IN THE COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO

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CAROL BOZIK,
Plaintiff,
vs.
MICHAEL HAUSER, D.M.D., M.D., AND THE MT. SINAI MEDICAL CENTER, et al.,
Defendants.

CASE NO. 408268
JUDGE BURNSIDE

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Deposition of MICHAEL S. HAUSER, D.M.D., M.D., a Defendant herein, called by the Plaintiff for Cross-Examination pursuant to the Ohio Rules of Civil Procedure, taken before me, the undersigned, Janine J. Howard, a Registered Professional Reporter and Notary Public in and for the State of Ohio, at the offices of Michael S. Hauser, D.M.D., M.D., 23250 Chagrin Boulevard, Commerce Park Square, Building Five, Suite 205, Beachwood, Ohio, on Thursday, the 24th of August, 2000, at 2:40 o'clock p.m.

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APPEARANCES:

On Behalf of the Plaintiff:
CARLIN & CARLIN
BY: William Carlin, Attorney at Law
29425 Chagrin Boulevard
Pepper Pike, Ohio 44122
On Behalf of the Defendants:
REMINGER & REMINGER
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The 113 St. Clair Building
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MICHAEL S. HAUSER, D.M.D., M.D.
of lawful age, a Defendant herein, having been first duly sworn, as hereinafter certified, deposed and said as follows:

CROSS-EXAMINATION

BY MR. CARLIN:

Q. Doctor, my name is William Carlin and I represent Carol Bozik. And first of all, I would like to take the time to thank you for coming here and making your time available so I can ask you some questions regarding this matter.

And I'm going to ask you some questions. You can see that the stenographer, court reporter, is taking down here everything that I ask you and taking down your testimony. If you don't know the answer to a question, you can tell me you don't know.

If you don't understand a question, please tell me and I'll try to rephrase the question so that you understand it; is that fair?

A. Yes.

Q. And obviously, you have to verbalize your answer so that the court reporter can take it down.

A. I understand.

Q. If you do answer a question, then I'm going to assume that you understood the question; is that fair?

A. Yes.

Q. And your attorney is here and any time during the course of this deposition you would like to consult with him, feel free to do so.

A. Thank you.

Q. You don't have to talk to him in a way that's on the record. You can talk to him and go off the record and ask him a question that you may have about this proceeding, or about anything, but that's why he's here so you can ask him a question.

A. I understand.

Q. If you would like to take a break at any time, let me know, and you could do that.

A. Thank you.

Q. Doctor, we are here at your office and I believe this is in Beachwood, Ohio; is that correct?

A. Correct.

Q. And I think that you had a patient and her name Carol Bozik; do you recall her?

A. Yes.

Q. And I think that you performed a bilateral sagittal osteotomy on about August 28th of 1996; is that correct?
A. That's correct.
Q. The bilateral sagittal osteotomy, that's also jaw reconstruction; is that correct?
A. Correct.
Q. So, when I refer to that surgery, I'll just refer to jaw reconstruction surgery; is that fair?
A. That's fine.
Q. And, Doctor, I think that Carol Bozik was about 42 years old when she had this procedure; does that sound about right?
A. Yes.
Q. Doctor, what did you tell Carol Bozik would happen if she did not have the procedure?
A. Well, she came to me to have the procedure done. I believe other practitioners, according to her deposition, told her that her teeth were wearing away. They would continue to wear away and deteriorate if she did not have the operation. The operation would help minimize that, and also improve her bite.
So, she was coming to me to do two things:

One, to stop deterioration of her teeth. Second, to provide her with a bite which she did not have before I treated her.
Q. And I think, basically, what you are indicating is that the alternative method of treatment, if not continued, consequences of not having the surgery is, she would stay the same?
A. Yes. She was advised of that.
Q. The surgical procedure is not medically necessary for her health and welfare, is it?
A. It wouldn't be medically necessary in the way that if you had a ruptured aneurysm, for example, you would have to have surgery right then and there in order to save your life. In that sense, it's not medically necessary.
It's more necessary in the way that a total hip replacement would be necessary. The patient could live with chronic deterioration from the hip and/or they can elect to have corrective orthopedic reconstruction. So, it would be more in line with that type of orthopedic reconstruction.
Q. But, you are not saying that it is medically necessary?
A. It's medically necessary if this patient

wishes to improve her function, she would need to have a medical procedure, but she would live just as long without having the procedure. So, it depends how you want to interpret that.
Do you want to interpret total hip replacement as medically necessary or does a patient live with a cane? And maybe a cane would be preferable to that.
Q. So, if she did not have the procedure, the bite, the malocclusion -- is that what they call it, the bite?
A. That's correct.
Q. So, if she did not have the procedure, then her bite would continue to be, I guess, maloccluded?
A. Correct.
Q. And what are the consequences of having a maloccluded bite?
A. There can be several. It is more difficult to eat with a malocclusion. Her particular malocclusion seemed to be contributing to the wearing away of her front teeth. That would progress.
In addition, some patients should have corrective surgery that have a maloccluded bite

such as the kind Ms. Bozik had, for aesthetic purposes. It doesn't look like she had a jaw; many reasons like that, many reasons why people want that corrected.
Q. So, for one, would be the maloccluded bite?
A. Yes.
Q. The other might be aesthetics?
A. Yes.
Q. What would the other case be?
A. In her case, to prevent further erosion of the teeth.
Q. So, would there be any other reasons that she would need this particular jaw reconstruction?
A. Not in her particular case. Those are the main reasons that come to mind.
Q. Okay. Do you feel -- even as we sit here right now, Doctor, in retrospect, do you feel that Carol Bozik was a candidate for this, an appropriate candidate for this type of procedure?
A. Yes.
Q. Was it possible that she could have been treated orthodontically as opposed to orthognathically?
A. No. She had orthodontics for at least a

year before she saw me. The orthodontist determined that her bite could not correct satisfactorily with braces. She had what we call a significant malocclusion bite quite far off. There was alignment, which I could do with braces. In fact, he even stated she would have to continue the braces after the surgery in order to resolve her bite problems, they were so significant.

Q. Based on your examination of Carol Bozik, were there any skeletal problems that she had that might have made the procedure more difficult or not probable to have a favorable outcome?

A. In answer to the second part of your question, the answer would be, no, as far as not probable for favorable outcome. But, there were aspects that would make her surgery more difficult to do. The primary one being that she had a small mouth. She had difficulty opening wide. And that makes any operation inside of the mouth more difficult.

Q. Doctor, after the surgical procedure, there apparently was a left facial nerve paralysis?

A. That is correct, to a degree she had partial paralysis of certain branches of the

facial nerve.

Q. Prior to the procedure, that left facial nerve paralysis was not present, was it?

A. It was not.

Q. And I think also in regards to that, they call it -- they have called it in these records here, "left facial nerve paralysis." I have seen it called Bell's palsy or neuropathy. Are those terms that generally describe the position of Carol Bozik subsequent to the surgery?

A. To a degree, not always, ideally. But, basically, they are describing the fact that she had motor weakness of the muscles of her face.

Q. And I think that prior to the surgery, she did not have the motor weakness and some time during the course of the surgery, apparently, that left facial paralysis occurred or was caused to occur; would you agree with that?

A. I wouldn't agree with that. During the surgery, of course. We did pot see any facial paralysis. After the surgery, on the night of the surgery, I did not see any facial paralysis. The next morning when she visited me in our clinic at Mt. Sinai Hospital, I did see left facial paralysis. So, it became evident to me

the following day.

Q. Would you agree that the left facial paralysis was the consequence of the surgery?

A. It would be my opinion that it most likely is.

Q. I mean, it just wasn't some coincidence that she had Bell's palsy?

A. Well, we can't rule that out, unfortunately.

Q. Okay.

A. Because I have had patients in the past who have spontaneously developed Bell's palsy. So, that is a possibility, but I think it is more likely that it is related to the surgery.

Q. When you say you have patients in the past who have developed Bell's palsy, was that as a result of the surgery, probably?

A. I think it was just a spontaneous development and we don't know why people develop Bell's palsy. It is just the seventh nerve of the facial nerves fail to function appropriately. We don't know the reason. I have had patients where that happens, so I had to include that in the possibilities.

Q. But, you would agree -- not to belabor

this, the concerns, you would agree in this case involving Carol Bozik, the Bell's palsy was a consequence of the surgery?

A. I think more likely it is.

Q. And, Doctor, is there anything that Carol Bozik did or failed to do that may have potentially caused that Bell's palsy?

A. I don't think so.

Q. Doctor, do you have a theory as to how this Bell's palsy developed in the course of the surgery?

A. Yes.

MR. SCOTT: Now, again, in the course of the surgery, I think that the Doctor has indicated that he can't testify that it developed actually during the course of the surgery, because the Doctor only saw her the day following the surgery.

To that extent, I object, but I think I understand what you are saying. I expect the Doctor does too.

BY MR. CARLIN:

Q. I think that what we are saying is that the Bell's palsy developed -- probably developed as a result of the surgery; I think we could agree on

that?
A. Well, I think it is related to the surgery in the following way: As a doctor, we try to understand the medical consequences of our treatment. And the best understanding I have is that Carol's jaw -- actually, both sides were very difficult to split. The operation, as you mentioned before, is called a sagittal osteotomy, or sagittal split. We actually have to divide the jaw, the inside and the outside bony halves of each side of the jaw down the middle.

