COURT OF COMMON PLEAS

STARK COUNTY, OHIO

Doc. 305

DAVID S. RICHESON, :

PLAINTIFF, :

-VS- : CASE NO. 87-1811

DR. GEORGE PRIOLEAU, ET AL. :

DEFENDANTS.

- - -

Deposition of ROBERT L. MCLRURIN, M.D., a witness herein, taken by the plaintiff as upon direct examination pursuant to the Ohio Rules of Civil Procedure and pursuant to agreement and stipulations hereinafter set forth, at the offices of Robert L. McLaurin, M.D., 111 Wellington Place, Cincinnati, Ohio at 2:05 on Tuesday, April 17, 1990 before Lisa Conley, a notary public within and for the State of Ohio,

- - -

STIPULATIONS

It is stipulated by and among counsel for the respective parties that the deposition of ROBERT L. MCLAURIN, M.D., a witness herein, may be taken at this time by the plaintiff as upon direct examination pursuant to the Ohio Rules of Civil Procedure, and pursuant to agreement; that the deposition may be taken in stenotypy by the notary public - court reporter and transcribed by her out of the presence of the witness; that the transcribed deposition is to be submitted to the witness for his examination and signature, and that signature may be affixed out of the presence of the notary public - court reporter.

- - -

APPEARANCES:

On behalf of the Plaintiff:

Amy Sue Taylor, Esq.

of

Michael F. Colley Co., L.P.A.

536 South High Street

Columbus, Ohio 43215

On behalf of the Defendant, Timkin Mercy Medical Center:

Alicia M. Wyler, Esq.

of

Day, Ketterer, Raley, Wright & Rybolt

800 William R. Day Building

121 Cleveland Avenue South

Canton, Ohio 44702

On behalf of the Defendant, Dr. George Prioleau:

Lee J. Bell, Esq.

of

Buckingham, Doolittle & Burroughs

3721 Whipple Avenue, N.W.

P.O. Box 35548

Canton, Ohio 44735

- - -

I N D E X

E X H I B I T S

PLAINTIFF'S EXHIBITS	MARKED
No. 1 A copy of two-page letter.	28

- - -

ROBERT L. MCLAURIN, M.D.

of lawful age, a witness herein, being first duly sworn a5 hereinafter certified, was examined and deposed as follows:

DIRECT EXAMINATION

BY MS. TAYLOR:

Q. Please state your name.

A. Robert L. McLaurin.

Q. And your professional address?

A. 111 Wellington Place, Cincinnati, Ohio.

What's the name of your corporate entity?

A. Robert L. McLaurin, M.D., Inc.

Q. Was that the same for 1986?

A. Yes.

Q. And in 1972 also?

A. Yes, I believe so.

Q. Do you have any partners?

A. No.

Q. Have you in the past had partners?

A. Not in my corporation, no.

Q. Where else have you had partners?

A. Well, when I was Chairman of the Department of Neurosurgery at the University, which

was p to 1982, there were other members of the faculty that were associated on the faculty. They were n partners in a type of economic capacity, but we functioned as a group at the University.

Q. Tell me what current practice involves.

A. I'm sorry?

Q. Tell me what your current practice involves.

A. Well, it's entirely neurosurgery.

Q. Are you a full-time neurosurgeon?

A. NO, I'm not a full-time neurosurgeon. I have cut back on my neurosurgery, because I have returned to school in the past few years. So I'm doing about half-time neurosurgeon.

Q. YOU returned to school. What type of school are you going to, sir?

A. Well, I'm going to law school.

Q. At the University of Cincinnati?

A. Yes.

Q. When do you expect to graduate?

A. The twentieth of next month.

Q. Then what are you going to do?

A. Hell, for the record, I don't know.

Q. Are you intending on practicing law?

A. I'm intending on continuing both neurosurgery and law.

Q. Are you going to be making up a -- Why don't you tell me what you mean by practicing both.

A. I intend to continue practicing neurosurgery part time and law part time.

Q. Is there a firm that you are going to be a member of or associated with?

A. I don't have any definite commitments at this time, no.

Q. Did doing medical/legal reviews spur you on into going into law school?

A. Well, I think that was one thing that got me interested in law school and being involved in a fair number of personal injury cases, which, of course, are very common in the practice of neurosurgery. An3 between those two factors I think I became interested in the law, yes.

Q. When did you first start reviewing cases €or medical/legal matters?

A. I can't remember when I first did that. I presume it was maybe as long as 20 years ago.

Q. On the average, how frequently do you review medical malpractice -- medical/legal matters?

A. Well, I would think that probably in the past few years I have reviewed maybe three or four per year, something of that sort,

Q. And how many depositions have you had taken with respect to medical malpractice matters?

Let's go over the last five years.

A. Well, this necessarily has to be a guess, but I would guess that it would be in the neighborhood of maybe 15, something of that sort.

Q. Have you ever testified in court for a medical malpractice matter?

A. Yes.

Q. How many times have you testified in court?

A. To the best of my recollection, only twice.

Q. Do you recall for whom you have testified?

A. Well, I don't remember the names. One of those was for the plaintiff, and the other was for the physician.

Q. What percentage of your reviews and

depositions are for the defendant?

A. I would estimate probably two-thirds, 60 percent, 65 percent.

Q. Have you ever reviewed cases for Mr. Bell or his law firm?

A. Yes.

Q. How many cases have you reviewed for his firm?

A. Again, I don't recall specifically, but I would imagine it would be three or four.

Q. And have you had --

A. Well, wait a minute, I'm not sure that's correct. Quite frankly, I can only recall one other one specifically, So I'm going to say two or three.

Q. Were depositions taken in those cases?

A. I'm sorry?

Q. Were depositions taken in those cases?

A. I believe there was. One was a deposition. One that I can recall, yes.

Q. What medical malpractice insurer do you have?

A. PIE.

Q. How long have you been with PIE?

A. Well, I think probably six to eight years.

MR. BELL: hn objection as to relevance as to his insurance company, but I just want to note that on the record. Anything in that regard I object to, but the doctor can go ahead and answer.

BY MS. TAYLOR:

Q. Have you ever been a board member for PIE?

A. No.

Q. For the local board?

A. NO.

Q. Have you ever participated in any claim reviews?

A. No, no. I have reviewed a case for PIE but not claim reviews, no.

Q. Who did you review the case for?

A. You mean which attorney?

Q. which attorney.

A. Mr. Kalur.

Q. And do you recall what that case was about?

A. Quite frankly -- well, I'-- I don't recall what the case was about. It was approximately

a year ago, or a little more, that I reviewed that case, and I don't really recall what the nature of the case was.

Q. Is it a pending case?

A. No, I think it's been resolved. Actually -- Wait a minute, I do remember now. It's coming back to me.

It was a case in which there was a complication of an arteriogram, and the patient became paralyzed following an arteriogram, that was what the case was. I think that the case is being appealed at this point. I'm not certain about that.

Q. Have you reviewed any other cases for PIE besides that one case?

A. I don't believe so.

Q. Have you reviewed cases on behalf of P. Co.?

A. No.

MR. BELL: I object to this line of inquiry as to insurance companies. That's not appropriate. That's not going to lead to anything discoverable. I have no objection to cases he's reviewed, but I don't think you should be making reference to which insurance company it's for.

BY MS. TAYLOR:

Q. Doctor, you previously stated that you are the Chairman of the Department of Neurosurgery?

A. That's correct.

Q. Is that at UC?

A. Yes.

Q. Is that the same thing as the Chief of the Department of Neurosurgery?

A. Yes.

Q. How does the Chairman of the Department of Neurosurgery coordinate with Cincinnati General? Is it the same position?

A. Well, Cincinnati -- you're talking about Cincinnati General Hospital --

The name was changed probably five years ago. The Chief of Neurosurgery at the University -- Well, let

teaching hospital for the University. Therefore, the Chief of Neurosurgery for the University is automatically the Chief of Neurosurgery at the

University ~ ~ s p i t a l .

Q. And how many years were you the Chief of Neurosurgery for the University?

A. Twenty-eight years.

Q. And why did you step down as the Chief of Neurosurgery?

A. Well, I was requested to step down because a new Chairman of the Department of Surgery arrived on the scene and disagreed with some of my administrative methods, which had been in effect for 29 years without any problems; and because he disagreed with some of my administrative policies, he requested that I step down.

Q. What was the name of the new Chairman of the Department of Surgery?

A. Dr. Joseph Fisher.

Q. And who followed you then as the Chief of Neurosurgery of the University?

A. Dr. John Tew, T E W.

Q. Now, as the Chief of Neurosurgery, do you have responsibilities for Children's Hospital?

Q. [illegible] at Children's?

A. Yes.

Q. And am I correct, when you were the Chief of Neurosurgery for the University of Cincinnati, you were primarily doing pediatric neurosurgery?

A. No. Well, pediatric neurosurgery has always been one of my major interests and subspecialties, so to speak. Actually, my two subspecialties or interests in neurosurgery have been one, in pediatric work, and secondly in relation to trauma.

Q. What percentage of your practice have you -- practice of neurosurgery have you devoted to pediatrics?

A. Probably, overall, 40 percent.

Q. And what percentage of your practice, neurosurgery practice, have you devoted to trauma?

A, Hell, earlier a larger percentage. Well, let me see. Let me try to answer that.

Early in my career, I would say that probably 40 percent of my practice was trauma. In the last 10 years, I have purposely reduced the amount of trauma that I care for, and so right now it's probably not more than 20 percent, or maybe even less, 15 percent.

