:

Objection.

THE WITNESS:

I think you are losing me a little bit with what seems like legalese to me.

MR. BECKER:

Nancy?

THE COURT REPORTER:

Yes, sir.

MR. BECKER:

I'd like you to, if you would please, to repeat that question for the doctor.

THE COURT REPORTER:

Sure.

"Can we agree, Doctor, if in fact the Cleveland Clinic's surgeon told the parents that there would be intraoperative monitoring, the parents had the right to rely on that representation by Dr. Luciano and the

right to rely on the belief that the intraoperative monitoring would be done in a valid and reliable manner?"

THE WITNESS:

I think it was reasonable for them to conclude, based on him telling them that, that there would be monitoring and it would be done appropriately.

EXAMINATION BY MR. BECKER:

Q. Thank you.

Now, would you agree with me, Doctor, that the most appropriate intraoperative monitoring technique in 1996 for this type of lipoma in the lower end of the spinal cord would have been spontaneous and stimulated EMG?

A. I would say more importantly stimulated EEG.

Q. EEG or EMG?

A. I am sorry if I said EEG. I meant EMG.

Q. Are you assuming that Dr. Cheek -- well, strike that.

Would you agree with me that the neurophysiologist should develop an

appropriate anesthesia protocol with the Department of Anesthesiology that would facilitate a reliable and valid EMG monitoring?

MR. PARKER:

Objection.

THE WITNESS:

I think they have to develop an approach in each case. I am not sure how you mean "protocol" here.

EXAMINATION BY MR. BECKER:

Q. Well, do you have any knowledge whether Dr. Happel developed any protocols -- written protocols or gave lectures to the Department of Anesthesiology? What should be used and what should be avoided or minimized during spinal cord surgery?

MR. PARKER:

Objection.

THE WITNESS:

I don't have firsthand knowledge of any lectures he's given. I know he gives lectures.

EXAMINATION BY MR. BECKER:

Q. Do you have any knowledge whether

he ever created a written guideline or protocol for the Department of Anesthesia?

MR. PARKER:

Objection.

THE WITNESS:

No, I am not aware if he has done that. But I believe that in each surgical case it's considered separately, so what may be appropriate in one setting is not in another.

EXAMINATION BY MR. BECKER:

Q. Can we agree that Dr. Cheek had a responsibility to let Anesthesia know before this case began what type of anesthesia would be appropriate to facilitate a reliable and valid EMG monitoring?

A. I think he had a responsibility to be aware of what the anesthesia was and if it was not going to be appropriate for monitoring to intervene.

Q. Okay. And do you think Dr. Cheek had a responsibility to let the Department of Anesthesia know in this case -- the anesthesiologist know in this case that we should do whatever we can to avoid

neuromuscular blockades during the critical aspects of the surgery?

A. Again, it's going to vary from case to case. He may have actually wanted a neuromuscular blockade, to some extent.

Q. Why would a doctor want a neuromuscular blockade when one is engaging in EMG monitoring?

A. For the convenience of the surgeon.

Q. Well, wouldn't a neuromuscular blockade potentially give a false negative information to the surgeon?

A. Well, it might give false positive information. If you stimulate and don't get a response it might be because it's a neuromuscular blockade.

Q. I guess I would call it false negative; you call it false positive. Whatever. False information: I think we can agree on that.

A. I think it might tend to make them alert the surgeon to something being wrong when it wasn't wrong. In other words, erring on the conservative side because they

would try to elicit a response, but the blockade would overwhelm it. And then they'd get no response. They'd tell the neurosurgeon that, but it would be the wrong information. But it wouldn't necessarily harm the patient.

Q. It wouldn't harm the patient?

A. Correct.

Q. You said?

A. That's right.

Q. Well, doesn't the surgeon rely on the information he gets from the EMG monitoring professionals?

A. Yeah. I didn't say that he wouldn't. I am just saying, again -- and maybe this just simply goes back to false negative/false positive. But if there is too much of a neuromuscular blockade, then when they stimulate nerves they won't get a response. They will turn to the surgeon and say, "Something is wrong. We are not getting a response." But it won't mean --

Q. Or they could turn up --

MR. PARKER:

Mike, you are interrupting the answer.

MR. BECKER:

Excuse me, Doctor.

THE WITNESS:

-- but it won't mean there is any damage.

EXAMINATION BY MR. PARKER:

Q. I understand that. Or the technician could turn up the electrical charge even higher until he does get a response, and then at that time the physician could get a false negative or positive, correct?

