State of Ohio,)
County of Cuyahoga.)

- - -

IN THE COURT OF COMMON PLEAS

- - -

MARTIN T. McCUE,
Plaintiff,
v.
PARMA COMMUNITY GENERAL HOSPITAL, et al.,
Defendants.

Case No. 326206

- - -

THE VIDEOTAPED DEPOSITION OF MILTON P. MIDIS, M.D.

MONDAY, NOVEMBER 30, 1998

- - -

The videotaped deposition of MILTON P. MIDIS, M.D., a Defendant herein, called for examination by the Plaintiffs, under the Ohio Rules of Civil Procedure, taken before me, Lauren I. Zigmont-Miller, Registered Professional Reporter and Notary Public in and for the State of Ohio, pursuant to notice, at the offices of Gallagher, Sharp, Fulton & Norman, 7th Floor Bulkley Building, 1501 Euclid Avenue, Cleveland, Ohio, commencing at 3:40 p.m., the day and date above set forth.

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APPEARANCES:

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APPEARANCES CONTINUED:

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ALSO PRESENT:

Kenneth M. Simon - Video Discovery, Inc.

- - -

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MR. GUNNING 42, 43(2), 44(2), 45(2), 46, 47(3), 50(2), 52, 54(2)

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MILTON P. MIDIS, M.D.,

a Defendant herein, called for examination by the Plaintiffs, under the Rules, having been first duly sworn, as hereinafter certified, deposed and said as follows:

MR. SIMON Before we get started let me put something on the record if you don't **mind.**

We're here for the discovery deposition of Dr. Milton Midis. I would object to any use of this videotaped deposition outside of discovery process. That's all Ihave. Thanks.

MR. VADNAL: Note my objection also.

MR. JEFFERS: I'll take one of those, too, please.

MR. MALIK: okay, everybody done?

- - -

CROSS-EXAMINATION

BY MR. MALIK:

Q. Doctor, my name is David Malik. I have some questions for you.

Have you ever had your depo taken

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A. Never.
Q. So if there's anything you don't understand, let me know, okay?
A. Okay.
Q. The first thing I'm going to show you is an exhibit marked A, which is called the Parma Community General Hospital Consent to Operation and Treatment. It has the name of Martin McCue on it. Would you take a look at that for me.
A. Okay.
Q. Can you tell me if you in any way, shape or form contributed to the execution of that document?
A. In other words, did I write this document?
Q. No. In other words, did you meet with Mr. McCue and explain it to him?
MR. SIMON: YOU mean the form itself, David?
BY MR. MALIK:
Q. The form.
A. No, I was not involved in this form itself.
Q. Okay. Typically in your practice do you get involved with that form with patients?
A. No, sir.

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Q. What's the date on that form?
A. 1-26-96.
Q. So I take it on 1-26-96 you did not meet with Mr. McCue at all?
A. That's correct.
Q. Can I have that back?
A. Yes, sir.
Q. Handing you Exhibit B, which is the Parma Community General Hospital consent form. Did you in any way, shape or form participate in the execution of that form with Mr. McCue?
A. No, sir.
Q. And again, you did not meet with him with respect to that form on the 26th, correct?
A. Correct.
Q. Okay. Handing you Exhibit C, which is marked Parma Community General Hospital, can you tell me what this is?
MR. JEFFERS: Do you have an extra one of those around, Dave?
MR. MALIK: No. It's part of the medical record.
MR. JEFFERS: I've got it in there, just for simplicity's sake.
A. This is an anesthesia record.

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Q. Did you participate in filling out that anesthesia record?
A. Yes, sir, I filled it out in its entirety.
Q. Okay. So everything on there is your handwriting?
A. That's correct.
Q. Okay. Starting at the top of that and going down can you tell us what it says?
A. Okay. It's got the date, ASA status.
Q. The date is what?
A. 2 it looks like a 1-96.
Q. M-hm.
A. And it's an ASA classification three.
Q. What does that mean?
A. That means that the patient meets the ASA category three of one through five.
Q. Well, ASA is what?
A. Well, it's American Society of Anesthesia classification system.
Q. So three would mean what?
A. Three means a person who has a severe systemic disease that can impair them at times.
Q. Okay.
A. But that's not a constant threat to life.
Q. Next, please.

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A. Okay. Description of the operation itself. The anesthesia type, which is a general anesthetic, that's what that abbreviation stands for. My name, the surgeon's name. Then starting on the left is a list of medicines that were given.
Q. Could you tell us what those are?
A. Yes, sir. Number one is oxygen. and if you follow from left to right it shows the various rates in liters per minute during the operation. Then the next one is Nitrous Oxide, and that begins at zero and then goes up to various levels during the operation and returns to zero. The next one is Isoflorane, which is a volatile anesthetic agent or a general anesthetic agent. That shows the various concentrations, and that's in percent.
The next one is Diprivan, which is a sedative hypnotic agent used for putting patients to sleep in this circumstance. The next one is Fentanyl, which is a narcotic. The next one is Lidocaine, and that's in milligrams. I can say the Fentanyl was in micrograms before that in case you wanted specific doses.
The next is Zemuron. That's again in milligrams, and that's a muscle relaxant agent. Below that is -- S-U-C-C is Succinylcholine, and that's a

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muscle relaxant agent as well.
Q. Which of those medicines was given intravenously?
A. Every agent below Isoflorane was given intravenously.
Q. Okay. Would you please continue?
A. Okay. The next was -- I wrote Robinul and did not give any. The next one down is Zofran, and then I crossed it out and decided to give Inapsine in this case as an antiemetic agent.
Q. What is Robinul?
A. Robinul is an agent that I use to help dry mucous secretions in cases like this, and I decided not to use it.
Q. What was the next one you said you used?
A. Inapsine.
Q. What's that for?
A. That's an antiemetic. It keeps people from getting sick in the stomach. It can be -- and it can be used intraoperatively and postoperatively.
Q. Next, please.
A. Okay. Next down is a record of vital signs. Next after that is some timing sequences with ones, twos and threes that are described to the right. Next down is a record of vital signs and fluids that