Carol's right side -- it was difficult enough to do on her left side. It was even more difficult because I found that the cleavage plane between the inside and outside halves of the jaw seemed to be virtually nonexistent. So, her jaw was much harder to separate than other patients that I have.

The second issue is that she had extensive calcification and calcified ligaments behind her jaw, running from behind the jaw where the base of the nerve comes out, down to the ankle of the jaw. Because her jaw was so difficult to divide in the process of the routine manipulation, I suspect there was contusion of the facial nerve

by the calcified ligaments and the area was subsequently very swollen and became black and blue, what we call ecchymosis, but the patient calls black and blue.

And that would be due most likely to what we call retromandibular hematoma; that is, a large blood clot that developed behind the jaw from veins that run back there, also due to the indirect contusion from the routine manipulation.

So, we have had what I understand as contusion of the nerve from the calcified ligament compounded by a large hematoma from the routine manipulation that continued to compress the nerves. And that's probably why she has the deficits she has.
Q. Are you saying then that the Bell's palsy was caused by a compression injury as opposed to, let's say, a cut of the nerve itself?
A. Yeah, and in that sense, I would agree with you. It was not caused by a cut because we were never cutting back there. It was caused by indirect contusion of the nerve which happens to be near these rigid and calcified ligaments and onto that, she developed a very large hematoma

and blood clot, which continued to put more pressure on that.
Q. Was that noted in your records?
A. Well, it wasn't noted that she had this. What is noted in my records was that I feel the condition was due to contusion and hematoma. And that was noted in the records.
Q. Doctor, do you know as we sit here right now, that you did not cut that nerve or sever that nerve accidentally in the course of the procedure?
A. I don't know how I could have, because we had no instruments or anything that would do that near the site of the nerve.
Q. You are dealing with the inside of the jaw; is that correct?
A. Correct.
Q. And the nerve is located on the outside of the jaw; is that correct?
A. The nerve is located on the outside of the jaw, behind the jaw and really comes out of the skull underneath the ear, at the sialo highway. The sialoid process is what it is called.
Q. Doctor, and I think when -- how long does a jaw reconstruction normally last?

MR. SCOTT: The time course, is that what you are asking, Bill, or perhaps you are talking about something else?
BY MR. CARLIN:
Q. I want to ask you a yes or no question. You have done, I'm sure, many jaw reconstructions?
A. I have done hundreds.
Q. And as a general proposition, how long do those procedures normally last?
A. Generally, it takes me between two hours to five or six hours per jaw, depending on the complexity of the operation.
Q. So, you are talking about maybe one, two, or three hours per side?
A. Yes, that would be realistic.
Q. Was Carol Bozik's procedure prolonged?
A. It was not prolonged. As a total, the separating part of the jaw did take longer in her case because of the heavy calcified ligaments and the lack of cleavage plane. The overall operation didn't take long because of the fastens of the jaw and fix of her bite actually went very smoothly. So, I have taken more time for other patients than I took for Carol.

Q. Doctor, have you ever had an injury like the type of injury that Carol Bozik had in any of these other operations that you have performed?
A. I have not.
Q. Have you ever heard of such an injury occurring in the course of a jaw reconstruction procedure?
A. I have never seen one or heard of one for this type of operation. There are some other dura reconstructive procedures that involve surgery around the jaw joint that can have facial nerve injuries, but not this one.
Q. Well, in fact, cancer procedures where you are removing cancers and getting into the neck and so forth, sometimes --
A. Yes.
Q. -- at least, nonsurgical procedures, you would see Bell's palsy-type injuries?
A. Yes, you can.
Q. And I just want to go back here though. It would be your opinion -- I want you to know this: I don't know that the jaw was actually severed. I have seen nothing that would indicate that.
But, it would be your opinion that you did

not sever it accidentally in the course of the procedure?
A. Correct, because we are not working near the main trunks or the main division of the facial nerve. So, it would, essentially, be impossible.
Q. But, it would be your opinion that it probably would be due to a compression injury?
A. Yes. The contusion causes compression and I would agree with that.
Q. You have never had this happen before?
A. Correct.
Q. And you have never seen it or heard of it happening before?
A. Correct.
Q. Doctor, I think -- why don't you just mark this, Janine?
(Thereupon, Plaintiff's Exhibit A to the deposition was marked for purposes of identification.)
BY MR. CARLIN:
Q. Doctor, I'm handing you what has been marked as Plaintiff's Exhibit A, could you identify that?
A. Yes. This is the second half of an

operative report dated 8/28/96. The surgeon is me and the patient is Carol Bozik.
Q. And I think the operation code is "Mandible"?
A. Excuse me, it's not the operative report. It is the anesthesia record of the operation.
Q. Right. And it appeared as though -- do you know who -- what anesthesiologist was involved with this?
A. I don't remember. Let me see, Dr. Hardaway, a very experienced anesthesiologist.
Q. Was that from Mt. Sinai?
A. Yes.
Q. Do you normally work then in conjunction with an anesthesiologist on these types of procedures?
A. Yes.
Q. And it appeared as though the anesthesia was commenced at 7:32 in the morning?
A. Correct.
Q. And then the anesthesia ended at about 12:15 in the afternoon?
A. Correct.
Q. And I guess my question in regards to that is, whether or not this was an unusually long

procedure?
A. No, I have had some procedures that have taken much longer than this. What was unusual on this record and in my observation was how difficult it was for the anesthesiologist to put the breathing tube in Ms. Bozik.
It took them an hour to do so because of her very small jaw, which they found would not open wide enough to allow the specialized breathing tube that has to go in a very, very long way through the nose instead of the mouth because we were doing jaw surgery.
Her calcified ligaments prevented them from doing the standard intubation, what we call. They had to bring in standard equipment just to do this for her.
Q. Doctor, when you went into this surgery, did you anticipate that kind of difficulty?
A. No. I anticipated that -- her mouth was small, because I examined her and I anticipated that she opened slightly less than average. I have here that she opened 40, but she didn't really open 40, because she was already open 8 millimeters, because her teeth were 8 millimeters off, which was below normal. But, I have

operated on several patients who have been operated on with that amount.
Q. Doctor, I would just like to switch gears a little bit. I'm going to hand you your curriculum vitae, which I know you have probably seen before, I don't know how I got it, but I think somehow --
(Thereupon, Plaintiff's Exhibit B to the deposition was marked for purposes of identification.)
BY MR. CARLIN:
Q. Doctor, handing you what has been marked as Plaintiff's Exhibit B, could you identify what that is?
A. Yes, this is the curriculum vitae of July 1997 of me.
Q. Doctor, are there any areas, you know, that would need to be updated?
A. Yes.
Q. Do you have an updated curriculum vitae?
A. I do.
Q. Do you want to just use that?
A. I think it would be more logical.
Q. Okay. Thank you.
Doctor, we have remarked Plaintiff's

Exhibit B, and this is a more updated curriculum vitae; is that correct?
A. Yes.
Q. This is your curriculum vitae; is that right?
A. That's correct.
Q. Doctor, did you grow up in New York?
A. Yes.
Q. And did you go to high school in New York?
A. Yes.
Q. And what high school did you go to?
A. New York Town High School.
Q. And then you went to State University of New York at Albany?
A. Correct.
Q. And then you went to Boston University, Boston University, and that's the School of Graduate Dentistry?
A. Correct.
Q. How long did that school last for, four years?
A. Correct.
Q. So, you go to dental school for four years?
A. Right.
Q. Then you went to medical school?

A. I did go to medical school, but not right after the dental school. Dentistry allows certain people -- in fact, most dentists to practice right after dental school upon passing a licensing exam. So, the typical dentist goes to dental school, then goes out into practice.
That's not the case for my field, which is the oral and maxillofacial surgery. You are required to do a minimum of what's now a four-year residency. Although, many oral surgeons, including me, did extra training, including medical school and general surgery.
So, the sequence was dental school. Then I went to Harvard for oral maxillofacial surgery. Then I went to medical school at the University of Massachusetts. They accepted me with advanced standards because of all of the training and high grades that I had obtained.
After medical school, I spent a second year residency in general surgery at Harvard, which you have to do in order to obtain a medical license. I was then hired by Emory University as an assistant professor to teach doctors how to become oral maxillofacial surgeons. They hired me because of my extensive background and the

type of training I had. I did that for two-and-a-half years.
Then I was recruited by the family, Mt. Sinai, in Cleveland, to Program Director and Chief of Dentistry in order to continue the type of training and education that I provide and to provide the kind of patient care that they have had or hope that I had. I believe that I did.
Q. Just so I understand, Doctor, you go to dental school for four years?
A. Yes.
Q. After you graduated from dental school, do you take an -- did you take an examination of any kind to become certified in dentistry?
A. Yes. You take the Board exam and if you pass the Board exam and fill out the appropriate form, then you become a licensed dentist in whichever state the Board exam applies.
So, I could have, at that point, gone out and been a general dentist, made crowns and bridges and whatever. But, I elected to become a specialist in oral maxillofacial surgery, which is the field of jaw surgery, reconstructive jaw surgery, fixing up jaw fractures, tumors, trauma, removal of teeth, provisions of anesthesia for

patients having this done that requires specialty training.