A. I think you've lost me on that.

Q. If there's a neuromuscular blockade and there is no response, the technician or the doctor -- I am not sure who is controlling this -- could turn the intensity up of the charge. --

A. They could do anything, but --

Q. -- to a point that --

A. -- what they probably would do is they might turn and check the train of four.

Q. Right.

A. They might check how the equipment was wired up, you know, if an electrode moved. They might do a lot of

things.

Q. Who are you assuming was conducting the train of four on this case?

A. I am assuming it was the anesthesiologist.

Q. Okay. Would your opinion as to whether or not the Cleveland Clinic did anything wrong or violated standard of care be altered or changed if you knew that a resident was doing the train of four?

A. Not necessarily.

Q. What are you assuming was done relative to the train of four in this case? You've already assumed -- you told me you are assuming it was done by the anesthesiologist. When were you assuming it was done?

MR. PARKER:

I am going to object. I think you are misinterpreting his testimony. But go ahead, Doctor.

THE WITNESS:

Well, I --

EXAMINATION BY MR. BECKER:

Q. Let's start over, Doctor.

A. Okay.

Q. Aren't you assuming that the train of four was done by the anesthesiologist?

A. I don't really know who did the train of four, of course, but I assume it was either done by the anesthesiologist or someone under their supervision. That's my assumption.

Q. Actually, I thought I told you it was a resident up until that moment. You assumed the train of four was done by the anesthesiologist, correct?

A. No. The anesthesiologist or one of their -- someone under their supervision.

Q. Okay. And what year resident are you assuming this person was?

A. I wasn't.

Q. Okay.

You don't know?

MR. PARKER:

He wasn't making the assumption, is what he is telling you, Mike.

EXAMINATION BY MR. BECKER:

Q. And how often are you assuming the train of four was done?

MR. PARKER:

Mike, you are turning a statement that he made of what may have been done -- you are turning that into an assumption. And I guess you can do so, but it is wrong to impose that assumption on the doctor. Object to the form.

MR. BECKER:

The appropriate way to handle that is just enter an objection.

MR. PARKER:

Okay.

MR. BECKER:

You know that.

EXAMINATION BY MR. BECKER:

Q. What are you assuming relative to how often this train of four was actually being conducted?

A. I would guess maybe every 15 minutes to every half an hour.

MR. PARKER:

Move to strike.

EXAMINATION BY MR. BECKER:

Q. On the basis of that assumption?

A. Just that it seems if you are

changing your neuromuscular blockade and anesthesia that it might be a reasonable thing to do. But again, I am making assumptions here. I don't know what their standard practice is there, and I do know that it would certainly vary from one location to the next.

Q. And are you assuming that there was just a manual train of four done? It wasn't continuous monitoring?

A. I really don't know.

Q. Okay.

And are you assuming that the train of four considered the intensity of the response, or simply whether or not there was a response, however slight?

A. Well, I suppose it's very hard to pretend that I know what happened at the time. But if the physicians are saying they did what was reasonable, then if they were failing to get a response with their direct monitoring, at that point they would probably want to look at the train of four. Beyond that, you know, I don't assume that they did anything in particular with the train of four.

Q. Well, is there any reference that

Dr. Luciano in his operative report or any of the medical records states that he relied upon a train of four?

A. Not to my recollection, but if he was -- if stimulation was occurring and they were getting responses, again, I don't know that they would need it.

Q. Can we agree that the clinic should have had a competent and skilled professional in the operating room to interpret the EMG tracings?

A. Yes.

Q. Hello?

MR. PARKER:

You got an answer, "yes."

THE WITNESS:

I said "yes."

EXAMINATION BY MR. BECKER:

Q. Are you assuming there was in fact a trained and skilled professional -- are you assuming there was in fact a trained and skilled professional competent to read and interpret EMG tracings during this surgery present during the operation?

A. Yes.

Q. And who would that person be?

A. That I don't know. It could be Dr. Cheek; it could be someone working with Dr. Cheek; it could be a technologist who was there.

Q. Well, are you aware whether technologists are licensed or permitted by their own society to interpret EMG tracings?

A. Actually, that's been a point of contention. What their society would like at present -- I don't know what the consensus is, but the electrodiagnostic technologists have at different times proposed, I believe, different things from having just a technologist have to be present, to having a physician have to be present, to have the physician intermittently present. And I believe there are different patterns of practice all over the country in that regard.

Q. Well, what is your understanding from reading Linda Gagnon's deposition as to whether she was skilled and competent interpreting EMG tracings?

A. I don't recall from her deposition. If you know --

Q. I want you to assume it's true that she felt that she was not skilled and trained in interpreting EMGs.

A. I'm sorry. Could you repeat that?

Q. Please assume it's true that she has testified that she wasn't skilled in interpreting EMG tracings.

A. Okay.

Q. Then it would be incumbent upon Dr. Cheek or someone else, some other physician or clinical neurophysiologist, to interpret those EMGs, correct?

