IN THE COURT OF COMMON PLEAS
OF CUYAHOGA COUNTY, OHIO

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KEVIN KISS, a minor, by and through his next friend and natural mother, Anne Kiss, et al.,

Plaintiffs,

vs. Case No.

ANDREAS MARCOTTY, M.D., et al., 402393

Defendants.

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DEPOSITION OF GREGORY S. KOSMORSKY, D.O.
Monday, January 28, 2001

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Deposition of GREGORY S. KOSMORKSY, D.O., a witness herein, called by the Plaintiffs for examination under the statute, taken before me, Karen M. Patterson, a Registered Merit Reporter and Notary Public in and for the State of Ohio, pursuant to notice and stipulations of counsel, at the offices of The Davis Eye Clinic, 789 Graham Road, Cuyahoga Falls, Ohio, on the day and date set forth above, at 1:25 o'clock p.m.

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APPEARANCES:

On behalf of the Plaintiffs:

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On behalf of the Defendant Andreas Marcotty, M.D.:

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D. CHERYL ATWELL, ESQ.
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On behalf of the Defendant Cleveland Clinic Foundation:

Roetzel & Andress, by
ANNA CARULAS, ESQ.
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On behalf of the Defendant Signature Eye Associates:

Ulmer & Berne LLP, by
PAMELA E. LOESEL, ESQ.
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GREGORY S. KOSMORSKY, D.O., of lawful age, called for examination, as provided by the Ohio Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF GREGORY S. KOSMORSKY, D.O.

BY MS. TOSTI:

Q. Doctor, would you please state your full name for us.

A. Gregory Stephen Kosmorsky.

Q. And your home address?

A. 460 Lassiter Drive, Highland Heights, Ohio.

Q. Zip code?

A. 44143.

Q. Is that a single-family home?

A. Yes.

Q. And your current business address?

A. 789 Graham Road, Cuyahoga Falls, 44221.

Q. And at the time that you rendered care to Kevin Kiss, what was your business address?

A. Cleveland Clinic Foundation.

Q. The main campus?

A. Yes.

Q. In July of 1998, were you seeing patients anywhere else besides the main campus of Cleveland Clinic?

A. No.

Q. Who is your current employer?

A. Charles Davis.

Q. And who was your employer at the time that you rendered care to Kevin Kiss?

A. Cleveland Clinic Foundation.

Q. When did you leave Cleveland Clinic Foundation, your employment at Cleveland Clinic Foundation?

A. The end of May of 2000.

Q. What was the reason that you left?

MS. CARULAS: Note my objection. Go ahead.

A. Better opportunity for my family.

Q. Aside from the professional services that you provide for Charles Davis, do you provide professional services for any other entity?

A. No.

Q. And in July of 1998, aside from the services that you provided for Cleveland Clinic Foundation, professional services, did you

provide services for any other entity?
A. No.
Q. Have you ever had your deposition taken before?
A. Yes.
Q. How many times?
A. I don't recall.
Q. Approximately, doctor.
A. Ten.
Q. How many of those were in medical negligence actions?
MS. CARULAS: Note my objection, and we'll have a continuing line of objection. Go ahead.
A. I don't specifically know. In what reference? Me as the Plaintiff's person or --
Q. No. Just whether the case was a medical negligence action that your deposition was taken in.
A. I think they all were.
Q. Now, I want to go through some of the general instructions for deposition. I'm sure counsel has had a chance to talk with you. This is a question-and-answer session. It's under oath, It's important that you understand my

questions. If you don't understand my questions, or if I've phrased them inartfully, let me know, and I'll be happy to rephrase the question or to repeat the question. Otherwise, I'm going to assume that you understood my question and that you're able to answer it.

It's important that you give all of your answers verbally because our court reporter cannot take down head nods or hand motions.

If at some point you would like to refer to the medical records, please feel free to do so.

During the course of this deposition, one of the defense counsel may choose to enter an objection. You're still required to answer my question unless counsel instructs you not to do so. Do you understand those instructions?

A. Yes.

Q. Doctor, have you ever been named as a Defendant in a medical negligence case?

A. Once.

Q. In that case, what was the allegation of negligence?

A. Poor outcome after surgery.

Q. What type of surgery?

A. Decompressive surgery of the orbits for thyroid eye disease.
Q. Where was that case filed?
A. Cleveland Clinic.
Q. Was it in Cuyahoga County?
A. I wouldn't be able to tell you that.
Q. How was the case resolved?
A. Settled out of court.
Q. When was that case in suit?
A. I don't recall.
Q. Approximately how long ago?
A. Ten years.
Q. Have you ever acted as an expert in a medical negligence proceeding?
A. Yes.
Q. How many times?
A. I would say about nine.
Q. How many times for Plaintiff and how many times for Defendant were you acting as a medical expert?
A. I would have no way to recall that.
Q. You don't recall whether you were testifying for a Defendant or a Plaintiff in the case?
A. It was always with the Cleveland

Clinic, with the lawyers there asking me questions. I don't -- I have no specific recollection of who is Plaintiff or who is Defendant.

Q. On the case where you were named as a Defendant, do you recall the Plaintiff's name in that case?

A. No, I do not.

Q. In the cases where you acted as a medical expert, was Cleveland Clinic one of the parties in the case?

A. At all times.

Q. Have you ever given testimony in any case involving issues dealing with vision loss from papilledema?

A. I don't specifically recall. I can't recall.

MS. ATWELL: I'm going to interject. I presume, when you said cases, you meant medical/legal cases?

MS. TOSTI: Yes. I think we said testimony. I don't know of any other case he would be --

MS. ATWELL: I missed that word. Sorry.

Q. Have you ever given testimony in any case involving vision loss after a fenestration of a cyst or shunting procedure?
A. No.
Q. Now, doctor, you are licensed to practice medicine in the State of Ohio; is that correct?
A. Correct.
Q. And were you so licensed at the time that you rendered care to Kevin Kiss?
A. Yes.
Q. Are you licensed in any other states?
A. No.
Q. Have you ever been?
A. Yes.
Q. What other states?
A. Pennsylvania and Missouri.
Q. Has your license in Ohio or any other state been suspended, called into question, revoked?
A. No.
Q. Now, doctor, are you board certified in any areas of medicine?
A. Yes.
Q. What areas are you board certified

in?

A. Adult neurology and ophthalmology.

Q. When did you receive your certification in adult neurology?

A. 1985, I believe.

Q. When did you receive certification in ophthalmology?

A. I think it was 1988.

Q. Did you pass both of those certifications on the first try?

A. Yes.

Q. Where do you currently have hospital privileges?

A. Cuyahoga Falls Hospital, Akron City, Akron General, St. Thomas, and the Cleveland Clinic. I'm a consultant for radiology.