At the time, the training period was three years, so I did that. At the end of that time, I could have gone out and become a practicing surgeon. I went beyond that. I obtained a Medical Degree, which is an option.

Q. How long did it take you to obtain a Medical Degree?

A. Two additional years because they gave me advanced training standards in medical school because of the high grades I attained.

Q. So, as opposed to obtaining a Medical Degree, which would take four years?

A. Right.

Q. So, as we sit here right now, what are you Board certified in?

A. Oral and maxillofacial surgery.

Q. Are you Board certified in anything else?

A. No. I am licensed in dentistry in Ohio and I am licensed in medicine in Ohio, if that's what you are getting at. But, I am Board certified in the specialty of oral and maxillofacial surgery.

Q. You are licensed as a Medical Doctor in the State of Ohio?

A. Correct.

Q. And where is the Board of Maxillofacial -- Oral and Maxillofacial Surgery?

A. It's in Chicago.

Q. And do you go to Chicago to test for this?

A. Yes. It's a rigorous process. You have to first pass a multiple-hour written examination. And then for those who pass that, then you have to go and appear before the Board and take and all day oral examination, and as I recall, in front of eight different examiners in order to become Board certified.

Q. Do you have to be Board certified in the State of Ohio in order to practice oral and maxillofacial surgery?

A. No. Although, most hospitals -- well, let me back up. You don't have to be. Most hospitals would prefer that you are.

Q. What hospitals are you affiliated with right now?

A. Right now, I do my primary surgery at University Hospitals of Cleveland. I'm attending surgeon. I'm a consulting surgeon at the VA Medical Center in Cleveland. They have an oral surgeon on staff, but when they require more

specialized oral and maxillofacial surgery, they call me because of the extra training and experience that I have.

And then I have privileges at Zebba, Z-e-b-b-a, Laboratory Center in Lyndhurst, Ohio. I am on the staff of Richmond Heights General Hospital, which was called Mt. Sinai East. I'm not sure of the official name now since University Hospitals bought it.

Q. Doctor, would it be correct to say that you do most of your surgery and spend most of your time then at University Hospitals?

A. The major surgery I do at University Hospitals. And the other I do in the office in which you are sitting right now.

Q. How often do you go to University Hospitals to do surgery?

A. Approximately, once a week.

Q. Does University Hospitals require you to be Board certified in oral and maxillofacial surgery?

A. I don't know if they require it, because new surgeons who are joining the staff would not be Board certified. It takes a number of years to obtain it. So, for a new surgeon, they

probably would not. For a surgeon who has been there for a period of time, they might expect that, but I don't know if it's an absolute requirement.

Q. So, if you wanted to find out if it was a requirement, how would you go about doing that?

A. I think, I would look at the bylaws.

Q. Of University Hospitals?

A. Yes.

Q. Where would you find the bylaws of University Hospitals?

A. I probably have a copy somewhere.

Q. Doctor, do you sit on the Board at all of this Board of Examiners, whatever it is in Chicago, the Oral and Maxillofacial Surgery Board?

A. No.

Q. You must go there for meetings once a year?

A. Yes. It's not necessarily in Chicago, but the American Association of Oral and Maxillofacial Surgeons, which is pretty much the governing body of our specialty, holds meetings several times a year. In fact, I'm scheduled to go to the one in San Francisco in about one month from now. And I go to several meetings a year.

Q. Doctor, I am kind of curious, being at University Hospitals, there was an article in the paper the other day, you might have seen that, they asked the question to the doctors who are seeking privileges there, whether they have privileges anywhere else?
A. Yes.
Q. Did you see that article?
A. I did see that.
Q. But, you are indicating that you do have privileges at other hospitals besides University Hospitals?
A. Yes. The thrust of the article was not whether or not you had privileges somewhere else. It was whether you had a material financial interest in another institution.
Specifically, they did not want employees -- doctors of the Cleveland Clinic having privileges at University Hospitals and potentially moving patients over to the Cleveland Clinic. I would not be in that category. I am an independent practitioner.
Q. Are you presently involved with any kind of teaching position?
A. Yes.

Q. And who are you affiliated with or associated with?
A. Case Western Reserve University. I'm an attending oral and maxillofacial surgeon and Assistant Clinical Professor of Oral And Maxillofacial Surgery.
Q. How much of your time do you devote to that?
A. I would estimate about 15 to 20 percent of my time.
Q. And actually, with University Hospitals, that is a teaching hospital and they are affiliated with Case Western Reserve Medical School; is that correct?
A. That's correct.
Q. So, would that consist primarily of residents?
A. In my case, I primarily instruct residents.
Q. You don't go in as a formal classroom setting and teach, do you?
A. I have, but I generally don't.
Q. So, Doctor, all of this training that you have had, I think you were finished with your training in what, about 1981?
A. I was finished with the formal training in

oral and maxillofacial surgery in 1981. Then I went to medical school subsequent to that. I did a year of general surgery subsequent to that. So, I'm finished with all of the formal training that I had in 1984.
Q. So, you graduated from high school in 1972?
A. I believe, 1969.
Q. Graduated, excuse me, 1969?
A. Yes.
Q. So, you are about 49 years old?
A. Correct, almost.
Q. And you went through your medical training, dental training, oral and maxillofacial surgical training in 1984?
A. Correct. When high school students or college students who come to me frequently for things like wisdom teeth ask me what it takes, I say, 15 years from the time you finish high school in order to have all of the extended training to do what I do.
Q. But, not all oral and maxillofacial surgeons have that extent of training, do they?
A. No. The majority of them have all of the training that I have minus the medical school and the general surgery.

Q. So, you went to medical school where?
A. At the University of Massachusetts in Worcester.
Q. And then you had training where in surgery?
A. In general surgery, at Harvard Surgical Service, which at that time was New England Deaconess. Now, if you read the journal, it's Beth Israel. It's two of the largest teaching institutions at Harvard.
Q. How long does that training go for?
A. It depends for what the objective is. My objective was one year of surgical training so I would qualify for a medical license. However, if I wanted to become a Board eligible general surgeon, I would have to have five years, but I already had a field in which I have Board eligibility, which is oral and maxillofacial surgery. And I did that and I did not want to become a general surgeon.
Q. As we sit here today, do you have the training and so forth to be a general surgeon?
A. No. I would have to go four additional years. But, keep in mind, a general surgeon who did those four years has no training of maxillo surgery. They would have to go many, many years

because they would have to become a dentist first. In addition, they would have to serve a minimum of four years.
Q. So, you are kind of like one step above the general surgeons?
A. For us to get in the equal point in time, I would be ahead of them.
Q. Doctor, have you ever given a deposition before?
A. Yes, I have.
Q. And how many times?
A. Dozens.
Q. Have you ever been named as a Defendant in a medical malpractice suit?
A. Yes.
Q. How many times?
A. Three.
Q. The last time, could you just tell me briefly about that, what happened?
A. Yes.
MR. SCOTT: Objection. You may answer.
THE WITNESS: I was attending surgeon at Emory University and a resident surgeon treated a patient that subsequently

developed an infection after having had a wisdom tooth removed. The patient required hospitalization for the infection.
I was called to be the surgeon and I drained the infection and treated the patient. And the patient got better and had no residuals. Yet, the University was sued and I was sued. And the case was subsequently dismissed when it was realized that it was no case.
BY MR. CARLIN:
Q. How long ago was that?
A. That would have been 1986.
Q. Where was that?
A. Emory University, Atlanta, Georgia. And then I had no lawsuit served until Ms. Bozik and subsequently -- well, I don't know if it is, not really the primary Defendant, Mt. Sinai Medical Center is because it was an elderly woman that had her teeth removed, complained that she still had residual bone. She went to a dentist and the lawsuit indicated there were root tips. And there are no root tips. And that case is pending.
Q. Where is it pending?
A. Cuyahoga County.

Q. Who is the attorney for the Plaintiff involved in that case, do you recall; do you know?
A. I don't.
Q. Was your deposition taken in that case?
A. No. That case is stayed because it is -- because the primary Defendant is Mt. Sinai Medical Center.
Q. And then there was another time?
A. No, Ms. Bozik.
Q. Oh, you are counting Ms. Bozik?
A. Yes.
Q. Have you ever rendered an opinion about a standard of care in a case, in a medical malpractice case?
A. Yes.
Q. How many times?
A. Numerous.
Q. When you say, "numerous," would that be more than 15?
A. I think it would be in that ballpark. Actually, I probably have given approximately 15 depositions, along those lines, but I have written many opinions where the cases may have been settled or dismissed.

I'm primarily hired by defense attorneys to defend malpractice cases against doctors. Although, I did from time to time render an opinion on behalf of Plaintiffs when I think the case is meritorious.
Q. Have you ever given a deposition in a Plaintiff's case?
A. Yes.
Q. And approximately, how many times?
A. Eight or ten.
Q. Eight or ten times you have given depositions?
A. For a Plaintiff's case?
Q. For the Plaintiff's cases?
A. Yes.
Q. So, how many times have you given depositions for the Defendant's cases?
A. Twice as many, perhaps more.
Q. Maybe 20 or so cases?
A. Yes.
Q. Doctor, have you ever prepared a list -- and sometimes in the Federal Courts they call it, Civil Rule 23 List, that lists all of your depositions?
A. No.