Q. And what do you do with respect to th
remaining 40 percent of your practice of neurosurger
A. Well, that is the rest of neurosurge surger
A very large part of that has to do with vertebral
disc surgery, because that's a common problem in
neurosurgery. And I would say that probably the
remaining -- well, say the remaining 50 percent of
thereabouts of my practice, probably 35 percent of
that would be disc surgery.
Q. When you were the Chief of the Division
of Neurosurgery, what percentage of your time did you

A. Practicing neurosurgery, and teaching
neurosurgery, and the research of neurosurgery.
Q. Do you have a residency program at the
University of Cincinnati?
A. Yes.
Q. How many neurosurgical residents were
there at University?
A. There are six at any given time.
Q. Have you ever practiced in an

environment where there are no neurosurgical residents?

A. Well, sone of the hospitals at which I practice in this community, I'm on the staff of, do not have a residency program.

hospitals?

A. Oh, yes.

Q. Have you practiced at any hospital where they do not have surgical residencies?

A. Well, I have in the past, I'm not practicing at any right now. I have practiced in the past at hospitals without any surgical residents, yes

Q. What hospitals would that be?

A. I'm thinking specifically of Our Lady of Mercy Hospital, which had no surgical residents. I believe that Bethesda Hospital for a period of time did not have any surgical residents. Those are the two that come to my mind.

Q. What's the University of Cincinnati Surgical Association?

A. What is it?

Q. Yes.

A. Well, I guess -- Where did you get that term? Is that from my Cv or something?

Q. No. Is there no such entity or --

A. I thought it was Neurosurgical Association, that's why I want to see.

Q. What did I say?

A. You said Society, I think.

Q. Association, excuse me.

A. Well, wait a minute.

Q. If I misspoke --

A. What were you asking?

Q. What's the University of Cincinnati Surgical Association?

A. Well, I don't even know that one, to tell you the truth. I was thinking really of the Montray Surgical Society, which is at the University of Cincinnati, I don't know what that is.

Q. There's a department of surgery at the University of Cincinnati providing loans to physicians that are corning on staff. Has it in the past provided loans to physicians?

A. The department of surgery?

Q. Yes.

A. I can't answer that. I don't know whether they have or not. They haven't provided any loans to any of my residents that I'm aware of. I

presume you're asking about [illegible]

Q. Resident5 or to bring in staff members, attending.

A. I'm not aware of that at all,

Q. It's my understanding that you are acquainted with Dr. Prioleau?

A. Yes.

Q. And do you know exactly when he was at the University of Cincinnati?

A. Well, he left, I think, in 1982, I believe. And I believe he was here approximately two years, so I would guess it was 1980.

Q. Was he here from January to December o those years, a portion thereof?

A. I can't remember the exact dates, quite frankly.

Q. Do you have any recollection as to how Dr. Prioleau came to practice, became a member of the University of Cincinnati?

A. Yes. I had recruited him from the

training.

Q. Did anybody assist you in recruiting Dr. Prioleau?

A. hell, his chief from the University of California was -- who was a close friend of mine, was the one who recommended him to me. And I knew that the program out in California was an extremely good program, and that Dr. Prioleau had been specifically trained in a certain area in which we were somewhat deficient in neurosurgery, and, therefore, that was the basis for my recruiting him.

Q. Who was this close friend of yours at the University of California?

A. Dr. Charles Wilson.

Q. And what was the specialty of were deficient in here?

A. It's called transphenoidal surgery on the pituitary gland. And the University of California was, and still is, a place where this has been highly developed and has been a specialty, and we hod not previously done much. We had done some but not much in the way of transphenoidal surgery, and I was anxious to have someone on the staff who was more familiar with it.

Can you tell me what specifically was done to evaluate his practice while he was at the

University of Cincinnati?

A. Well, specifically, I guess, daily observations. I made rounds with him regularly, once a week, and we consulted probably almost every day about patients, and we held conferences, several conferences, on a weekly basis in which he would participate, as well as the other members of the faculty. So there was a very close observation of his care of patients and his management of the teaching responsibilities.

Q. Did you ever assist him or perform surgery with him?

A. Yes.

Q. What type of surgery did you perform with him?

A. I think primarily it was transphenoidal surgery, because that's the one that I can recall most prominently, because that's what I was anxious to learn more about.

Q. What was his position when he was at the University of Cincinnati?

A. Well, I believe he started as an Assistant Professor. I think he remained as an Assistant Professor during his time here.

Q. What are the qualifications for being an Assistant Professor as opposed to an Associate professor?

A. Well, an Associate professor generally has tenure, and by and large one does not become an Associate Professor until they've demonstrated their abilities and responsibilities over a period of at least five years, and usually it takes longer than that actually, because the University, of course, does not want to grant tenure to people until they have demonstrated over a period of years their commitment to the process of teaching.

Q. Looks like it took you three years to become an Associate Professor at UC?

A. I beg your pardon?

Q. Looks like it took you three years to become an Associate Professor at UC?

A. That was probably a little bit anomalous, if it only took me three years. And the reason for that was that during that time the Chief of Surgery -- I mean, the Chief of Neurosurgery left to become Chief of Neurosurgery at the University of Chicago, and, therefore, I was, I guess, moved up in rank a little bit earlier than usual.

Q. Now, did Dr. Prioleau have any other positions while at the University of Cincinnati, any other administrative positions?

A. well, he had some administrative responsibilities, and I believe he was on some committees at the hospital, I don't recall specifically which committees they were, but I do remember he was on the Operating Room Committee at the University Hospital, and he may have been on one or two other committees, and he certainly had some responsibility for the residency program.

Q. And the residency program, did he primarily teach about the transphenoidal procedure?

A. Well, he taught general neurosurgery and a great deal of trauma, because he was acting as the principal neurosurgeon at university Hospital, and University Hospital sees a lot of trauma. So he was involved in a good deal of trauma there. He was involved in the transphenoidal surgery when that came along, and he was involved in the general practice of neurosurgery otherwise.

Q. Did he have any private patients?

A. Yes.

Q. Do you have any recollection as to the

number of patients he would have had in private practice?

A. No, I don't have a good recollection of that. His practice was not extensive, because he was

During the first year probably that he was here, he was pretty much confined to the University Hospital, which at that time did not have much in the way of private practice. And so it was probably during the latter part of his tenure here that he was developing a private practice, an extensive one.

Q. Did he associate himself with any specific neurosurgeons?

A. I'm not quite sure what you're asking. You mean other than the faculty?

Q. Was there a neurosurgeon that he was getting, not a partnership kind of an arrangement, but that he associated himself with, had his private office with?

the four.

Q. Who were the other two?

A. Dr, McClinon, James McClinon. And I'm blanking on the name of the fourth one. He's now practicing in Cleveland. I'll think of his name in a minute, but right now I can't recall it. Matt Likavek was his name.

Q. Who's Dr. Tornheim?

A. Well, she's a PhD in the Department of Anatomy at the University.

Q. What was your role in the writing of the article, "Acute Responses to Experimental Blunt Head Trauma"?

A. Well, at that point we had a research grant from the National Institutes of Health to investigate some aspects of head injury. And Dr. Tornheim was one of the principal investigators on that research project, and Dr. Prioleau and I both participated in it with her.

Q. Did the research continue after Dr. Prioleau left?

A. Yes. It has been discontinued since then, but, yes, it continued after he left.

Q. Are you acquainted with a Dr. Thibadacu, L. Thibadaeu?

A. The name doesn't sound familiar. Is that --

Q. THIBADAEU.

A. Thibadseu. I presume -- Can I see the article?

Q. sure, sir.

A. No, I don't know him. That must have been after Dr. Prioleau went to Yale, because that was published in 1987.

Q. The article of general neurosurgery was published in '84, and that was after he left also?

A. I'm looking at the wrong one.

Q. I was just referring you to the other article.

A. You're talking about Thibadaeu?

Q. Right.

A. That was '87.

Q. And the article in '84 that you co-authored with Dr. Prioleau?

A. That was published in '84, but that was work done prior to his leaving. But the one in '87 would definitely have been one after he left here. Articles in medical journals usually are (published one or two years after the work has been done.

Q. I notice that you have an abstract that was done in the proceedings in the Fifth Conference of Neurotraumatology that you co-authored with Dr, McGuire -- excuse me, Dr. prioleau?

A. Can I see what you're referring to?

Q. Sure, sir.

A. Proceedings, yes, okay. Yes, um-hmm.

Q. Since Dr. Prioleau left the University of Cincinnati, have you kept in contact with him?

A. Oh, on probably several occasions I've seen him at neurosurgical meetings. I have not kept in regular contact with him.

Q. Have any of the other neurosurgeons at University kept in contact with Dr. Prioleau?

A. Not to my knowledge.

Q. Do you know how you came to be a witness in this case, an expert in this case?

A. In this case?

Q. Correct.

A. I was requested by Mr. Bell to review the case.

Q. Have you discussed this case with Dr. Prioleau?

A. No.

Q. Have you talked with Dr. Prioleau since you were retained as an expert in this case?

A. No, I'm sure I haven't.

Q. Do you recall when you first were retained or contacted by Mr. Bell?

A. Well, not really. I don't. I think it wits a year ago or thereabouts, probably. I don't have any dates on here, but I would presume it was about a year ago.

Q. How were you contacted by Mr. Bell?

A. Well, I don't recall specifically whether he wrote to me or whether he initially called me on the telephone, quite frankly.

Q. Do you have any of the correpsondence from Mr. Bell?

A. I'm sorry?

Q. Do you have any of the correspondence from Mr. Bell?

A. I don't have it here. I have it wjth the rest of the records.

Q. Where are the rest of the records?

A. Across the hall.

MS. TAYLOR: Why don't we go off the record and we'll look at that.

(Off the record.)