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were given.
Q. Okay.
A. On the right side of the page I have an X at the top right corner for description, to 0R meaning the patient went to the operating room. Then it describes he was sitting for a spinal. It describes the dose of narcotics that was given and it describes their purpose.
Q. What narcotics was he given?
A. He was given Fentanyl, 50 micrograms, and preservative-free morphine, 0.5 milligrams.
Q. Is there a trade name for the morphine?
A. One of the trade names is Astramorph, and I believe that's the one that our hospital stocks.
Q. Okay. And whose decision was it to give him that combination of Fentanyl and Astramorphine?
A. The decision was the patient's and mine together.
Q. I see. Now, when was that decision made?
A. That decision was made before the patient received general anesthetic.
Q. Okay. Now, when did you first see the patient?
A. It's been two years and I don't remember.
Q. Isn't there a record of when you first saw

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the patient in terms of time?
A. No.
Q. You didn't see him before the date of that operation, did you?
A. No.
Q. So you saw him on the day or the morning of that operation, correct?
A. That's correct,
Q. Okay. So, are you telling me as you sit here today you do not know what time in the morning you saw him?
A. I saw him preoperatively, so that would either be in the pre-op holding area or immediately upon arrival in the operating room.
Q. Okay. Do you have any independent recollection of this patient?
A. None whatsoever.
Q. Okay. Do you have any independent recollection of any discussion with this patient?
A. Specific to this patient?
Q. Mm-hm.
A. No, sir.
Q. Do you have any independent recollection that is of how you know that you did the patient discussed the spi

Page 13

A. Well, I always introduce myself to patients every time I give an anesthetic and I always discuss postoperative analgesia and discuss the course of the anesthetic that we're going to undertake with the patient.
Q. And so you're saying as a course of habit that should have been your procedure on that day?
A. That was my procedure on that day.
Q. How do you know that?
A. Because I always do that.
Q. I see. Now, let's assume I'm Mr. McCue and let's assume I'm in the operating room and you're coming to meet me for the first time. What would you say to me?
A. I would introduce myself, hi, I'm Dr. Midis, I'm going to give you your anesthesia today. Then I would review the anesthesia preoperative assessment by Dr. Garcia and then ask them a few questions pertaining to the illnesses that they have that may cause problems with anesthesia and address those issues first. Then I would discuss postoperative analgesia with the patients.
Q. Okay. Talk to me, tell me what you would say.
A. Okay. I'll assume -- well, I will say --

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if you're Mr. McCue I would say, we have several choices for postoperative analgesia for you, each has minor pluses and minuses, all are equally safe. Number one, you can get intramuscular injections on a periodic basis administered by the nurses; number two, you could get a PCA pump, a push button analgesia pump; and number three, you could get a spinal or epidural narcotic. And then there's the pluses of -- sorry, just getting nervous in here.

MR. SIMON: Relax, take your time. Tell him what your normal routine and practice is.

A. Okay. The pluses of the push button pump are you can push the button whenever you want to. A little more chance of nausea and vomiting with that than with the other methods. The negatives are you actually have to wake up uncomfortably to push the button in your first evening to get comfortable to go back to sleep or to get comfortable.

With the spinal anesthetic -- with the spinal narcotic the advantages of that are that you're relatively comfortable the first evening and you have a very good night's sleep on average. The negatives are that occasionally the person can get some itching and an occasional urinary retention, which both can be

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treated relatively simply.

Q. Okay. Anything else?

A. Then I'd say -- then I would tell the patient they both have equal safety factors, and then if they have any more questions with regards to one or the other I answer them and then let them make a choice.

Q. I see. Now, in your dialogue right now I didn't hear you say anything about the risks of spinal analgesic. Do you discuss those risks?

A. Well, I just said the side effects, which included pruritus, or itching, and urinary retention.

Q. What about severe headaches if there's a central spinal fluid leak?

A. I didn't discuss that with the patient -- I probably didn't discuss it with the patient that day because I don't -- it's such a small percentage that it's essentially infinitesimal with the type of needle gauge and the type of needle used and the operator.

Q. Now, Doctor, I have reviewed the records fairly thoroughly, and I do not see in any of the records where it's indicated that you explained the risks and the benefits and the alternatives of the procedure of the spinal to this patient. Can you show me anywhere in the medical records where it indicates

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you did that?

A. No.

Q. As a matter of course would you indicate it in the medical records that you did that?

A. I usually don't.

Q. I'm sure you're familiar with the term informed consent correct?

A. (Witness nods.)

Q. And what does that mean to you?

A. Not being a lawyer, my understanding is that it's basically getting permission from a paticnt to give them, to perform a procedure on them.

Q. Okay. Does it surprise you that informed consent could require that the patient be explained the risks. benefits and alternatives of the treatment?

A. Yes, sir.

Q. It does surprise you?

A. No, it does not surprise me.

Q. Okay. But nevertheless, in this case you did not explain anything about headaches to this patient?

A. I don't explain things that are such a small percentage that they essentially are almost nil for all practical purposes.

Q. I'm handing you what has previously been

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marked as Exhibit M. Can you tell me what that is?

A. This is a Whitacre needle, a spinal needle.

MR. JEFFERS: This is exhibit which?

MR. MALIK: M.

BY MR. MALIK:

Q. That has been represented to me to be the gauge and type of needle you used for *this* patient. Is that accurate?

A. Yes, sir.

Q. Could you take it out of the package and show it for the camera, please?

A. (Indicating.)

Q. Okay. Now, who supplies that needle to you?

A. Drug supply company.

Q. Okay, Does Parma Hospital supply that needle for your use?

A. Yes.

Q. Does Parma Hospital supply the drugs for your use?

A. Yes, they do.

Q. Does Parma Hospital supply the equipment for your use?

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A. Yes, sir.
Q. Does Parma Hospital supply the nurses for your use?
A. Yes, sir.
Q. Does P it supply the operating room for your use?
A. Yes, sir.
Q. Does Parma Hospital supply you with all the t you need to be an anesthesiologist in that institution?
A. All the physical tools, yes.
Q. Okay. What is attached to that needle in giving a spinal analgesic?
A. Could you rephrase the question?
Q. Is there a syringe attached to that needle, is that how it's given?
A. No, sir.
Q. Can you explain to me how it's given?
A. A patient like this where -- for example, it says sitting, the patient would be in a sitting position, a nurse would be holding the patient steady, reassuring them or just holding them for proper position for me. I would then put on sterile gloves and place sterile Betadine antiseptic solution on their back to sterilize the skin, and then I would wipe it