Q. You have never done that?
A. No, no.
Q. The cases that you have rendered opinions on behalf of Plaintiffs for, were they primarily in Cuyahoga County or primarily outside of Cuyahoga County?
A. Primarily, outside of Cuyahoga County -- yeah, outside of Cuyahoga County.
Q. The case -- so, you have had about 8 to 12 cases where you have rendered opinions on behalf of Plaintiffs, and most of those have been outside of Cuyahoga County?
A. Yes.
Q. Could you tell me any cases where you have rendered an opinion and given a deposition that were inside of Cuyahoga County?
MR. SCOTT: For the Plaintiff?
MR. CARLIN: For a Plaintiff, yeah.
THE WITNESS: I cannot think of one. Basically, we run into conflict of interests all of the time. So, that's why that doesn't come up very often.
BY MR. CARLIN:
Q. Of the opinions that you have rendered on

behalf of your colleagues in the medical profession and Defendants in general, have the primary -- where you have rendered depositions -- given depositions and rendered opinions on behalf of Defendants and doctors, are they primarily in Cuyahoga County?
A. That will vary, probably more in Cuyahoga County and not only because I know the prominent defense attorneys in this county, but I get calls from Toledo, Akron, Columbus, Cincinnati, and Charleston, West Virginia to defend doctors. And I will say that I have a pretty extensive reputation in this field and that's why they called me.
MR. CARLIN: Okay. Off the record for a second.
(Thereupon, a discussion was held off the record.)
BY MR. CARLIN:
Q. Doctor, do you keep the depositions that you give?
A. I might. It is hard to say, because not being an attorney, I don't keep the legal records in the same way that I keep patients' medical records. So, it may be haphazard.

Q. So, you might have a box of depositions that you have looked over --
A. Yes.
Q. -- laying around somewhere?
A. Yes.
Q. If they were laying around somewhere, where would they be?
A. In my attic.
Q. At home?
A. Yes.
Q. Have you ever rendered an opinion on a case that might be similar to the case that we are discussing here?
A. I have never seen this type of complication. So, I never would be in a position to render a deposition. I probably have rendered opinions regarding orthognathic cases, surgery case where a person may have brought a suit against a doctor.
Q. When was the last time you ever rendered an opinion in an orthognathic case on behalf of a Plaintiff; as we sit here now, when was the last time?
A. I just don't remember and I apologize.
Q. That's fair.

A. Not being an attorney, I don't keep that same file in my brain. So, I just cannot give an accurate answer.
Q. Would it be correct to say that most of the opinions that you have rendered in regards to a standard of care have involved jaw reconstruction?
A. No.
Q. How many cases have you rendered an opinion in -- or what percentage of cases that you have rendered an opinion in on behalf of a Plaintiff or a Defendant regarding a standard of care have involved jaw reconstruction?
A. I can tell you in general, it would be a relatively small percentage because you look at the practice of an oral and maxillofacial surgeon, even a surgeon like myself, who does a relatively high number of these cases compared to my peers, still I do many more of other kinds of cases.
So, assuming cases are filed on a percentage basis, you know, see problems in this kind of case, and this kind of case, and this kind of case, more of the cases involve other types of surgery. So, more of the complications

involve other types of surgery, and therefore, more of the lawsuits involve other types of surgery.
Q. In regards to Plaintiff's attorneys who have contacted you, have any Plaintiff's attorneys ever contacted you where you have rendered an opinion regarding a standard of care more than once?
A. Yes.
Q. And what Plaintiff's attorney would that be?
A. Mr. Mester of Nurenberg, Plevin has called me occasionally. I don't remember the cases.
Q. Did you give depositions in those cases?
A. I think so. Again, I don't have the clarity that you are hoping for this because it doesn't involve Ms. Bozik.
Q. I understand that.
A. Right.
Q. Believe me, that sounds fair to me. I can understand that.
A. I have done criminal defense cases for Gerald Messerman where a doctor has been criminally accused of an accident and have successfully defended the client.

Q. You mean, they have been criminally accused of assaulting someone or something like that?
A. Yes. I have given testimony for the State of Ohio and the State versus a doctor who was accused of Medicaid fraud. I have given grand jury testimony in a similar case.
Q. On behalf of the State of Ohio?
A. Yes. So, I am very experienced.
Q. Have you ever rendered an opinion regarding a gentleman by the name of Dr. Smirnoff?
A. That doesn't sound familiar, but something vague about that, and perhaps, I have.
Q. I understand that we are talking here. I'm not going to come out and say, "Hey, you said this or didn't say this."
A. Yeah.
Q. I understand you are talking in terms of it's kind of vague, and in generalized terms?
A. Right.
Q. Have you ever testified in Court in Cuyahoga County about a standard of care?
A. I'm certain that I have. In fact, a case now comes to mind. I was acting on behalf of defending dentists in a multiple doctor suit. The case was Lane, L-a-n-e, versus multiple

doctors. Kirby was the first name and I was defending him.
Q. Was he a maxillofacial surgeon?
A. He was a dentist. This is a patient who had oral cancer and went on to have multiple operations for resection and reconstruction of her jaw and oral cancer. And the patient felt that many of her caregivers had misdiagnosed or overlooked the diagnosis of cancer and brought suit against all of these doctors. And that was last year. The case took a month.
Q. And that was the last time you could recall testifying in Court?
A. Yes.
Q. What percentage of your time would you say that you spent rendering opinions, reviewing cases in regards to standards of care?
A. Five percent.
Q. Doctor, in a sagittal osteotomy, isn't there a certain amount of resection involved with the jaw?
A. I don't know if "resection" is the right word. You have to divide the jaw and reposition it.
Q. Within the past two years, have you given

any depositions in regard to a standard of care?
A. Yes.
Q. Did any of those cases involve a jaw reconstruction?
A. Yes.
Q. Would it be correct to say the last re -- what would be the last jaw reconstruction case that you believe you have rendered an opinion about a standard of care that you have given a deposition in?
A. Actually, I did give a deposition, approximately, six months ago on behalf of a Plaintiff for a patient who had jaw reconstruction after facial fractures. And the jaw reconstruction was believed by the Plaintiff to have been done improperly.
And I reviewed the case and agreed, and gave a deposition explaining my opinions. The case is filed either in Hamilton County, which I think is Cincinnati. And I think that case is scheduled for trial in a couple weeks. So, I might have another opportunity to testify live.
Q. Who is the Plaintiff's attorney in that case?
A. Donald Moore, M-o-o-r-e.

Q. Is he in Cincinnati?
A. Yes. I cannot give you his address because I will not be able to find a file.
Q. And the Defendants have taken your deposition in that case?
A. Yes.
Q. Prior to that, can you remember the last time you rendered an opinion about a standard of care on behalf of a Plaintiff where you gave a deposition?
A. It is just not clear to me. I just don't keep that in my memory bank.
Q. Do you keep any kind of a written chronicle regarding the cases that you appear on where you rendered an opinion about a standard of care?
A. No, I don't.
Q. And you have actually never made any kind of chronicle for anybody of the cases you have appeared on or given deposition in?
A. Correct.
Q. Doctor, are you married?
A. Yes.
Q. Do you have any children?
A. Yes.
Q. How old are your children?

A. Twenty as of two days ago, and 15.
Q. And have you only been married one time?
A. Correct.
Q. Do you live in the Cleveland area?
A. Yes.
Q. And what city do you live in?
A. Shaker Heights.
Q. Doctor, I just want to go back.
You are presently employed by whom?
A. Myself.
Q. You don't operate as a corporation?
A. Correct.
Q. And how long have you been employed under these present circumstances?
A. I believe I started complete solo private practice July 1, 1999. And that is when I was completely responsible for not only my own business, but also hiring and maintaining employees and employee records, et cetera. Before that, I would lease the employees from the Mt. Sinai Medical Center.
Q. Prior to this, or at least the time in 1996, during the jaw reconstruction surgery on Carol Bozik, you were an employee of Mt. Sinai?
A. I was an employee of Mt. Sinai and I was

also in private practice simultaneously.
Q. How did Carol Bozik come into this whole equation; was she a patient of yours, or Mt. Sinai, or a patient of yours?
A. She was a private patient of mine. She was referred directly from Dr. John White, an orthodontist, directly to me. And I saw her in my office, which was originally on Park East Drive off Chagrin Boulevard.
Q. Doctor, handing you -- why don't you mark that -- why don't you mark that?
(Thereupon, Plaintiff's Exhibit C to the deposition was marked for purposes of identification.)
BY MR. CARLIN:
Q. Doctor, I am handing you what has been marked as Plaintiff's Exhibit C, could you identify what that is?
A. Yes. This is my Consent for Orthonagthic Surgery. This is the one initialed and signed by Carol Bozik 8/96.
Q. And I think you have the original right there in your file?
A. Yes, I do.
Q. Dr. Hauser, is there anything in this

particular consent form that would have addressed the injury that was probably sustained in the course of the surgery that Carol Bozik had, in particular, the Bell's palsy?
A. As a matter of fact, there is. Although, that would be unexpected, so it's not listed as such. But, we do have some generalized statements that would cover some of these unusual occurrences.
And if we go to Number 5.c, we have "Jaw joint, TMJ difficulty or pain," which I think is a complaint of Ms. Bozik. She complains of some headaches right around the jaw joint. And in the following sentence we have, "Facial muscle function may possibly be reduced." And that would cover what is wrong with her.
She cannot, as I understand her deposition, completely close her eye and that is due to the fact that the facial muscle which controls that and the function is reduced. So, I would say that pretty clearly would encompass that.
Q. But, are those the only things in here that you would say that address the problems that Carol Bozik has now?
A. Well, she has other problems which we

addressed. The things that we anticipated, for example, are stated: Pain, she had pain. She had quite a lot of swelling, which I have circled. The reason I circle that is because that can be very extensive in some patients and it certainly was for Carol.