Q. I'm sorry, I didn't hear the end of what you said.

A. Consultant for the radiology department.

Q. The hospital privileges that you mentioned, are those admitting privileges?

A. Yes.

Q. How about at Cleveland Clinic, do you have admitting privileges at Cleveland Clinic?

A. I don't think so.
Q. In regard to the consulting that you do for radiology at Cleveland Clinic, what is it that you are consulting on?
A. For specific -- a specific type of surgery.
Q. What type of surgery?
A. Repair of a cavernous dural fistula through an orbitotomy approach.
Q. Is that something that they're doing a research study on?
A. No.
Q. So they --
A. It's a service that I had provided at the Clinic while I was on staff but no one else can do.
Q. How is it that you have particular expertise in that area?
A. Through my training.
Q. Is that a surgery that you have participated in?
A. Many times.
Q. Now, at the time that you rendered care to Kevin Kiss, where did you have hospital privileges?

A. At the Cleveland Clinic.
Q. Have your hospital privileges ever been called into question, suspended or revoked?
A. No.
Q. In July of 1998, did you hold any administrative positions with the Cleveland Clinic?
A. No.
(Interruption.)
A. I just got you a portion of my CV, if that's what you wanted. I didn't put any of the papers.
MS. TOSTI: I would request a complete copy of his curriculum vitae with publications, or whatever other materials.
THE WITNESS: I can do that. I can print it out for you before you leave. If you'd like that now, I can just have it printed.
MS. TOSTI: That would be helpful, because then if I have further questions, we can do that before we terminate the deposition.
(Discussion off the record.)
Q. Doctor, you served a residency in ophthalmology at the Cleveland Clinic Foundation; is that correct?

A. Yes.
Q. I have only the beginning portion of your curriculum vitae at this point in time. In regard to grants, you have indicated ischemic optic neuropathy decompression trial. Is that grant still pending currently?
A. No. It's been terminated.
Q. Was that a study that you were involved in?
A. Yes.
Q. What did that study involve, just in general terms?
A. The assessment of a type of surgery called an optic nerve sheath fenestration on the effects of ischemic optic neuropathy.
Q. Is that a type of surgery that you perform or have performed in your practice?
A. Yes.
Q. Doctor, I'm going to have some additional questions in regard to your curriculum vitae, but I want to have an opportunity to look at it, so I'm going to skip by those things and we'll go back to them when your curriculum vitae is available.
Have you ever taught or given formal

presentations on the subject matter of papilledema?

A. Yes.

Q. Do you have any of those presentations that have been reduced to a written form, videotape, audiotape?

MS. CARULAS: Note my objection.

A. I have lectures that I have on -- that are in the form of 35 millimeter slides.

Q. Is that something that we would be able to get copies of if I requested them?

MS. CARULAS: Note my objection. I don't think that's appropriate to go and request his 35 millimeter slides. I mean, that's something you can do later, if you want to put a request in to me, but if you want to --

MS. TOSTI: I'm not requesting them at this particular moment, if that's what you think.

Q. But those are available; you have 35 millimeter slide presentations on papilledema that you have done?

A. I think I have them downstairs.

Q. Do you have any syllabus or handouts from those presentations that you've done on papilledema?

A. No.
Q. How many slide presentations do you have on that subject?
A. On papilledema?
Q. Yes.
A. Just one. Here you go.

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(Thereupon, PLAINTIFFS' Deposition Exhibit 1 was mark'd for purposes of identification.)

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Q. Doctor, in regard to what has been marked as Plaintiffs' Exhibit 1, would you identify what that document is for us, please.
A. That's my curriculum vitae.
Q. Is it current and up-to-date?
A. No. Only up until 1999.
Q. Are there any additions or corrections that you would like to make to it?
A. Well, I really hadn't planned to update it past 1999 because my academic career is not primary in my life any longer. So I have other papers that I've published in the meantime, but I'm not really going to add them.
Q. Well, doctor, any of those additional

papers, do they have to do with papilledema?
A. I don't think so.
Q. Any have to do with increased intracranial pressure?
A. Yes.
Q. Can you tell me what the ones that do not appear on your curriculum vitae that deal with increased intracranial pressure are?
A. I'm writing a chapter on pseudotumor cerebri for Neurosurgical Clinics of America.
Q. Has that actually been submitted for publication?
A. Not as of this moment.
Q. Do you know when it is supposed to be published?
A. No, I do not.
Q. Any other publications that do not appear on your vitae?
A. I'd have to go and check, actually. I don't really know. I know there are, but I don't know what they are.
Q. Can I see the CV? Doctor, you have a lecture and presentation that's entitled Delaware Valley Medical Center, Langhorn, Pennsylvania, August 19, 1988, on papilledema and transient

vision loss. Do you have any type of written materials, slides or other materials from that particular presentation?

A. It's the same one that I noted before.

Q. Doctor, on your curriculum vitae, do any of the publications that are listed on here deal with the subject matter of papilledema?

A. I would have to go back and look.

Q. I'm going to ask you to take a look through these, and I would also ask that any of them that you feel deal with the subject matter of papilledema, that you would put a checkmark next to it or circle the number.

A. (Doing as requested.)

Q. Doctor, would you tell me what you have reviewed in preparation for this deposition.

A. My note dated July 22, 1998.

Q. Have you reviewed any other medical records of Kevin Kiss aside from the pages that involved your care?

A. No, I have not.

Q. And I'm just going to run through a couple things. Have you seen any records from the rest of the outpatient department visits that

he's had?
A. No, I haven't.
Q. Anything from any of his inpatient Cleveland Clinic admissions?
A. No, I haven't.
Q. Or any records from providers that cared for Kevin Kiss outside of the Cleveland Clinic care?
A. No.
Q. Have you referred to any textbooks or articles in preparation for this deposition?
A. No.
Q. Any of your own articles?
A. No.
Q. Have you reviewed the deposition of Dr. Mark Luciano?
A. No.
Q. And since the filing of this case, have you discussed this case with any physicians?
A. No.
Q. Other than with counsel, have you discussed it with anyone else?
A. No.
Q. And aside from the clinical notes in

the Cleveland Clinic medical records from your visit on July 22nd of 98, do you have any other personal notes or personal file on this case?

A. No.

Q. Have you ever had a separate correspondence file dealing with Kevin Kiss aside from notes that appear in the Cleveland Clinic records?

A. No.

Q. Doctor, is there a textbook in your field of practice of ophthalmology that you consider to be the best or the most reliable?

A. Let me back up. I did send one note that I recall seeing to -- who was it to? Luciano or -- I did see a note that I sent to someone, a brief note, but I don't remember.