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off in the center area, that's after palpating the posterior crest of the hips for positioning.
Then I would try to feel with my thumb in the center area of the back to see if I couldfeel one of the spinous processes, and when I do then I explain to the patient while I'm doing this that I haven't stuck a needle in him yet for the spinal and that the first thing they're going to feel is going *to* be a local anesthetic under the skin so that the needle is not uncomfortable for placement.
Then I give them a warning and then I use the local anesthetic that's supplied in the anesthesia trays, which is, I believe, one percent Lidocaine. I make a skin wheel, meaning a raised area with local anesthetic infiltrated, and then with this type of needle I put in a finder needle, meaning a needle of a little larger gauge this can pass through.
I place that approximately two to three centimeters into the skin and then slip this needle through. Then I brace with two fingers holding the hub and the shaft, brace my fingers against the patient's back and advance it until I use one of the signs amongst many that I'm in the proper space.
Q. And what are those signs that you're in th proper space?

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A. The signs are feel *of* going through various areas of resistance. One that -- several that are more notable are area of increased resistance which is called the ligamentum flavum, and that's an area just before the epidural space. After that there's a loss of resistance and a relatively easier passage of the needle, and that's the epidural space. Then what's typically felt with needles of this shape is a subtle popping feel as you go into the subarachnoid space.
Q. All right. I'm handing you a pi that I got out of Neter. I don't know if y of these help us t t where you p t the needle, t i they do can you let me know? And if th that will be Exhibit N.
A. This is probably not as useful as some pictures, but I can give you a rough idea.
Q. All r H a red pen, would y use that?
A. Okay.
MR. SIMON: Object to the use of any diagrams for purposes outside of this discovery deposition, the reason being the doctor said that's not representative and he's just doing it to give you a rough idea. So I object to any

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other use.
MR. JEFFERS: I bjec because he said it was not representative and, therefore I think it inappropriate t use it.
MR. SIMON: I agree.
MR. SIMON: What are you gc t do, are you going t mark an X?
THE WITNESS: I'm going t a an arrow of e space th t in n the chart that I would have entered.
M ION: Okay.
BY MR. MALIK:
Q. I have another t fo 1. Do any of these help?
A. This one is not applicable because it's of the thoracic region (indicating). This one is not exactly applicable because it's the upper lumbar region versus the mid or lower lumbar regions, but it could serve to illustrate the purpose if it would not be taken out of context, because there's a few things that are not applicable to the lower lumbar regions. Basically --
MR. JEFFERS: I t to the

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use of this because it's not properly representative of the area.
MR. SIMON: Note my same objection.
MR. JEFFERS: You can go ahead.
MR. GUNNING Is that being marked as N?
MR. MALIK: M-hm.
(Thereupon, Plaintiffs' Exhibit N to the deposition of Milton P. Midis, M.D., was marked for purposes of identification.)
A. The space that would be entered is the L3-4 interspace, and it would initially be approached, I'm just going to draw an arrow here between the spinous processes of 3 and 4.
MR. JEFFERS: Can we mark that as a separate sheet then?
MR. SIMON Why don't we mark that as O.
MR. MALIK: Fine.
(Thereupon, Plaintiffs' Exhibit O to the deposition of Milton P. Midis, M.D., was marked for purposes of identification.)
MR. JEFFERS: I object to

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that because I can't remember which one of these many things before him is not representative. I don't know whether it's representative or not for this purpose.
MR. SIMON same objection to all of these exhibits. He testified earlier they weren't representative, he's going to do the best that he can with what he's been provided just to give plaintiffs' counsel a general idea of what space he was entering.
A. In this diagram should I draw an arrow?
Q. That would be fine. And the arrow indicates what?
A. The arrow indicates in this cross-section the way the needle, if the patient was sitting like this (indicating), how far in the needle would be going.
Q. And how far did you say it went in?
A. I always put them in to the point where, about one millimeter beyond where I get, feel a pop of the dura mater or I get a flashback in my needle.
Q. And in terms of millimeters, centimeters, how far would that be?
A. It varies so much in patients.

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Everybody's got a different shaped curvature of their back that I couldn't say. It's not something that I record or I believe anybody really records.
Q. Are we done with those?
A. No. I'm still studying this.
ME. SIMON can you, in fact, demonstrate on that diagram where the tip of the needle was, or if not let him know that also.
A. No, I can't really do it properly on this.
Q. What would you need to do it properly?
A. A cross-section like this that would show different areas of the spine itself within that, the spinal cord.
Q. That's exhibit what, N?
MR. SIMON That's exhibit O.
A. O.
Q. Okay. So a cross-section of Exhibit O is what you would need, correct?
A. Yes, in more detail of the area that's hollow here (indicating).
Q. All right. So that I understand you clearly, is the medication then given via a syringe through that needle?

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A. Yes, sir.
Q. Okay. And how many cc's of medication is given?
A. In this instance it would have been two cc's of medicine, one cc of either medicine.
Q. Do you explain the method of administration of the spinal? In other words, do you explain to the patient it's coming through one of these Whitacre needles?
A. I don't get into the details of which particular brand or style of needle I use unless the patient asks me specifically.
Q. Do you get into the idea that it's given through a needle?
A. Yes, sir.
Q. So you tell the patient that you're going to put a needle in their back?
A. (Witness nods.) And as they're sitting up it's reiterated what I'm doing because they can't see because their back's to me. I'm feeling your back at this point or that you will then get a numbing medicine under the skin first before you get a needle that's going to go back there.
MR. SIMON Doctor, on that answer you nodded your head. In the future when you indicate a response make

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it verbal, say yes because the court reporter has trouble taking down nods of the head.