She had a lot of bleeding, discoloration, which is the black and blue, and which she had extensively on the left side, where I postulate with medical certainty that she had retromandibular or some other hematoma.

The numbness and tingling of the lip, tongue, chin, gums, cheeks, and teeth, which may be temporary or permanent. She has not been back to see me as I requested, but she probably had some degree of numbness in the lips, tongue, and which I told her she would, and she agreed.

And initially, that she might have some shifting of the jaw after the surgery requiring some additional orthodontics. And that was stated in Number 5.b.

She does have some limitation of jaw openings which may be permanent. Again, that's stated in point Number 5.c. So, you can see we have what I would consider very thorough and very

extensive informed consent, and I believe beyond the standard that is met by most other doctors in other surgical disciplines.

Q. But, Dr. Hauser, you are not suggesting that she was informed of the risks of having left facial paralysis permanently, are you?

A. Well, since she does have reduced muscle facial function, which that clearly is, and it does state that in a general consent. Specifically, one cannot say that, but you cannot specifically inform somebody of some occurrence that you have never seen and would never anticipate. That would be totally illogical. How can one put that in an informed consent?

Q. That's fair enough. But, what I am saying, in the informed consent, you are not suggesting that Carol Bozik was informed of the risk of having the facial paralysis that she now has, are you?

A. She could not have been, by any logical standard.

Q. And I understand what you are saying is that you couldn't possibly have anticipated that, so you couldn't inform her of that potential risk?

A. Right.

Q. Is that what you are saying?

A. Yes. For example, if you came for an opinion about surgery and I spent an hour informing you of all kind of things that could not possibly happen, what good would that possibly do? It would not. So, the informed consent either lists the things that will happen, or rare occasion, might happen. And that is logical informed consent.

Q. Again, I just want to make sure I understand this.

When Carol Bozik came to you and you gave her a very inclusive consent for the orthonagthic surgery, you did not inform her of the risks of Bell's palsy or a facial paralysis prior to her having that surgery?

A. I did not inform her of the risk of Bell's palsy. I did inform her of the risks of the facial paralysis and that facial muscle could be reduced. We did not talk about Bell's palsy, nor would I want to discuss something that one has never seen and not likely to occur.

Q. Let me say this: You would, at least, agree that you did not inform her of the

potential risks of the injury that she now has; would you agree with that?

I mean, yes or no?

A. No, I would have to disagree. She was informed that facial muscle function could be decreased. She was not informed that she could return similar to a Bell's palsy.

Q. You are saying that -- okay. Why don't I try this again so I have an answer on this. You can answer me the question. First, I will give you an opportunity to explain. I want to hear your explanation. I want to understand what your explanation is.

How could you inform someone of something that is not even on the radar screen?

A. Correct. You have answered your own question.

Q. I understand that. But, what I am saying to you is this: that when Carol Bozik underwent her surgical procedure, the jaw reconstruction on August 28th, she was not informed of the potential risks of the injury that she now suffers from?

MR. SCOTT: Objection.

THE WITNESS: I would have to

disagree based upon my previous answer, that she was definitely informed that facial muscle function could be reduced. I read this to her word-for-word. I believe she would even testify or did testify that that was the case.

So, in that sense, I did, but it does not say here that you could have an injury similar to Bell's palsy with facial paralysis. Why would it? Nobody in here -- because that would not be seen. It would be illogical for me to use her valuable time that way.

BY MR. CARLIN:

Q. So, I see, from what I am understanding, what you are saying, you never anticipated such an injury, so there is no surgery under which you would tell her about a potential injury, would you?

A. In this operation, you are correct. There are other operations we are deliberately dissecting along the facial nerve where we do discuss that. We did not dissect along the facial nerve here, so we cannot discuss that.

Q. So, the injury that Carol Bozik presently has, we could agree that it is a permanent facial paralysis; would you agree with that?

A. Well, I don't know what degree of injury she has because I have not seen her for a number of years. But, to whatever degree of dysfunction she has, if she has any, since it has been four years, I would agree that it is permanent, but I don't know what degree of injury she has.

Q. And are you saying that the injury that she had would have been covered in regard to consent and in regard to addressing potential risks from a surgery by part 5.c that says, "Facial muscle function may possibly be reduced"?

A. Yeah, in a broad sense, I would have to agree. In a specific sense, no, but in the specific sense, we cannot get consent. You cannot advise somebody of something that you have never seen or heard of happening.

Q. That's fair enough. So, you would agree, though, in a specific sense, you did not inform Carol Bozik of the risks from this surgery that she had from the injury that she presently suffers from?

MR. SCOTT: Objection.

THE WITNESS: I think we answered that already. I could not inform her that she might have an injury similar to Bell's palsy,

because one could not anticipate that, so one could not inform that.

But, we did inform her that you could have muscle function. From time to time, we see that. So, in a general sense, she was advised that she could have some muscle facial dysfunction. That's the best answer I can give.

MR. CARLIN: Just let me ask you, and I'll move on and chase another rabbit. But, I would like some specific sense, yes or no, did you inform Carol Bozik of the risks from this surgery that she presently suffers from right now?

MR. SCOTT: Bill, I object. I think the Doctor has answered that three times now.

MR. CARLIN: I know you did, Doctor, and if you could just say "yes" or "no."

THE WITNESS: I would have to defer to counsel. I have answered it in a very clear and concise fashion.

MR. CARLIN: I know you have answered it very clearly and concisely, maybe. Why don't I ask you this way:

You and I agree when Carol Bozik had the

surgery, she was not informed of the risks from that surgery that she presently suffers from; would you agree with that?

MR. SCOTT: Objection.

THE WITNESS: No, I disagree. She was informed extensively of the risks of the surgery and what other risks, of the facial muscle function which could be reduced. And right now, she has reduced muscle facial dysfunction. This informed consent is thorough. Carol Bozik initialed everything. She clearly remembers doing so.

And she also doesn't necessarily remember what she signed, because she was actually very surprised after her surgery when she had came back and had swelling and numbness and all of these things, she said, "You didn't tell me about this." And I said, "Carol, let's look at this." And then she had recall.

MR. CARLIN: But, you didn't tell her about Bell's palsy, did you?

THE WITNESS: No. One would not tell a patient about Bell's palsy for this operation.

MR. CARLIN: You didn't tell her

about facial paralysis, did you?
MR. SCOTT: Objection. Because Doctor has again testified as to that particular point where we were talking about reduction of muscle function.
THE WITNESS: Yeah. In the sense that paralysis, you know, caused reduction of muscle function, she was advised of that. Did I use the word "paralysis"? No.
BY MR. CARLIN:
Q. I mean, there would be no question that the surgical procedure did not turn out as you anticipated; would that be correct to say?
A. I would agree with respect to the motor injury around the face, yes. In other aspects, the surgical treatment did turn out as anticipated.
Q. Not in regards to the motor --
A. Yes, I would agree that that was an unintended outcome of the surgery.
Q. For which she was not told?
MR. SCOTT: Objection. That's really the same question now, about multiple times, Bill. And so, we have gone over the business and I think Doctor has explained it very

well several times now.
You know, I know what you are trying to accomplish and I give you credit for going back at it all of these times, but that's enough.
BY MR. CARLIN:
Q. All right. Doctor, would you agree that this is a complication that Carol Bozik suffers from now that doesn't normally occur?
A. Yes, I would agree with that.
Q. Doctor, would you agree that it is a complication that has -- the left facial paralysis that Carol Bozik suffers from is a complication that does not normally occur in the absence of something going wrong?
MR. SCOTT: Objection. Now, first of all, I want to object to the word "normally." And I want to know if you are using that interchangeably with "anticipated" as opposed to "normally."
MR. CARLIN: Normally. I'm using it in the context in which it's normally used, which is normal.
MR. SCOTT: But, the input of this issue is simply that, can this kind of thing happen even when due care is used; is that what

you are asking?
MR. CARLIN: What I am asking is what I was asking. Why don't you reread the question and see how that works?
(Thereupon, the Reporter read the record as requested.)
BY MR. CARLIN:
Q. Would you agree with that?
A. I don't follow your wording. It is an unanticipated consequence of the surgery. Now, the surgery was done correctly in that she had this complication as a result of her particular anatomical problems. So, nothing was done wrong, but that doesn't mean she didn't have an outcome that was unsatisfactory.
Q. Would you agree that this is the type of injury that does not normally occur in the absence of medical negligence?
MR. SCOTT: Objection. That's the same question.
THE WITNESS: Yeah. This injury occurred -- I just want to make sure I am stating this clearly. There was no negligence anywhere which caused this particular problem.
BY MR. CARLIN:

Q. And would it be your opinion that the procedure on Carol Bozik that you performed, there was no deviation from the standard of care?
A. That is my opinion.
Q. Okay. Doctor, going over to your notes, and I've got them here somewhere. And I think probably these are the same notes that I have a copy of that you have right there and if the originals -- why don't you just mark this whole packet?
Is that okay with you, John?
MR. SCOTT: Yes, it is, as long as we identify them one, two, three, seven or eight -- you know what, you better mark all eight of them. This way we can shoot through them.
(Thereupon, Plaintiff's Exhibits D through L to the deposition were marked for purposes of identification.)
BY MR. CARLIN:
Q. Handing you what has been marked as Plaintiff's Exhibit D, could you identify what that is?
A. Yes. This is the operative report done by me for patient, Carol Bozik, 8/28/96.