A. Again, it might be. It depends on what she means by "interpret EMG." In other words, if you stimulate a nerve root and you get a burst of activity, it really doesn't take a great deal of expertise to interpret that as being a response, which is why in many cases a technologist is in the OR for most of the procedure. And the supervising physician, or sometimes Ph.D., will come and intermittently at the start or at the end of the procedure or if there is a problem during it, or --

Q. Well, how do you know --

MR. PARKER:

Mike --

MR. BECKER:

-- as to whether he stays in the surgery suite or not.

MR. PARKER:

Mike, you interrupted the answer, to begin with, and then you get to ask the next question which, in case I forget, I'll object to if it's the question you just posed.

MR. BECKER:

I am sorry, Doctor, I didn't mean to interrupt you, I thought you were done.

THE WITNESS:

I am. Go ahead.

MR. BECKER:

Okay.

Could I have my question back, then, Nancy?

THE COURT REPORTER:

I couldn't get it, because you were both talking at the same time.

MR. BECKER:

Okay. That's fair enough.

I guess I think I asked you how do you know what Lee Happel's practice is, whether he stays in the operating suite and monitors during the critical part of the surgery.

MR. PARKER:

Objection.

THE WITNESS:

Well, I guess I'd preface this by saying I'm not sure it matters outside of New Orleans what Lee Happel does --

MR. BECKER:

Okay.

THE WITNESS:

-- but it's -- do you want me to continue?

MR. BECKER:

Yes, sir.

THE WITNESS:

Okay.

-- but he is not present in all of the surgeries all of the time.

EXAMINATION BY MR. BECKER:

Q. Do you know whether or not when you come to the critical part of the surgery, once the patient is open in their spinal cord surgery, that he is present during the actual resection of the lesion of the lipoma?

A. I don't really know.

Q. Okay.

A. But I would guess that sometimes he's there and, depending on the competence of the technologist who is assisting him, sometimes he may not be.

Q. Okay. Doctor, you understand, and maybe I didn't make this clear to you, that in Ohio physicians -- experts have to state an opinion within a reasonable degree of medical probability. They can't guess, okay?

A. Okay. Well, then --

Q. So please don't guess any further, okay?

A. Within a reasonable degree of probability that's my response, then.

Q. What is your response?

A. That sometimes Dr. Happel is in the OR the whole time and sometimes he's not, depending on the competence of the

technologist working with him.

Q. Well, how do you know that?

A. Because I talk with Dr. Happel and I talk with the technologists.

Q. Do you appreciate that when you are interpreting EMGs that one has to be there and interpret it on an online and realtime basis?

A. Yes. Someone would have to do that.

Q. Are you of the opinion that they utilized appropriate instrumentation during this spinal cord monitoring?

A. As far as I can tell, yes.

Q. What type of instrumentation are you assuming they utilized?

A. Well, for somatosensory evoked potential recording, I am assuming that they used a Nicolet or similar system. For the EMG, my impression is that the recollection as to exactly what equipment was used is not clear. But in someone's deposition, I believe -- or in a letter from some -- one of the people who were deposed, a Grass machine was used for EMG monitoring with a paper

readout.

Q. What kind of machine?

A. Grass.

Q. What does that mean?

A. That's Grass Corporation, founded by Albert Grass. It was one of the first EEG electrophysiology companies in America.

Q. Well, are there any limitations for utilizing an EEG machine for EMG monitoring?

A. Well, I think you can adequately record EMG with an EEG machine for the purposes of monitoring. As a matter of fact, when you are trying to interpret an EEG, the EMG signal is usually many times greater than the EEG signal as a constant cause of artifact. In other words, what I am trying to say is that an EEG signal is in terms of microvolts and an EMG signal is in terms of millivolts. They were using a system that would record at the microvolt level.

Q. They have different types of filters, EEG machines and EMG machine?

A. That is correct.

Q. And an EEG machine is much more

sensitive than an EMG machine?

A. To what?

Q. To lower decimals?

A. EEG machines typically record at the microvolt level, but their filter settings are not quite the same as an EMG machine for performing routine electromyography. However, the frequency spectrum of the EMG signal easily reaches into the EEG frequency range that's used in routine recordings. I don't know if they had opened the filters even further than that or done something to adapt the equipment, but even if they hadn't they should be able to easily record an EMG signal.

Q. Well, are they able to do electrical stimulation with an EEG machine connected up with the machine?

A. Yeah. The one doesn't really have much to do with the other. The stimulator is a separate unit. It's just providing current that can be applied in different areas of the body. The EEG or even EMG recording equipment is simply for recording the output coming from the EMG muscle.

