

JA MIRRA HEASLEY, ETC., ET AL.
VS.
ST. JOSEPH HEALTH CENTER, ET AL.

TRUMBULL COURT of COMMON PLEAS

CASE No. 00 CV 969

DEPOSITION of STEPHEN H. LACEY, M.D.
THURSDAY, AUGUST 8, 2002

COPY

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IN THE COURT OF COMMON PLEAS

TRUMBULL COUNTY, OHIO

JA MIRRA HEASLEY,)
 etc., et al,)
 Plaintiffs,)
 vs.) Case No. 00 CV 969
 ST. JOSEPH HEALTH)
 CENTER, et al.,)
 Defendants.)

Deposition of STEPHEN H. LACEY, M.D., a
 Witness herein, called by the Defendants for
 cross-examination pursuant to the Ohio Rules of
 Civil Procedure, taken before me, the
 undersigned, Eric G. Smead, an RPR and Notary
 Public in and for the State of Ohio, at the
 offices of Stephen H. Lacey, 1611 South Green
 Road, South Euclid, Ohio, on Thursday, the 8th
 day of August, 2002, at 11:25 o'clock a.m.

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I N D E X

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Mr. Burnett	26:1

APPEARANCES:

On Behalf of the Plaintiffs
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 On Behalf of the Defendant Dr. Brennan:
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 On Behalf of the Defendants St. Joseph
 Health Center, Womens Care Center and
 Dr. Lee:
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 By: Margo Stoffel, Attorney at Law
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 On Behalf of Stephen H. Lacey, M.D.:
 Reminger & Reminger Co., L.P.A.
 By: Michael D. Shroge, Attorney at Law
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 101 Prospect Avenue
 Cleveland, Ohio 44114

1 STEPHEN H. LACEY, M.D.
 2 of lawful age, a Witness herein, called for
 3 examination, as provided by the Ohio Rules of
 4 Civil Procedure, being by me first duly sworn,
 5 as hereinafter certified, deposed and said as
 6 follows:
 7 CROSS-EXAMINATION
 8 BY MR. TREADON:
 9 Q. Sir, would you state your name, please?
 10 A. Stephen Henderson Lacey.
 11 Q. And, Dr. Lacey, my name is Tom Treadon.
 12 I represent Dr. Brennan and his group --
 13 Dr. Brennan is a radiologist -- and I have some
 14 questions today with regard to your treatment
 15 of Ja Mirra Heasley, and if I don't make myself
 16 clear, please ask me to repeat my question or
 17 clarify, would you do that?
 18 A. Yes.
 19 Q. Have you been deposed before?
 20 A. Yes.
 21 Q. So you know what the drill is, pretty
 22 much?
 23 A. Pretty much.
 24 Q. Okay. Can you tell me what your
 25 occupation is, please?

5

1 A. I'm an orthopedic surgeon specializing
2 in hand surgery.
3 Q. And just briefly from college forward
4 could you tell me about your educational
5 background and your training?
6 A. I went to Yale University, graduated in
7 1964. Then I went to Ohio State Medical School
8 and graduated in 1969. Then I came to
9 Cleveland and took a surgical internship and an
10 orthopedic residency and finished that in 1974.
11 Q. Where did you take that, University
12 Hospitals?
13 A. University Hospitals of Cleveland. And
14 then went into the Army for two years and
15 served at Fort Campbell and then took a
16 fellowship in hand and upper extremity surgery
17 in Hartford, Connecticut at Yale University and
18 finished that in 1977; then came to Cleveland
19 in 1977 and essentially have been here ever
20 since specializing in hand and upper extremity
21 and orthopedic surgery.
22 Q. You're licensed in what states?
23 A. I'm licensed in Ohio, Connecticut,
24 Massachusetts.
25 Q. And you're board certified?