BY MS. TAYLOR:

Q. How much are you charging per hour for this case, sir?

A. For the deposition or for the review of records?

Q. Either and both.

A. Well, I charge -- I charge $200 an hour for review of the records, and my usual charge is $300 an hour for a deposition.

Q. You wrote a letter in this case, a report in this case?

Well, I guess I probably did, looks like it.

MS. TAYLOR: I'd like that marked as an exhibit, please.

(Plaintiff's Exhibit No. 1 was marked for identification.)

BY MS. TAYLOR:

Q. Doctor, I notice in the letter that's dated April 24th, 1989 from Mr. Bell, it starts off, "Thank you for agreeing to review the above case," would that be the first correspondence you had?

Q. How much have you received from the defendants in your reviewing of this case?

MS. WYLER: I'll object.

A. In terms of money?

Q. Correct.

A. I don't have any idea. I don't recall.

Q. Am I correct, you received $1,100 for the review of the depositions of Mr. Prioleau, Shoneheim, Retter, Richeson, and the ho

A. Well, I assume that's be received, I hope.

Q. And it's reasonable to assume that you billed for other depositions you have reviewed in t case?

A. Yes. As far as I know, I have billed for whatever time I have spent, yes.

Q. I notice, Doctor, we have two sets of medical records here.

MR. BELL: That's my copy there.

MS. TAYLOR: Well, I would like all of the copies of the letters -- of letters of you back and forth with Dr. McLaurin.

BY MS. TAYLOR:

Q. I notice, apparently, you reviewed an

arbitration brief in this case?

A. Yes.

Q. I do not see that in this pile of materials. Perhaps you can find it, because I'm missing it.

MR. BELL: I took it back. I don't plan to give you that arbitration brief. You can file a motion with the court.

BY MS. TAYLOR:

Q. What was set forth in the arbitration brief?

A. well, it was -- To the best of my recollection, it was simply a summary of the case.

Did you receive any summaries of the medical records?

A. I don't believe so.

approximately 50 percent of your professional time doing neurosurgery?

A. At present, yes.

Q. And when did you cut beck to doing 50 percent?

MR. BELL: I object to that question

tine?

A. A hundred percent of my professional time, I'm sorry, is in neurosurgery because the time I'm goi to school is not professional time, that's educational time. But my professional time is 105 percent neurosurgery.

Q. How many hours a week would you estimate you do neurosurgery, practice neurosurgery?

A. Well, it's a good 20, 25 hours a week.

Q. How many hours are you taking at UC in law school?

A. Well, at the present time, I'm taking 12 hours.

Q. And, of course, you study for at least that amount of time a week?

A. I would think so, yes.

A. No.

Q. Are you working through any law office?

A. No.

Q. The 12 hours per week you're taking at UC, that's considered full time, correct?

A. yes.

Q. What were the circumstances behind Dr.

Prioleau leaving UC?

A. Specifically, he decided to leave when my position as chairman was terminated. He had come here from the University of California to work with me on the faculty, and when my position was terminated, Dr. Prioleau decided to leave. And he was recruited to Yale university.

Q. And you said that he decided to leave when your position was terminated. What effect did the termination of your position as the Director of the Division of Neurosurgery have on his position?

A. Well, obviously, I was his chief, and he did not know who was going to be the chief from there on or what the circumstances would be, and he didn't want to continue in his position without knowing who the chief was going to be, or whether he would have a job, I suppose, down the road. And he had an opportunity to join the faculty at Yale and did so, and I thought it was a very sensible move for him.

Q. When did you first become aware of who the new chief for the Department of Neurosurgery was going to be?

A. Probably about a year after my termination. I don't remember specifically,

Q In the interim from the time that you were terminated as the Chief of the Department of Surgery until when Dr. Tew --

A. Uh-hmm.

Q. -- became the chief, who was the Acting Chief of the Directors?

A. Dr. Prioleau was acting chief for a short time, until he left, and then -- actually, Dr Fisher, Joseph Fisher, I think, took over being nominally chief of the division, although, he is not a neurosurgeon But there was no actual neurosurgical chief as such for a period of a good many months

Q Four months, three, four months?

A. Well, it would have been at least that, I guess. I don't recall exactly.

Q Was Dr. Prioleau ever formally the Acting Chief of the Department of Neurosurgery?

A. He was the acting chief until the time that he left, yes.

Q. What duties did he have as the Acting Chief of the Department of Neurosurgery?

A. Well, essentially it was a matter of continuing to administer the residency training program.

Q. And that would have been for a good number of months?

A. Well, I think it was probably only about three, four months.

Q. Have there ever been any other black neurosurgeons at UC?

A. Not on the faculty, no. We did have a black member of the residency program.

Q. Who was that?

A. Who?

Q. Yes.

A. I can't recall his name now, this was some 10, 12 years ago.

Q. Did the University, or the Department of Neurosurgery, or the hospital receive any type of federal funding for having a black neurosurgeon on their faculty?

A. Not to my knowledge.

Q. Were there any type of -- other types of compensation, federal or local, for having a black neurosurgeon?

A. Not that I'm aware of, no.

Q. Do you know the circumstances behind Dr. Prioleau receiving a loan from the --

A. Oh, --

Q. -- surgical association I mentioned before?

A. That's something that Dr. Fisher obviously controls. I'm not aware of that. I was not aware of it. I think I did -- After Dr. Prioleau left, I believe I did become aware that he had received a loan of some sort, but I know no details about it, because that was strictly between him and Dr. Fisher.

Q. Do you know anything, what it was for?

A. I have no idea.

A. Did I socialize with him? Well, yes, I suppose that I socialized with him.

I think we went to certain neurosurgical social functions, He was invited to the reception when I remarried in 1982. So there were occasional social functions, yes.

Q. What was the type of procedure that was done on Mr. Richeson?

A. Well, that was an anterior cervicaldissectomy and interbody fusion.

Q. Are you acquainted with that procedure?

A. Yes.

Q. How many of those procedures have you done in the last five years?

A. Not many in the last five years, because I have gone back to doing my surgery posteriorly rather than anteriorly.

Originally, I did this kind of surgery from behind, and then for several years I started doing it from anteriorly, which was the way this was one was done, and in the past few years I've gone back to the old method, because I prefer it. So in the past few years, I've not done many of then. Prior to that, I was doing them more frequently.

Q. How frequently do you do the cervicaldissectomies and interbody fusion?

A. Well, are we asking now about the last five years?

Q. Let's go with the last five years.

A. As I just finished saying, not often at all, probably one a year, because I do most of my surgery from behind rather than in the front. But prior to five or ten years ago, I was doing then quite

Q. what's, "quite frequently," mean?

Q. How frequently do you do the posterior approach of that procedure?

A. About one or two a month,

Q. Why is it you changed back to the posterior approach?

A, Because I -- Well, there are some technical reasons. It does not involve a fusion, for one thing, so that, in my judgment, it is a little simplier from that standpoint. I think it accomplishes the same things as far as the patient is concerned, and I don't think there are any greater complications or postoperative discomfort, and, therefore, I just prefer it.

Neurosurgeons are divided into two camps, one that prefer the anterior approach and one that prefer the posterior approach, and neither one can say that the other is not entirely appropriate, but it simply is a matter of preference.

Q. When Dr. Prioleau was at the University of Cincinnati, how frequently were they doing the anterior cervicaldissectomy and interbody fusion?

A. I suppose he was doing -- I would estimate one or two a month at that point.

Q. Do you know that for a fact, sir, or are you just estimating?

A. I'm really just estimating, because I don't really know precisely how much surgery he was doing on the cervical spine in 1980 to '82, that would have been ten years ago. I'm estimating that it was at least once a month, and I suspect it was not more than two times a month.

Q. But it could have been less than that, too, correct?

A. Less than --

Q. One or two a month.

A. I doubt that it was less than one a month, although, I can't be dogmatic about that, but I would doubt that it was less than that.

Q. And you have reviewed the medical

A. Yes.

Q. Can you explain to me why there was a bone fusion at only one of the levels as opposed to both levels?

A. I'm not sure exactly why he decided to do a fusion at one level and not the other. Again

from in front, they are divided.

Some neurosurgeons do not feel that fusion is necessary, another group of neurosurgeons feel that fusion is necessary. And, again, there is no clear-cut preference as to those procedures. Now, why he decided to do a fusion at one level and not the other, I'm not certain.

Q. That isn't something you would have taught or done at UC, is it?

A. No, probably not. Although, I have done them without fusion, and I have done them with the fusion myself, personally.

Q. But have you done them both ways in the same operation?

A. NO.

Q. Would you agree with me that that's somewhat unusual?

A. I think it's a little unusual. I don't think there's anything to be criticized by it, though, because it can be done either way.

Q. Sir, was the surgery in this case indicated?

A. I would think so. Yes, I believe so. It was.

Q. What kind of conservative treatment was provided? You're looking right now at --

A. Well, I was trying to review my notes about Dr. Prioleau's deposition.

Q. You're looking at approximately six, seven pages of yellow notes?

A. Right.

MS. TAYLOR: I'd like to get those marked when we're done and get copies of them.

A. Specifically, my notes about the deposition of Dr. Prioleau. And all I have recorded is that there was a six-week history, and I did not record what treatment had been recommended during that tim

Q. Is it fair to say you don't recall whether any type of conservative treatment was provided?

A. Well, there was six weeks of some type of management.

Q. Is it fair to say you don't know the circumstances of what type of conservative treatment?

A. No, I do not at this moment.

Q. Doctor, what's a normal amount of blood

fusion?

A. Probably 50 cc.

Q. That's not a very bloody procedure, is it?

A. No, not normally.

Q. Do you recall how many cc's of blood were lost in this case?

A. I don't recall.

Q. In this case, approximately 200 cc of blood was lost. Is that an unusual amount of blood to lose during this procedure?