Q. Doctor, why don't you just describe the operation, if you can?
First of all, what time did Carol Bozik come into the Mt. Sinai Medical Center?
A. I would have to look at other information, which we don't have. But, she would have come in, approximately, 6:30 in the morning. She would have been admitted the day of the surgery, which is typical. She would be presented in the preoperative area, assessed by me, the doctors who work with me, and the anesthesia team.
She was then brought to surgery. She was put to sleep with difficulty, as we mentioned before, by the anesthesiologist. When she was put to sleep, we commenced surgery.
In oral surgery, it is hard to describe without a visual head. But, you essentially make an incision in the back of the jaw and expose what we call the ramus of the mandible, which is the back of the jaw, which is -- to do that, you have to use various drills and saws to create a cleavage plane.
Then you begin separating the inside of the bone from the outside of the bone along the cleavage plane while protecting the nerve that

gives feelings to your lip and teeth. We were able to do that successfully.
It was very difficult to split her jaw because her cleavage planes were less prominent than most patients. Then we discovered that she had these difficult attachments due to calcified ligaments, which made her operation harder than most, especially on the left side where she had unusual calcification and very, very minimal cleavage plane.
Q. It seems on the right side you didn't confront too many difficulties, at least, from your notes?
A. Yeah. I do recall it was somewhat more difficult to split than average, but not as difficult as the left side which was much more difficult to split than average.
Once we successfully split both sides, you can then move the portion of the jaw containing the teeth forward and keep the portion of the jaw containing the side of the jaw and the jaw joint back where they started.
So, you literally lengthen the jaw, which I am describing, which I know the court reporter cannot pick up which ones. You lengthen the jaw

to the new length so the bite is correct. You put miniature screws in to keep it in the same length and put it back together and test to make sure everything is correct. (Indicating.)
Q. Doctor what time, approximately, did her procedure begin?
A. I think she went into the operating room at 7:30 and we might have started the surgery, approximately, 8:30.
Q. And then, when she enters -- when she entered the operating room, did they begin anesthesia immediately?
A. I think they do. That's generally why the anesthesiologist is there.
Q. Because it indicates that the anesthesia started at 7:32?
A. Okay. Then I would accept that's when they began the process of anesthesia.
Q. And there is also an indication on Plaintiff's Exhibit A, that the procedure started at, approximately, 8:33; does that sound about right?
A. Yes.
Q. And it also indicates that the procedure ended at about 11:53; does that sound about

right, too?
A. Yes.
Q. Doctor, in regards to Plaintiff's Exhibit D, that's the operative report, you indicated that "Care was taken to avoid the nerve at all times." What nerve were you talking about?
A. The mandibular nerve, the nerve that gives feelings to the teeth, gums, and lips.
Q. But, not the facial nerve?
A. Well, yes, that is not an operative field. So, that would not be discussed in this operation.
Q. You dictate -- when did you dictate this operative report?
A. I dictate immediately after surgery and I train the doctors to do the same. And this one was dictated by me, by the initials, "M.H." I dictate my own operative reports in general.
Q. I think you indicate somewhere here, and I don't see exactly where it was, but "The left mandible began to split unfavorably involving the buccal cortical segment"?
A. Correct.
Q. Could you just explain that?
A. Yes, literally splitting. The correct

pronunciation is buccal, which is the outside layer of the bone from the lingual, or the inside layer of the bone in order to create that advancement.

In her case, because there was no actual cleavage plane like we find in most patients, it did not want to split along the normal cleavage plane and began splitting in a way that -- in a direction that we don't want it to. So, we have to modify how we do the cutting and splinting in order to just redirect it.

Q. How long was the left side retracted for?

A. I don't know, specifically. It would have been somewhat longer than the right side because I remember the left side was harder to do. But, I have retracted jaws for greater length of time than Carol's because I have had jaws even more difficult than this.

Q. And what about not only in regard to the length of the retraction, but what about the retraction -- I guess, the strength of the traction?

A. Yeah.

Q. Was there anything unusual about that?

A. No, only that all of her tissues were what

we described, which was tight. There was no resiliency to them. But, the retractors go along the bottom of the jaw. The nerve that comes out of the skull is up here, so the retractors are never near her nerve. (Indicating.)

The retractors are just merely pulling the lip and the gum, various tissues away. If she had an injury due to the retractors, she would have been basically localized at this part of her face. So, it doesn't even follow. (Indicating.)

Q. Doctor, you are rubbing with your left hand?

A. The lip and chin area. (Indicating.)

Q. The lip and chin area?

A. Right, right. And from time to time, we do operations where we have retractors near what we call the marginal mandibular branch of the nerve. We have to retract for a period of time. You can have weakness of the muscles of the lip and chin.

But, Carol's injury is really along her eyes. It really has nothing to do with the retractors. The retractors are near the part of the facial eye that goes up, nerves that go, you know, to the eye. (Indicating.)

Q. Well, we have discussed before the possibility of it being a compression-type of injury?

A. Yes.

Q. Would that have been compressed as a result of the retractors?

A. No.

Q. It would have been compressed as a result of the hematoma that you described?

A. Yes, that would have definitely been part of that.

Q. Well, what caused the hematoma?

A. The indirect pressure or contusion of the back of the jaw and all of those calcified ligaments behind the jaw, which run up to the facial nerve, as you are manipulating the jaw in the standard fashion to get this very, very stiff and rigid jaw to separate.

The indirect compression on the retromandibular vein and the retromandibular nerve as it runs right next to the highly calcified ligaments would have caused this injury, in my opinion.

Q. Doctor, I think I have handed you what has been marked -- what was previously marked as your

notes, as Plaintiff's Exhibit B, and it runs really through Plaintiff's Exhibit L. I would just like to briefly ask you some questions about those.

I think on Plaintiff's Exhibit F, and I think this was a note from the front page which apparently is 1/25/96, that's the first time you ever saw her?

A. That's correct.

Q. Carol Bozik?

A. Yes.

Q. And she was referred to you by Dr. White?

A. Yes.

Q. And I think you wrote in your notes here, you explained "numbness permanent," as "possible," I think you write that on there?

A. Yes.

Q. And how do you explain that?

A. When a patient comes to the initial consultation, I, in addition, to explaining what type of surgery and a little bit about the surgery, I explain what some of the side effects are going to be. And I explained some of them, more common ones.

The reason I have found that it is

beneficial to do that right at the initial consult, even though we get more extensive, detailed written informed consent later on, I think it's fair to a patient to have a pretty good idea what you are getting into, because many patients grossly underestimate the side effects of this kind of surgery.

And some of them after hearing that they might be permanently numb, especially, or might have to have extended time off from work, or they might bleed where they need transfusion, sometimes once they hear that, they don't want to go any further, don't want to continue with the whole procedure.

So, I explain up front some of the more major problems that we see on a more routine basis just to let the patients know what they are getting into because I don't want a patient to come back several months later, and now, be hit with, "What? You never told me I could be numb," or "I would never need several weeks off," or "You never told me I might need a transfusion."

Q. Do you have an independent recollection of explaining all of these things to Carol Bozik?

A. I have an independent recollection that I

explained the standard things that I explain, and I do remember that Carol was unusually inquisitively, much more so than other patients. She was unusually nervous than most patients.

She also stands out in my mind, even in preparation for legal action. Carol is unique in my mind because of some of her preexisting problems.

Q. She pretty much had extensive preexisting problems?

A. Yes.

Q. I mean, she had gone through quite a few female procedures and so forth?

A. Yes.

Q. On 8/8/96, you indicate that you reviewed the risks of surgery?

A. Yes, I did.

Q. And is that essentially the risks that we have discussed as contained in Plaintiff's Exhibit C?

A. Yes.

Q. You don't want to go down that path again, do you?

MR. SCOTT: No.

BY MR. CARLIN:

Q. I am just kidding you.

Doctor, when you make these notes -- and I note that on the next page, and I think it's been marked as Plaintiff's Exhibit G, I note that these notes were actually made on the date of the surgery; this is on August 28th of '96?