6

1 A. Yes.
2 Q. And when did you become board certified
3 and what is the certification?
4 A. I'm board certified in orthopedic
5 surgery, having been certified in 1975. I
6 am -- I also have a certificate of added
7 qualifications in upper -- hand and upper
8 extremity surgery, and I have just been
9 recertified in that two years ago.
10 MR. BURNETT: Doctor, if you can
11 direct your voice towards the speaker phone, I
12 would appreciate it.
13 MR. TREADON: I will move it a
14 little bit so you can hear better.
15 THE WITNESS: And what is board
16 certification, was that your other question?
17 BY MR. TREADON:
18 Q. No, I didn't ask any other questions.
19 Do you treat adults and children?
20 A. Yes.
21 Q. And what percentage of your time is
22 devoted to the act of clinical practice of
23 orthopedic surgery, approximately?
24 A. 90 percent.
25 Q. And do you teach?

7

1 A. Yes.
2 Q. Where?
3 A. I teach at University Hospitals and at
4 MetroHealth Medical Center.
5 Q. And this is, I assume, residents?
6 A. Orthopedic residents and medical
7 students.
8 Q. Why don't you tell me just generally,
9 Doctor, about your practice, what do you do on
10 a daily basis --
11 A. Well, I usually operate --
12 Q. -- aside from giving depositions?
13 A. I usually operate in the morning except
14 on Fridays. Every Friday I just see patients
15 all day, but every other day of the week I'm
16 usually in the operating room until noon or so,
17 and then in the afternoon I will see patients.
18 Q. You do hand surgery and upper extremity
19 surgery. Does that mean -- can you define what
20 that means?
21 A. Well, hand surgery is a broad subject
22 now. My specialty goes as far proximal as the
23 shoulder, and I used to do, oh, I'd say 60 to
24 70 percent hand surgery, and now I do about 90
25 percent hand surgery, meaning upper extremity

8

1 surgery. I should clarify that.
2 Q. And upper extremity surgery means
3 everything from the tips of the fingers to the
4 shoulder, pretty much?
5 A. Yes.
6 Q. That includes the shoulder, elbow,
7 wrist, hand?
8 A. Correct.
9 Q. Okay. I'm going to ask you some
10 opinions today as we go through Ja Mirra
11 Heasley's chart, and if you could answer those
12 questions only to a reasonable degree of
13 medical probability, that is more likely than
14 not, in other words, I'm going to ask you for
15 some opinions and if you could answer your
16 questions based upon that premise, would you do
17 that --
18 A. Yes.
19 Q. -- rather than repeating that each time
20 I ask you an opinion?
21 A. Yes.
22 Q. I would like to turn, if you would, to
23 your progress notes and ask you when you first
24 saw Ja Mirra Heasley and how is it that you
25 came to see her?

9

1 A. I first saw her on November 15th, 1999.
 2 She was referred to me by Dr. Haber, who's a
 3 pediatric orthopedic surgeon in Youngstown, and
 4 he had been following her for a brachial plexus
 5 injury. When I first saw her she was 11 months
 6 old. Unfortunately whoever transcribed this
 7 note put in he instead of she.
 8 Q. Yes.
 9 A. But I know very well it's a she. And
 10 Dr. Haber just sent her to me because he
 11 thought I ought to take a look at her and
 12 evaluate her upper extremity and see if
 13 anything could be done to improve the
 14 situation.
 15 Q. You did a physical examination?
 16 A. Yes.
 17 Q. And could you tell me what you found in
 18 your examination that was abnormal?
 19 A. The abnormal finding, most striking
 20 finding was the internal rotation of the
 21 shoulder. This child had very poor external
 22 rotation, in other words, she was unable to
 23 rotate her shoulder out from her body, her arm
 24 out from her body.
 25 Q. You mean laterally?