BY MR. MALIK:

Q. Now, aside from this operation on that day were you involved in any other operations at the same time?

A. The same day or the same time?

Q. Well, first let's go to the same time.

A. No.

Q. What about the same day?

A. I don't know if I had any cases after that case.

Q. Was this the first case of the day

A. It appears like it was, yes, sir.

Q. Is there a log of which cases you would be on that day?

A. I don't know.

Q. If I to what cases you were on that day who would I ask.

A. The recovery room record of which anesthesiologist brought a patient to the recovery room would probably be a good indicator of who did the case.

Q. And what time is indicated on that sheet that you were there, the beginning time?

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A. The start time for anesthesia was 7:45.

Q. Okay. And about how much time prior to 7:45 do you believe

MR. SIMON: If you know.

A. I don't know.

Q. Well t You said you have a habit.

A. A typical day I come in about 7:25 to 7:30.

Q. Okay. Prior to 7:45 what medications or narcotics was Mr. McCue given to take the edge off him for the operation?

A. None that I'm aware of.

Q. Is it your duty to be aware of any medications that might have been given earlier?

A. Yes, sir.

Q. Would the fact that he may have been given medications earlier surprise you?

A. It would, because I would have been notified by the nurses if they gave the patient any medicine to sedate them, and they typically don't.

Q. Could sedation affect the patient's understanding of what you tell them?

A. Absolutely.

MR. MALIK: could we go off the record for a minute?

(Thereupon, there was a brief recess.)

BY MR. MALIK:

Q. Handing you what is going to be marked as Exhibit P. It's called an Outpatient Procedure Care Record from Parma Community General Hospital. Can you take a look at that for me?

MR SIMON Take your ti and look through it.

A. Okay.

Q. Is there an indication in there that there was an IV started on February 1st?

A. Yes, sir.

Q. Okay. And what drugs were given?

A. There were two drugs, Axid and -- this is not my handwriting and this is not my record. Just reading it it says that there was Axid 150 milligrams given it looks like PO, meaning orally, at 7:00 and that there was Zinacef 750 milligrams given IV at 7:40.

Q. Okay. And what is Axid?

A. Axid is a histamine blocker that decreases the amount of acid in the stomach and the amount of gastric juices.

Q. And what is Zinacef?

A. It's an antibiotic.

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Q. i you a physician o -- can I have that back?

A. Yes, sir.

Q Actually, we need to mark that as P , Plaintiffs Exhibit P t the it of Milt P. Midis M was marked for purposes of identification.)

BY MR. MALIK:

Q. Okay. Handing you a physician's order dated 1-26-96 called standing anesthesia pre-op orders. Can you tell me what that is?

A. Okay.

Q. Have you seen that before?

A. This is a general anesthesia pre-op order form.

Q. Have you seen that form before?

A. This specific one?

Q. The form.

A. Oh, the form, yes, sir, I have.

Q. Okay. Did you see that specific one before?

A. I can't recall.

Q. Okay. What does it say to give the patient preoperatively?

A. Okay, it looks like -- and I'm trying to

Page 30

read this person's handwriting -- Valium five milligrams oral one hour pre-op p.r.n. for anxiety or nervousness, and then the next line says, Axid 150 milligrams orally one hour pre-op, and then it has something beside that one that says *G* something 0700.

Q. Was this patient given Valium prior to you seeing him?

A. I don't believe he was.

Q. If in fact he was, should you have been notified?

MR. JEFFERS: could I hear that question back?

BY MR. MALIK:

Q. If in fact he was, should you have been notified?

MR. VADNAL: Objection.

A. I should have been notified, yes, sir.

Q. Okay. And who should have notified you?

A. One of the nursing staff.

Q. What about Dr. Gittinger?

A. No.

Q. Why not?

A. Because he is usually not involved in the anesthesia process.

Q. Okay. Does Dr. Gittinger control any of your actions in the operating room?

A. He influences some of my actions in the operating room.

Q. And what do you mean by that?

A. What I mean by that is some things are done with a mutual understanding. In other words, if there's a position of a patient that I think is not in the patient's best interests hemodynamically or for ventilation of lungs or something like that then I try to find a position that will then satisfy their needs of better surgical access to whatever they're trying to do while I'm looking after the patient's best interests hemodynamically.

Q. In this case was Dr. Gittinger in the operating room when you gave the spinal?

A. I don't know.

MR. GUNNING I'm sorry, could you repeat that answer?

A. I don't know.

Q. Is there a separate physician's attestation sheet that you appeared for the operation other than the documents you have before you?

A. I don't know what an at --

Q. That attests that you performed the procedure, that you gave the anesthesia. Is there a separate f for that at Parma?

A. I'm not really sure what you're talking about.

Q. Oh a : I : it that you have not l out any forms other than the one t' in front of you that indicates you were present for the procedure that was taking place?

A. That's correct.

Q. Who would have been in the operating room at the time you gave the spinal?

A. It would have been -- well, I can -- I don't remember, and I don't note it on my anesthesia record who's in the operating room.

Q. Other than that anesthesia record are there any other records that you fill out, any other pieces of paper with your signature on them or your writing?

A. Sometimes there are.

Q. In this case?

A. In this case?

Q. M-hm.

A. I don't know.

MR. SIMON: In your review of the records from Parma Hospital do you recall anyplace in there that you may have signed off on an order or anything?

A. I don't remember, but there may be something else with my name on it.

Q. Is there anything on this page entitled Perioperative Patient Care Record and Plan that has your signature on it?

A. No, sir.

Q. Okay. So we have no written record, correct, of you explaining the risks, benefits or alternatives of a spinal to Mr. McCue?

A. That's correct.

Q. Can you point me to any documents which indicate prior to 2-1 of '96 that Mr. McCue was scheduled for a spinal?

A. That's a misleading question.

MR. SIMON objection.

BY MR. MALIK:

Q. Can you point me to any documents that show that prior to 2-1-96 Mr. McCue was scheduled for a spinal?

MR. SIMON Answer his question and explain the process.