MS. CARULAS: There's the one letter.

A. One letter.

Q. That's contained in the medical records, though; correct?

A. Yes. You meant separate from that?

Q. Yes.

A. No.

Q. Back to my question. In regard to your field of ophthalmology, is there a textbook

that you feel is the best or most reliable in that field?

MS. CARULAS: Just note my objection.

A. Ophthalmology?

Q. Yes.

A. It's such a broad field. In neuro-ophthalmology, it would be Walsh and Hoyt.

Q. Do you refer to that book from time to time in your practice?

A. Yes.

Q. Do you consider it to be an authoritative text?

MS. CARULAS: Note my objection. Go ahead.

A. Yes.

Q. As you sit here today, are there any publications that you feel have particular relevance to the facts of this case?

A. I couldn't recall them.

Q. Well, I'm just interested in whether there's one at this point that you feel has particular relevance.

A. I don't know.

Q. Doctor, could you describe your practice for me as it is today.

A. It's a combination of general ophthalmology and neuro-ophthalmology.

Q. And in 1998 was your practice similar to that also?

A. Yes.

Q. How does neuro-ophthalmology differ from general ophthalmology?

A. In essence, in the sorts of diseases it takes care of and the special training it takes to do that.

Q. What type diseases would a neuro-ophthalmologist involve themselves with? And I'm just thinking of general categories, that a general ophthalmologist would not.

A. Papilledema, transient visual loss, ischemic optic neuropathy, diplopia, nystagmus, the unusual looking optic nerve, unexplained visual loss, functional visual loss, lid abnormalities, pupil abnormalities.

Q. Now, doctor, currently in your practice, are you doing surgical procedures?

A. Yes.

Q. Was that also true in 1998?

A. Yes.

Q. What is the area called where the

optic nerve enters the eyeball?

A. It's variously known, but I think I refer to it as the neuro-optic junction.

Q. Is it also called the optic papilla?

A. Not technically. The optic papilla is what you see on the inside of the eye.

Q. What you can see on the inside of the eye, is that also sometimes referred to as the optic disc?

A. Yes.

Q. What is papilledema?

A. It's a swelling of the optic nerve.

Q. And what usually causes that to occur when it does occur?

MS. CARULAS: Note my objection. It's an awfully broad question.

A. There's a huge list. It's an enormous list.

Q. When papilledema is present, is it usually bilateral?

A. Yes.

Q. Is papilledema and disc edema the same thing?

A. Depends on who you talk to. Disc edema is a more broad designation. That means

the optic nerve could be swollen from causes other than a raised intracranial pressure.

Q. When you refer to papilledema, does that indicate that it is swollen, the optic nerve is swollen, due to increased intracranial pressure?

A. That's how I use the term.

MS. CARULAS: Objection.

A. That's how I use the term.

Q. When you use the term "papilledema," you're referring to swelling that occurs in the optic nerve from increased intracranial pressure?

A. Or presumed increase, yes.

Q. Now, I think you indicated previously that in your practice you do see patients that have papilledema.

A. Yes.

Q. Approximately how often do you see patients with that particular diagnosis?

A. New patients or followup?

Q. Well, in a week's time or a month's time, how many patients would you see with that diagnosis?

A. Half dozen.

Q. Have you had patients referred to you for evaluation, management and followup for papilledema?

A. Yes.

Q. And when you were employed by the Cleveland Clinic, did you have such referrals?

A. Yes.

Q. How is papilledema diagnosed?

A. By observation.

Q. When you say observation, is that through a funduscopic exam of the eye --

A. Yes.

Q. -- using an ophthalmoscope?

Now, as you look at the internal structures of the eye, what is it that tells you that papilledema is present? What do you look for as a physician as you're examining those internal structures?

A. An elevation of the optic nerve.

Q. Anything else?

A. There are numerous other things that you can look for.

Q. Well, if you would just describe for me what those are.

A. Congestion of the blood vessels on the

surface of the disc, an interpretation that the nerve -- each of what are called ganglia and cells are swollen and they're simply being pushed up from behind. You can see hemorrhages, you can see what are called cotton wool spots or little infarcts on the disc. You can see serous retinal detachment, you can see the choroidal vascular membrane growing up through the optic nerve or around the optic nerve. There are lots of clues. You can see optic pseudodrusen.

Q. Is there any system used to grade the severity of the papilledema?

A. There is no set system. Everyone has their own, based on their experience.

Q. Based on your experience, are there different grades or levels of papilledema?

A. Yes. That's one way to characterize it.

Q. What do you use to describe it?

A. A zero to four plus scale.

Q. What would a zero be?

MS. CARULAS: If I may, and I think I've been pretty patient as we've gone along here, Dr. Kosmorsky is here to talk about his particular involvement on July 22nd, 1998, and I

do not believe that there was, per se, a finding of papilledema at that time that would be relevant to his examination.

And so I guess my question is, you know, this is not something that perhaps should be addressed to Dr. Marcotty as opposed to Dr. Kosmorsky. I think we're getting a little bit astray.

MS. TOSTI: I believe that I do have a right to inquire of the doctor in regard to the papilledema since a portion of his impressions dealt with that particular diagnosis in Kevin Kiss's case. So I will proceed with that, with your objection noted.

MS. CARULAS: Well, I want to work here together so that, you know, obviously we can accomplish this.

MS. TOSTI: I'm going to continue to ask him these questions, because I have a right to know what his knowledge and experience is with this particular diagnosis, since that's the diagnosis that was apparently given to Kevin Kiss.

MS. CARULAS: I think you're entitled to ask him what his impression is. I'm not sure

you're entitled to ask him about questions as they perhaps relate to anyone.

MS. TOSTI: I have a right to inquire as to his knowledge and experience in regard to this patient, and I will continue with that. Your objection noted.

MS. CARULAS: As it segues into this particular visit as of July 22. I'm just telling you, I'm going to let you go to a certain extent. We may have to cut this off if I think it's getting too far astray.

Q. Doctor, mechanically, how does increased intracranial pressure lead to papilledema?

A. That's the topic of a very long discussion; it would require a lot of knowledge of anatomy and physiology, and I don't think we really need to get into that. That's a very detailed question. It sounds simple on the surface. It's a lot more difficult. And I simply would have to teach you a lot of things for background before you even would begin to understand it.

Q. Is a finding of papilledema cause for concern in a patient?

MS. CARULAS: Objection. Now what you're getting into is issues of standard of care that did not face this particular gentleman in his care and treatment of this patient. I'm here and he is here to talk at length about his evaluation and treatment. Now what you're attempting to do is make him an expert in this case. He is not here as an expert; I've not identified him as an expert, and it's not fair to him.