11

1 of the triceps muscle, which extends your
 2 elbow, and there is some over-pull from the
 3 muscles in the arm that flex your elbow.
 4 Q. Does it ultimately mean she cannot fully
 5 extend her arm into a straight line, is that
 6 what that means?
 7 A. No, because she can.
 8 Q. Okay.
 9 A. She could at that time. One, it's just
 10 that they position their elbow in slight
 11 flexion. For another reason, two, it's to
 12 position the hand away from the front of the
 13 body. It's sort of a habit they get into, so
 14 there is really two reasons for that.
 15 Q. You mentioned two things, brachial
 16 plexus injury and Erb's palsy. How do you
 17 define a brachial plexus injury?
 18 A. The -- you define it by doing a physical
 19 examination and determining which muscles are
 20 weak or paralyzed, and then you extrapolate
 21 that back to the nerves which supply those
 22 muscles, and then you can determine what part
 23 of the brachial plexus has been injured.
 24 Q. And that's a bundle of nerves, as I
 25 understand it?

10

1 A. It's hard to describe this but --
 2 Q. Maybe you can demonstrate.
 3 MR. TREADON: You can't see it,
 4 John, but --
 5 THE WITNESS: He can't see it. If
 6 you can imagine your hand on your stomach and
 7 you take your hand off of your stomach and
 8 rotate it out to the side, she was unable to do
 9 that (indicating). This is a very common
 10 problem in this type of what we call Erb's
 11 palsy. This is very common.
 12 BY MR. TREADON:
 13 Q. Okay. Any other abnormality? You say
 14 internal rotation of shoulder or did you mean
 15 external?
 16 A. She was unable to externally rotate, and
 17 she positioned her shoulder in internal
 18 rotation.
 19 Q. I see. Any other abnormalities?
 20 A. She had a slight flexion contracture of
 21 the elbow which is another common finding in
 22 Erb's palsy.
 23 Q. And what does that mean?
 24 A. Well, there is some argument about why
 25 that occurs. There probably is some weakness

12

1 A. It's a -- yes, that's the best way to
 2 describe it.
 3 Q. And that was your diagnosis back in
 4 November of 1999, brachial plexus injury?
 5 A. Yes.
 6 Q. Distinguish that from what you term
 7 Erb's palsy.
 8 A. That's the same thing.
 9 Q. Okay.
 10 A. Erb's palsy is just another term used to
 11 describe birth injury of the brachial plexus.
 12 It's one type of birth injury. Erb's palsy
 13 refers to injury to the upper portion of the
 14 brachial plexus. There is another type called
 15 Klumpke's, and that refers to the lower portion
 16 of the brachial plexus, but in her case it was
 17 just the upper portion.
 18 Q. Is this a problem, Erb's palsy and
 19 brachial plexus injuries, that you treat
 20 routinely?
 21 A. Yes.
 22 Q. Do you have any estimate as to how many
 23 per year, for instance, you might treat?
 24 A. I see about three or four.
 25 Q. A year?

13

1 A. A year.

2 Q. Are you able or is it appropriate to
3 classify the brachial plexus injury as mild,
4 moderate, severe or is that something you don't
5 do?

6 A. Yes, I can -- I can classify those based
7 on a simple system like that, yes.

8 Q. Okay. Can you do it in a case of Ja
9 Mirra Heasley when you first saw her in
10 November of 1999?

11 A. Yes. Compared to many cases of Erb's
12 palsy that I have seen, I would say that she
13 has a moderate palsy, and the reason I say that
14 is because she is -- she was lacking a
15 considerable amount of external rotation
16 strength in her shoulder that required, in my
17 estimation, required a tendon transfer to
18 improve. If she had been mild, I wouldn't have
19 recommended a tendon transfer.

20 Now, the other thing was that she --
21 she did not have much involvement of her hand
22 and wrist. She had really very good function
23 of her hand and wrist and fingers and had she
24 been a severe Erb's palsy she would have had
25 difficulty down there, so I would put her in

15

1 Usually that doesn't happen after -- after a
2 year.

3 Q. Okay. So your plan at that point was
4 what?

5 A. My plan at that point was to reconstruct
6 the shoulder with the tendon -- with the
7 shoulder release and the tendon transfer.