Q. First of all, are there any other documents that indicate he was scheduled for a spinal, yes or no?

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A. No, there are no other.
Q. All right. Handing you Exhibit G, which is called an anesthesia evaluation, consisting of two pages. Can you tell me if in any of those two pages your signature is on there?
MR. JEFFERS: This is Exhibit which?
MR. SIMON G.
MR. MALIK: G.
MR. JEFFERS: G as in good?
MR. MALM: M-hm.
A. My signature is on page 2.
Q. Okay. So you would have reviewed that document, correct?
A. Yes, sir.
Q. And when would you have reviewed that document?
A. In the minutes preceding giving anesthesia to the patient.
Q. Okay. And who else has signed that document?
A. Dr. Garcia and Martin McCue.
Q. And is there anything on that document which indicates a spinal analgesic was supposed to be given?

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MR. SIMON objection.
He's asked and answered you, the basis of your question.
MR. MALIK: I know, but I'm referring specifically to the exhibit.
A. In this specific exhibit, no.
Q. Okay. Are there any other anesthesia evaluation forms other than that one that you're aware of?
A. No, sir.
Q. Okay. And when you signed off on it what did you sign off for?
A. I signed off for the medicines in the recovery room area. That was the purpose of my signature, because there were orders for several drugs to be given if need be in the recovery area.
Q. Okay, So prior to 7:45, which is approximately the time the operation began, you would have reviewed that document, correct?
A. Right around the time of 7:45, yes, sir.
Q. Okay. Are you aware of the policies and procedures at the hospital regarding informed consent?
A. I'm not aware of a specific policy with regards to my anesthesia department that mention informed concept.

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Q. So then you have not reviewed any written policies regarding informed consent, correct?
A. I may have at some point, but I don't remember.
Q. Where did your knowledge come from about informed consent?
A. It was basically taught to me in residency and medical school.
Q. And where was that at?
A. Medical school was at the Medical College of Virginia and residency was at the Cleveland Clinic.
Q. Okay. And how would it have been taught to you in medical school? Would that have been in a class?
A. No, sir.
Q. Would that have been -- can you explain it to me?
A. There were no specific courses and there were no specific lectures on that subject that I'm aware of. It's a basic principle that one gets permission from patients to perform a procedure on them just like it's a basic principle that one tries to do good to people and not harm. They're fairly basic not specific lectures.
Q. So you did not have any

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course, any lecture materials, any book learning, any videos, any discussions regarding informed consent in medical school correct?
A. None that I can remember from that far back.
Q. And at the Cleveland Clinic?
A. None that I can remember from that far back.
Q. And at Parma Hospital?
A. None that I can recall.
Q. And through your employer?
A. None that I can recall.
Q. And who is your employer?
A. I'm a member of Parma Anesthesia Associates.
Q. Is it routine for anesthesiologists at Parma Anesthesia Associates to give spinal analgesics in this kind of operation?
MR. JEFFERS: object.
MR. SIMON I'm going to object also.
You can answer if you know.
A. Okay. Everybody in our group has different practices, and I am aware that it's routine for my colleagues to give postoperative care --

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postoperative pain analgesic choices and everybody has a different style, and that's -- I can't answer that with a yes or a no.

Q. Well, there aren't really any other choices for postoperative analgesia other than the ones you've talked about today, right?

A. To the best of my knowledge, there aren't.

Q. Okay. Now, is an analgesic anesthesia?

A. No, it's not an anesthetic. Analgesia is the relieving of pain.

Q. Does it come under the classification of anesthetic or anesthesia?

A. Yes, they're closely related to each other.

Q. Now, you're telling me that it was your decision to give the spinal along with Mr. McCue's decision to accept it, correct? That's your testimony today, correct?

A. It was -- I'm going to rephrase that. It was Mr. McCue's decision to accept a spinal anesthetic after I presented him with the several options for analgesia in the postoperative period.

Q. Okay. You don't recall, however, seeing any of the hospital's protocol for the administration of spinal anesthesia though, correct?

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MR. JEFFERS: Objection.

A. Correct.

Q. And are you even aware whether or not the hospital had an anesthesia protocol for spinal analgesics on February 1st, 1996?

A. I have to say that I'm not aware there was a specific protocol with regards to that type of analgesic.

Q. And the room in which the spinal was given was either the operating room or the pre-op area?

A. In this case it was in the operating room.

Q. Okay. Prior to Mr. McCue have you had occasion to give a spinal anesthetic that resulted in a central spinal fluid leak?

MR. JEFFERS: objection.

MR. SIMON: objection.

You can answer.

A. Okay. With a 25 gauge needle in the Whitacre type I have never had nor am I aware of any colleagues who've ever had cerebrospinal fluid leak that's ever caused any symptoms.

Q. Okay. But in giving a spinal analgesic have you ever had occasion to cause -- what did you call it, a cerebrospinal fluid leak?

A. Yes, sir.

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Q. Have you?

MR. JEFFERS: well, I lost the question.

MR. SIMON Could you repeat that?

BY MR. MALIK:

Q. Have you had occasion to cause a cerebrospinal fluid leak?

MR. JEFFERS: Objection.

MR. SIMON: Objection.

Go ahead if you know.

A. Yes, I have. But, like I said, in a different circumstance than this kind.

Q. Now, is this -- is the headache which results from a cerebrospinal fluid leak also known as a postdural puncture headache?

A. That's correct.

Q. Okay. The actual procedure to give the spinal takes how long?

A. In a person of this stature who's healthy, less than five minutes.

Q. Okay. Did you tell Mr. McCue when the onset of a postdural headache could occur?

A. No. I stated before that I typically don't discuss that with patients because it's never

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happened in my practice with the use of that gauge of needle, nor in any of my colleagues that I'm aware of.

Q. Okay. Is it your practice to put important information in the patient's file?

A. Important?

Q. M-hm.

MR. SIMON: objection. Did you say in his file?

BY MR. MALIK:

Q. In the patient's record, medical record.

MR. SIMON: Objection; vague question.

A. Could you rephrase the question?

Q. M-hm. IS it your policy to put important information in the medical record --

MR. SIMON objection.

Q. -- regarding tl patient?

MR. JEFFERS: Objection.

A. I typically put things like doses in the files and I typically put things that are going to guide me in the future management of the patient.

Q. Can you show me in the records where Mr. McCue understood the risk to his spine of the spinal injection?

MR. SIMON: Objection.