Q. Doctor, your impressions of Kevin Kiss, when you examined him on July 22nd, 1998, were optic atrophy both eyes secondary to papilledema, which is resolved; correct?

A. Yes.

Q. Is a finding of papilledema cause for concern?

MS. CARULAS: Objection. It's not an appropriate question for this particular witness.

Q. You may answer, doctor.

A. It depends upon the situation. Sometimes it's -- when it's first seen, it deserves evaluation.

Q. Are there complications associated with papilledema?

MS. CARULAS: Note my objection.
A. There may be.
Q. Is it true that blindness may result from persistent papilledema?
MS. CARULAS: Objection. Again, very broad.
A. As a general statement, that is true.
Q. What is optic atrophy?
A. That is injury to the optic nerve.
Q. Is it actually death of optic nerve fibers?
A. Yes.
Q. Isn't it true that prolonged or persistent papilledema can in some instances cause optic atrophy and vision loss?
MS. CARULAS: Objection.
A. In a general sense, yes.
Q. Is optic atrophy something that generally occurs over a period of time?
MS. CARULAS: Note my objection. If you're able to answer that without specifics.
A. That requires a specific situation to answer that.
Q. Does it sometimes occur with an acute immediate result, optic atrophy?

MS. CARULAS: Just note my objection.
A. In general, it takes six weeks to occur.
Q. Does the risk of optic atrophy increase with the duration of papilledema?
MS. CARULAS: Note my objection. If you're able to answer that in a general way.
A. In a general sense, that's the presumed -- that's an observation that's been made.
Q. Now, doctor, when optic atrophy occurs, are there any visible changes that you can see as a practitioner when you do an internal examination of the eye?
A. Could you restate that?
Q. When there is optic atrophy and you do an internal examination of the eye, can you see any changes in the internal structures of the eye that would indicate to you or would be consistent with optic atrophy?
A. Change in the color of the optic nerve.
Q. And there are usually blood vessels, I believe, that are visible in the disc area. Are there any changes in the blood vessels when optic

atrophy occurs?
A. They may occlude.
Q. Now, when there is vision loss as a result of persistent papilledema, what portion of the vision is lost first?
A. That's an it-depends situation. What specifically do you have in mind?
Q. With persistent papilledema, is peripheral vision usually what is lost first?
MS. CARULAS: Note my objection. Go ahead.
A. In a general sense, yes.
Q. And with persistent papilledema that results in vision loss, is the vision loss a progressive type where there would be some vision loss, and then that vision loss would increase as the papilledema persists?
A. That really depends on the underlying cause.
Q. If it's due to increased intracranial pressure.
MS. CARULAS: Note my objection.
A. That still depends what the characteristics of the pressure are, when it began, how high it is, what the spikes are. A

lot of it is it-depends.

Q. Can it be progressive, though, the vision loss?

MS. CARULAS: Objection.

A. You can imagine a situation where it would be.

Q. And when persistent papilledema is present, how is that treated? And we'll limit it to persistent papilledema due to increased intracranial pressure.

MS. CARULAS: Wait a minute. Now you're getting specifically into an issue of standard of care that has nothing to do with this gentleman's care. It's inappropriate in this setting. He wasn't there, he didn't evaluate the patient and so forth.

MS. TOSTI: I didn't ask him anything about the patient. I'm asking him in general as to how persistent papilledema is treated; that is, papilledema that's caused by increased intracranial pressure.

Q. So I'm asking you, doctor, as to your knowledge and background, how that is treated.

MS. CARULAS: It would be my guess, however, that you are thinking about linking it

to this case.

MS. TOSTI: I prefer you not guess. This is my question, and I'm asking the question as it's --

MS. CARULAS: I was being facetious. Obviously, you are attempting to tie this into this particular case. He is here to talk about his involvement, his examination and so forth. Now you're getting into an issue of standard of care. We're not going to let you go.

MS. TOSTI: I have a right to delve into this doctor's knowledge and background as to the treatment, as to his knowledge about papilledema, and how it relates to optic atrophy.

He has indicated his impressions are that this child had optic atrophy secondary to papilledema, and, therefore, I have a right to go into his knowledge about this particular disease entity. Now, that's what we're questioning about, his knowledge, at this point, and I would ask that you answer my question, doctor.

MS. CARULAS: 1 disagree. I mean, I have had specific rulings from a number of courts that say you cannot just pull someone out of

their setting and what they did and attempt to bring them in as an expert witness. I mean, we've been very patient, all of us, in letting you ask general questions of this man. You have never even gotten into the point of what --

MS. TOSTI: Your objection is noted on the record, and if the Court wants to rule on it, they can, but I'm going to continue with my questions.

MS. ATWELL: I'm going to join in the objections.

MS. LOESEL: So am I.

MS. CARULAS: The point is here, and I don't want to get into a situation where we have to go fight with motions and so forth, what she is asking you here is to give an opinion as far as the care that was rendered in this case when you weren't there.

MS. TOSTI: I have not directed my question whatsoever to the care rendered in this case. I have asked a general question in regard to diagnosis. I have not related it to this particular patient.

MS. CARULAS: My point here is it's inappropriate, number one. I can instruct him

not to answer and we can go and fight this in the court, if you want to do that.

MS. TOSTI: I don't believe that you have any basis to instruct him not to answer my question. However, that is up to you, whether you want to do it, if you think that you have legal grounds to tell this doctor and instruct him that he cannot answer my question.

He has rendered care to this child, he has rendered impressions as to the child's diagnosis, and I have a right to delve into his knowledge and experience in regard to those particular diagnoses: papilledema and optic atrophy, and, therefore, I will continue to ask those questions.

MS. LOESEL: Are you asking him to render an opinion with regard to his diagnosis at the time that he saw the patient?

MS. TOSTI: I am asking him the question that I asked him, and, Karen, if you would please read that back to me, the last question.

(Record read.)

Q. My question to you is: How is persistent papilledema that is the result of

increased intracranial pressure treated?

MS. LOESEL: Objection.

MS. ATWELL: Objection.

MS. CARULAS: Note my objection. In what setting?

MS. TOSTI: In any setting. I'm asking him just generally what are the options available. I haven't given him anymore specifics than that.

MS. CARULAS: How does that apply to his July 22 care?

Q. Doctor, do you understand my question?

A. Yes.

Q. Would you answer it.

MS. LOESEL: Objection.

MS. ATWELL: Objection.

THE WITNESS: Should 1 answer it?

MS. CARULAS: My point is, and I do have basis to instruct you not to answer it, because he is here to talk about his only involvement, one day, and -- let me just finish for the record here -- and he was not asked to treat persistent papilledema.