8 Q. And can you explain in layman's terms
9 what that means, what you physically do in the
10 operation?

11 A. What's done is we take a muscle, very
12 strong muscle, people may have heard of this.
13 They're called the lats. You will see these in
14 weightlifters when they make a muscle.

15 Latissimus dorsi or the lat is
16 transferred to another part of the shoulder to
17 give more strength to provide external
18 rotation. That's basically what the procedure
19 is. I also took another muscle, which really
20 isn't important, but it's to take a strong
21 muscle that is working and making it more
22 useful for the shoulder.

23 Q. And you did that procedure in, according
24 to my review of your records, in July of 2000?

25 A. Yes.

14

1 the moderate category.

2 Q. That was your -- that would be your
3 initial assessment?

4 A. Yes.

5 Q. What was your plan of treatment?

6 A. I felt that -- well, you have to realize
7 that patients with this type of problem, the
8 biggest problem they have is they grow in their
9 shoulder.

10 The difficulty in positioning their
11 hand in space is all due to the problems in the
12 shoulder, and so my plan of action was to try
13 to improve the motion in her shoulder and to
14 try to give her better strength to externally
15 rotate the shoulder, and I talked to her mother
16 about doing a tendon transfer, which is a
17 common thing that is done for this particular
18 problem.

19 Q. And I see that your next visit was
20 approximately maybe four months later in March
21 of 2000 and what was done at that time?

22 A. I just looked at her again. I was
23 thinking that perhaps there might be some more
24 improvement over the intervening four months,
25 but I did not see any evidence of improvement.

16

1 Q. And was that procedure successful?

2 A. Yes.

3 Q. And how do you define success?

4 A. The -- this child as I followed her
5 along developed very, very good external
6 rotation strength of her shoulder, improved
7 the -- well, began to get rid of this tendency
8 to internally rotate the shoulder and hold the
9 hand in front of the body and, of course, this
10 is something that takes a long time to
11 develop -- to improve and to adjust to, but she
12 really came along very well with external
13 rotation and improved this quite a bit.

14 Q. And so this tendency for her to hold her
15 hand over her abdomen was alleviated --

16 A. I think --

17 Q. -- is that fair?

18 A. -- for the most part, although she still
19 does that a little bit. I think the last time
20 I saw her she was still wanting to do that, but
21 when you really test her she has markedly
22 improved external rotation strength.

23 Q. Rather than me ask questions, why don't
24 we go from your notes from the point of surgery
25 on and define her progress for us.

17

1 Let's start with the visit, if you
2 would, of July 24th, 2000.

3 A. Just checked the -- on July 24th I just
4 checked her dressing to make sure she was still
5 in the proper position. The position she was
6 in, this thing called the shoulder spica, was
7 the position that I was just in when I was
8 swearing to tell the truth. That's the
9 position she was in.

10 We kept her in that position for,
11 let's see, about six weeks, as I recall, and
12 then she came along all right. I noticed when
13 she came in on November 20th that she had
14 weakness of her triceps muscle, and she was
15 unable to extend the elbow against gravity, and
16 I was concerned about that thinking that might
17 have been just from positioning her in that
18 position for so long. But this cleared. So
19 that all improved. It might have been simply
20 from positioning.

21 By February 19th of 2001 she had
22 definite improvement in triceps function, and
23 she was able to bring her hand to her mouth in
24 a much better position, and then there were a
25 couple visits that were missed in there.

19

1 you don't have any specific plans for
2 definitive treatment at this point?

3 A. Correct.

4 Q. Have you prescribed rehabilitation,
5 physical therapy for this child?

6 A. I think we did. Her mother had us -- as
7 I recall, we did something through her school
8 or something. Maybe that is somebody else.
9 Let me just check here. Usually in children --
10 here we go -- no, that is something else.

11 In children we just let them play
12 and follow along and show the parents what to
13 do, but as I recall she did -- I just don't
14 have any notes in here from therapy that she
15 was receiving that, but I thought she was
16 through some sort of program they have down in
17 her hometown.