Q. Do you have any knowledge or experience in whether or not EMG records are maintained?

A. For intraoperative monitoring?

Q. Yes.

A. No. I would imagine in some places they are and some places they aren't, depending, probably, on the size of the record.

Q. I didn't hear the end of that answer.

A. Depending in part on the size of the record that is recorded.

Q. Would you expect the EMG records to be maintained if within 24 hours after surgery there is evidence of an untoward event?

A. Well, for how long?

Q. For a reasonable period of time. Would you expect the EMG records to be maintained if there is evidence of an untoward event immediately post-op?

MR. PARKER:

Objection.

THE WITNESS:

Of course, I don't know what you mean by "a reasonable period of time." I am sure the records were there immediately after the surgery and the records were probably there for several weeks after, but I don't know how long they were kept there.

EXAMINATION BY MR. BECKER:

Q. Okay. Would you expect -- if there was an untoward event where a nerve was compromised during surgery, would you expect the particular hospital to maintain the EMG records for at least 6 months?

MR. PARKER:

Objection.

THE WITNESS:

Again, this is sort of a medical-legal question, and what I would think would probably happen --

EXAMINATION BY MR. BECKER:

Q. Why do you think it would probably happen?

A. What I think would probably happen is that whatever standard record-keeping procedure is used for that particular record would be employed in this

same situation, whether there was an untoward event or not.

Q. Would you think that the records would be particularly maintained if there was an untoward event?

MR. PARKER:

Objection.

THE WITNESS:

That's what I just said. I don't think there would be a different practice employed in record storage. If they already had a particular practice in place I think they would maintain that, but this is highly speculative.

EXAMINATION BY MR. BECKER:

Q. Well, I guess I don't understand what your expertise is, then. It's not in intraoperative monitoring, correct?

A. It's in clinical neurophysiology. So, for instance, I am the director of a clinical neurophysiology residency program. I have participated in the board that creates the examination for the added qualification in clinical neurophysiology. Clinical neurophysiology is a fairly broad field that

encompasses intraoperative monitoring. So, for example, if the need arose and they said someone now has to give a lecture on intraoperative monitoring to the residents or to perhaps even some anesthesiologists, I could be called upon to do that. In other words, I am familiar with the literature and I certainly talk to other people around the country, not just to Dr. Happel, who are engaged in the practice of intraoperative monitoring, but I do not personally do it.

Q. Well, do you know whether or not neuromuscular blockades should be avoided in a patient who is having lipoma untethered if he shows signs, preoperatively, of light weakness?

MR. PARKER:

Objection to form. Also asked and answered.

THE WITNESS:

I think, unfortunately, you are looking for a black-and-white answer. I know that you could go to different medical centers and you could get different responses. It depends in part on what the surgeon wants as

far as stabilizing the patient. In addition, if you were to say, "If there is a neuromuscular blockade can we perform monitoring?" Well, the answer would be "yes," because it's always a matter of degree.

EXAMINATION BY MR. BECKER:

Q. Okay.

A. And there are references in the literature that would support that. You can do motor evoked potentials on the spinal cord, stimulating it directly. You can stimulate the nerve roots, as was the concern in this case, directly and you can have a partial neuromuscular blockade, and you will find that being done at a number of centers.

Q. And how do you know that, Doctor? Through what other people told you?

A. That is correct.

Q. I got you.

A. And from the literature. There is a recent textbook, "EEG," by Ebersole and Pedley, and if you look in the chapter on intraoperative monitoring it's discussed in several different places.

Q. Is that a reliable textbook?

A. That is one of the most reliable textbooks.

Q. Can you spell the last name of that again, Ebersole?

A. Ebersole is spelled as it would sound, E-B-E-R-S-O-L-E.

Q. What is the other name?

A. Pedley, P-E-D-L-E-Y. Pedley is the chairman of neurology at Columbia University, and Ebersole, I believe, is at the University of Chicago.

Q. And there is a section in there -- what is the name of the textbook?

A. I believe it's "Principles and Practice of Electroencephalography."

Q. And does it discuss EMG monitoring?

A. It discusses EMG monitoring in context of intraoperative monitoring. There is a chapter on intraoperative monitoring.

Q. What other things fall under clinical neuropsychological specialties such as yourself?

MR. PARKER:

Objection to the form.

THE WITNESS:

I don't think you meant to say "neuropsychological," did you?

MR. BECKER:

No, I don't. Excuse me, I misspoke. Neurophysiological items.

THE WITNESS:

So you mean what are the different areas of clinical neurophysiology?