Now, if you have a particular opinion

on that that you care to share here, you can do that. But the point is, 1 mean, he's here to talk strictly about his involvement, and that's a question that has nothing to do with his involvement.

Q. Do you understand my question, doctor?

A. Yes.

Q. Would you answer it, please.

A. I have to ask counsel whether I should.

MS. CARULAS: Let's step out for a second.

(Discussion off the record.)

MS. TOSTI: Would you read back my last question.

(Record read.)

MS. CARULAS: Note my objection.

A. The answer depends upon the specific situation. If you had cor pulmonale, you would treat that first. If you had a metabolic acidosis, you would treat that first. If you had a drug, an offending drug, like vitamin A on tetracycline or doxycycline or nalidixic acid, any one of hundreds of drugs that could do that,

you would stop the offending drug. If you had any reason to believe there was a mass lesion, you would remove the mass lesion. If you had subarachnoid hemorrhage, you would treat the underlying aneurysm or dural fistula or vascular malformation; if you had any one of a number of things. It just depends on what the underlying etiology *is.*

Q. All of those things you just mentioned could cause increased intracranial pressure?

A. They may, in specific circumstances, yes.

Q. Is Diamox ever used to treat papilledema?

A. Diamox is a drug that has been used to treat papilledema.

Q. In persistent papilledema in which medical intervention has not worked, is optic nerve sheath fenestration sometimes used to treat papilledema?

MS. CARULAS: Note my objection. Go ahead.

A. In some instances, people would **do** an optic nerve sheath decompression.

Q. Have you done that in some instances,

doctor, for patients that you have cared for?

MS. CARULAS: Note my objection. Go ahead.

A. I have.

Q. Doctor, when a patient has papilledema, is it important to continue to monitor the papilledema to see if whatever treatment is chosen is resolving the problem?

MS. LOESEL: Objection.

MS. ATWELL: Objection.

MS. CARULAS: Note my objection. Now I'm going to instruct him not to answer. You're asking him a standard of care question which has nothing to do with his involvement in this case.

Q. Doctor, what is visual field testing?

A. Visual field testing is done by various sorts of mechanisms, but it's basically an attempt to evaluate what a person sees in the periphery.

Q. And how do you go about doing visual field testing?

A. Depends on the methodology.

Q. How do you do it?

MS. CARULAS: Note my objection, but go ahead.

A. We have automated Humphrey perimeters.
Q. What is sequential visual field testing?
A. Sequential.
MS. CARULAS: Note my objection, but go ahead.
A. As a specific test? I'm not sure.
Q. Have you ever heard of sequential visual field testing?
A. You simply mean doing them in sequence, one after the next?
Q. Yes.
A. Sure.
Q. Do you use that sometimes to evaluate patients that have an ongoing vision problem?
MS. CARULAS: Objection.
A. I have in the past.
Q. Is sequential visual field testing helpful in monitoring a patient with persistent papilledema?
MS. ATWELL: Objection.
MS. LOESEL: Objection.
MS. CARULAS: Objection.
A. In the general sense, it could be.
Q. Have you used it in your practice to

monitor patients that have persistent papilledema?

MS. LOESEL: Objection.

MS. ATWELL: Objection.

MS. CARULAS: Objection. Again, we're going down the same line again. Whether he's done it in other patients has nothing to do with the issue of standard of care in this case for the other players. But go ahead. I want to try to work with you here as much as possible. Have you ever used it?

A. I have.

Q. Doctor, would you agree that when a patient is found to have persistent papilledema that the patient should be followed closely for signs of optic atrophy?

MS. LOESEL: Objection.

MS. ATWELL: Objection.

MS. CARULAS: Objection again. Don't answer that. It has nothing to do with his evaluation of this patient on July 22, 98, which is his only involvement in this case.

Q. Well, doctor, I believe you have rendered your impressions in this case, that this particular patient, Kevin Kiss, had optic atrophy

secondary to papilledema, so 1 would ask my question again: Would you agree that if a patient is found to have persistent papilledema that the patient should be followed closely for signs of optic atrophy?

MS. ATWELL: Objection.

MS. LOESEL: Objection.

MS. CARULAS: Same situation. Just couching it on what his impression was has nothing to do with asking him a standard of care question as to care he was not involved in.

Q. I would ask you to answer the question.

MS. ATWELL: Objection.

MS. LOESEL: Objection.

MS. CARULAS: I'm going to tell him not to answer it.

MS. TOSTI: You're instructing him not to answer?

MS. CARULAS: A standard of care question, yes, I am. Indeed I am. It's inappropriate as to this witness.

Q. Doctor, do you intend, if this case goes to trial, to be rendering opinions as to whether or not persistent papilledema should be

followed closely for optic atrophy?

MS. ATWELL: Objection.

MS. LOESEL: Objection.

A. I have no way of answering that. That depends on what -- I don't really understand the system here, so I don't know to what degree I would be required to do what. So I couldn't answer that.

MS. TOSTI: Are you telling me that he will not express any opinions on that particular subject at trial in this case?

MS. CARULAS: Yes. I always think it is better from my standpoint to have outside experts, because you will always argue from the Plaintiff's standpoint that a treating doctor from within the Cleveland Clinic system at the time is biased.

So, yes, I will have independent experts, and I do not plan to call Dr. Kosmorsky as an expert witness on that issue, and that's why I'm telling you I don't think he should be commenting on anything here other than his specific --

MS. TOSTI: And I do think it relates to his specific care of this particular patient

as to his knowledge and experience with this particular disease entity.

MS. CARULAS: I strongly disagree. I mean, I don't see how those questions have anything to do with his factual involvement in this case, which is the only reason I believe you're here to question him, or you're entitled to be here to question him, to find out what his involvement was as a fact witness. He is here as a fact witness.

Q. Do you have an independent recollection of Kevin Kiss as you sit here today?

A. Not at all.

Q. Based on your review of the record, when is the first time that you came in contact with Kevin Kiss?

A. First and only time is the dated chart record of 7-22-98.

Q. How is it that you came to see him on July 22nd of 98?

A. Well, simply reading from the note, it says that he had been referred by Dr. Luciano.

Q. And what is your understanding, either from your recollection or review of the record,

as to why Kevin was referred to you by Dr. Luciano?

MS. CARULAS: If you know. If you know.

A. Well, I would have to go back and read why. I see my former technician Shauna had written down a sequence of events as told to her, and I believe it was to answer the question of why his vision was subnormal.

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(Thereupon, PLAINTIFFS' Deposition Exhibits 2A, 2B & 2C were mark'd for purposes of identification.)