A. Correct.

Q. Do you make these notes first, or do you dictate the surgical procedure for your operative report first?

A. That can vary. It sometimes depends where I am. If I am in my office and I have the chart here, I make the notes first, and then I'll dictate. If I am sitting in the operating room, or recovery room, or something and I don't have my chart, then I do the dictation. I can't tell you which one.

Q. Is the dictation equipment right in the operating room?

A. It's not right in the operating room, but it's nearby. You can dictate nearby.

Q. So, when you dictate into that equipment, who eventually comes and types it out for you?

A. I don't know. I think it's the MRC Group. It's a corporation that does transcription.

Q. And is that a regular dictation machine or does it go into a computer of some kind?

A. I think, at Mt. Sinai it was into a phone. You call a certain phone number and it goes into a dictation system that the MRC Group runs.

Q. Doctor, who was present in the surgical room at the time of this procedure?

A. I would have to -- Dr. Troy Frazee.

Q. Was Dr. Frazee a resident?

A. Yes, he would have been my assistant.

Q. Where do you see Dr. Troy Frazee?

A. He's listed on the operative report.

Q. He's assistant surgeon, Troy Frazee?

A. I would have to look at the possibility, the operating room record, or the hospital record that I don't have here. It would probably tell me if some of the other residents were there.

Q. Are there any nurses there?

A. Yes. And you have a scrub nurse and a circulating nurse.

Q. Do you know who the scrub nurse and circulating nurse were?

A. No.

Q. If I were to ask you when you have an opportunity at some time, when you have a free

moment, would you be able to check and find out who the scrub nurse and the circulating nurse were?
A. Yes. We may be able to do it today.
MR. SCOTT: It would be in your records, I presume.
MR. CARLIN: Yeah, it would be in my records. I don't know if I have it right here. I know I couldn't identify who they were.
THE WITNESS: Yeah. I might be able to, if you have the Mt. Sinai record. The operating room team keeps records of who is in the room. I can honestly say that for them to be of help to you would be minimal, because they would probably have no recollection, because nothing visible happened in this case.
You know, it wasn't as if it was something that they would note, "Oh, there was a lot of hemorrhage," or "This patient had to arrest and we had to revive the patient." There was nothing that I believe, that can enlighten you to as much as you would try to find out.
BY MR. CARLIN:
Q. Troy Frazee, who is that?
A. He was the surgical resident, the main

surgical resident at the time.
Q. Do you know where he is now?
A. Yes. He is a surgical resident in general surgery at Huron Road.
Q. Was Troy Frazee doing his residency in general surgery?
A. At the time he was with me, he would have been doing his residency in oral and maxillofacial surgery.
Q. What hospital is he at again now?
A. Huron Road.
Q. And I guess, I'm trying to -- I was asking you about the two nurses that were there.
A. There may have even been more than two nurses, because my recollection of how operating rooms work, the nurses come out, substituting, giving each other breaks. You might have a situation where you might see four or five different names.
Q. Yeah, I looked at the names, but I couldn't really read them. I was just wondering if you had an opportunity, if you would look at that, if you would, and see if you can identify who those were -- who they were and give them to your lawyer?

A. I will do that if I can.
Q. Will you do that, please?
A. Yes.
MR. CARLIN; if you can. Does that sound fair, John?
MR. SCOTT: It sounds fair, except if you have the record, we might just do that right now.
MR. CARLIN: Yeah, I would presume to do it right now.
MR. SCOTT: But, I mean, do you have the operating record for the nurses present here?
MR. CARLIN: No, I don't. I do not have it. I don't really know, because, I mean, I don't see -- how long was Carol Bozik in the hospital?
THE WITNESS: I believe, one day; one day and one night. She would have come in early on the morning of the surgery. She would have her surgery. She would have gone to recovery. She would have gone up to her room. She would have come down to our clinic the next day. And she would have been discharged probably later that morning.

BY MR. CARLIN:
Q. She's given a general anesthetic, right?
A. Correct.
Q. So, she's completely unconscious?
A. Yes.
Q. That's not like being asleep, is it?
A. I'm not sure what you are getting at.
Q. What's the difference between being unconscious as a result of a general anesthesia and being asleep?
A. In that sense, you cannot arouse the person from general anesthesia until the anesthesia has worn off. Normal circumstances, somebody can be asleep, you can arouse them and somebody wake them up.
Q. Doctor, in the surgery room itself, is there any kind of videocamera there that tapes the procedure?
A. We don't have that.
Q. Do they ever do that?
A. In certain situations, that can be done, especially endoscopy, where you are operating by looking at a television screen. It is very similar to that, but it is very, very difficult to tape this type of operation.

Q. Do you do the entire procedure yourself?
A. I do what's called the critical parts myself. For example, the cervical incision the resident may do, putting the sutures, they may do. And the operation, I do. Although, this operation requires often six hands in the mouth at a time doing various functions. So, I only have two, as you can see here, you know. So, there are other doctors' hands in the patient's mouth and I am doing the critical steps. (Indicating.)
Q. Did Troy Frazee do any of the procedure?
A. I'm sure he did some of the procedure because he had to be two of the six hands at any time.
Q. So, you are not saying that Troy Frazee actually takes over and does some of the procedure under your instruction, but what he does is assist you?
A. Correct.
Q. But, he doesn't do the procedure himself, does he?
A. No. But, at any point in time, different people have to do different things. So, if somebody is looking, they will see six different

hands doing things all at the same time. So, I don't see how you can say I'm not doing the procedure he's not doing the procedure. We are all doing it. We can't do it otherwise.
Q. Do you explain that to the patient?
A. I think it is just assumed that you will have assistance in the operating room.
Q. Okay.
A. If they would prefer not to have an assistant, I imagine they cannot have the surgery. So, there is nothing you can do.
Q. So, on 8/28, we have your notes here that -- and I think that you were indicating that there were very tight muscles and tissues, very small jaw. And I think that was something that you wrote in your operating report; is that correct?
A. That's correct.
Q. And I think on 8/29/96, there is a note and under it, it says, "Note," could you read what that is?
A. Yes. "Some deficiency of left facial nerve present today, which was not present postoperatively yesterday." And that would be yesterday to my observation.

Q. And you are indicating that the left eye does not close?
A. Yeah. I'll read what it says. "Decreased frontal buccal and slight decrease of marginal mandibular branch." There are various branches of the mandibular nerve and these three have decreased function.
It's "Left eye does close with slight lag." That means she was able to close it, but it would close more slowly than the right eye.
I have clear memory of watching that. She was able to close it all of the way, but it would happen slowly. Because of that, I advised her to lubricate the eyes as necessary, especially if it was observed to remain partly open during sleep.
Q. And I think you then wrote, the last note for 8/26 -- or excuse me, I'm sorry, under "Note," last note of 8/29/96, and it's on Plaintiff's Exhibit H, the last sentence there, could you read that?
A. "I feel condition is temporary, secondary to swelling or hematoma since it was fine yesterday. Also, possibility of spontaneous Bell's palsy coincident with first post-op day of surgery," which I already explained to you

earlier in the deposition.
Q. We discussed the possibility of it being spontaneous Bell's palsy?
A. Yes.
Q. I don't want to revisit that. But, basically, I think we are all agreeing that the Bell's palsy was probably as a result of the surgical procedure?
A. Yeah, I think it is more likely than -- secondary to the contusion swelling and hematoma than to a spontaneous viral-type of occurrence in the nerve.
Q. At least, initially, you thought that this was a temporary condition which was due to the hematoma?
A. Yes.
Q. And I think today, as we discussed this and we were talking about the potential for a compression injury in causing this paralysis, you discussed that it was due to the -- probably or may have been due to the hematoma?
A. Yes.
Q. And apparently, it turned out that it wasn't temporary, but it was more permanent?
A. Yes, part of it was. Part of it resolved.

Q. Which part of it resolved?
A. I think she has better motion of part of her face than she did when I was seeing her in the postoperative visits. And I think some of it continues today. According to her deposition, she doesn't close her eye completely.
Q. Correct.
A. The reason the parts of -- I'm reasonably sure that part has remained permanent.
Q. And I guess I am wondering what parts resolved?
A. I don't remember. She has visual facial drooping at rest. To my recollection, I think she had some of that when I saw her in the postoperative visit. So, I think she has gained back some of her nerve function.
Q. Doctor, going over to 9/6/96, and I guess this is about a week and a day or two later, and that's identified as Plaintiff's Exhibit I?
A. Yes.
Q. And there was a note there about two-thirds of the way down, "Patient did not anticipate" -- could you read that, "Husband supportive"?
A. Yes, "Husband supportive. Patient did not anticipate postoperative problems with pain,

swelling, bleeding, ecchymosis, despite extensive," which I underlined, "preoperative informed consent."
Q. What is ecchymosis?
A. Black and blue. She was substantially black and blue along the left side of her face, the back of the jaw, and the neck area. That would be very consistent with that retromandibular bleed or hematoma.
Q. I think on the next page, Plaintiff's Exhibit J, I think that's a note from 9/13/96, "Two weeks," and I guess that's "Post-op"?
A. Yes.
Q. And I think you wrote in there "Improving"?
A. Yes.
Q. And "Saw Dr. Levine"?
A. Yes.
Q. Who is Dr. Levine?
A. He's -- or was the Chief of opthalmology at Mt. Sinai Medical Center at that time. And I think it would be beneficial for her to see an eye doctor since she felt she was having some problem with her eye because it wouldn't close. So, I wanted her to see a good eye doctor.
Q. And did you then recommend Dr. Levine?