EXAMINATION BY MR. BECKER:

Q. Yes, just give me a few, please.

A. Sure. There is electroencephalography, which can be broken into adult and pediatric and neonatal.

Q. That's known in jargon as an EEG?

A. Correct.

Q. Go ahead.

A. There is epilepsy monitoring, which is continuous EEG recording either from the scalp or using intracranial electrodes with simultaneous video monitoring.

Q. Okay.

A. There is polysomnography, which is the overnight recording of EEG and other physiological parameters for people with sleep

disorders.

Q. Okay.

A. There is intraoperative monitoring.

Q. Okay.

A. Those are the main areas of clinical neurophysiology. The only one I haven't mentioned would be electromyography.

Q. Why didn't you mention that?

A. Because we sometimes divide clinical neurophysiology into central versus peripheral. All of the ones I mentioned first were central. Electromyography would peripheral.

Q. Is that in your specialty, or not?

A. I don't practice electromyography, although I have had additional training in it.

Q. You don't practice electromyography, Doctor?

A. No. What I am saying is that I don't practice routine EMG. That's typically performed in the outpatient setting with a needle exam of muscles and stimulating nerves.

Q. Okay.

A. However, I am involved extensively in the monitoring of EMG.

Q. You lost me. Please repeat that.

A. I said, however, I am involved extensively in the monitoring of EMG in other settings such as --

Q. Give me an example.

A. -- such as during EEG for movements, epilepsy monitoring in a similar way, and muscle tone and movement during polysomnography.

Q. But if you take your work in the sleep studies, your work in epilepsy and EEGs --

A. And evoked potentials.

Q. -- evoked potentials, does that account for at least 90 percent of your actual clinical professional time?

A. Well, in academics your time is divided in a number of different ways. But of my clinical professional time, I would say it's about 90 percent of it, yes.

Q. And the other 10 percent would be what?

A. Seeing patients in a clinic.

Q. But as far as actually doing intraoperative monitoring, overseeing intraoperative monitoring, counseling anesthesiologists relative to intraoperative monitoring, that is something that you do not do in your professional practice, correct?

A. That's correct.

Q. I may have cut you off and I don't mean to, Doctor. We were talking about Lee Happel, and you had told me -- or at least one thing that you may have consulted with him on. Were there others that you haven't mentioned?

MR. PARKER:

Objection to the form. But go ahead and answer.

THE WITNESS:

No.

EXAMINATION BY MR. BECKER:

Q. Did you ever discuss with Lee Happel whether he knew of Dr. Schwartz?

A. I don't recall asking him that.

Q. Did you tell Lee Happel you were an expert on a medical-legal case involving

intraoperative monitoring?

A. I think at some point I did mention that to him, yes.

Q. You don't think -- you don't recall whether he asked or you told him who the plaintiff's expert was?

A. No.

Q. And did you tell him what the allegations of the plaintiff were in this case?

A. No, I don't believe I did. I just asked him the question that I had mentioned earlier this afternoon to you.

Q. Is Dr. Lee Happel, is he within your department?

A. Yes.

Q. Does he have an official title?

A. Well, he is a professor of neurology.

Q. Well, I guess what I meant is: Is he considered, like, chair of the Department of Intraoperative Monitoring, if there is such a thing?

A. There isn't such a thing, but, yes, he would be considered as the person who

is in charge of intraoperative monitoring.

Q. Do you have an opinion whether or not intraoperative monitoring helps to reduce iatrogenic injuries?

A. I believe in general it does.

Q. Why do you believe that?

A. Well, intraoperative monitoring, per se -- in my own more direct experience I am involved in EEG intraoperative monitoring for patients undergoing carotid endarterectomy, And in that situation I believe it's been shown to be a useful tool. Also it intuitively makes sense that it would be helpful.

Q. Why does it intuitively make sense?

A. Well, because if you are worried about compromising a neural structure and you can monitor its function you might be able to detect if the function has been interrupted.

Q. Do you know whether or not the anesthesia agents called Pavulon and Zemuron are neuromuscular blockers?

A. Yes, they are.

Q. Would you agree with me that the

use of neuromuscular blockades potentially compromises the validity and the reliability of EMG monitoring?

MR. PARKER:

Asked and answered.

THE WITNESS:

It could if it was overdone.

EXAMINATION BY MR. BECKER:

Q. Are you assuming that there -- that there were EMG's leads appropriately placed in this case?

THE COURT REPORTER:

I didn't hear that.

THE WITNESS:

Can you repeat that?

EXAMINATION BY MR. BECKER:

Q. Are you assuming that Dr. Cheek appropriately placed EMG leads?

A. Yes.

Q. Okay. What is the basis of that assumption?

A. Well --

MR. PARKER:

It's an assumption, Mike. There is a basis to conclusions, and an assumption

is an assumption.