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Q. Doctor, I'm going to hand you three pages of notes that I've marked as Plaintiffs' Exhibits 2A, 2B and 2C that are dated July 22nd, 1998, and if you could just tell me if those are the notes that you were just referring to.

A. Yes, they are.

Q. Now, in regard to those notes, the handwriting that appears on the first three pages, is that your handwriting or someone else's?

A. That's my technician, Shauna.

Q. Does your handwriting appear on these particular pages?
A. From the middle to the bottom of page 2C and 3.
Q. So on page 2C, your notes are at the end of that page; is that correct?
A. Correct.
Q. When you saw Kevin, did you go and confirm the information that the technician, Shauna, had reported on the patient?
A. I don't recall if I had personally done that.
Q. Would it be your usual procedure to do that, to confirm whatever history or information she collected on a patient?
A. I would usually question her about that, or the individual that I was examining.
Q. Now, is Shauna someone that specifically works with you, doctor?
A. Well, not now. She did.
Q. At the time?
A. Correct.
Q. She was assigned to your service?
A. Correct.
Q. And she would see your patients?

A. Correct.
Q. Typically would she see the patient first and then you would see the patient?
A. Correct.
Q. Would she be present at the time that you would then see the patient?
A. No.
Q. She would see the patient prior to you going in to see a patient?
A. Right.
Q. At the time that you saw Kevin Kiss, did Dr. Luciano provide you with any information about Kevin's condition when he made that referral?
A. Not that I recall.
Q. How is it that you would normally be informed about a referral?
A. It would just be on my schedule.
Q. Would you be provided, usually, with any type of documentation on the patient when you would receive a referral for the patient?
A. Sometimes and, annoyingly, others, no.
Q. Would you have the Clinic notes from the patient's prior visits available to you?
A. At times, and at other times, no.

Q. Do you know in this instance whether you had the Clinic notes from the patient's prior visit available to you?

A. I don't even recall the visit.

Q. Doctor, in regard to the information that Shauna has included at the beginning note, is that information that you likely confirmed with Kevin and his family?

MS. ATWELL: Objection.

A. I can't say in this instance. I simply don't recall the visit.

Q. Would that be what you would usually do on a visit?

MS. ATWELL: Objection.

A. That would be what I would do on many visits.

Q. What was your understanding as to when Kevin's vision loss occurred?

A. Well, all I saw was that he had lost vision by July. I don't see a timeline in the record. So at this point, I am unable to tell you that. I do note here that he was to follow up with Dr. Marcotty in April, and at that point had an emergency shunt. So I don't know whether that visit was triggered by an ophthalmologic

finding or not. I can't really say.
Q. Are you referring to the notes Shauna wrote?
A. Yes, on 2B.
Q. Doctor, is it common for a young child not to be fully aware of the extent of vision loss when they suffer vision loss?
A. That's very dependent upon the child. It really just depends upon how intuitive they are and how talkative they are. So that's really a very much it-depends thing.
a. Have you, in your experience, seen instances where children have lost vision and are not fully aware of the extent of loss of vision?
A. Yes. And I have had four-year-olds who are quite well aware and could express it easily.
Q. When you saw Kevin, was anyone else in attendance with you?
A. I don't recall.
Q. Do you recall if there was a family member present when you saw Kevin?
A. I don't recall.
a. Now, aside from what appears in Shauna's note, did you obtain any additional

history from Kevin or his family on that date that you recall?

A. Once again, I don't recall. I just don't.

Q. Did you perform an examination of Kevin on that date?

A. I did.

Q. And what did your examination consist of?

A. Review of the visual acuity, which was 20/20 minus two in the right eye, and count fingers at two feet in the left eye without wearing glasses.

The fact that his pupil exam had revealed an abnormality called an afferent pupillary defect, the plus 4 APD indicates a very abnormal pupillary response on the left.

His motility, or motion of the eye, appeared normal. Slit-lamp examination was normal. And his fundus examination revealed normal sized small cups, only a mild or trace amount of optic atrophy in the right, and three plus optic atrophy on the left, which is significant. And VMP is vertical macular perimetry, which I noted to be normal on both

sides.

Q. Was there any papilledema present when you examined the interior of his eye?

A. No.

Q. Now, doctor, you indicated that, I believe, in his left eye you noted three plus optic atrophy; is that correct?

A. Correct.

Q. What specifically did you see in the interior of his eye that indicated to you it was a three plus optic atrophy?

A. A pallor that was equivalent to that of my relative scale based on my experience.

Q. Did you take any photographs when you examined the interior of his eye?

A. Not according to this note.

Q. Were you able to determine if this optic atrophy was the result of a chronic condition?

A. No. There's no way to tell that.

Q. ***So*** it could be acute or it could be chronic?

A. Well, chronicity from anywhere out from about four to six weeks to forever. Optic atrophy cannot be dated in that way.

Q. I just want to clarify what you're saying. The condition that you saw could have resulted from a condition four to six weeks ago or longer; would that be fair?

A. That would be fair.

Q. Were there any exudates, hemorrhages or anything like that that --

A. None that I noted.

Q. If there were exudates and hemorrhages, would that be more of an indication of an acute problem?

A. Yes, it would.

Q. Now, there was visual field testing done on that particular visit; is that correct?

A. Yes, there was.

Q. Was that done before you saw Kevin or after you saw Kevin?

A. Usually it's done before.

Q. Doctor, I'm going to give you two pages that I'm going to mark as as 3A and **3B**.

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(Thereupon, PLAINTIFFS! Deposition Exhibit 3A & **3B** were mark'd for purposes of identification.)

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Q. And I would ask what's been marked as Plaintiffs' Exhibit 3A and 3B, are those part of the visual field testing that was done on Kevin on July 22nd of 98?

A. They appear to be.

MS. ATWELL: Could I just ask, what is 3A, the right or left eye?

THE WITNESS: Right eye.

Q. Now, why did you test Kevin's visual fields?

A. Because he had subnormal visual acuity.

Q. And was the actual visual field testing done by a technician?

A. Yes.

Q. Was that done at the bedside, or is there a special area where they do the visual field testing?

A. The latter.

Q. Where is the visual field testing done?

A. There are rooms in the institute where the field machines are.

Q. And when the visual field testing was done, what were the findings?

A. Well, the right eye actually appears relatively normal. There may be mild contraction of the field, but that's arguable for a young person.

The left eye, there's what's called a central scotoma, which is the dark black area, definite contraction of the field. In other words, it's smaller than it should be in both upper and lower nasal visual field loss.

Q. Now, doctor, did you at any time, either before the 22nd other after the 22nd, speak to Dr. Andreas Marcotty about Kevin?

A. Not that I recall.

Q. I believe Dr. Marcotty did some visual field testing on the 14th of July. Did you have his visual field testing made available to you for review at the time that you saw Kevin on the 22nd?