Do you understand the question, Doctor, or do you want him to rephrase it?

A. Yes, rephrase it.

Q. Can you show me in the records where Mr. McCue understood the risk to his spine of the spinal injection?

A. There's nothing that's written in there.

Q. Let me see if you agree with the following statements. Do you agree that a physician has a duty to inform the patient of the dangers associated with treatment?

MR. JEFFERS: I'm going to object. It's too generic.

MR. SIMON: I'm going to object, too. I *think* it calls for a legal conclusion.

But if you can, answer.

A. Repeat that.

Q. Do you agree that physicians have a duty to inform patients of dangers associated with treatment?

MR. JEFFERS: objection.

MR. VADNAL: Note my objection.

MR. GUNNING: Me, too.

A. I think dangers that are reasonable, are reasonably, that have a reasonable probability should be explained to the patient.

Q. So you would agree with that statement?

MR. GUNNING: Objection.

A. No, because yours was a vague, generalized question.

Q. I see, okay.

Do you agree that patients should also be informed in non-technical terms of the procedure?

MR. VADNAL: Objection.

MR. GUNNING: objection.

MR. JEFFERS: objection.

MR. SIMON: objection.

You can answer.

A. Are you asking me the physical --

MR. SIMON: Do you want him to repeat it?

A. Yes, repeat it or rephrase it.

Q. Do you agree that patients should also be informed in non-technical terms of the procedure?

A. Yes.

Q. Okay. Do you agree that patients should also be informed of alternatives available to them?

A. Yes, sir.

Q. Do you agree that patients should be informed of the goals that are expected to be achieved?

MR. VADNAL: objection.

MR. GUNNING: objection.

MR. SIMON: Objection.

A. That's a reasonable statement.

Q. Do you agree that patients should be informed of the risks of alternative treatments?

A. Of the common risks and the prevalent risks, yes.

Q. Do you agree that patients should be informed of the risks of no treatment?

MR. JEFFERS: Of what?

MR. MALIK: No treatment.

MR. SIMON: Objection.

MR. GUNNING: Objection.

A. Now, for what -- are you referring -- what type of treatment are you referring to?

Q. I'm referring to the spine on all of these.

A. To the spine, okay. Yes.

Q. You agree that the underlying principle of informed consent is that the patient has the right to self-determination as to what happens with his body, his or her body?

MR. GUNNING: Object

MR. VADNAL: Objection.

MR. SIMON: Object

You can answer.

MR. JEFFERS: Object.

A. It's such a vague question or broad question.

MR. SIMON Do you want to try and rephrase it?

MR. MALIK: NO.

BY MR. MALIK:

Q. Do you agree that the underlying principles of informed consent are that the patient has a right to self-determination of what happens to their body, in this case of what happens to their body in the administration of a spinal analgesic?

A. Yes.

Q. Do you agree that physicians must give their patients the information they need to make an informed decision?

MR. VADNAL: objection.

MR. GUNNING: objection.

MR. SIMON: Objection.

A. I think it's important for a patient to get information with regards to types of treatments so

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that they can make a decision on the type of treatment.
Q. Okay. Do you agree that one of the most important parts of your job as a physician in communicating with your patients is to educate the patient?
MR. GUNNING: objection.
MR. JEFFERS: objection.
MR. SIMON objection.
You can answer.
A. Education seems to be too much of a one-way word, meaning me giving them information. I would like to think of it more as a two-way thing, the patient speaking to me and me speaking to the patient, [illegible]
Q. But the ultimate goal being to have the patient gain an understanding of what is to be, correct?
A. Yes, sir.
Q. Do you recognize the American Medical Association policy on informed consent?
A. I don't know what that document is.
Q. Do you recognize the Ohio State medical board s policy on informed consent?
A. I don't know what their policy is.
Q. Okay. Do you consider informing the

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patient that a cerebrospinal fluid leak could occur to be a material fact in their determination as to whether or not they want the spinal analgesic?
MR. JEFFERS: object.
MR. SIMON: Objection.
MR. GUNNING: Objection.
A. I would say no.
Q. Okay. Do you agree that informed consent is a process not just simply signing of a form?
MR. GUNNING: Objection.
MR. JEFFERS: object.
MR. SIMON objection.
THE WITNESS should I answer the question?
MR. SIMON: Yes, you can.
A. Yes, it's a two-way process.
Q. What information do you believe that a reasonable person would want to know in making an informed decision about a spinal analgesic?
MR. GUNNING: Objection.
MR. SIMON Objection.
A. Well, I've answered that before, but I'll answer it again if you'd like since you asked again. Common side effects and risks that one could reasonably expect.

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Q. Do you consider an injection, a spinal injection an invasive procedure?
A. Yes, sir, I do.
Q. Did Parma Anesthesia Associates have the exclusive right to provide anesthesia services at Parma Hospital?
A. Yes, sir.
Q. And that was on February 1st of '96, correct?
A. Yes, sir.
Q. How many anesthesiologists are there or were there on February 1st?
A. I believe there were eight at the time.
Q. Okay. *Are* you considered a staff physician there?
MR. JEFFERS: A what, please?
MR. MALIK. Staff.
A. I'm on the staff of the hospital as a physician and I'm a member of the anesthesia group.
Q. And on February 1st of 1996 what would you have been wearing when you did this procedure?
A. I would have had scrub pants and scrub shirt, typical OR garb. I would have had one of the various sterile hats -- not sterile hats, operating room caps on, and I would have been wearing a mask for

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the greater part of the time.
Q. Okay. So now am I correct in understanding that these kinds of spinals are given in these kinds of procedures, correct? Is that correct?
A. Yes.
Q. Okay. So basically there is a predetermined plan that the giving of a spinal could occur on the date of the surgery, correct?
MR. SIMON objection as to form.
A. That's not correct.
Q. Okay. Mr. McCue came in on January 26th of 1996 to discuss the anesthesia , correct?
A. That's correct.
Q. At that time did Parma Anesthesia Associates or the hospital where you worked give spinal analgesics for these kinds of operations?
A. Not for the operation, for the postoperative pain relief.
Q. Okay. That was a common practice in that facility, correct?
A. Yes.
Q. Okay. Did you become aware that Mr. McCue developed a cerebrospinal fluid leak?
MR. JEFFERS: Objection.