A. Well, it's a little more than average, but 200 cc is not anything to be concerned about. We don't -- you know, we don't usually even think about giving transfusions until at least 500 cc or more have been lost. So I would estimate that the usual loss would be less than that, but that certainly is not anything to be concerned about.

Q. And what's your standard practice, sir, wjth respect to where the patient goes after having an anterior cervicaldissectomy -- excuse me, an anterior dissectomy -- yes, dissectomy?

A. Well, to the recovery room.

Q. And after the recovery room, does your

patient normally go back to the floor?

A. Yes.

Q. Does the patient go back to a neurosurgical floor?

A. In the hospital that I am practicing in now, yes, because there is a neurosurgical floor. In the hospital that I previously practiced in, there was not such a thing as a neurosurgical floor.

Q. And what hospital is that?

A. Iiolmes Hospital.

Q. When did you practice at Holmes?

A. When I was on the University staff. That essentially was the private practice hospital for the University.

Q. And when did you practice at Holmes?

A. From 1953 up until 1982 -- or no, probably 1985.

Q. And what's your standard order with respect to vital signs after an anterior dissectomy?

A. Well, principally --

Q. Once they're out of the recovery room, of course.

A. Well, usually it's a matter of -- I

signs after they're out of the recovery room are not terribly important.

It's a matter of -- that is in terms of blood pressure, and pulse, and respiration, which we usually consider the vital signs. Now, obviously, we do check those at least after the patient is out of the recovery room every couple of hours for probably eight hours, and then maybe every four hours after that for another 24 hours, but it's not something that needs to be checked very frequently in those patients.

Q. Unless, of course, the patient is starting to have complaints?

A. I'm sorry?

Q. Unless the patient has some complaints?

A. Obviously, if the patient starts having some problems, those orders will be changed, but that would be the routine on a patient who made a normal postoperative recovery,

vital signs, that being blood pressure, pulse, and respiration, more frequently than when she was or had on a patient, the nurses would not need to have a physician's order?

They wouldn't have to ave them ordered,

no.

That would be within the nursing practice to the frequency of checking vital signs?

A. That's right. Nurses have some routines of their own that would at least comply wjth what the physician ordered, but sometimes it's even more than what the physician orders.

Q. Do you know how many anterior dissectomies and interbody fusions were performed at Temken Mercy Medical Center in 19821

A. No, I have no idea.

Q. Excuse me, 1986.

A. I have no idea.

Q. Do you know what the staffing status was of the nurses at that hospital in 1986?

A. Certainly not in any detail, no.

Q. Khat do you know about the staff?

A. Well, I've just reviewed the deposition, I think, of -- What was her name? How do you pronounce that?

MR. BELL: Sonlin.

A. Sonlin, yes, and she -- I believe she talks about nursing and a charge nurse and staff nurse so I don't know anything more than that about it.

Q. And do you have any knowledge about the qualifications of these nurses at the hospital?

A. Other than being either LPN or registered nurses, no.

Q. You don't know anything about their experience with patients who have had anterior dissectomies?

A. No.

Q. Do you have any knowledge about the closeness of Mr. Richeson's room to the nursing station

A. No.

Q. Do you have any knowledge as to the proximity of the crash cart or ET tubes to Mr. Richeson's room?

A. No.

Q. Am I correct, Doctor, that it's standard practice to have a chest x-ray done for patients that have had anterior dissectomies the morning following surgery?

A. It hasn't been my practice, no.

Q. How would you confirm that a bone plug where there's been a fusion done remains in position?

If my question is unclear, I'll

rephrase it.

A. Well, it will be checked at some later time by a cervical spine x-ray, but not immediately

Q. How soon would standard practice be to do a cervical spine x-ray to check the bone plug?

A. Not for several days, unless the patient were having some symptoms in the meantime

Q. What type of symptoms would you be concerned about?

A. Well, if the patient were developing problems with his spinal cord, such as weakness of his arms or legs, then one might be concerned that the blood had been displaced and was pushing on the spinal cord, and so certainly under those circumstances, one would get an x-ray, but barring some event of that sort, I would not see any need to get an x-ray

Q. Am I correct, doctor, from your review of the records -- please feel free to refer to them

Mr. Richeson had no complaints, at least from the nurses notes, of a sore throat before 9 p.m. the day after having had surgery, correct?

A. I believe that's correct, yes

Q. The surgery was completed on October 23rd, 1986 at 5:30 p m., correct?

A. I'm sorry, what was the date?

Q. The surgery was completed on October 23rd, 1986 at 6x30 p.m.?

A. I believe that's right, yes.

Q. So from 6:30 p.m. on the 23rd until 9 p.m. the following day, there are no notes regarding a sore throat?

A. I believe that is correct, yes.

Q. There were -- Am I also correct, there were no complaints about an inability to swallow -- Strike that.

Let's go chronologically on this.

A. Yes, I believe that's correct,

Q. There were no complaints of a tightness in his throat until 9:30 p.m. on the 24th?

A. I'm having a little difficulty at this moment finding the nurses' notes for that time. Let's see. Let's go off the record just a second.

(off the record.)

BY MS. TAYLOR:

Q. Starting with the evening after the surgery that was performed by Dr. Prioleau, there are no complaints about any respiratory problems until what time? Am I correct, the records reflect 10:30

p.m.?

A. Okay. States having some difficulty breathing, yes. 10:30 p.m., right.

Q. Doctor, you will agree with me that is unusual for a patient to suddenly have complaints of a sore throat over a day after a surgery was performed?

A. A little bit unusual, it's certainly not unheard of. Just from anesthesia alone sometimes the patient's sore throat will be worse a day or two later than it is immediately, and they may not even complain of it immediately, then later on it becomes more sore. So that's not too unusual just from the anesthesia itself.

Q. That's from the intubation?

A. From the intubation.

Q. But wouldn't you expect, Doctor, that the patients -- or there would have been some comment in the nursing notes of a sore throat or some complaint regarding their complaint over a day after surgery?

A. It depends on whether the patient complains to the nurses about it. If the patient doesn't complain to the nurses, obviously, the nurse wouldn't put anything down. And I'm sure that I have

seen instances in which the patient -- it wasn't significant enough to the patient that he would complain about it for 12, 24 hours, something of that sort. Well, it may be a little unusual, it certainly is not terribly unusual, in my judgment.

Q. Am I correct, Doctor, from your review of the depositions of Dr, Prioleau and the nurses' depositions you looked at, there is no agreement between Dr. Prioleau and the nurses as to when he was called and what information was provided to him by the nurses?

A. There is not disagreement, is that what you said?

Q. No. There is disagreement between Dr. Prioleau and the nurses as to when he was called and what information he received from the nurses, as well as when he arrived at the hospital?

MR. BELL: I'm going to object to that question.

A. I was not aware of so much disagreement or any disagreement.

Q. Therefore, it's your opinion, then, that the testimony of the nurses, as well as the nursing notes by the nurses, in addition to the

deposition of Dr. Prioleau, they're all in agreement as to the chronology of what occurred in this case?

A. Well, to the extent that I can recall, yes. Dr. Prioleau was first called at about 8:30, and he was told that the patient had some hoarseness.

Let's see, is that correct? Yes, he had some hoarseness, and had some difficulty in swallowing, and a sore throat, and some swelling on the right side of his neck had been noted by the nurses, and Dr. Prioleau was notified about that at --

Q. ht 8:301

A. I believe that was the correct tine, at least that was the time that I think Dr. Prioleau -- Well, Dr, Prioleau said about 8:30 in his report, and the nurses' notes say 9:30 -- well, no. I guess they don't give a definite tine about that. Well, they say 10:00, I think.

And Dr. Prioleau, I believe, at that time requested that they give him some medication and then he was called again at 10:30, 10 to 10:30, because of more swelling, and at that time he was having some difficulty in breathing, and that's when Dr. Prioleau made the decision to go to the hospital. I'm not aware of any specific discrepancies in those.

Q. How, Doctor, what's your understanding of the degree of swelling that was present on Mr. Richeson's right side of his neck?

A. I understand that he had a moderate amount of swelling.

Q. Explain to me what you mean by, "a moderate amount of swelling."

A. Well, how do you define moderate amount? It was more than a very slight amount, but less than an extremely large amount.

Q. Well, are we talking about swelling of just the incision line?

A. No, of the tissues in that general area.

Q. Did you frequently have swelling, a moderate amount of swelling of the tissues, when you did anterior dissectomies?

A. Some of them have a moderate amount of swelling, Most have a small amount of swelling, but sometimes there is a moderate amount of swelling.

Q. What causes there to be a moderate amount of swelling?

A. Well, I think there's a great deal of variation in the amount of swelling tissues from one person to another. Sometimes it is a matter of some

seepage of blood occurring after surgery, in some individuals, and, then, some people, their tissues just swell more easily than others.

Q. Do you have an opinion as to what caused the swelling in Mr. Richeson's neck?

A. Well, I think, in his neck it was a matter of Some bleeding of the surgery, primarily.

Q. Do you have an opinion as to when that bleeding started?

MR. BCLL: Excuse me, Amy, I have no

THE WITNESS: I hope it was, because that's --

MS. TAYLOR: Yes.

A. When it started? I have no idea when it started. My guess is that it was -- that there was probably sone bleeding there from the early postoperative period.

Q. And that bleeding continued thereafter?

A. Perhaps it continued, yes.

Q. When you say, "continued," it would have continued at least until the time of the arrest, correct?

A. Well, it's impossible to say whether the bleeding itself continued up to that time, because what happens is that after there has been bleeding, then there can be what we call edema of the tissues around them, the bleeding, and edema simply means an accumulation of fluid in the tissues.