A. I actually don't know. It would normally be my habit to indicate if there had been a change if I had previous fields.

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(Thereupon, PLAINTIFFS' Deposition Exhibit 4A, 4B & 4C were mark'd for purposes of identification.)

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Q. Doctor, I'm going to hand you what I've marked as Plaintiffs' Exhibits 4A, 4B and 4C, and I would ask if you have ever seen these particular visual field testings on Kevin Kiss before.

A. Again, I don't recall. I've seen thousands of visual fields.

Q. Are they consistent with what your findings were on the 22nd?

MS. CARULAS: Note my objection.

MS. LOESEL: Objection.

MS. ATWELL: Objection.

A. In other words, do they show similar patterns to what I see?

Q. Yes.

A. Yes.

Q. Doctor, the visual field testing that you did on Kevin, or had done on Kevin on July 22nd, are they consistent with a patient that has had chronic papilledema?

MS. LOESEL: Objection.

MS. ATWELL: Objection.

MS. CARULAS: Note my objection.

A. They could be chronic or acute, and

they don't even have to be from papilledema. They could be from optic atrophy from any cause, from a toxic optic neuropathy, from drusen, from vascular occlusions, optic neuritis, congenital optic nerve defects. The list goes on and on.

Q. Doctor, isn't visual acuity loss one of the later findings that you see with chronic papilledema?

A. It can be.

Q. Well, patients with chronic papilledema usually don't start with loss of central vision, do they?

MS. CARULAS: Objection.

A. Say it again.

Q. Patients with chronic papilledema usually don't start with loss of central vision, do they?

A. Patients with chronic papilledema may present with loss of central vision.

Q. Do they usually?

A. With chronic papilledema?

Q. Yes.

MS. CARULAS: Note my objection.

A. In my experience, chronic papilledema is with central visual loss.

Q. Aside from what appears in your handwritten note that we just discussed, did you find any other deviations from normal on your examination of Kevin?

A. Not from -- not other than what I discussed on the note, no.

Q. And what were your impressions from your assessment on July 22nd, 1998?

A. Optic atrophy OU, which means both eyes, secondary to papilledema which is resolved, should remain stable.

Q. And the basis for your impression that Kevin had optic atrophy secondary to papilledema, which was resolved, was what?

A. Because of my review of Shauna's note on page 2B that said that the patient had been noted to have papilledema in the past, and, therefore, my logical conclusion was that the optic atrophy was from that.

Q. Now, in Kevin's case, is it likely that his shunting procedure relieved the papilledema?

A. In Kevin's case?

Q. Yes.

A. Relieved it?

Q. Yes.
A. Shunting, if papilledema is due to increased intracranial pressure, shunting almost always resolves the papilledema.
Q. Now, doctor, in Shauna's note, she indicates on, I think, the second page of the note, which should be 2B, about halfway down, that the patient was never told to follow up with Dr. Marcotty. Did you ever discuss this with the patient or with Kevin's mother?
A. Not to my recollection.
Q. Did you ever discuss it with Dr. Luciano as to why Kevin never followed up with Dr. Marcotty?
A. Not to my recollection.
Q. Do you know what the source of that information is in Shauna's note?
A. I do not.
Q. Do you have an opinion whether Kevin should have been told to follow up with Dr. Marcotty after his cyst fenestration procedure in February?
MS. ATWELL: Objection.
MS. LOESEL: Objection.
MS. CARULAS: Objection.

A. Well, that's -- anybody should follow up with a doctor who has had surgery.

Q. With an ophthalmologist?

MS. LOESEL: Objection.

MS. ATWELL: Objection.

MS. CARULAS: Note my objection. She's asking you whether you plan to give an opinion in this case as to the relationship -- you know, whether you're going to give an opinion in this case.

MS. TOSTI: I would prefer you not to explain my questions to the witness. If you have got an objection, enter it, but I don't want you explaining my question to the witness.

MS. CARULAS: Well, I think your question was vague.

MS. TOSTI: You can make an objection then. But I'm not going to have you sit here and reexplain my question to this witness. Now, if he doesn't understand the question, he can ask me. But I'm not going to have you interpret my question for the witness. I think that's inappropriate, and I would object to that.

MS. ATWELL: I'm going to join in the objection, and I'm not going to give the witness

any information, but since he's indicated he has not reviewed the chart, if you want to tell him when any procedure or visit or surgery had occurred, that would be up to you.

MS. TOSTI: And I already did that in my question.

MS. ATWELL: I don't believe you did.

Q. I said, doctor, do you think that Kevin should have been told to follow up with Dr. Marcotty after his cyst fenestration procedure in February of 1998?

MS. ATWELL: Objection.

MS. CARULAS: Well, that wasn't your question. You're now saying a different question.

MS. TOSTI: And he said I think the patient always should follow up with a doctor. I believe that was your answer. And I said, doctor, should the patient have been told to follow up specifically with an ophthalmologist after the cyst fenestration.

MS. LOESEL: Objection.

MS. ATWELL: Objection.

MS. CARULAS: Objection. Again, he wasn't involved in this care. If you want to

give him the exact specifics of this, this and this, but if you have an opinion in the abstract, I suppose, if you can comment on this particular case.

A. In the abstract, certainly, yes.

Q. Certainly the patient should have been told to follow up with an ophthalmologist?

A. In a general sense.

Q. Yes?

A. Yes.

Q. Doctor, at the beginning of Shauna's note, there's a box, I believe, under a typed stamped name that is your name. What does the V and the W stand for in that box?

A. Vision, and W is wearing, so that's the glasses.

Q. What's the NV stand for?

A. Near vision.

Q. Now, once you had completed your evaluation of Kevin, did you discuss your findings with his parents?

A. I don't recall.

Q. Did you make any recommendations regarding treatment for Kevin?

A. I don't think so, because I said per

Dr. Luciano, so I think my -- normally, when I say per whoever referred the patient, 1 left the treatment up to the person who referred the patient and simply rendered an opinion.

Q. Did you provide Dr. Luciano with any recommendations regarding treatment for this patient?

A. If I did, I don't recall. I mean, had he been shunted, and I don't know whether he was, but had he already been shunted, then there would be little reason to do anything else.

Q. I believe at this time he had already received a shunt in April.

A. Then it probably would account for when I said do nothing else, because he already had the definitive treatment.

Q. At the point that you saw Kevin, were there any other treatment options available for him in regard to his vision?

A. It goes back to the same thing we talked about before. It depends upon the underlying cause. If it was elevated intracranial pressure, he already had the treatment. There was no reason to do anything else.