EXAMINATION BY MR. BECKER:

Q. Why are you making that assumption? How's that?

A. I am making that assumption because I know indirectly that Dr. Cheek has been highly regarded in the field of intraoperative monitoring. I know that --

Q. How do you know that?

A. -- I know that he's at one of the premier institutions for clinical neurophysiology.

Q. What's that? What institution is that?

A. You didn't know he was at the Cleveland Clinic?

Q. Dr. Cheek?

A. Yeah.

Q. I didn't know he was at the Cleveland Clinic. You mean today?

A. No. At the time of the intraoperative monitoring procedure, that's where he was.

Q. Oh, I see. You know where he is today?

A. I have no idea.
Q. Do you know whether or not --
A. Wait. Let me backtrack on that. He may have said -- it may be in his deposition, which I have read. I just don't recall.
Q. You haven't read his deposition?
A. I did look at his deposition, yes.
Q. Well, is your deposition -- is his deposition referenced in your notes?
A. I only received it a few days ago.
Q. You only received what a few days ago?
A. His deposition.
Q. Of whom?
A. Dr. Cheek.
Q. You committed to act as an expert on this case before you saw what Dr. Cheek had to say about what happened and didn't happen?
A. That is correct.
Q. Do you have an opinion where the EMG leads should have been placed for this particular surgery, what part of this young

man's body?

A. Yes. I think they should have been placed where I believe Dr. Cheek described in his deposition he placed them, which would have been on either side of the anal sphincter and on both legs.

Q. Okay.

Do you have an opinion whether there was any -- this young man had a subclinical neurogenic bladder?

A. No, I don't.

Q. Doctor -- and please appreciate that I am being sincere in this question. I understand you are a clinical neurophysiologist and you run the residency program there. But during -- and you've indicated you can potentially lecture on the topic, "intraoperative monitoring," but in the real world and from a practical standpoint during a month, do you ever actually engage -- have a discussion or come into the topic of intraoperative monitoring?

MR. PARKER:

Objection to form.

THE WITNESS:

No. I don't in any routine way.

EXAMINATION BY MR. BECKER:

Q. Do you have any -- you said -- have you ever lectured on intraoperative monitoring?

A. Yes. I believe I have to our residents and fellows.

Q. Okay. When you lecture in intraoperative monitoring do you use kind of like a PowerPoint presentation or do you have handouts or none of the above?

A. None of the above. And the only reason I say that because it's been several years at least since I have done that.

Q. Have you done it once or more than once?

A. Several times.

Q. Does Dr. Happel lecture to the residents on intraoperative monitoring?

A. Yes.

Q. Does he do it more often than you do?

A. Yes.

Q. Do we agree that if they were doing the train of four on the ulnar nerve

that doesn't necessarily reflect what's happening in the lower part of this child's body?

A. Well, that is correct, if you are referring to during a surgical manipulation.

Q. Right. But as far as utilizing the site of the ulnar nerve from the train of four, that wouldn't necessarily reflect whether or not there is an agent, a neuromuscular blockade impacting the lower part of the spinal column?

A. Only by inference.

Q. Do you know, Doctor, whether or not it's Dr. Happel's practice for himself to perform the train of four, or does he allow anesthesiology to do that?

MR. PARKER:

Objection.

THE WITNESS:

I don't know in every case what his practice is.

EXAMINATION BY MR. BECKER:

Q. Can you agree with me, Doctor, if they did a train of four and hypothetically it was two out of four and then they augmented

the neuromuscular blockers, that there would likely thereafter for some period of time be a -- if they retested again be a zero out of four?

MR. PARKER:

Objection.

THE WITNESS:

I don't know. But if I was to speculate on what might be happening, assuming they were doing the monitoring, which includes stimulating nerve roots as they were going along, as long as they were getting responses, again, I don't think they would attend too much to the train of four. I am assuming they performed the monitoring, which included intermittently stimulating nerves --

MR. BECKER:

Okay --

THE WITNESS:

-- in the sciatic resection.

MR. BECKER:

-- you're not as --

MR. PARKER:

Mike. Are you finished, Doctor?

THE WITNESS:

Yes. I am finished.

MR. PARKER:

Okay. And I am going to move to strike.

EXAMINATION BY MR. BECKER:

Q. Are you assuming whether or not there was any -- strike that.

You stimulate by providing an electrical charge, correct?

A. Correct.

Q. What voltage or intensity are you assuming was done during these stimulations?

A. At some point I believe someone mentioned 100 milliamperes. I am not entirely sure about that, because I am just referring to some notes that I had made months ago. Is that correct?