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MR. SIMON objection.
MR. JEFFERS: TO the assumption that he ever did.
MR. GU[illegible] Objection.
A. No.
Q. Okay. After this operation did you ever see Mr. McCue?
A. Never.
Q. We can agree at some point Dr. Gittinger came in to do the surgery, correct?
A. Yes, sir.
Q. But you don't recall when, correct?
A. No, sir.
Q. On February 1st of 1996 would you please tell me your official title?
A. Milton P. Midis, M.D.
Q. And you considered yourself a treating physician of Mr. McCue, correct?
A. Yes, sir.
Q. Are there any journals that you consider authoritative in the field of anesthesiology?
MR. JEFFERS: objection.
MR. SIMON objection.
MR. GUNNING: Objection.
A. There are lots of journals.

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Q. Can you name some?
MR. JEFFERS: I want to object.
MR. SIMON objection.
MR. JEFFERS: This may be inferential that he's answering the question before when he responds to this one.
MR. SIMON I concur. I just add that he never acknowledged that any of these are authoritative, and the way the question is reading it may be inferred.
MR. MALM: well, I can clarify that, that's real simple.
BY MR. MALIK:
Q. Are there any journals or books that you consider authoritative in the field of anesthesiology?
MR. JEFFERS: objection.
MR. SIMON: objection.
You can answer.
A. There are books -- authoritative is a bad word for that. There are books that are guidelines or suggestions of different people's practices of anesthesia.

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Q. Are there any books or journals that you consider accurate in the field of anesthesiology?
MR. SIMON same objection.
MR. JEFFERS: Objection.
A. No.
Q. No?
A. No.
MR. MALIK: I think I'm done. Let me double-check.
(Thereupon, Plaintiffs' Exhibit Q to the deposition of Milton P. Midis, M.D., was marked for purposes of identification.)
BY MR. MALIK:
Q. Do you know what the complication rates are for spinal injections resulting in headaches?
MR. JEFFERS: objection because it's not related to the type of needle used in this particular case versus other gauge needles, et cetera, and procedures.
MR. SIMON I join in the objection.
MR. GUNNING. Me, too.
A. With this type of needle in the hands of private practicing physicians it's essentially zero.

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Q. Okay. Did you tell Martin McCue who your employer was?
A. No.
Q. How were you assigned to Martin McCue's case?
A. I was randomly assigned, as are all the anesthesia cases.
Q. And when did that occur?
A. Either the evening before or the morning of the procedure.
Q. So you come into the hospital on the morning of the operation and where do you go to see where you're scheduled?
A. There are several schedules posted throughout the operating rooms.
Q. Is there any way that the patient would know that you're employed by Parma Anesthesia Associates as opposed to the hospital?
MR. JEFFERS: Objection.
MR. SIMON: Objection.
A. I don't know.
Q. Would five milligrams of Valium affect Martin McCue's mental function?
MR. JEFFERS: objection.
MR. SIMON Objection.

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MR. JEFFERS: There's no indication anywhere in the record that he was ever administered that.

A. It may affect his mental judgment.

Q. As a member of Parma's medical staff are you required to follow the hospital policies, procedures and protocols?

A. Yes.

Q. You agree that a patient cannot make an informed decision without a complete explanation of the risks of a procedure?

MR. SIMON: objection.

MR. GUNNING: Objection.

A. I don't agree with that statement.

Q. Do you have an obligation to explain the potential for permanent or serious complications of a procedure?

MR. JEFFERS: Objection.

Orally --

BY MR. MALIK:

Q. Although the risk is remote.

MR. SIMON: objection.

MR. GUNNING. objection.

MR. JEFFERS: Objection.

A. I don't have --

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THE WITNESS: should I go ahead and answer?

MR. SIMON yes, go ahead.

A. I'm not aware that any physician that I know of in practice, either in anesthesia or in surgery or internal medicine, spells out something no matter how infinitesimal or remote in obtaining consent for procedures.

Q. [illegible] the s[illegible] and symptoms of a cerebrospinal fluid leak?

A. The signs and symptoms are usually a posterior headache which is almost completely relieved by laying down, can be aggravated by sitting up or standing. This is all things that are possible, not a hundred percent. Patient could have nuchal rigidity, meaning stiffness in the neck, caused by pain with movement of the head, possibly photophobia, and the timing is also suggestive. Usually it's the day following a procedure and is usually self-terminated by day two or three.

Q. If it' not self-terminated by day two or three [illegible] is e[illegible]ur called to remedy the situation?

A. Typically a conservative course of therapy is suggested to a patient; however, a more aggressive approach is also presented to the patient.

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Q. What's the conservative course of therapy?

A. The conservative course of therapy usually involves bedrest and hydration, either intravenously or taking lots of fluids, caffeine has been shown to be helpful for some patients, and pain relievers if they need it.

Q. And what's the aggressive form of therapy?

A. The aggressive form of therapy would be an epidural blood patch.

Q. And have you performed epidural blood patches before?

A. Yes, sir.

Q. What's the procedure in doing that?

A. Is basically having a patient in a sitting position and a volume of blood is withdrawn usually from the antecubital space in the arm sterilely, and then once the epidural space is found in the back it's administered.

Q. Are you familiar with the level of severity that these headaches can reach?

A. Yes.

Q. And in its -- can you give me a range of severity?

A. Usually the day of surgery the patient if

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they're going to be a severe headache, which you usually know by day two, by day one they begin complaining in a -- now, this is all maybes, okay, this is not an absolute -- in a range of one to ten. They may have a pain in the range of three out of ten on the first day if it's going to be a very severe headache the next day.

Q. But you're telling me that on a scale of one to [illegible]n the s[illegible]rity of the headaches can reach ten?

A. *Yes,* can.

Q. [illegible] And [illegible] would be [illegible] symptoms of a ten headache?

A. The same things that I told you about before. It would just be a subjective thing just based on the patient's subjective description. Pain is not an [illegible] it's a [illegible]

Q. So it could be worse for some [illegible]ti[illegible]t than others is what you're telling me?

A. *Yes.*

Q. And it [illegible]aries with the individual?

MR [illegible]ION: [illegible]bjection.