Q. Doctor, if Kevin had papilledema from increased intracranial pressure that was unrelieved by his shunting procedure or medication, treatment, is he the type of patient that a fenestration of the optic nerve might be done on? Is that a type of a problem that --

A. In other words, should I have done an optic nerve sheath fenestration?

Q. I'm not asking if you should have.

A. That's what it sounds like.

Q. I'm saying a situation in which you have persistent papilledema, even after the surgical options to decrease increased intracranial pressure, is that the type of patient that you might consider doing an optic nerve fenestration on?

MS. ATWELL: Objection.

MS. LOESEL: Objection.

MS. CARULAS: Note my objection.

Q. I'm not saying in his case it was appropriate.

A. You're saying if someone didn't respond to the shunt?

Q. Yes.

A. My general tack would be to have the

shunt checked and redo it, because I have never seen anybody who didn't respond to an appropriately done shunt.

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(Thereupon, PLAINTIFFS' Deposition Exhibit 5 was mark'd for purposes of identification.)

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Q. Doctor, I'm going to hand you what's been marked as Plaintiffs' Exhibit 5. Could you identify that document for us?

A. It looks like a note from me to Dr. Marcotty dated July 23rd, 1998 with a copy to Dr. Ernesto Gerardo, and it says, "Kevin will be following up with you in the near future due to his optic atrophy secondary to his edema from his arachnoid cyst. At this point he is 20/20 and hand motion. I expect that as long as his intracranial pressure remains normalized with his shunt tube, his situation should remain very stable."

Q. Why did you recommend ophthalmology followup for Kevin with Dr. Marcotty?

A. It's just my habit, once anybody has any sort of problem with their eyes, you follow

them simply to make sure nothing else happens in the future.

Q. Now, you mentioned that as long as his situation remained stable -- I'm sorry, you mentioned that as long as his intracranial pressure remains normalized with his shunt tube, his situation could remain stable. If Kevin's intracranial pressure increased, would he be at risk for further vision loss?

A. Anyone would be.

Q. Now, did you tell Kevin or his family as to whether they should follow up with Dr. Marcotty?

A. I, again, don't recall, and I didn't specifically say in the note when, so I don't know.

Q. Well, I think you indicated that it would be in the near future, and I was just wondering if you had, in your mind, as to what that meant, near future.

A. Usually it means within several months.

Q. Now, doctor, in February of 98, Kevin was noted to have papilledema after his cyst fenestration. Should he have had --

A. You'll have to go over that again.
Q. Kevin had his cyst fenestration done, I believe, in December, and then was noted to have papilledema in February. Should he have been evaluated by an ophthalmologist and visual fields done?
MS. LOESEL: Objection.
MS. ATWELL: Objection.
MS. CARULAS: Objection.
A. Are you asking me to be an expert on that?
Q. I'm asking you if that would be the standard, to go ahead and do visual fields on a patient that has papilledema following a cyst fenestration.
A. Do I become the expert witness at that point?
MS. ATWELL: Objection.
MS. LOESEL: Objection.
MS. CARULAS: I do not plan to call you as an expert witness. You did not review those documents. You were not there to have firsthand knowledge. If you don't have an opinion, you can tell her you don't have an opinion. I can instruct you not to answer.

A. It's sounding to me like you're asking for expert advice, so I would just say I don't have an opinion on that then.

Q. Do you have an opinion as to whether Kevin's optic atrophy and resulting vision loss was preventable?

MS. LOESEL: Objection.

MS. ATWELL: Objection.

MS. CARULAS: Note my objection as well.

A. That's something I couldn't answer directly, no. That would depend upon detailed review of the past medical record, which I did not do.

Q. So your answer is you do not have an opinion?

A. I do not have an opinion.

Q. Did you at any time ever discuss Kevin's vision loss with Dr. Marcotty?

A. I really don't recall. I mean, I suppose it's possible, because he was in my department at some point and might have asked me, but I surely don't recall without a chart in front of me. I probably couldn't have answered his question anyway.

Q. Did you have any conversations about Kevin's vision loss with any other physicians at Cleveland Clinic that you recall?

A. Not that I recall. I could have had a resident with me, for instance, and spoken with him, but I have no recollection of that at all.

Q. And you don't have any recollection of speaking with Dr. Luciano regarding your findings of July 22nd; is that correct?

A. I don't remember. I mean, I could have, but I honestly don't remember if I did. That's quite awhile ago.

Q. Do you know of any other Cleveland Clinic ophthalmology consult done on Kevin prior to the one that you did on July 22nd?

A. Not that I'm aware of.

Q. Do you have any criticism of any of the care that was rendered to Kevin Kiss?

A. I don't know what care was rendered to Kevin Kiss, so I can't comment.

Q. Do you have any criticism of Kevin or his family in any way for the vision complications that he suffered?

A. No.

MS. TOSTI: I don't have further

questions for you, doctor.

MS. ATWELL: No questions.

MS. LOESEL: No questions.

MS. CARULAS: Okay. You have the right to read over the transcript and make sure it was taken down accurately. I always recommend that.

(Deposition concluded at 2:55 o'clock p.m.)

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AFFIDAVIT

I have read the foregoing transcript from page 1 through 69 and note the following corrections:

PAGE	LINE	REQUESTED CHANGE

_____

GREGORY S. KOSMORSKY, D.O.

Subscribed and sworn to before me this _____ day of _____, 2000.

_____

Notary Public

My commission expires _____

CERTIFICATE

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

I, Karen M. Patterson, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named GREGORY S. KOSMORSKY, D.O. was by me first duly sworn to testify to the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony as above set forth was by me reduced to stenotypy, afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony.

I do further certify that this deposition was taken at the time and place specified and was completed without adjournment; that I am not a relative or attorney for either party or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 8th day of February 2000.

Karen M. Patterson, Notary Public
Within and for the State of Ohio

My commission expires October 7, 2004.

Gregory Kosmorsky M.D

TO THE WITNESS: DO NOT WRITE IN TRANSCRIPT EXCEPT TO SIGN. Please note any word changes/corrections on this sheet only. Thank you.

TO THE REPORTER: I have read the entire transcript of my deposition taken on the _____ day of _____, 20____ or the same has been read to me. I request that the following changes be entered upon the record for the reasons indicated. I have signed my name to the signature page, and I authorize you to attach the following changes to the original transcript:

PAGE	LINE	CORRECTION OR CHANGE AND REASON THEREFORE
31	2	occlude → collapse
45	6	Shona
45	2	ibid
46	18	ibid
48	6	ibid
49	2	"
49	25	"
50	24/25	vessels, macula, Keighley
57	15	Shona
58	5+17	"
61	11	"

3/8/01
Today's date

Signature of Deponent