And so it's a combination, of course, of the bleeding plus the edema that really caused the problem, and also it caused the swelling that one sees. And so it's impossible to determine, then, whether there was actually still active bleeding occurring or whether the bleeding had stopped and there was still accumulation of edema.

Q. Have you ever had the situation arise in your practice when a patient has had edema such as it would threaten the airway after having an anterior dissectomy?

A. Not after an anterior dissectomy. I have had it after carotid artery surgery.

Q. Do you have an opinion as to why you have not had that situation with an anterior dissectomy?

A. No. It's a very rare occurrence in anybody's experience, I think, and I just simply have

not had that occur in any patient that I can recall.

Q. Could one reason be that you rarely have this edema threatening an airway with an anterior dissectomy be because of the small amount of blood that is lost during surgery?

A. It isn't the blood lost during surgery that causes the problem, it's the bleeding that occurs after the surgery that causes the problem. The amount of blood that's lost during the surgery has nothing do do with it, because that's going to be removed at the time of surgery.

Q. Do you have an opinion as to why you have not seen edema threatening an airway with an anterior dissectomy as opposed to the carotid artery surgery?

A. I have an opinion. Carotid artery surgery is obviously -- deals with arteries, and bleeding from arteries is more dangerous and more rapidly accumulating and more extensive bleeding than bleeding from anterior dissectomies, which is usually venous in origin and, therefore? is under lower pressure and accumulates more slowly, and so on.

So that anterior -- Therefore, carotid artery surgery is more likely to have an accumulation

of blood and be under higher pressure than the bleeding that occurs after anterior dissectomy,

Q. The bleeding with an anterior dissectomy, why is it normally venous?

A. Because it's blood from -- that one gets into from -- You don't get into major arteries, that's what it amounts to. You avoid all the major arteries in doing -- approaching and performing an anterior dissectomy, so that the bleeding one gets into is the bleeding primarily from the bone itself or from the muscles that attach to the bone, and most of that is venous bleeding under low pressure.

Q. Did Mr. Richeson do anything to cause himself to have this bleeding?

A. I don't know that he did, unless --

Q. From your review of the records, have you seen anything he did to cause himself to have th bleeding?

A. I don't know of anything he did. The only thing I was going to refer to is, I know there was smoking, and there was some question about smoking. And, of course, coughing, particularly vigorous coughing, can cause some venous bleeding, but I don't know that that occurred in his case.

Q. Don't patient's after surgery, don't they normally have some type of respiratory therapy to encourage them to breathe deeply and cough so they can clear the airways; isn't that standard procedure?

A. Breathing deeply, yes. We don't necessarily encourage coughing immediately after surgery. Well, we do encourage deep breathing and even what we call a blow-bottle in which the person will blow on or inhale through under pressure to expand the alveoli of the lungs, but that's a little different than vigorous coughing. We don't normally encourage vigorous coughing.

Q. You don't see any indication in his record that Mr. Richeson did any vigorous coughing, do you?

A. No. That's why I said I have no awareness that that occurred in his case. I just do recall that there was some problem about his smoking.

Q. But smoking itself would not have Caused him to have this bleeding?

A. No. No, smoking would not.

Q. Doctor, referring back to the nursing notes, at 9:30 p.m. there is a nursing note that he complained of some tightness in his throat. Would you

agree with me that that is an unusual complaint for a patient who has had an anterior dissectomy?

A. It's a little unusual, but the feeling of tightness, or sore throat, or soreness of the throat, is not by any means too unusual just from the surgery itself or from the anesthetic, from the endotrachial tube.

Q. Are you saying that the sore throat is the same complaint as a tightness in the throat?

A. Well, I'm not sure exactly. You know, a patient uses the term tightness in their throat and they use it in different ways, and I'm not quite sure exactly what tightness in the throat really refers to. It is obviously not a pain, but it's a feeling of, I guess, some discomfort or some constriction in the throat that's a sensory or a subjective experience, and the patient describes it as tightness in the throat.

Q. Would you agree with me that a complaint of tightness in the throat and discomfort radiating to the chest, those two symptoms would have -- should have concerned the nurses?

A. Should have concerned them?

Q. correct.

A. Well, it should have concerned them to the point of noting it and reporting it to the physician.

Q. Immediate reporting to the physician, correct?

A. Well, it doesn't sound like it was an emergency situation.

Q. Doctor, wouldn't the complaint of discomfort radiating to the chest -- that is an unusual complaint for a patient who has had an anterior dissectomy, correct?

A. I don't know what part of the chest they were referring to. If they're talking about the upper part of the chest, no, that's not unusual. The surgery is here at the upper part of the chest, so that wouldn't be too unusual. If they're talking about the chest down here in the region of the heart, that would be unusual, yes.

Q. And the concern of a patient complaining of discomfort radiating to the chest could be that a patient might be having a cardiac problem such as an MI, correct?

A. If it was radiating down to the pericardial area, to the region of the heart, and it

was described as a tightness or pressure sensation in that area, that would certainly make you concerned about a myocardial infarction.

Q. Wouldn't you agree, patients who have myocardial infarction, they can have tightness anywhere Over the chest wall, not just the pericardial ares?

A. True. But 90 percent is going to be in the pericardial area or the left arm.

Q. And the neck, correct?

A. Or radiating up to the neck, correct.

Q. At 9:30 p.m. there were no vital signs noted in the nursing notes?

A. Not on this sheet, unless they were recorded on some other sheet.

Q. If there were no vital signs recorded on this sheet or any other sheet for the 9:30 p.m. period when the patient was complaining of tightness in the throat and tightness radiating to the chest, that would be a deviation from nursing standards, wouldn't it?

MS. WYLER: Object.

MS. TAYLOR:

Q. Would you expect a nurse to do pulse and respiration on the patient -- to a patient who's

complaining of tightness of the throat and tightness radiating to the chest?

A. It certainly should be done during that area of time.

Q. What is the best of time, sir?

MR. BELL: He didn't complete his answer.

A. I don't see any vital signs on this particular sheet. And so while I don't recall specifically at this moment, I would have to guess that there are some vital signs recorded elsewhere, because this sheet goes actually from 3 p.m. to 11:30 p.m., and I'm sure they checked something or other during that time.

Q. Doctor, do you have in front of you -- Can you pull out what's considered the --

MR. BELL: Give him a page number.

BY MS. TAYLOR:

Q. The clinical record, let me show it to you.

A. Okay.

Q. For October 24th?

A. Okay.

Q. The vital signs that are recorded by

the nurses, the last two sets of vital signs are at 6 p.m. and 10 p.m.; is that correct?

A. Correct.

Q. So am I correct, based upon the records that you reviewed in this case --

A. Uh-hmm.

Q. -- there were no vital signs taken when the patient complained of this tightness in the throat and discomfort radiating to the chest?

A. At 9:30?

Q. Correct.

A. Well, I don't know whether those were taken precisely at 10100, but they were certainly taken within a short time of 9:30. And there was essentially no change in the vital signs between 6 p.m. and 10 p.m., so I have to conclude that there was not any significant change going on at that time.

Q. Doctor, of course, you're speculating as to what the vital signs would have been at precisely 9:30 p.m. when the patient was complaining of these symptoms, correct?

A. It's not pure speculation.

At least from the vital signs, you knew

what the patient was at 10 from the vital signs?

A. They were the same.

Q. Except they were decreased?

A. They were decreased in relation to 9 p.m. and 10 p.m. I have to believe that this 10 was an unusual feature, an unusual recording. It appeared that the respiration was certainly in keeping with what it had been within the previous 24 hours. I can't explain why that was recorded as 10, but there was certainly no significant change in the vital signs during this 24-hour period.

Q. But you do not know for a fact as to what Mr. Richeson's blood pressure or his pulse or his respirations would have been at 9:30 p.m.?

A. Obviously not. But if they resulted -- If they were different, the result of anything significant going on, they would not have come back to normal.

MS. TAYLOR: Can we take a short break? I got to call and make sure someone picks up my little wild man.

(off the record.)

BY MS. TAYLOR:

Q. Do you know whether or not Mr. Richeson

had the Philadelphia collar on at 9:30 p.m.?

A. According to the nurses' notes here, that had been removed, I believe, at 8 p.m. -- no, at 9 p.m. The front of the collar was removed for several minutes, and it says that he was instructed that he's to only have the collar off to wash his neck. So I would have to assume it was still on.

Q. At 10:00 did the nurses note that the patient complained of a sore throat, his voice being very hoarse, inability to swallow, pressure on the right side of his neck?

A. Uh-hmm.

Q. Would those -- If you had been advised as a physician, advised of those symptoms in a patient that had had an anterior dissectomy a little over 24 hours before, what would have been your practice? What would you have done?

A. Are you asking from a nursing standpoint or as a physician?

Q. As a physician.

A. Well, that seems to be sort of a continuation of what the complaints were at 9:30, which was sore throat and tightness and discomfort, and the only thing that has been added here is

difficulty in swallowing.

Q. It's inability to swallow as opposed to difficulty in swallowing.

A. Well, obviously, he was able to swallow something because he would drown if he didn't and, of course, that goes along with the person having the feeling of tightness and pain in the throat or discomfort in the throat, sore throat. And the only other thing that has been added is the hoarseness.

So the answer to your question is: I don't see that there has been a great deal of change other than the hoarseness; therefore, I don't think I would do anything specific at that point.

Q. Are those syinptoms consistent with edema of the neck area in a patient that's had an anterior dissectomy?

A, Yes,

Q. And, Doctor, from viewing a patient who's developing or has edema of the neck after having had an anterior dissectomy, one cannot see the degree of internal swelling as opposed to the external swelling, correct?

A. Yes, that's correct.

Q. So a patient can have significant

swelling inward and have minimal appearance on the outside of swelling, correct?