A. [illegible]

MR. MALIK: I [illegible]nt to thank you [illegible]octor.

MR. JEFFERS: I have some

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questions.
(Thereupon, there was a brief recess.)
- - -
CROSS-EXAMINATION
BY MR. JEFFERS:
Q. In administering a spinal analgesic such as was done here I think you indicated the patient sits in an upright position, correct?
A. Yes, sir.
Q. And in getting that patient to an upright position I take it you have explained to him why he's getting in that position, correct?
A. Yes, sir. Now, that's after a discussion --
Q. Correct.
A. -- with the patient about that procedure.
Q. But you work him through describing each event as it's about to occur because his back's to you?
A. Yes, and it allays anxiety. I don't like patients jumping, nor does any physician, so I tend to talk them through various things that I'm doing.
Q. In terms of the area, after you sterilize it one of the next things you do is you use a local anesthetic in the area where you're going to insert the needle, correct?

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A. Yes, sir.
Q. And in giving the patient a local anesthetic you use a needle, correct?
A. Yes, sir.
Q. This needle does not enter the spinal canal in any manner, shape or form, correct?
A. No, sir.
Q. And notwithstanding the fact that it's to give a local, it's a fact, is it not, that the patient is going to feel the initial pinprick of the needle, correct?
A. Yes, sir.
Q. And while you're doing this or immediately before you're doing it you've also described that you're inserting a needle, correct?
A. And that they should expect a pinch.
Q. Right. And isn't it a fact that you never ever, ever have inserted a needle for a local without telling a patient that you were doing such, correct?
MR. MALIK: Objection.
A. I have, and the only exception to that would be patients who are obtunded, in which case I've discussed it with the family members, nursing home patients who are unable to give consent.
Q. I'm sorry, I hadn't thought about that one.
But in a patient who is sitting there and discussing things with you?
A. Yes, sir, that's correct.
Q. So that there's no ands or buts that this patient would have known that he has originally been stuck by a needle prior to the time that you inserted the needle for the local analgesia, correct?
A. — no my would not discuss the giving of various modalities like that to a patient.
Q. Now, a patient would obviously have to cooperate with you in order to place the needle for the spinal, correct?
A. They would have to sit up.
Q. Pardon me?
A. In this case it was a sitting position, the patient would have had to sit up.
Q. And once the patient had the initial needle for the local, if that patient had desired that you no longer proceed you would not have, would you have?
A. That's correct.
Q. Okay/ The subject of Valium, would you look through -- do you have the chart in front of you?

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A. I have a copy.
Q. Have you reviewed the chart, or just those areas dealing with anesthesia?
A. I concentrated on the areas just dealing with anesthesia and looked over briefly the other parts but didn't study them thoroughly.
Q. In whatever search you may have made do you find that this patient was ever administered Valium?
A. No, sir.
Q. P.r.n. means what, please?
A. Means as needed.
Q. So when a doctor writes an order administer X milligrams of Valium, whatever, p.r.n. the doctor is saying?
A. If needed.
Q. If needed. And that is a decision or determination generally made by the patient saying I need it correct?
A. Correct.
MR. JEFFERS: I don't have any other questions. Thank you very much.
- - -
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///

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CROSS-EXAMINATION
BY MR. VADNAL:
Q. Doctor, I represent Dr. Gittinger in this lawsuit.
What type of anesthesia was used for the actual surgical procedure itself?
A. General anesthetic.
Q. And the decision to use a general was made by the patient after you had a discussion with the patient?
A. Yes, sir.
Q. And the decision to use a general, Dr. Gittinger himself did not play any role in that decision?
A. No, sir.
Q. Okay. And then there are questions of course pertaining to this postoperative injection that was provided. And again, the decision to receive that is made by the patient after you discuss various options with the patient?
A. Yes, sir.
Q. And again, Dr. Gittinger did not have any involvement in that as well?
A. That's correct.
Q. You were asked and you made comment that

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from time to time Dr. Gittinger can influence your actions in the operating room. Was there anything that Dr. Gittinger did in this particular case that influenced any of your actions with respect to giving the actual injection itself?
A. None whatsoever.
MR. **VADNAL:** Thank you. I have no other questions.
MR. **GUNNING:** None for me.
MR. MALM: I'm all done.
THE VIDEOGRAPHER: Doctor, you have the right to view the videotape and/or read the transcript, or you can waive such rights.
THE WITNESS: I'll let my lawyer answer that question.
MR. **SIMON** we're going to request that the doctor be provided copies of both the videotape and the written transcription for his review.
Can we get a waiver of the seven days, David?
MR. MALIK: sure.
- - -
(DEPOSITION CONCLUDED)

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- - -

MILTON P. MIDIS, M.D (Date)

- - -

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) CERTIFICATE
STATE **OF OHIO,**
COUNTY OF CUYAHOGA.) *SS:*
I, LAUREN I. **ZIGMONT-MILLER,** Registered Professional Reporter and Notary Public within and for the State of **Ohio,** duly commissioned **and** qualified, do hereby certify that the within-named witness, **MILTON** P. MIDIS, M.D., was by me first duly **sworn to** tell the truth, the whole truth and **nothing** but **the truth** in the cause aforesaid; that the testimony then given by him **was** reduced to **stenotypy** in the presence **of** said witness, and **afterwards** transcribed by me through the process **of** computer-aided transcription, and that the foregoing is **a** true and correct transcript of **the** testimony so given by him **as** aforesaid.
I do further certify that **this** deposition was taken at the time and place in the foregoing caption specified.
I do further certify that I **am** not a relative, employee or attorney of either party, or otherwise interested in the event of **this** action.
IN **WITNESS WHEREOF,** I have hereunto **set** my hand and affixed my seal of office at Cleveland, **Ohio,** on this 17th day of **December 1998.**

Lauren I. Zigmont-Miller, RPR and Notary
Notary Public in and for the **State** of Ohio.
My commission expires December **3,2000.**

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