18 Q. Would you typically have the mother or
19 the caretaker do home exercises or therapies?

20 A. Yes, generally. I showed her some
21 general stretching exercises, but mostly kids
22 this age you can't really get them to cooperate
23 with too much of a therapy program.

24 Q. Would it be fair to say you're pleased
25 with the results you have obtained over the

18

1 And then the final visit was in
2 March of 2002, and at that point I thought that
3 her rotation -- her external rotation was much
4 improved. Her triceps had returned, and I
5 thought perhaps in the future we might do
6 something more to fine tune this, but I didn't
7 really have any suggestions for further surgery
8 at that time.

9 Q. When you say "fine tune," you mean the
10 problem with the elbow flexion -- or excuse me,
11 the elbow function posturing?

12 A. Yes.

13 Q. That means the tendency to keep the
14 elbow flexed as opposed to straight?

15 A. Yes. That's -- that's just a persistent
16 problem in kids with Erb's palsy.

17 Q. And then in February of -- there was a
18 missed appointment, February 2002. Another one
19 in January of 2002, and then your last visit as
20 you just alluded to was March of this year?

21 A. Yes.

22 Q. Do you have any plans to see her again?

23 A. I wanted to see her in a year, so next
24 March.

25 Q. You have no -- would it be fair to say

20

1 couple years you have treated this little girl?

2 A. Yes.

3 Q. What is her prognosis in your view?

4 A. Her prognosis is pretty good. The elbow
5 may be a problem, and sometimes that's due to
6 some subtle changes in the shoulder.

7 As she grows older we have to watch
8 this to see -- we have to watch her shoulder
9 very carefully to determine whether there is a
10 problem with dislocation. This is one of the
11 biggest problems we have in these kids, and we
12 will have to follow that along and see if the
13 shoulder starts to ride out, in other words, if
14 it starts to dislocate out the back or sublux
15 out the back. Then we have to do something to
16 counteract that.

17 So that's -- in terms of a prognosis
18 it's pretty good. So far I have not seen any
19 problem with her shoulder as far as
20 dislocating, so I think her prognosis is pretty
21 good.

22 Q. Rather than talk about disabilities,
23 what are in your view her abilities, I mean, as
24 far as daily living, and what does the future
25 hold as far as her being able to function

21

1 independently?

2 A. Oh, I think she is going to be able to

3 function independently without any problem.

4 She will have to make some compromises to the

5 shoulder -- to the shoulder motion.

6 This is just a persistent problem in

7 kids like this. So she is not going to have a

8 normal upper extremity by any means, but she

9 will be able to function in society very well.

10 Q. And living independently?

11 A. And live independently.

12 Q. Do you see any significant limitations

13 on her abilities to work or be employed?

14 That's a very broad question and I understand

15 that.

16 I recognize that she may not be able

17 to lift very heavy objects. Of course, she may

18 not be able to do that whether she had the

19 problems with her shoulder or not, but do you

20 see any significant limitations on the kinds of

21 employment she could pursue?

22 A. I think doing heavy labor would be --

23 would be pretty much out of the question. She

24 should be able to do any sort of clerical or

25 secretarial work no problem at all with that.

22

1 She has -- her hand is pretty much

2 normal, so anything that would require strength

3 of the shoulder would be out, but everything

4 else I think she would be able to function

5 well.

6 Q. She can handle objects?

7 A. She can handle objects. She can

8 position them in space reasonably well.

9 Q. She can reach?

10 A. She can reach.

11 Q. She can feel?

12 A. Yes.

13 Q. There is no problems with sensation?

14 A. No, there is no sensory problem.

15 Q. If this is not a fair question, tell me.

16 Can you quantify by percentages her disability

17 or is that something that you would rather not

18 do?

19 A. Boy, I would rather not do that.

20 Q. That's --

21 A. It's difficult in a three-year-old child

22 anyway.