A. Yes, that's possible.

Q. So the nurses and the physician would have to be on alert in a patient who has had a procedure such as an anterior dissectomy that they can develop significant swelling in the neck from having had the procedure and some bleeding, correct?

A. That certainly is possible, yes. It's very rare, but it certainly is possible,

Q. And so the nurses and the physicians would have to be on alert for this potential problem after surgery?

A. The problem that you're referring to is internal swelling?

Q. Edema of the neck,

A. Edema of the neck, you --

Q. You seem to have a problem. Please help me correct my question so I can ask it.

A. The main concern is, of course, pressure or swelling of the tissues inside the trachen the wind pipe, because that's the thing that really is the most dangerous. The swelling in the tissues out on the side of the neck is not significant, that

doesn't do any harm to the patient, It's only if that pressure becomes such that it obstructs the trachea or if there is swelling of the tissues inside the trachea

answer it.

Q. Okay. Let me try asking this question: After a patient has had an anterior dissectomy and develops edema --

A. Uh-hmm.

Q. -- in the throat area --

A. And you're talking about external edema or are you talking about the symptoms of internal

A. That would be the difficulty in breathing.

Q. Are there any other symptoms for internal swelling?

A. Of course, the hoarseness and soreness of the throat are due to some edema, That can be attributed either to the surgery itself or to the

endotrachial tube, but it doesn't reach a critical point unless it obstructs breathing. And so that's really the red flag, when a person is having trouble breathing.

The other symptoms, the sore throat and the hoarseness, are sufficiently common after any kind of surgery, in particular that involving use of endotrachial tube, that in itself is not a critical -- usually a critical matter.

Q. The patient's complaints of an inability to swallow, would you agree with me that that is a symptom that could be consistent with internal compression from swelling?

A. Well, it's consistent with some edema, causing some soreness and feeling of tightness in the throat or irritation and tightness and so on. It is not a symptom of obstruction, no.

Q. What about threatened obstruction as opposed to actual obstruction?

A. All of these can be considered as threatened obstruction,

Q. Symptoms of threatened obstruction?

A. Threatened obstruction, because edema and whatever the cause of it maybe can progress to a

critical point. This is what happens, of course, in a youngster who has croup, and it can progress to a critical point. But the fact is that it is extremely rare that it ever progresses to that point.

Q. What's the range of time in which a patient who has internal edema develops sufficient edema to cause occlusion of the airway or sufficient edema to cause obstruction of the airway?

A. There is no time frame on this. As I say, a youngster with croup can develop croup very rapidly, within a matter of almost a few minutes or a few hours.

Q. What about the patient that has had neck surgery?

A. Has had neck surgery and endotrachial tube, that's usually over a period of hours or even a day or two.

Q. What symptoms, aside from a patient complaining of difficulty in breathing, should place the physician and/or the nurse on alert that there is developing swelling in the throat area after having had an anterior dissectomy?

A. All of these things that we have talked about are indications of irritation, which are

associated with some swelling. Now, many of these things -- most of these things thus far have been things that are very commonly seen after this kind of surgery, and it is only when it reaches a point where there is some evidence of obstruction of the airway that one needs to become very concerned.

Q. Would you agree with me that patients that are developing hypoxia tend to be anxious?

A. Yes.

Q. Would you agree with me that morphine depresses the respiratory drive of patients?

A. It does in certain doses. I don't think that there would be any significance from the dosage that was given, and I don't recall *precisely what the dosage was, but I did not feel that the dosage was enough to cause any respiratory depression. It was given mainly to decrease his anxiety and apprehension, and the dosage for that would not cause respiratory depression.

Q. What dosage of morphine causes respiratory depression?

A. Well, you'd have to have a dose of probably 12 to 16 milligrams,

Q. Would you agree with me that it is not

appropriate to give a medication such as morphine for anxiety in a patient who has symptoms of a consistent internal edema to the throat area after having had an anterior dissectomy?

A. Again, it's a matter of dosage, I think you would not want to give a dosage that would cause respiratory depression, but the effect of morphine -- There's several effects of morphine, of Course, and one of the earlier effects is to decrease anxiety and discomfort and apprehension. And so if one gives a dosage for that particular symptom, I don't see that there's any contraindication to it.

Q. According to the nurses' notes, at. 10:30 p.m., Dr. Prioleau was once again advised. He was advised that the patient had complaints of increased swelling and dyspnea, correct?

A. Difficulty breathing, yes.

Q. Would you agree with me that those complaints should have been a red flag to the nurses that a major problem could be developing?

A. Yes.

Q. And that this patient needed to be seen immediately by a physician?

of time, yes. I don't know what you mean by immediate. I don't think it's a matter of five minutes or ten minutes that the patient needed to be seen.

Q How soon should have a patient with those complaints have been seen?

A. Well, that's a very difficult question to answer. I don't think there is a magic time under those circumstances. I think it is obvious that the situation at that time was not such that the patient was an emergency in the sense that somebody needed to see him within the next minute or five minutes or ten minutes, but it is something that a person should have -- physician should see him within the next -- oh, I don't know, between a half hour and an hour we'll say, something of that sort is the difference between emergency, a true emergency and an urgent situation And I would say that this was urgent but not an emergency.

Q. Do you see any vital signs that were taken at 10:30?

A. I don't recall any specific ones that were taken at 10:30.

Q. Do you have any knowledge as to what his respiratory rate was at 10:30?

A. I recall that -- Well, no, I don't know at 10:30. recall a respiratory rate of about 25, I think, and I'm not sure whether that was at 10:30 or a little after that.

Q. Who did that respiratory rate?

A. I'm sorry?

Q. Where do you get that information?

A. Dr. Prioleau taken before he got there.

Q. Would I find that in the nursing notes? Where in the chart would I find that?

A. I don't remember where I got that, frankly. remember a respiratory rate at some point, a reference to a respiratory rate being in the figure of -- 25 sticks in my mind, but I don't recall where I got that.

Q. My review of the records doesn't show any mention of a respiratory rate until after the patient arrests after the 10 p.m. check.

was thinking of.

Q. That was the 16 respiratory rate.

A. No.

Q. If you found a respiratory rate of 25 somewhere else, I would be interested in it, sir

THE WITNESS: Can we go off the record?

MS. TAYLOR: Sure.

(off the record)

BY MR. TAYLOR:

Q. From your review of the record though, Doctor, the medical records for Mr. Richardson, you do not see a respiratory rate recorded for him after the 10 a m rate and before his respiratory arrest, correct?

MR. BELL: Can we go off the record for him to have a chance to review his progress? I don't know if Dr. Prioleau mentioned it in the progress notes.

THE WITNESS: I can't tell you where that figure came from, but it must have been from Dr Prioleau's deposition.

BY MS. TAYLOR:

Q. Where do you think you saw that, Doctor?

A. By exclusion, I think it must have been in Dr Prioleau's deposition

Q. Because it's not in the medical records, as best you can see today when you're looking at those

records?

A. I don't see it recorded in the progress notes here or in the nurses' notes.

Q. With respect to the 10:30 p.m. notation by the nurse, there are no recorded objective signs or symptoms regarding the ability of Mr. Richeson to breathe or any difficulty he had, correct?

A. What are you referring to when you say, "objective"? Are you talking about just the respiratory rate?

Q. Doctor, at 10:30 p.m. there are no notes regarding the quality of his breathing, correct?

A. Again, I'm not quite sure what you're including in quality of breathing, He was obviously breathing, and he told them he had some difficulty breathing.

Q. Is there any notation as to any stridor?

A. No.

Q. Any notation as to whether or not he was having wheezing?

A. No.

Q. Any notation as to the rate of his respiratory?

A. No, I don't see it here, That's what

we've been discussing.

Q. Is there any notation --

MR. BELL: Amy, I wanted to point this out, because you asked the Doctor where he saw the reference to the breathing rate of 25, and it's on page 51, I believe, of Dr. Prioleau's deposition.

BY MS. TAYLOR:

Q. Going back, Doctor, is there any description by the nurses as to the color of Mr. Richeson at 10:30 p.m. as to whether or not he had cyanosis?

A. No.

Q. There's no notation as to whether or not he had any sweating?

A. That's correct.

Q. There is no notation, am I correct, as to whether or not he had any mottling?

A. That's correct.

Q. Am I correct that there is no assessment by the nurses that included -- no evaluation as to his breathing?

A. No, I can't say that. What you've been asking about are abnormalities, and, of course, nurses don't write and make notes about the absence of

everything that might be abnormal. They make notes about things that are abnormal, so the fact that they were not recorded does not mean that they were not observed, it simply means that they were not present.

Q. And the nurses also do not record whether they made an objective finding that he was not having difficulty breathing, do they?

MR. BELL: I object to the form of the question.

BY MS. TAYLOR:

Q. There is evidence he was breathing, but there is no evaluation as to any difficulty he had or any easeness he had?

A. This is a very difficult line of questioning for me. A person states they have difficulty breathing. Now, unless they have wheezing, or stridor, or cyanosis, or something, there are no objective observations that one can make.

Now, a nurse who even looks at a patient who says he has difficulty breathing will record obviously if the patient is turning blue, which is what we mean by cyanosis, but a nurse does not normally put down, "Patient was not turning blue." If he was turning blue, they would put it down. And so

the absence of those things is as important to me as if they were present and were recorded.