MR. PARKER:

He's asking you what assumption you've made and you may or may not have made one. If you made one, tell him; if you haven't, tell him.

THE WITNESS:

I haven't. The only assumption I have made is that what was being done was

appropriate to the extent that they were receiving a proper response.

EXAMINATION BY MR. BECKER:

Q. Do you know anything about Dr. Cheek's drug and alcohol habits during June of 1996?

A. I was recently informed that he did have difficulties with drugs and alcohol.

Q. Do you know of a machine called a Nicolet Viking?

A. Yes.

Q. What is that?

A. It's a system that can be used for intraoperative monitoring for evoked potentials or for EMG recording.

Q. And should they have used the Nicolet Viking in this case?

A. Well, they have other vendors to choose from. It would not be inappropriate to use a Nicolet Viking.

Q. Now, for the somatosensory evoked potential they used a machine called Cadwell. Are you familiar with that?

A. Somewhat.

Q. The somatosensory evoked

potential machine, the SSEP?

A. Yes.

Q. I believe it was called Cadwell. Are you familiar with that machine?

MR. PARKER:

He just answered the question.

THE WITNESS:

Cadwell is a major manufacturer of EEG equipment.

EXAMINATION BY MR. BECKER:

Q. I am sorry. I didn't hear your answer, Doctor.

A. Cadwell is a major manufacturer of EEG and monitoring equipment.

Q. Do you know whether or not there is a software package available for the SSEP Cadwell machine such that it can also do EMG monitoring?

A. I do not.

Q. Let's go to your report, Doctor. You have it at hand?

A. One moment.

MR. PARKER:

Do you need a break, Doctor? We've been at it for a while.

THE WITNESS:

It's okay.

MR. PARKER:

Everyone is okay. I am the only one suffering, Mike.

MR. BECKER:

How are you suffering, Alan?

MR. PARKER:

I've had a diet Coke and it was quite awhile ago, so I'm suffering. But go ahead.

THE WITNESS:

Yes, I am ready.

EXAMINATION BY MR. BECKER:

Q. In the second paragraph of your report, you referenced, Doctor, some -- "Some substantial guesses about negligence in the operative monitoring are being made." Do you see that?

A. Is that on the first page?

Q. Yes, sir. First page.

A. Yeah, I do see that.

Q. Are those your words? Is that your word, "guesses"?

A. Correct.

Q. Are you -- is it your opinion that the opinions and conclusions by Dr. Schwartz are not reasonable?

A. Yes.

Q. Why?

A. Well, in the materials I had initially, he assumed there was no anal monitoring. Subsequently -- or I guess he assumed that they didn't have enough equipment to record enough channels to do proper EMG monitoring. Then I received a letter where he acknowledged the fact that there may have been an additional piece of equipment, I believe the Grass system, that would have provided enough channels. So when I wrote my statement, Dr. Schwartz was unaware that they seemed to have adequate equipment to monitor all of the parameters that Dr. Cheek indicated.

Q. Well, didn't --

A. Then --

Q. Excuse me. Go ahead.

A. Then he made the point that under no circumstances should there be neuromuscular blocking, which is his opinion and it's not

held by everyone else, and that that would have prevented the recording -- in his estimation or his guess, of recording an EMG signal if one stimulated the nerve roots. And I don't -- I don't agree with that, either. Dr. Schwartz, like me, wasn't there. He is lacking certain data that would substantiate his doubts about the procedure, but because he's lacking certain information he's assuming that wrong things were done. So that's why I say "substantial guesses."

Q. Okay.

Do you think Dr. Lee Happel would be a more appropriate expert to be supportive or critical of Dr. Cheek's conduct here than you?

MR. PARKER:

Objection. You are not entitled to that. That's not under Rule 26 discovery. I had probably ought to instruct the witness not to answer it, but I am not going to do that. Go ahead and answer it, Doctor, but I object.

THE WITNESS:

I think it's reasonable for me to

look over the information provided and give a response that is accurate about the case, about the questions raised, particularly, by Dr. Schwartz.

If you mean that somebody would make a more convincing expert witness because their daily work involves intraoperative monitoring, that may be. But if you are simply asking am I in a position to review the facts of the case and comment in a meaningful way about questions that have been raised by Dr. Schwartz and Neff, my answer would be yes.

EXAMINATION BY MR. BECKER:

Q. Do you have any criticism of Dr. Neff's opinions -- or disagreement?

A. In my statement I have a brief paragraph. Dr. Neff asserts that had the anal sphincter been monitored there would have been no bladder incontinence. However, the technologist recalls this was part of the monitoring routine. So as far as I could tell, Dr. Neff was, in his deposition that I had, basing his opinion on the absence of anal sphincter monitoring.