23 Q. If she keeps at it and keeps doing her

24 exercises and living her life, do you expect

25 she can have a relatively normal existence --

23

1 A. Yes.

2 Q. -- assuming everything else being equal?

3 A. Yes.

4 Q. And any future surgical or definitive

5 treatment we're looking how far down the road,

6 number of years, assuming everything -- maybe a

7 better way to put it is when would you

8 anticipate any further definitive treatment or

9 is that difficult to say?

10 A. It's difficult to say. It would depend

11 on what happens with the shoulder. Sometimes

12 we have to do what I said, an osteotomy, change

13 the direction of the bone, but so far I don't

14 see any need for that.

15 Q. Her right hand, fine motor skills, are

16 they intact?

17 A. Yes.

18 MR. BURNETT: I'm sorry. What was

19 the question?

20 MR. TREADON: Her fine motor skills

21 in her right hand are intact.

22 MR. BURNETT: Okay.

23 MR. TREADON: And the answer was

24 yes.

25 BY MR. TREADON:

24

1 Q. You agree with the statement that she

2 will in your view to a reasonable degree of

3 medical probability be able to live totally

4 independently in daily activities?

5 A. Yes. She will do them differently. I

6 hate to volunteer information, but --

7 Q. That's okay. Go ahead. That's why we

8 are here. We are here to get information.

9 A. She will do things differently from the

10 way other children do them, but she will -- she

11 finds a way. These kids find a way to do

12 things. It doesn't fit the customary way of

13 doing things, but they find a way.

14 MR. TREADON: That's all the

15 questions I have.

16 - - -

17 BY MS. STOFFEL:

18 Q. Dr. Lacey, my name is Margo Stoffel. I

19 met you a little bit earlier. I represent St.

20 Joseph Health Center and Dr. Lee as well as the

21 Womens Care Center. I just have a few

22 questions for you.

23 I know you were faxed Dr. Lynn

24 Mikolich's report. Have you had an opportunity

25 to review that report?

25

1 A. I skimmed it, yes.
 2 Q. From your brief review of that report do
 3 you have any disagreements with any of
 4 Dr. Mikolich's findings?
 5 A. No, I really don't. I think it's a very
 6 thorough review.
 7 Q. If you would like to take some time to
 8 read it more thoroughly, that's fine.
 9 A. That's basically what I found. Again,
 10 it's difficult to -- for her to normally use
 11 the shoulder, but for the most part she is
 12 coming along reasonable well, and she is
 13 reasonably functional.
 14 Q. I know that you stated that she should
 15 not have any difficulties with clerical duties,
 16 things like that. I assume that would mean
 17 using a computer?
 18 A. Yes.
 19 Q. You could not anticipate that Ja Mirra
 20 will have any problems using a computer?
 21 A. She should not have any difficulty doing
 22 that.
 23 MS. STOFFEL: I have no further
 24 questions for you.
 25 - - -

27

1 Q. That's all right.
 2 A. As I said in the beginning, the
 3 disability is going to involve the strong use
 4 of the right shoulder and any activity that
 5 requires strength in the right shoulder.
 6 Strength in rotation, for instance, is going to
 7 be a problem to her.
 8 Did you want me to be more specific?
 9 Q. Yes, please, if you would.
 10 A. What sort of disability -- I don't quite
 11 understand. Disability is a pretty broad term.
 12 Q. Okay. I'm just trying to get an idea,
 13 for instance, will she be able to hold a mirror
 14 while she is brushes her hair?
 15 I understand she is left hand
 16 dominant. Could she hold a mirror with her
 17 right hand and brush with her hair with the
 18 left hand, close to her face? Will she be able
 19 to hold a baby in that arm while she feeds the
 20 baby, things like that?
 21 A. She should be able to do that.
 22 Q. To hold the baby?
 23 A. Eventually, yes.
 24 Q. So why do you say "eventually"?
 25 A. Well, she is three years old.