Q. So are you assuming from the fact that there are no vital signs or no comments regarding the patient's breathing ability that his vital signs would -- or were normal and that he did not have cyanosis or any mottling or any other symptoms consistent with signs -- or symptoms consistent with --

A. Yes I am assuming he was not cyanotic and was not mottled, and did not have stridor, because those would be the obvious things a nurse would record under these circumstances. But a course would not record that they were not present. She would record only if they were present, because those are the obvious things that one looks for under these circumstances

Q. At 10:45 it was noted that the patient continued to be agitated and that morphine was provided.

A. Uh-hmm.

Q. Is there any evaluation or assessment recorded of his respiratory status at 10:45?

A. Well, only that the patient was talking to the charge course Now, a person has to be able to

breathe pretty well to be able to talk. So that in itself indicates that his respirations were not too impaired at that point, A person can't talk when they have a *very* impaired respiration.

Q. What assessment do you see at 10:45 as to the degree of his swelling?

A. I don't see any specific note about that, except that the patient said that he had some swelling -- a swelling sensation -- I'm sorry, swelling sensations.

Q. But going back to 10:30 p.m., what assessment do you see written in the nursing notes as to the swelling he may or may not have had?

A. I don't see any. I assume it had not changed since previously recorded.

Q. What assessment or what nursing notes do you see between 10:45 and 11:30 p.m.?

A. About swelling?

Q. About anything.

A. Between 10:45 and 11:30, there's nothing between those two times.

Q. Would you agree with me that from 10 p.m. until the time of the arrest that there were -- there are noted no vital signs on Mr, Richeson?

A. I see none on the nurses' notes. That's correct.

Q. And you've also looked at the progress notes, and there were no vital signs noted in the progress notes, correct?

A. Yes, But I also have noted that apparently Dr. Prioleau --

Q. In his deposition?

A. -- in his deposition noted that vital signs were somewhat -- or respirations were somewhat increased.

Q. And Dr. Prioleau in his deposition also stated that he arrived at the 10 p.m., correct?

MR. BELL: Objection. If you are going to ask him any questions about Dr. Prioleau's deposition, I'd like you to show him the deposition, the page, the line.

MS. TAYLOR: Sure, I can do that.

Q. Here we go, Doctor. Here's Dr. Prioleau's deposition. Why don't you flip to page, you would, please, page 31.

When did he say he arrived at the

hospital?

A. "Exact time, I'm not certain about. It was sometime shortly after 10:00, perhaps 10:30."

Q. And the nurses' notes reflect that he was present at 11:30 a.m., correct?

A. Yes, that's correct.

Q. And the nurses' notes reflect that Dr. Brigleaw was notified at 10:30 a.m. of the patient's complaints, correct?

A That's correct.

Q. Would you agree with me rectrospectively that Mr. Richeson was exhibiting signs of edema compressing his esophagus and his trachea sometime before his arrest?

MR. BELL: Objection. You can answer.

A Well, yes As I have stated before, all of those things that he had were signs of some edema and irritation of the -- mainly the trachea, to a lesser extent, the esophagus, if at all

Q Am I understanding correctly, from your testimony, it's not the fact that he was having signs of this developing edema, this internal edema, that's something that the nurses and the doctors were aware of and they should be concerned about, but the

is not a rush situation, something you treat immediately. Am I understanding correctly?

Some degree of edema is normal, is inevitable, because any time you do surgery you're going to have some edema, any time you put an endotracheal tube down, you're going to have some edema. So that edema and swelling of those tissues is a normal thing, and it is only when it reaches a certain critical point that it becomes an urgent situation to deal with.

Q. At what time in this case did it become an urgent situation?

A. I think when they started talking about difficulty in breathing, then it became an urgent situation.

soon for the patient to be seen by a physician? How soon? I'm trying to understand that, sir.

A. I thought I had pointed that out specifically before. I'm thinking about the terms of an hour for an urgent situation and five to ten minutes for an emergency situation.

Q. When did it become an emergency situation in this case?

A. I think when he arrested it became an emergency situation.

Q. So until the time he arrested it was an urgent situation, and urgent in the sense that he needed to be evaluated by a physician?

A. Right, When he arrested, it became an emergency situation,

3. Would you agree with me that it is easier to intubate a patient who has not totally occluded his airway?

A. Oh, sure.

Q. Would you agree with me that in a patient that has threatened occlusion of airways, having difficulty breathing, such as in this case, it's important to get them intubated while they are still breathing?

A. Surely, absolutely, This was exactly why Dr. Prioleau recommended had that he be transferred to the ICU and be intubated, because he was still breathing at that point, and he wasn't waiting until he arrested. Unforturnately, he did arrest prior to that time, but that was exactly why Dr. Prioleau recommended that, because he wanted to get it done before he stopped breathing,

Q. Once a patient arrests, isn't it important that the most experienced person intubating patients attempt to intubate the patient?

A. Well, by and large I would say that's true. I'm not sure exactly what all you're including in the most experienced. You know, hospitals are set up so that there are teams of people who perform certain functions under certain circumstances, and the person who's on the team to perform that function may not necessarily be the most experienced person in the hospital, but he is the person who's assigned to perform that function at that particular time.

Q. In a patient such as Mr. Richeson, who's haviny occlusion of an airway, wouldn't you want to have someone such as an anesthesiologist or a nurse anethetist intubate that patient?

A. It would be yes, obviously, but it isn't always possible to do that nor is it usually necessary to have the most experienced person perform these things. As I say, the team approach in a situation like this does not necessarily use the most experienced person at all times,

Q. However, if the person is available, it is wise to use the person who's most experienced, and a patient such as Mr. Richeson would be a difficult intubation, correct?

A. Can I hear the first part of the question again?

Q. In a situation such as this, with a patient who's occluding or who has occluded the airway from swelling, if that person is available, is it incumbent upon the physician to request that the person who's most experienced attempt the intubation?

A. If that person is immediately available certainly, but if there is a somewhat less experienced person who's on -- who's assigned on that team at that particular time to perform that function, then that's the way the hospital usually operates and --

Q. Even if it's to the detriment of the patient?

A" No, no, it's not to the detriment of the patient. What it amounts to is that the most experienced anesthesiologist cannot be on call for emergencies 24 hours a day for everybody, and so that has to be delegated, that responsibility has to be delegated to other individuals who may not be quite as experienced but who are experienced sufficiently to handle 99 percent of the problems. And that's the only way hospitals can function.

And so one does not necessarily have to have the most experienced person In the hospital do it even under emergency conditions, because that would imply that the most experienced person has to remain in the hospital 24 hours a day, 7 days a week, and be on call all of that time, and that can not occur.

Q. Doctor, assume for me, if you will, Doctor, please, that there was a nurse anesthetist in the hospital who was available and could have come to intubate Mr. Richeson at the time of the arrest.

A. Uh-hmm.

Q. Assuming that fact, Doctor --

A. Uh-hnm.

Q. -- wouldn't it have been wise, prudent of the physician to request that the nurse anethetist

who was available attempt the intubation of this patient?

MR. BELL: I object.

A. I think that depends on many factors. I think it depends on the setup in the hospital, the modus operandi in the hospital, whether the physician even knew that the person was available. I think there are many factors that would have to be considered in making that judgment. I don't know that I can answer it any better than that. But as I say hospitals are set up differently, and there are teams that are supposed to respond under certain conditions, and the physician relies on those teams. And then if there are further problems, then, obviously, further requests have to be made.

Q. Do you have an opinion as to how long Mr. Richeson was without oxygen to have caused the injuries he has?

A. Probably. As a matter of fact, I don't know that he was totally without oxygen at any time, but he was hypoxic, which means that he had decreased oxygen for, I would estimate, probably 10 to 15 minutes, or something of that sort.

Q. Do you have an opinion as to whether or

not a tracheostomy, first of all, would have been successful in this case?

A. I don't think it would.

Q. Why not, sir?

A. Because I think the blockage was below the point where a tracheostomy would have done any good.

Q. What about using an ET tube, an endotracheal tube, in the tracheal incision, have you ever done that?

A. If that could have been inserted, that's correct. Now, that would take some time to do all of that, of course, and actually, generally speaking, it takes less time to intubate the usual way rather than doing a tracheostomy and intubate that way

Q. But that is a viable option in a patient that has an airway obstruction?

A. It s a viable option. I think just a tracheostomy itself would not have been successful I'm sure a tracheostomy with a tracheal tube through the tracheotomy opening would certainly have been a viable option, but as I say, that takes more time usually than intubation through the nose/trachia route

Q. How long does it normally take to do a

tracheostomy plus put in an ET tube?

MR. BELL: Objection,

BY MS. TAYLOR:

Q. Have you ever done a tracheostomy and inserted an ET in a trachia?

A. Yes, sure.

Q. How frequently?

A. I used to do it frequently. I haven't done it recently.

Q. "Frequently," means how often?

A. How many times have I done it?

Q. Yes.

A. Probably 25, 30 times.

Q. When was the last time you did that?

A. I imagine I haven't done it for the last ten years, quite frankly. But that's a procedure that takes, I don't know, probably a minimum of 20 minutes at any rate.

Q. Therefore, it's a procedure you like to do on a patient that hasn't obstructed already?

A. I'm sorry?

Q. It's a procedure you like to do on a patient that hasn't obstructed already.??

A. Well, yes. You prefer to intubate a

patient who's not obstructed. That's correct.

Q. Why is that? Why?

A. Why?

Q. Why?

MR. BELL: I object to that question. That's ridiculous.

A. To prevent hypoxia,

Q. Is there any problem that the actual obstruction -- any difficulty the actual obstruction makes to intubate the patient?

You've got the patient who's now obstructed from internal pressure, let's say edema; does the presence of the edema make the intubation of the this obstructed patient more difficult?

A. Well, it may make it a little more difficult. It doesn't make it impossible, as a rule. It makes it more difficult in this case. Of course, the problem was -- or part of the problem was that the trachea was displaced and that, of course, makes it more difficult.