A. I did.
Q. Do you know Dr. Levine?
A. Yes.
Q. Is he a friend?
A. I wouldn't say, "a friend." I've never socialized with him. He's a colleague.
Q. Did you recommend also the neurologist that was involved with this case?
A. Yes.
Q. What was his name?
A. Well, I recommended that she see a competent neurologist who I know personally, Dr. Laurence Kinsella. But, for various reasons, she didn't see Dr. Kinsella. She ended up seeing Dr. Zayat, whom I don't know.
Q. Did you ever see the reports of Dr. Zayat?
A. Yes.
Q. And do you recall right here what those reports said?
A. Somewhat. I would have to read them if you have any questions about them.
Q. I think they are a part of your record, aren't they?
A. Yes.
Q. And I think he did some neurological

testing?
A. Yes.
Q. And what was your understanding of the results of the neurological testing?
A. That she had a decreased facial nerve function on the left side.
Q. And I think over here on October 11th on Plaintiff's Exhibit K, at least, on October 11th of 1996, you indicated to her that she would need six to eight months to recover nerve function?
A. That is actually what she reported to me that Dr. Zayat told her.
Q. And at least, I suppose, at that time, it was anticipated that this nerve function would be restored or returned within a certain amount of time?
A. Yes. It was my understanding that nerve functioning should return on the basis of the mechanism of injury.
Q. Doctor, just bouncing back to your operative report, what is the mandibular nerve?
A. The mandibular nerve is the nerve that runs inside the jaw, from about the middle of the back of the jaw, up to the bicuspid teeth and then goes out to your lip. It is the nerve that

dentists numb, when he gives us a mandibular shot. It is different from it. It gives feeling.
Q. It's not a motor nerve, it's a nerve for feeling?
A. Correct.
Q. It is different than the nerve -- I thought I asked you about this, but I think on the 8/29/96 note, that you had. "Nerve deficiency with left facial nerve noted today which was not post-op yesterday"?
A. Yes.
Q. I think you described that immediately after the surgical procedure, you didn't note anything wrong with her face?
A. That is correct. In fact, I have clear recollection of visiting her in her room the night of surgery. She was sitting up in bed. She had her bandages on, which go on the side of her face, and she had both eyes closed and she didn't open her eyes at all, which surprised me, because most patients do that. I guess it was more comfortable for her.
Her husband was sitting there. He's a very quiet man. I don't know if you met him. I

explained the surgery, the fact she may have swelling, the fact she may have pain, the various things we do to keep patients comfortable during the night.
She was asymmetrical of the face. I was looking very close to her. She did not have inability to close the eyes. That's why I was very surprised when I saw her the next morning to see that the eye had difficulty closing. But, even on the next morning, it actually could close. It closed more slowly. As time went on, she progressively lost the ability to close it all of the way.
Q. Okay. The Lorenz square drive screws, 13-15 millimeters placed above the nerve; could you just describe that?
A. Yes. Perhaps, if I showed you the x-ray, it would be easier to understand.
Q. Sure. Is this Lorenz, is that actually the name of the company that makes the screw?
A. Yes, sir, that is the brand of screws.
Q. That's Florida Screw, they were bought out by Biomet?
A. You are correct.
Q. I notice you also using some Stryker

instruments here, too?
A. Yes.
Q. Good.
A. These are large.
Q. I have some Biomet and Stryker. I like them both. Do you like those companies?
A. I don't have ownership position in them, that I am aware, but I use their equipment.
Q. Is it good equipment?
A. Yes, it is good equipment.
Q. Do you prefer the Lorenz equipment over the Stryker or the Stryker over the Lorenz?
A. I use them for different uses. The Lorenz makes screws that I use. The Stryker makes saws.
Q. Lorenz makes saws too. Have you ever seen those?
A. I think I have seen them at the trade shows. I have not used them.
Q. Go ahead.
A. Back to the subject at hand.
These are the screws and they are going in the ramus of the jaw. They are placed in a standard fashion. And although to you, they look like they are going straight back, they are actually going at an angle from the outside

cortex of bone engaging the inside cortex of bone to allow the jaw to be advanced as indicated by this. (Indicating.)
MR. CARLIN: Why don't you let the record reflect that Dr. Hauser has x-rays from Carol Bozik of 8/29/96, which is the day following the procedure and he has it inserted into a light screen.
Go ahead.
MR. SCOTT: There is no question pending. Did we not just answer the question?
THE WITNESS: Yes. The question was about the jaw and I answered that.
BY MR. CARLIN:
Q. Yeah. Is the 13 to 15 millimeters, that's the length of that?
A. That references the length of the screw. We actually measure the appropriate depth for each screw, which is a time consuming standard thing to make sure we have the most appropriate screw for the indication.
Q. What is the "ARM"; what does that mean?
A. That's probably millimeters. It's probably MM.

Q. It's MM, that's what it is. Okay.
Going to Plaintiff's Exhibit J, it's in your notes under September 13, 1996.
A. I have that.
Q. And I think you have here, "On 9/13/96, two weeks post-op, improving. Saw Dr. Levine, received eyedrops at night for eye. Eyes okay."
I think down here you have, "Facial nerve frontal, 10 percent"; is that what you have?
A. Yes.
Q. What does that mean?
A. That is my clinical estimation of how much function there is compared to normal. So, if she was able to move the frontal branch, which work the eyebrow, if you will, I would raise that a hundred percent. If she couldn't move it at all, I would give her a zero. And she moved it a little because it --
Q. And the left side?
A. -- seemed to have 75 percent of the strength compared to the opposite side.
Q. Was that 75 percent or 25 percent?
A. I think it's 75 percent, and as I recall, she had 75 percent. The upper lip, she had zero function. She really couldn't move it at all.

When you asked earlier if she had improved, this is an area that I believe she has improved to some degree.
And the lower lip she had 25 percent of the normal function. I believe she has more than that now based on the deposition testimony. I have not had a chance to examine her much beyond October, but she had 25 percent of normal function compared to the opposite side just, based on my visualizing her motion.
Q. How did you go about doing that?
A. I would ask her to pucker her lips, move her eyebrows, close her eyes.
Q. You asked her to do that asymmetrically?
A. If she can, yes. But, you can ask the patient to do it at the same time. It is easier to compare one side to the other.
Q. You asked her to do it asymmetrically?
A. Yes.
Q. Close your eyes, or lower and raise your eyebrows?
A. Correct, right.
Q. Open and close your eyes, then you just eyeballed it?
A. Exactly.

Q. There is a note on this, on 9/17/96, right there --
A. Yes.
Q. -- in the side there; whose note is that?
A. From the handwriting, that may be -- or "As per EMS," Ella Mae Shaker. She was my former secretary at Mt. Sinai Medical Center at the time. It says, "Patient couldn't go to Dr. Kinsella. However, patient is going to Dr. Joseph Zayat, neurologist, in Bedford."
Q. Do you know who made that note?
A. Probably "EMS," Ella Mae Shaker.
Q. That's your former secretary?
A. Yes.
Q. Why would she make that note?
A. I don't know. Perhaps the patient called and said that they were going to Dr. Zayat and she wants it noted in the chart, or I asked her to note that, I don't know.
Q. Doctor, it appeared at about this time, Carol Bozik was, I guess, diagnosed as being diabetic; do you recall that?
A. Yes.
Q. And was that related to the surgery anyway?
A. I don't think so. I found that her blood

sugar was elevated prior to surgery. I was probably the first person to detect that she had hyperglycemia or high blood sugar which elevated for surgery, which we anticipated that. I spoke to Dr. Azem, her internist. He said he would follow her for that.
Q. But, that wasn't related in any way to the surgery or the medication she was receiving, was it?
A. No, that's a metabolic condition that the patient either was born with, or in her case, later develops with time.
MR. CARLIN: Just give me one more minute to go through this. I think this is about it.
(Thereupon, a discussion was held off the record.)
MR. CARLIN: Doctor, I have no more questions. Thank you very much.
MR. SCOTT: Doctor will read.
(Thereupon, the deposition was concluded at 4:40 p.m.)
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I, MICHAEL S. HAUSER, D.M.D., M.D., do verify that I have read this transcript consisting of 95 pages and have had the opportunity to make corrections.

MICHAEL S. HAUSER, D.M.D., M.D.

Sworn to before me, ,
Notary Public

this day of , .

Notary Public

My commission expires .

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jjh

CERTIFICATE

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

I, Janine J. Howard, a Registered Professional Reporter, and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, MICHAEL S. HAUSER, D.M.D., M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by him was by me reduced to Stenotype in the presence of said witness, afterwards prepared and produced by means of Computer-Aided Transcription and that the foregoing is a true and correct transcript of the testimony so given by him as aforesaid.

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

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

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio on this 15th day of September, 2000.

Janine J. Howard, Registered Professional Reporter, and Notary Public in and for the State of Ohio.

My commission expires May 24, 2001.

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