Q. To be fair to Dr. Neff, I think

he used the words "had it been appropriately monitored."

A. No, I think at that time there was some uncertainty as to whether or not it had been monitored at all.

MR. PARKER:

I think you are reading more into Neff than he said, Mike. Maybe he will change his testimony at trial.

MR. BECKER:

I will stand by my comment. And I guess you are going to have to wait until trial, Alan, for that one.

MR. PARKER:

Yeah. I guess.

EXAMINATION BY MR. BECKER:

Q. There is no indication in this chart whether there was any type of -- where the EMG leads were placed, correct?

A. Well, Dr. Cheek in his deposition --

Q. No.

A. -- says he had a routine placement --

Q. Not deposition. Chart.

A. That I don't know. From what I have seen in the chart I haven't seen a clear description of where they were placed.

Q. There is no indication in the chart who was actually interpreting the EMG monitoring during surgery, is there?

A. Again, this whole situation seems to revolve somewhat around assuming that absence of proof is proof of absence. I think you could turn the question around. If you are asking was everything that happened documented? No, it doesn't appear to have been.

Q. Have you ever testified in a courtroom?

A. Yes.

Q. How many times?

A. Once.

Q. Did you answer me?

MR. PARKER:

Once.

THE WITNESS:

Yes, I said "once."

EXAMINATION BY MR. BECKER:

Q. What is your understanding as to

what Dr. Gerson will say on this -- relative to this case, what involvement he had?

MR. PARKER:

Dr. Gerson hasn't been deposed.

MR. BECKER:

Right. I know that.

THE WITNESS:

I don't know what he will say about this case.

EXAMINATION BY MR. BECKER:

Q. You have not been told what he is going to say?

A. No. I don't know if he's going to say -- no, I don't know what he's going to say. No one has said to me Dr. Gerson is going to say anything in particular.

Q. And do you know whether or not Gerson is going to say that he was present during the surgery?

A. I don't know.

Q. And do you know whether or not Dr. Gerson has already told individuals that he wasn't present at surgery?

MR. PARKER:

Objection.

EXAMINATION BY MR. BECKER:

Q. If you know.

A. Mr. Parker mentioned that he may have said he was there or he wasn't there. All I get was something very ambiguous, so I have no idea.

Q. You mentioned in your report that the documentation could have been a little bit better by Dr. Cheek?

A. Well, I think there's -- there's minimal documentation. I think, in view of this case, it would be helpful now in retrospect to have some more documentation.

Q. You say that Gerson and Cheek's and Anesthesia could have been more detailed. See that in the bottom left of your letter?

A. I am not saying necessarily they should have been more detailed, but certainly they could have been more detailed.

Q. Is it your experience that those kind of documentations are more detailed?

A. My experience has been variable. And, again, my day-to-day interaction with intraoperative monitoring is very limited.

Q. You say in the beginning of that

paragraph, "I find no clear evidence to support the view the intraoperative monitoring was inadequately performed."

Do you find any clear evidence that the intraoperative monitoring was adequately performed?

A. Yeah. The statements of the people who were involved. In particular, that is Dr. Cheek. I believe the --

Q. In the chart or the deposition?

A. In the depositions.

Q. Oh, okay. So when you say "clear evidence" you are referring to the depositions as well as the chart?

A. Well, I would also say I have no reason to suppose that something was not done correctly.

Q. Are you aware of any cases where there was a lipoma resection where the child or person preoperatively was asymptomatic of any neurogenic bladder and immediately post-op had total dysfunction of the bladder?

A. No. I don't have any direct experience with that.

MR. BECKER:

Doctor, I am going to end on that note. I thank you for your time.

And let's go off of the record. I want to chat with Alan for just a moment.

MR. PARKER:

While we are on the record, we will read and sign.

THE VIDEOGRAPHER:

We're going off of the record. It's 1:01 p.m.

WITNESS' CERTIFICATE

I, DR. BRUCE FISCH, read or have had the foregoing testimony read to me and hereby certify that it is a true and correct transcription of my testimony, with the exception of any attached corrections or changes.

_____
(Witness' Signature)

REPORTER'S CERTIFICATE

I, NANCY LAPORTE, Certified Court Reporter, State of Louisiana, do hereby certify that the above-mentioned witness, after having been first duly sworn by me to testify to the truth, did testify as hereinabove set forth;

That the testimony was reported by me in shorthand and transcribed under my personal direction and supervision, and is a true and correct transcript, to the best of my ability and understanding;

That I am not of counsel, not related to counsel or the parties hereto, and not in any way interested in the outcome of this matter.

NANCY LAPORTE
Certified Court Reporter
State of Louisiana

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