26

1 BY MR. BURNETT:
 2 Q. Doctor, I have a few questions for you.
 3 This is John Burnett. Can you hear me okay?
 4 A. Yes.
 5 Q. Probably be helpful given the speaker
 6 phone if you wait a heartbeat after I finish my
 7 question before you begin to answer because our
 8 voices will collide in mid air, okay?
 9 A. Got you.
 10 Q. Mr. Treadon asked you about abilities.
 11 Let me talk to you for a minute about
 12 disabilities.
 13 Please articulate those, what we can
 14 expect likely disabilities to be with this
 15 child and with this problem with the shoulder.
 16 A. The disabilities. She will have
 17 difficulty -- well, let's talk first about
 18 recreational activities, okay. She will have
 19 difficulty throwing a ball, playing tennis, any
 20 sort of racquet sport.
 21 Q. Okay.
 22 A. I'm just sort of introducing the thing
 23 with a recreational thing.
 24 Q. Okay.
 25 A. That's not a disability. I realize.

28

1 Q. Aside from that?
 2 MR. TREADON: I think the answer is
 3 obvious. I'm sorry, John.
 4 BY MR. BURNETT:
 5 Q. Doctor, Tom takes every chance he can to
 6 take a shot at me.
 7 I'm just trying to understand the
 8 problems with the use of the shoulder. Again,
 9 just in caring for children, in her daily
 10 hygiene in washing her, her left arm pit,
 11 things like that, what kind of difficulty can
 12 we expect in the future?
 13 A. Well, any activity that is directed
 14 toward the center of her body, personal
 15 hygiene, cleaning the other arm and so forth
 16 should be no difficulty whatsoever. She is
 17 very strong as far as internal rotation is
 18 concerned.
 19 Q. Okay.
 20 A. So she would be able to hold a baby.
 21 She would be able to hold something in front of
 22 her while she was doing something with her left
 23 arm.
 24 Q. Okay. The disability is -- I'm just
 25 trying to think what -- I'm just interested in

29

1 what kind of problems can we expect, what kind
2 of limitations in daily activities can we
3 expect with this girl.

4 I know if she is playing tennis or
5 things like that you told us she will have a
6 difficult time doing that. Will she be able to
7 play volleyball, basketball, things like that?

8 A. Well, she will be able to -- these kids
9 overcome these disabilities amazingly well, but
10 she will have difficulty doing things like
11 playing basketball because she won't be able to
12 get her arm completely above her head.

13 Q. Okay.

14 A. It's the abduction and external rotation
15 that are impaired. We have improved it, but we
16 can't make it normal. So anything, any
17 activity that involves external rotation, and I
18 said throwing a ball. Playing basketball would
19 be an example. Volleyball would be difficult.
20 She should be able to play golf pretty well.
21 She could accommodate to that pretty well.

22 Q. What about swimming?

23 A. She would have trouble swimming because
24 she can't get that arm all the way up and
25 rotate it.

31

1 is that correct?

2 A. That's correct.

3 Q. Okay. And with regard to any potential
4 surgery in the future, do you think it's likely
5 she is going to need that surgery?

6 A. No.

7 Q. And if she does need the surgery, what
8 would you expect it to -- you probably touched
9 on this with Tom, but I think I missed it, what
10 would you expect it to accomplish?

11 A. Well, I don't know what surgery she
12 would need yet.

13 Q. All right. And when do you think you
14 will know?

15 A. I may not know until she is ten or 11.

16 Q. All right. That's fair enough. So no
17 problem with the wrist or the fingers as far as
18 any kind of impairment. That is all intact.

19 What is the limitation in the elbow?

20 A. There really isn't much of a limitation
21 there. It's just that she tends to hold the
22 elbow in flexion.

23 Q. And that's just what you expect with
24 this kind of impairment, correct?

25 A. Yes.

30

1 Q. How about gymnastics?

2 A. That would be difficult.

3 Q. Does she have any problems with balance
4 because of the shoulder the way it is?

5 A. These kids tend to have a little bit of
6 trouble with balance, which they adjust to as
7 they grow older. And as I said, we follow them
8 along and see whether any fine tuning needs to
9 be done to try to improve that situation.