Q. How quickly do you think this displacement of the trachea occurred?

A. I think it was progressing. It didn't occur all of a sudden. It was progressive.

Q. Over the last few hours?

A. Yes, probably.

Q. Is this displacement of the trachea something that the nurses should have been able to visualize or palpate in Mr. Richeson?

A. Usually not, If there's some swelling there, it's very difficult in -- particularly if a person -- and I think he did have, they described it as a bull neck or something like that. In a very thin, scrawny neck you can feel it much more easily, of course, but in a person with a thick neck, it's sometimes very difficult to feel the trachea, particularly if there's no swelling there,

Q. But is it something, this diversion of

forewarning you, we need to leave about 5:25 at the latest to get to the next flight that we scheduled.

BY MS. TAYLOR:

Q. Do you know of Timkin Mercy Medical Center? Wave you ever been there?

A. No.

Q. Did you in any way assist Dr. Prioleau setting up practice in Canton?

A. No.

Q. Did you give any references to anybody with respect to his setting up practice in Timkin in Canton?

A. I may have written a note for him, a letter of support, because it's common practice that when a person applies to a new hospital and a new community that he has to have letters of recommendation from -- usually from someone -- with previous individuals he's worked with or trained with and so on, and so I may have written letters for him. I don't recall at this point.

Q. Are you acquainted with the cricothyroidic puncture?

A. Yes.

Q. Have you ever done that?

A. Yes.

Q. Do you think that would have been of any value in this case?

A. Not a bit. The obstruction was below that point.

Q. And upon what do you base that?

A. The obstruction was to the major -- to the hematoma and swelling further down in the trachea,

Q. Where in the trachea was the hematoma and swelling?

A. Well, the x-ray report indicated a hematoma that was retromedial down in the chest, and the cricothyroid is up here in the neck.

Q. So where was the obstruction?

A. Presumably it was lower, down below that in the trachea, somewhere between here and where it goes into the lung, but I don't know precisely where it was. But it was below the level of cricothyroid.

Q. And that is based upon the x-ray report taken that following morning?

A. Well, the x-ray report plus -- well, the swelling and the surgery is all below the cricothyroid. The cricothyroid is certainly where the Adam's apple is, which is relatively high, and that's where one does a cricothyroid puncture, but the swelling and the surgery is farther down in the neck, and so the swelling and the hematoma were below that point.

Q. Can you estimate for me at what depth

the -- using an ET tube -- and ET tubes are marked as to so many meters, correct?

A. Yes,

Q. Do you know at what level in Mr. Richeson the obstruction was?

A. No, I can't estimate that, I don't know. You know, that depends on his build, whether he had a long neck or a short neck, a lot of things of that sort. I couldn't estimate that with any degree of accuracy.

Q. Do you have any opinion with respect to the management of Mr. Richeson's diabetes?

A. Do I have any --

Q. Opinion5 with respect to the appropriateness or what type of management there was of his diabetes?

A. No. No, I really don't. I am certainly not an expert on the management of diabetes, and I would not want to render an opinion in that regard.

Q. Do any of your residents that come from University Hospital go up to Timkin or the Canton area for extra training?

Do any of your residents that are here

or your interns there in the area of neurosurgery do, any other training up at Timkin?

A. Not to my knowledge.

MS. TAYLOR: I think that's all, if you give me a minute.

(off the record.)

CROSS-EXAMINATION

BY MS. WYLER:

Q. Doctor, my name is Allcla Wyler. I represent Timkin Mercy Medical Center in this case.

I gather that you don't consider yourself an expert witness in the field of nursing standards of care; is that correct?

A. That's correct.

Q. However, in your review of the medical records in this case, the depositions of Nurse Sonlin and the other depositions that you reviewed, are you of the opinion that the nursing care that was given during the critical hours of the evening of October the 24th, 1986 up to the time of Mr. Richeson's arrest met the standard of care c
under the same or similar circumstances?

MS. TAYLOR: Objection.,,

A. Yes, I have an opinion.

Q. What's your opinion?

MS. TAYLOR: Objection.

A. I did not see anything that I thought was a deviation from the standard of care. It was acceptable,

Q. Doctor, have you ever participated in the drafting of nursing practices and procedures at any point in time during your lengthy career?

A. Yes, yes. Certainly when I was Chairman of the Department of Neurosurgery at the University, I was involved at that point in drafting certain nursing procedures,

Q. Did those nursing practices and procedures involve the care of patients who had undergone surgery such as the surgery that Mr. Richeson underwent in October of 19861

A. To the best of my recollection, it didn't. Most of the nursing procedures that I recall being involved in had to do more wjth acute trauma.

MS. WYLER: I don't believe I have anything further, Doctor. Thank you.

MS. TAYLOR: Just a couple more questions, Doctor.

REDIRECT EXAMINATION

BY MS. TAYLOR:

Q. Have you ever in your practice hac? the nurse -- ordered the nurses to do neck measurements on a patient?

A. No, I never have, No.

Q. Doctor, at what time should the nurses have -- or Dr. Prioleau ordered the nurses to do vital signs on Mr. Richeson after he began having symptoms of soreness of his throat?

MR. BELL: Objection, I think that's two questions. If you ask him about them separately, I would not have an objection.

A. At what time should he have ordered vital signs; is that what *you're* asking?

Q. Yes.

A. Well, you -- The reason I'm having difficulty is that I don't think vital signs are the most important things to observe at that point.

Q. What are the most important things to observe?

A. The breathing, which may include, of course, respiratory rate, but it certainly included other things that are even more significant or more -- may occur earlier than changes in the respiratory rate.

Even such things as stridor, such things as cyanosis, those are not what we call vital signs, but vital signs meaning changes in blood pressure, pulse, and respiration, are not the most important things to observe under those circumstances.

I think they should have observed that, but I don't think that those are the critical things to observe. It's much more important to observe these other factors,

Q. Would you agree, it's more important to observe those other factors you've been discussing, such as stridor?

A. To determine whether those are present, yes.

Q. How frequently should those be done in a patient who has had an anterior dissectomy and is having symptoms with increasing internal edema?

A. I would say at least every 15 to 30 minutes, if there seems to be a progression of things.

Q. Of course, if they're being observed, they should be recording the results, correct?

A. If they're present, they should be recorded. I don't think it's necessary to record things that are not present. You know, nurses have

enough things to do other than to record negative findings. And so nurses, as well as physicians, record primarily only the positive findings.

Q. Doctor, one more question: Once you graduate, what are your plans after you graduate?

A, Well, I'm planning to probably continue practicing neurosurgery and hopefully practice some law, too.

Q. Is there any special time that you anticipate knowing what you're going to be doing legally?

A. Any special time?

Q. I mean, right after you graduate, do you have an offer?

A. No, no.

Q. So at the time --

A. I'd be glad to accept an offer.

Q. So you don't know, Doctor, as to when you're going to be practicing law, or what your --

A. No.

MS. TAYLOR: Thank you. I have no more questions.

CROSS-EXAMINATION

BY MR. BELL:

Q. Doctor, I have one or two questions, very quickly.

In this case, did you form your opinions relative to the standard of care of Dr. Prioleau prior to receiving any arbitration brief?

A. I think so, yes,

Q. Did you prepare your report of July 11th, 1989 prior to receiving my arbitration brief?

A. Oh, yes. I'm sure of that, yes.

Q. Would it be a fair statement that your findings and opinions as to the standard of care are not based upon arbitration brief?

Objection. You're leading the witness, and I move to strike

BY MR. BELL:

Q. Asked another way: Were the conclusions that you reached prior to receiving the arbitration brief as to the standard of care influenced one way or the other by the arbitration brief?

A. No.

MR. BELL: I have nothing further.

Doctor, you have the right to read the deposition or you can waive that right. I leave it up

to you. I don't know this court reporter personally. It might about a good idea to review it, if you have time.

THE WITNESS: I would be glad to review it, if I don't have to do it in the next ten minutes or something.

ROBERT L. MCLAURIN, M.D.

- - -

DEPOSITION CONCLUDED AT 5:30 P.M.

- - -

CERTIFICATE

STATE OF OHIO:

: SS

COUNTY OF HAMILTON:

I, LISA CONLEY, the undersigned, a duly qualified and commissioned notary public within and for the State of Ohio, do hereby certify that before the giving of his aforesaid deposition, the said ROBERT L. MCLAURIN, M.D. was by me first duly sworn to depose the truth, the whole truth and nothing but the truth; that the foregoing is the deposition given at said tine and place by the said ROBERT L. MCLAURIN, M.D.; that said deposition was taken in all respects pursuant to agreement; that said deposition was taken by me in stenotypy and transcribed by computer-aided transcription under my supervision; that the transcribed deposition is to be submitted to the witness for his examination and signature; that I am neither a relative of nor attorney for any of the parties to this cause, nor relative of nor employee for any of their counsel, and have no interest whatever in the result of the action.

IN WITNESS WHEREOF, I hereunto set my hand and official seal of office at Cincinnati, Ohio, this

day of , 1990.

MY COMMISSION EXPIRES:
JULY 28, 1994.

LISA CONLEY
NOTARY PUBLIC - STATE OF OHIO

O THE REPORTER: I have read the entire transcript of my deposition taken on the _____ day of _____, 19 _____, or the same has been read to me. I request that the following changes e entered upon the record for the reasons indicated. I have signed my name to the signature page and uthorize you to attach the following changes to the original transcript:

PAGE	LINE	CORRECTION
5	16	The question was "1982" — not the same as 1972.
12	3	"are" should be "were"
17	14	"Montray" should be "Mont Reid".
24	2	Dr. McLennon.
46	13	"blood" should be "plug".
92	6	"relaxed medical" should be "retro-medicated"

Robert L. McNaul