10 Q. How about with an automobile
11 transmission in a car, can she reach down to
12 the console and adjust from the park to reverse
13 or drive?

14 A. She should be able to do that --

15 Q. Okay. How about --

16 A. -- in 13 years.

17 Q. In 13 years, right. Just give me a
18 moment here. For instance, can she -- will she
19 be able to use a Q-tip in her ear on the right
20 side, to clean her ear?

21 A. I don't know.

22 Q. The impairment we are talking about to a
23 reasonable degree of medical certainty is a
24 permanent impairment, correct? It's the degree
25 of impairment we don't really know a lot about;

32

1 Q. It's been my experience in these cases
2 that as the children grow older when they have
3 an Erb's palsy the hands actually -- or the arm
4 does not actually grow with the rest of the
5 body. It appears to be shrunken or shortened.
6 Has that been your experience?

7 A. Yes.

8 Q. What do you expect in this case?

9 A. I expect it to be smaller than her other
10 extremity.

11 Q. Do you hold that opinion to a reasonable
12 degree of medical certainty that it will be
13 smaller than the other extremity?

14 A. Yes.

15 Q. Is there any way to quantify at this
16 point how much smaller?

17 A. No.

18 Q. Can she shovel snow, for instance, or
19 does that probably fall in the category of
20 heavy labor, right?

21 A. Yeah, I think.

22 MR. TREADON: Depends how deep the
23 snow is, John.

24 MR. BURNETT: I'm not sure if I can
25 shovel snow.

33

1 THE WITNESS: That kind of activity
 2 would be more difficult than a normal
 3 situation, but she might be able to do it.
 4 BY MR. BURNETT:
 5 Q. Okay. What about difficulties in
 6 putting on her clothes, shirts and sweaters?
 7 A. Like I said before, she will find a way,
 8 but what she will do is she will put her right
 9 arm in the sleeve first because she can't
 10 abduct that as well as the other one and then
 11 get the sweater on or shirt on that way.
 12 Q. All right.
 13 A. But she will be able to do it.
 14 Q. She won't need help, she will just do it
 15 differently than you and I do?
 16 A. That's correct.
 17 MR. BURNETT: Doctor, that's all I
 18 have.
 19 - - -
 20 BY MR. TREADON:
 21 Q. Doctor, just to follow up on -- in a
 22 general sense would you agree with me that this
 23 little girl as she grows up will have far more
 24 abilities than disabilities, in other words,
 25 she will be able to do most things all of us do

C E R T I F I C A T E

35

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

I, Eric G. Smead, an RPR and Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, STEPHEN H. LACEY, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the witness was by me reduced to Stenotypy in the presence of said witness, afterwards transcribed upon a computer; and that the foregoing is a true and correct transcription of the testimony so given by the witness 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, employee of or attorney for any of the parties in the above-captioned action; I am not a relative or employee of an attorney of any of the parties in the above-captioned action; I am not financially interested in the action; and I am not, nor is the court reporting firm with which I am affiliated, under a contract as defined in Civil Rule 28(D).

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Akron, Ohio on this 12th day of August, 2002.

Eric G. Smead, an RPR and Notary Public in and for the State of Ohio.

My Commission expires January 10, 2005.

34

1 on a daily basis with some limitations?
 2 A. Yes, I agree with that.
 3 Q. And those disabilities that she has in
 4 many cases she will compensate for those in
 5 some way?
 6 A. She will find a way.
 7 MR. TREADON: Thank you. That's all
 8 I have. Doctor, you have the right to read
 9 this transcript or you can waive that.
 10 MR. SHROGE: It's up to you.
 11 THE WITNESS: I waive.
 12 - - -
 13 (Deposition concluded at 12:03 o'clock p.m.)
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